Bundle Quality, Patient Experience and Safety Committee 9 May 2025

Agenda attachments

ITEM 00 Quest Agenda 9 May 2025

0 09:30 - OPENING ITEMS

1 Chair's Welcome, Apols and Quorum

2 Declarations of Interest

ITEM 02 Board Member Register of Interests - Updated 26 March 2025

3 Minutes of the last meeting

3.1 Minutes of the Last Meeting: 4 February 2025

3.2 Committee Highlight Report-February2025

ITEM 03.1 2025-02-04 Draft QUEST OPEN MINUTES1

ITEM 03.2 Quest Committee Highlight Report February 2025

4 Action Log & Matters Arising

ITEM 04 Action Log

5 09:40 - Ops Report Q4 24/25

Annexes 5.1a, 5.1b and 5.1c are supplementary for information and are available in the ibabs reading room and upon request.

ITEM 05 Operations Quarterly Report Q4 2024-2025 - FINAL

ITEM 05.1 Quarterly Sub-Report March 2025 - QS Day Outcomes FINAL

5.1 FOR APPROVAL, ASSURANCE AND DISCUSSION

6 09:55 - Patient Story

6.1 Update on previous Patient/ Staff Story (Hearing Loss patient and the PTR Staff)

7 10:25 - Strategic Quality Plan 2025-28 (To include EQIA)

ITEM 07 Executive Summary Strategic Quality Plan 2025-2028 v1.1

ITEM 07.1 ANNEX 2 - DRAFT Strategic Quality Plan 2025-2028

ITEM 07.2 ANNEX 3 Draft Strategic Quality Plan Implementation

ITEM 07.3 ANNEX 4 - DRAFT Quality Plan EQIA

8 10:45 - Quality Impact Assessment - Urgent care response Service

ITEM 08 UCR QIA V0.5 April CQGG

8.1 10:55 - COMFORT BREAK

9 11:10 - Putting Things Right Report - Q3 and Q4 2024/25

ITEM 09 Putting Things Right Report

ITEM 09.1 Putting Things Right Report - Annex 2

ITEM 09.2 Putting Things Right Report - Annex 3

ITEM 09.3 Putting Things Right Report - Annex 4

ITEM 09.4 Putting Things Right Report - Annex 5

10 11:30 - Monthly Integrated Quality Performance Report

ITEM 10 MIQPR SBAR Quest FebMar25

ITEM 10.1 MIQPR QUEST February25 March25

11 11:40 - Medicines Management Assurance Report (including audit compliance report)

ITEM 11 MMAR SBAR QuEST

ITEM 11.1 Medicines Management Assurance Report - Annual Summary 2024-2025 v2

ITEM 11.2 Appendix 1 Penthrox Administration April 2024 - March 2025

ITEM 11.3 Appendix 2 WAST Anti-Microbial report 2024

12 11:55 - Internal Audit Report: Roll out of Penthrox

ITEM 12 Internal Audit Report Feedback from ARAC - Rollout of Penthrox

13 12:05 - Learning from Deaths (Mortality Reviews) Update report

ITEM 13 Learning from Deaths (Mortality Reviews) Report Quarter 3 and 4, October - March 2024-25

14 12:20 - Patient Experience and Community Involvement Biannual Report

ITEM 14 PECI Bi-Annual Report October 2024 - March 2025

ITEM 14.1 PECI Bi-Annual Report October 2024 - March 2025 Annex 2

14.1 12:35 - LUNCH

15 13:15 - Update on Health Inequalities Maturity Matrix and Population Health Plan

ITEM 15 Update on Health Inequalities Maturity Matrix and Population Health Plan

16 13:30 - Focus on Clinical Indicator - Return of Spontaneous Circulation
ITEM 16 QuEST Focus on ROSC v2

17 13:50 - Clinical Audit Plan and Action Tracker Q4 (update) 2024/25
ITEM 17 QuEST Clinical Audit Plan & Action Tracker Q4 2024-25 update
ITEM 17.1 QuEST Clinical Audit Plan Q4 2024 - 25

18 14:05 - Audit Tracker - March 2025 (2024/25 Q4)
ITEM 18 SBAR Audit Tracker to Committees - 24025 Q4 Reporting (Jan-Mar25) - QuEST 090525

19 14:10 - Feedback from Effectiveness Review, Committee Cycle of Business Monitoring Report and 2025/26 Priorities
ITEM 19 Effectiveness Review Follow Up, Committee Cycle of Business Monitoring Report and 2025-26 Priorities
ITEM 19.1 Annex 1 - QuEST Menti Results 04022025
ITEM 19.2 Annex 2 - Changes to board and committee operating arrangements 2025-26
ITEM 19.3 QuEST Cycle of Business monitoring report
ITEM 19.3a Cycle of Business notes

20 14:25 - Risk Management and Board Assurance Framework
ITEM 20 Executive Summary Risk Management Report QuEST 090525

20.1 CONSENT ITEMS

21 Duty of Quality Implementation Plan Closure Report
ITEM 21 Duty of Quality Implementation Plan

22 Health Inspectorate Wales Report
ITEM 22 Health Inspectorate Wales Report

23 Llais Report - Getting Urgent and Emergency Healthcare in Welsh Hospitals
ITEM 23 Llais Report
ITEM 23.1 Llais Report CYM 1 (1)

23.1 CLOSING ITEMS

24 14:45 - Key Messages for the Board

25 Reflections and Summary of Decisions/Actions

26 Any Other Business

27 Date & Time of the Next Meeting: 13 June (Extraordinary) and 5 August 2025

Length of Meeting: 05:25		Agenda Status:	[OPEN] QUEST COMMITTEE - 9 May 2025						Deadline for Papers: 30 April 2025
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	3.1 Minutes of the Last Meeting: 4 February 2025 3.2 Committee Highlight Report-February2025	Paper	Approval	Standing	n/a	Chair	
		4	Action Log & Matters Arising	Paper	Discussion	Standing	n/a	Chair	
09:40	00:15	5	Ops Report Q4 24/25 Annexes 5.1a, 5.1b and 5.1c are supplementary and for information only - Located in ibabs reading room	Paper	Information	CoB	Operations	Lee Brooks	Judith Bryce Toni-Marie Norman
			FOR APPROVAL, ASSURANCE AND DISCUSSION						
09:55	00:30	6	Patient Story - Dylan's Story - it concerns the death of Dylan (a child) of sepsis told by his parents. 6.1 Update on previous Patient/ Staff Story (Hearing Loss patient and the PTR Staff)	Video	Discussion	CoB	Quality	Liam Williams	Leanne Hawker, Alison Kelly
10:25	00:20	7	Strategic Quality Plan 2025-28 [To include Equality Impact Assessment]	Paper	Endorsement	Forward Planner	Quality	Liam Williams	Alison Kelly, Kate Blackmore
10:45	00:10	8	Quality Impact Assessment - Urgent care response Service	Paper	Assurance	Ad Hoc	Audit Wales	Liam Williams	Alison Kelly
10:55	00:15		COMFORT BREAK						
11:10	00:20	9	Putting Things Right Report - Q4 2024/25 [To include the annual review of metrics] 9.1 Annual Welsh Risk Pool Concerns Assessment 9.2 Section 23 Public Service Ombudsman for Wales reports	Paper	Assurance	CoB	Quality	Liam Williams	Claire Appleton Wendy Herbert Alison Kelly
11:30	00:20	10	Monthly Integrated Quality Performance Report 10.1 Annual review of metrics (in respect of the committee)	Paper	Assurance	CoB	SPP	Rachel Marsh	Hugh Bennett, Mark Thomas Mel O'Connor
11:50	00:15	11	Medicines Management Assurance Report (including audit compliance report)	Paper	Assurance	CoB	Clinical	Andy Swinburn	Jen Lloyd
12:05	00:10	12	Internal Audit Report: Roll out of Penthrox	Paper	Assurance	CoB	Clinical	Andy Swinburn	Jonathan Chippendale
12:15	00:15	13	Learning from Deaths (Mortality Reviews) Report - Quarters 3 and 4 October 2024 - March 2025 [To include recommendations from the Audit Wales Follow Up to the Quality Governance Review]	Paper	Assurance	CoB	Quality	Liam Williams	Alison Kelly
12:30	00:15	14	Patient Experience and Community Involvement Biannual Report (October 2024 - March 2025)	Paper	Assurance	CoB	Quality	Liam Williams	Leanne Hawker, Alison Kelly
12:45	00:40		LUNCH						
13:25	00:15	15	Update on Health Inequalities Maturity Matrix and Population Health Plan	Paper	Assurance	CoB	Quality	Liam Williams	Alison Kelly
13:40	00:20	16	Focus on Clinical Indicator - Return of Spontaneous Circulation	Presentation	Assurance	Forward Planner	Clinical	Penelope Creswell-Jones Andy Swinburn	Jonathan Chippendale
14:00	00:15	17	Clinical Audit Plan and Action Tracker Q4 (update) 2024/25	Paper	Assurance	CoB	Clinical	Andy Swinburn	
14:15	00:05	18	Audit Tracker Q4 2024/25	Paper	Assurance	CoB	Gov	Trish Mills	Lisa Trounce
14:20	00:15	19	Feedback from Effectiveness Review, Committee Cycle of Business Monitoring Report and 2025/26 Priorities	Paper	Approval	CoB	Gov	Trish Mills	Alex Payne
14:35	00:10	20	Risk Management and Board Assurance Framework [To include update on 'manage and monitor' regarding risks 223/224]	Paper	Assurance	CoB	Gov	Julie Boalch	n/a
			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.						
14:45		21	Duty of Quality Implementation Plan Closure Report	Paper	Information	Forward Planner	Quality	Liam Williams	Alison Kelly
	00:00	22	Health Inspectorate Wales Report	Paper	Information	CoB	Quality	Liam Williams	Alison Kelly
		23	Llais Report - Getting Urgent and Emergency Healthcare in Welsh Hospitals	Paper	Information	CoB	Quality	Liam Williams	Alison Kelly
			CLOSING ITEMS						
14:45	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: 13 June (Extraordinary) and 5 August 2025	Verbal	Information	Standing	n/a	Chair	n/a
14:55	**05:25**		**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
BEAUMONT-WOOD, Rhiannon	**Non-Executive Director** * Member of the Remuneration Committee * Member of the the Audit, Risk and Assurance Committee * Member of the Quality, Patient Experience and Safety Committee	Dorset Integrated Care Board (NHS Dorset), Non-Executive Director	Financial Interest	May 2023		
		Nursing and Midwifery Council (NMC), Designated Council Member for Wales	Financial Interest	June 2024		
		RBW Executive and Professional Coaching Ltd, Company Director (Company No 14938585) and Shareholder	Financial Interest	June 2023		
		Currently on coaching framework with Health Education and Improvement Wales	Financial Interest	June 2024		
		Registered Nurse (NMC)	Non-Financial Professional	January 1995		
		Registered Specialist Community Public Health Nurse	Non-Financial Professional	September 1996		
		Member of the Royal College of Nursing	Non-Financial Professional	2007		
BEESLEE, Jayne	**Non-Executive Director** * Chair of the Finance and Performance Committee * Member of the Remuneration Committee * Member of the Academic Partnership 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, Risk and Assurance Committee * Chair of the Charity 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	31 October 2024	
		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 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 (Barqoed) 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		
HUTCHINGS, Hayley	**Non-Executive Director** * Member of the Remuneration Committee * Member of the Academic Partnership Committee * Member of the People and Culture Committee	Employed at Swansea University, Professor of Health Services Research	Financial Interest	17 June 1995		
HITCHON, Estelle	**Director of Partnerships and Engagement**	Member of Academi Wales Expert Panel	Position in Charity or Voluntary Organisation	15 July 2024		
		Independent Governor (Non-Executive Director), Coleg Sir Gar/Coleg Ceredigion	Non-Financial Personal	01 January 2025		

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 the People and Culture Committee * Member of the Charity 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		
		Chairperson – Association of Ambulance Chief Executives (AACE)	Non-Financial Professional	September 2024		
		Company Director of the Association of Ambulance Chief Executives (AACE), Co No. (07761209)	Directorships	September 2024		
		Officer of the Order of St John	Any Other Interest	January 2024		
		Member of the Order of St John	Any Other Interest	2009	2024	
KNEESHAW, Carl	**Director of People**	Chartered Fellow of Chartered Institute of Personnel and Development	Personal or Departmental Sponsorship	April 2020		
		Fellow of Institute of Leadership	Personal or Departmental Sponsorship	October 2020		
		Safeguarding Lead for local outreach charity, Brunstad Christian Church – Huntworth, Bridgwater, Somerset	Position in Charity or Voluntary Organisation	September 2018		
LEWIS, Angela	**Director of Culture Change**	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	05 November 2024	
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 UNIVERSITY NHS TRUST

MINUTES OF THE OPEN SESSION OF THE MEETING OF THE QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE HELD ON 4 FEBRUARY 2025 VIA TEAMS

Meeting started at 09:30

PRESENT:

Bethan Evans	Non-Executive Director
Ceri Jackson	Non-Executive Director and Vice Chair of the Board
Rhiannon Beaumont-Wood	Non-Executive Director

IN ATTENDANCE:

Claire Appleton	Assistant Director of Putting Things Right (Left after item 12/25)
Kate Blackmore	Assistant Director of Quality Governance (Left after Item 12/25)
Julie Boalch	Assistant Director of Corporate Governance and Risk
Lee Brooks	Executive Director of Operations (Left after item 12/25)
Jonathan Chippendale	Consultant Paramedic
Kathryn Cobley	Head of Inclusion and Engagement (Item 4/25 only)
Penny Durrant	Deputy Director of Nursing, Quality and Governance
Leanne Hawker	Head of Patient Experience & Community Involvement (Left after Item 9/25 and rejoined at 16/25)
Wendy Herbert	Deputy Director of Quality and Nursing
Fflur Jones	Performance Auditor, Audit Wales (joined at item 5/25, left after 12/25)
Geraint Jones	Healthcare Inspectorate Wales (Left during item 13/25)
Alison Kelly	Business and Quality Manager
Osian Lloyd	Head of Internal Audit, NWSSP (Left after Item 12/25)
Mark Marsden	Trade Union Partner
Rachel Marsh	Executive Director of Strategy, Planning and Performance (Left after item 12/25)
Trish Mills	Director of Corporate Governance/ Board Secretary
Steve Owen	Corporate Governance Officer
Hugh Parry	Trade Union Partner (Left during item 8/25)
Alex Payne	Corporate Governance Manager
Jonny Sammut	Director of Digital Services
Andy Swinburn	Executive Director of Paramedicine (Left after Item 12/25)
Liam Williams	Executive Director of Quality and Nursing

OBSERVERS:

Maxine Evans	Joint Commissioning Committee (JCC) - Risk Manager (Left after item 12/25)
Emma Gracia-Young	Investigating Supervising Officer (Left after Item 12/25)
Michelle Kennedy	Deputy Director of Remote Clinical Care
Jacqueline Maunder	JCC - Committee Secretary & Associate Director of Corporate Services (Left after Item 12/25)
Charlotte Walker	Older People Improvement Lead (Left after Item 12/25)

APOLOGIES:

Henry Garrard	Trade Union Partner
Angela Mutlow	Director of Operations Llais

01/25 PROCEDURAL MATTERS

The Chair extended a warm welcome to everyone advising that the meeting was being recorded. Apologies were noted from Henry Garrard and Angela Mutlow.

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 5 November 2024 were confirmed as a correct record.

Chair's Action
Approval of the High Intensity User Policy; The request was for the approval of the updated High Intensity User Policy v1.13. This request was made in the interests of time and with a desire to seek approval for implementation as soon as possible (prior to the next meeting of the Committee in early February 2025). The Committee were asked to ratify the Chair's action.

Action Log
The action log was considered:

Action 51/24: *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*. It was suggested that this action was closed and an update brought back at a future date. It was clear that no progress has been made, and a definitive decision was unlikely to be provided imminently. It was agreed that this action was closed.

Action 68/24: Putting Things Right Report Quarter 2, July - September 2024. *The Committee asked that relevant colleagues consider the structure of the Putting Things Right Report and what the Committee needs to focus on. This should be considered for the next report.* Liam Wiliams advised that the report had been updated, and it was agreed that the action was closed.

Committee AAA report dated 5 November 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 5 November 2024.

RESOLVED: That

(1) Apologies were recorded for Henry Garrard and Angela Mutlow.
(2) The Minutes of the Open meeting held on 5 November 2024 were confirmed as a correct record.
(3) The Committee ratified the decision made by Chair's Action to approve the High Intensity User Policy. The item of business was issued via email on 12 December 2024 and approved as requested. The confirmation of the decision was confirmed via email on 18 December 2024.
(4) Consideration was given to the Action Log and the AAA report as described above.

02/25 OPERATIONS DIRECTORATE QUARTERLY REPORT – 2024/25 Q3

Lee Brooks presented the report and drew the Committee's attention to the following:

1. Manchester Arena Inquiry and Grenfell Fire Inquiry: There was good progress on these inquiries and expressed optimism about starting the scrutiny process with commissioners soon.

2. Powys Major Incident and December Critical Incident: The Committee were updated on the Powys major incident and the December critical incident, highlighting the challenges faced, including high call volumes and extended handover delays at Emergency Departments (ED). He mentioned that debriefs for these incidents were either completed or will follow.

3. Critical Incident Response: Details were provided on the response to the critical incident, including command arrangements and proactive media engagement, which helped manage the situation. He noted that the critical incident debrief will follow as normal.

   Mental Health Response Vehicle (MHRV): There were some good initial results from the MHRV which was introduced in November, noting there were encouraging outcomes.

4. Clinical Model Transformation: Lee Brooks highlighted the role of integrated care, particularly the care planning desk and the CPSS winter desk, in managing patient care and reducing the need for ED visits.

5. Welsh Call Answer Rate: The Welsh call answer rate in 111 services has improved, emphasising the team's efforts to improve overall performance.

Red Breathing Problem: There had been an increase in red breathing problems, particularly in the 06 and E01 determinant codes. Further analysis was undertaken which revealed more red activity originating from 111 calls compared to 999 calls. This was unusual and prompted further investigation. Lee Brooks explained that the team implemented a clinical validation to ensure it was appropriate to pass the call to 999 for an emergency response. This process led to a reduction in red activity moving from 111 to 999 for breathing problems in the 0-4 age group, indicating that these calls could be effectively managed within the 111 service. He highlighted the need to review the trigger words used in the call handling systems and the hand-off mechanism from a 111 call handler to a 999 call handler to address potential over-triaging

Rhiannon Beaumont-Wood acknowledged the importance of continuing with the clinical validation role or a similar model, particularly for paediatric cases, as children can become very sick quickly. She emphasised the need to keep a close eye on these cases to ensure safety. Lee Brooks confirmed that the clinical validation process was being assessed, with a paper expected soon to discuss the synergies between the call handling systems used in 111 and 999 process.

Liam Williams highlighted that the Trust has updated the call handling system to increase the number of questions that would require a higher priority response, particularly for sepsis. These changes were validated through external peer review and an international review. Liam asked the Committee to note the addition of a children's Nurse and a Physiotherapist as Advanced Clinical Practitioners (ACPs) to strengthen specialist knowledge within the Trust. He also mentioned the involvement of a Specialist Registrar (SPR) from Public Health Wales (PHW) to improve understanding and data flow between community-acquired infections and urgent emergency demand.

Rhiannon Beaumont-Wood inquired about the additional impact or collaboration from partners when the major incident was declared, asking if it was effective in terms of getting other stakeholders on board to help manage the challenging situation. Lee Brooks explained there will be a debrief process, which was not yet complete, and part of that will consider the impact of the collaboration.

Ceri Jackson asked for an update on the Cymru High Acuity Response Unit (CHARU) rollout, emphasising its importance for managing the most serious calls. Lee Brooks explained that it was moving in a positive direction with the Unit Hours Production (UHP) on CHARU, especially with hitting 90% on a weekly basis.

RESOLVED: That the report was received.

03/25 COMMITTEE EFFECTIVENESS REVIEW

Trish Mills provided a slide show on the Committee Effectiveness Review and drew attention to the following area of consideration within a committee effectiveness review.

- Broadly the idea of the Committee Effectiveness review was to consider the purpose and delegated remit of the Committee, the reporting and assurance and the use of Mentimeter for colleagues to provide ideas and comments.

- Aligning our Purpose: The aim was to ensure that Quest's responsibilities and activities were closely aligned with Health and Care Quality Standards, as well as long-term objectives for delivering excellence. This was a crucial step in maintaining a high level of quality, patient experience, effectiveness, and safety.

- Committee Delegated Remit and Reporting: This considered how to enhance the oversight of strategic direction and delivery within committees, especially given the long-term nature of strategic plans. These could be annual or biannual updates that provide a snapshot of how the plans were progressing. This ensured continuous monitoring without waiting for the full plan to be completed.

- Develop a system where strategic updates were integrated into regular committee reports. This could involve a brief section in each report dedicated to strategic progress, ensuring it remained a consistent part of the discussion.

Trish Mills added that each meeting could have a thematic focus on different aspects of the strategic plan which can assist in the flow. Going forward, workshops or sessions dedicated to envisioning what success looks like in 2028 would help clarify long-term objectives and ensure everyone was aligned on what "good" looks like.

It was suggested that the Quality and Performance Management Framework (QPMF) might better sit with this Committee rather than the Finance and Performance Committee. However, that framework is focused on floor to board quality and performance and is suited to the remit of the latter committee. Issues related to quality that arise could be referred to this committee.

Members noted the need for more frequent reporting on mental health legislation and infection prevention and control (IPC). Liam Williams explained that bringing together segmented services like Mental Health Response Vehicle (MHRV) and remote care into a cohesive mental health service could enhance coordination and response.

The Committee considered adding specific references to evidence-based practice in the Terms of Reference (ToR). The importance of robust data-driven decision-making was also emphasised by Rhiannon Beaumont-Wood.

Liam Williams highlighted the challenge of balancing high aspirations with the reality of external influences that impact the ability to deliver the desired quality of care, and how that can be reflected in the ToRs.

There was a discussion on whether to rename the Citizen Voice and Patient Experience section of the terms of reference to "Person-Centred Care" to better reflect a holistic approach, which was agreed. The need to include population health understanding and continuous engagement in service design in reporting was also highlighted.

Rachel Marsh highlighted the importance of leveraging public engagement to inform and improve the Trust's core service model. This was a crucial aspect of ensuring that services were designed to meet the needs of the community effectively.

Governance:

A comprehensive plan was in place for focusing on the Strategic Board Assurance Framework (BAF) in 2025/26, with a clear link to strategic direction and risk management. There was a robust structure in place for the reporting of the Monthly Integrated Quality Performance report (MIQPR) and Putting Things Right (PTR) Reports. Referencing the Duty of Candour report within the PTR report enabled the reporting process to be more streamlined. There was regular reviewing and refining of the reporting processes, which will help ensure they remained effective and aligned with the strategic goals.

Mentimeter Engagement: The Committee used Mentimeter to gather feedback on the effectiveness review, with participants contributing their thoughts on various aspects of the Committee's work. Trish Mills thanked everyone for their engagement and for their comments, noting that their comments will be circulated in due course. It was also noted that the changes to the ToR and Annual Report will also be circulated through a Chair's' Action as the committee would not have an opportunity to meet again before the Audit, Risk and Assurance Committee on 1 May where these documents would be presented.

RESOLVED:

1. **Members reviewed the committee's terms of reference and changes as agreed will be circulated for email approval by Chair's Action. The re-ordering of the terms of reference to align to the Health and Care Quality Standards was agreed for 2025/26.**
2. **Members reviewed the cycle of business and agreed to changes as agreed and this will be circulated for approval by Chair's Action**
3. **The Committee reviewed the draft Annual Report ahead of it being finalised and circulated for email approval by Chair's Action.**

04/25 PATIENT STORY

Liam Williams advised that the Putting Things Right (PTR) Team has recently recorded video about a Deaf patient/complainant, Gemma Hearn and the PTR staff who have been assisting her. They all expressed the challenges in responding to a Deaf complainant.

The patient story highlighted the challenges faced by Gemma, a profoundly deaf British Sign Language (BSL) user, in accessing healthcare services. Gemma experienced significant communication barriers, leading to distressing and embarrassing situations.

Several key issues were identified: Miscommunication due to language barriers, as BSL has its own grammar and structure different from English, limited access to suitable sign language interpreters, especially in urgent or emergency situations. The story has shown that the need for increased education and awareness among healthcare staff regarding the deaf community's needs.

Leanne Hawker emphasised the importance of recognising that not all deaf people have learned to read or write in English, and that communication technologies should have a strong visual emphasis. It was recognised that there was a need to adjust questions in 111 and 999 services to accommodate the deaf community's needs. There was potential for staff training in BSL to improve communication with deaf patients.

Wendy Herbert asked whether the Trust has made progress in addressing the issues faced by deaf users, as this was not the first time such a story has been raised.

Jonny Sammut highlighted the need for patient voice in co-designing future technologies and mentioned ongoing work with Microsoft on translation software that includes BSL components. He asked for collaboration to improve this area.

Ceri Jackson asked about the legal context and the accessible healthcare standards, emphasising the importance of continuous effort in improving services for the deaf community. Ceri Jackson also inquired about collaboration with charity partners to maximise opportunities for improving services for deaf users.

Bethan Evans inquired what the Trust needed to put in place for staff to be able to engage with patients, regardless of their personal circumstances.

Emma Gracia-Young explained that she was the first point of contact for Gemma, and it was a powerful story. The main challenge was securing a BSL interpreter, which took months due to availability issues. She added there was excellent work happening within the Trust, in the 111, and 999 services, but it was not always visible. She expressed there was a need for more BSL-trained staff or accessible interpreters. The meeting she had with Gemma and the team was very moving and highlighted the importance of continued efforts to improve services for the deaf community.

Kathryn Cobley acknowledged that the Trust was not in a better place regarding services for deaf users, despite efforts. She highlighted there were significant political and systemic challenges that need to be addressed. She emphasised the need for a robust review of all current systems and procedures related to booking interpreters and providing accessible communication. She raised concerns about capacity issues within the Trust, including the need for a working group, training, and time for staff to attend training. She emphasised the importance of addressing these capacity challenges to improve services for deaf users.

The Chair asked that the People and Culture Committee (PCC) monitor the progress of the wider accessibility initiative, focusing on supporting deaf individuals and others facing barriers to accessing services and engaging with the Trust. It was agreed that as Chair of the PCC, Ceri Jackson would take this action forward.

Liam Williams stressed the importance of the Trust's role as a partner in multi-agency meetings and the need for effective communication skills. He highlighted the potential of digital solutions to address communication needs and improve patient care.

The Chair thanked Gemma for sharing the story and all the colleagues involved.

The Committee received an update following the patient story from Sian Davies-Kumar at the last meeting and noted that the Palliative Care Paramedic model 3-year initial trial phase has now ended. The committee heard that the Trust was considering what the model should look like going forward.

RESOLVED: The Committee received the Patient Story via a video from Gemma Hearn and noted the update on the previous story relating to Sian Davies-Kumar and the Palliative Care Model.

05/25 AUDIT WALES QUALITY GOVERNANCE FOLLOW UP REVIEW 2024

Liam Wiliams acknowledged the support from the Audit Wales team in completing the review, which involved revisiting the work from 2022 and the audit for 2024. He emphasised the importance of having well-structured management actions to ensure clarity and the ability to close them effectively.

Liam noted that having actions reopened from a previous audit was never ideal, but it was a fair assessment that identified the need for additional work to reach the right place. He stressed the need for ongoing assurance through reporting cycles and committee reviews.

Fflur Jones acknowledged that the review saw many areas of progress in implementing the recommendations from the 2022 review. She noted that actions were taken against every previous recommendation, even if some were not fully complete. She mentioned there were opportunities to take things further to provide fuller assurance, as the report focused on the level of assurance provided to the Committee. Fflur Jones highlighted the positive response from the Trust in addressing both the 2022 and 2024 recommendations, being specific about when they would consider closing off those recommendations to avoid similar situations in the future.

Rhiannon Beaumont-Wood sought an understanding on the timeline for improvements in the mortality review and the full implementation of the Duty of Candour. Liam Williams explained there has been good progress in identifying cases, working with medical examiners, and learning from coroner inquests. The Trust was working to improve data collection and making certain fields mandatory in the Electronic Patient Care Record (ePCR). The Trust was also exploring how to track patients through the entire pathway, which involved working with Digital Health and Care Wales (DHCW) and using the national data resource.

Liam Williams commented that the Trust was fulfilling the Duty of Candour where there was clarity required on catastrophic or serious harm. However, identifying and reporting moderate harm remained a challenge, and more work was needed in this area.

Wendy Herbert agreed with Liam's points and highlighted the challenges faced when the Joint Investigation Framework was invoked. She noted that it became difficult to determine who was responsible for triggering the Duty of Candour when the investigation was shared with Health Board colleagues. She mentioned that when the incident clearly sat within the

Trust, the team triggered the Duty of Candour immediately. However, in joint investigations, the process took more time.

Ceri Jackson asked for more details on the progress with achieving robust outcome data through the work with DHCW. Liam Williams commented there was a commitment from the ELT to work with DHCW. The Trust was enhancing the use of ePCR data to better understand the quality of care and segment data more effectively will undoubtedly improve patient outcomes. Additionally, having Health Boards contribute their data will enable more comprehensive pathway analysis and a better understanding of population health impacts.

Bethan Evans acknowledged there was a strong commitment to continuous improvement and collaboration within the Committee. Both she and Ceri Jackson were open to further discussions offline to explore how to move forward effectively. It was agreed that the respective chairs, including vice chairs, could support the efforts related to the Duty of Candour by leveraging their roles in the Quest chairs network. This support would help in addressing the challenges and ensuring the necessary improvements were made.

RESOLVED: That the review was acknowledged and the associated responses in the review were noted.

06/25 THE DUTY OF QUALITY IMPLEMENTATION PLAN – UPDATE

Liam Williams mentioned that the closure report would need to be brought back for formal noting at a future meeting. The Committee discussed the presentation of the report, and it was agreed it would be listed under Consent items at the next QuEST Committee meeting.

RESOLVED: The Duty of Quality Implementation Plan Closure report would be presented at the next QuEST meeting under the Consent Items.

07/25 HEALTH AND CARE QUALITY STANDARDS: UPDATE ON THE SELF ASSESSMENT

Liam Williams explained that Health & Social Care (Quality & Engagement) (Wales) Act 2020 came into effect on 1 April 2023, introducing the Health & Care Quality Standards 2023, which replaced the 2015 Standards. These Standards applied to both clinical and non-clinical functions.

Rhiannon Beaumont-Wood inquired about the ongoing work with the quality outcomes framework and the approach the Trust was taking. She expressed support but sought to understand more about the framework's development. Kate Blackmore explained there were several components that have not been fully translated into the current documentation. These components included a RAG Rating: A system to measure performance (Red, Amber, Green).Trend Analysis: Tracking whether performance was improving or deteriorating.

Rhiannon Beaumont-Wood also asked about the culture within the Trust regarding the ownership of Health and Care Quality Standards, acknowledging it can be challenging to ensure these Standards were fully embraced. Liam Williams highlighted ongoing conversations with the Joint Commissioning Committee (JCC) about commissioning arrangements and the promotion of a quality and safety approach.

Liam emphasised the importance of data and analysis, noting that the new Framework will likely focus on outcomes informed by data. He acknowledged that the delay in the Framework's release was partly due to the need for comprehensive data analysis. He added there has been considerable progress in the culture around quality improvement (QI) and equality impact assessments (EQIAs) within the Trust over the past 18 months. There was a recognition that more work was needed, particularly at the middle and operational levels.

Bethan Evans added that at the next, all Wales Quality Chairs Group an agenda item was listed which will discuss the approach to the Duty of Quality and Candour.

RESOLVED: That the Quality, Patient Experience & Safety Committee note the Health and Care Standards Assessment Framework being adopted organisationally to secure assurance on compliance.

08/25 DATIX RECOVERY AND IMPROVEMENT PLAN

Liam Williams stressed that the plan sets out a journey for improvement rather than being a complete solution. The focus was on making the system more intuitive and ensuring that staff have confidence in reporting incidents, knowing that their reports will lead to actionable improvements.

Kate Blackmore highlighted the collaborative workshop held in September, which identified gaps and improvements at both local and national levels. She added that the recovery plan included improving the structure of the system and providing education tools for staff to understand their responsibilities and actions required for reporting.

Trish Mills mentioned the challenges faced with the once-for-Wales risk module and the decision to look for other solutions for managing risk.

Rhiannon Beaumont-Wood inquired about the integration of different software and the potential use of AI to assist with data assimilation. Kate Blackmore responded that they were working on ensuring data was centrally held and reportable and were considering the use of robotic processes such as Power BI to help systems communicate.

Ceri Jackson suggested that Jonny Sammut should speak to Jayne Beeslee, Non-Executive Director on the Trust Board (in her capacity as the Board Digital Champion) about the Datix recovery and improvement plan, particularly in the context of the All Wales digital network. It was agreed that Jonny Sammut would update Jayne Beeslee, with regards to her involvement in the All Wales Digital Network and the issues which are being addressed through this Improvement Plan.

Liam Williams assured the Committee that the Trust was taking a comprehensive approach to managing violence and aggression incidents. It ensured that line managers and the violence and aggression team were actively addressing and supporting these incidents.

Bethan Evans asked of the level of confidence in realising and delivering on the Datix recovery and improvement plan, noting that many of the finish dates stated in the plan have

already passed. Kate Blackmore acknowledged that some timelines do need to be revisited and proposed providing a t report at the next Committee meeting to update on timelines, closed actions, and any necessary extensions. The Chair suggested that a report should only be brought back if there were any significant risks identified.

RESOLVED: The Committee:

(1) Noted the current risks and challenges within the Datix Web and RL Datix Cymru platforms; and

(2) Noted the attached Recovery and Improvement Plan designed to mitigate the challenges stepped out in this paper.

09/25 PUTTING THINGS RIGHT REPORT QUARTER 3, OCTOBER 2024 – DECEMBER 2024

Claire Appleton provided an overview of the Putting Things Right (PTR) report, highlighting the following points:

1. The report was structured differently from previous assurance reports, with data and intelligence presented separately from the report content.
2. The report includes a heat map visualisation to focus on improvements since April 2024.
3. The report was divided into sections covering quality controls, internal and external assurance, and the impact of actions taken.
4. Delays and high demand continue to shape the Putting Things Right (PTR) and legal services agenda, affecting both emergency and non-emergency transport services.
5. External activities, such as prevention of future death reports from coroners, have referenced extensive delays in reaching people in the community.
6. There was concern about whether there was sufficient capacity and resourcing to respond to quality and safety asks through PTR and legal services, especially given the competing priorities and pressures.
7. Complaints management has improved, and there was a focus on learning from external assurance and driving internal improvement.

Kate Blackmore added that the new format of the report was a significant improvement, especially with the focus on triangulating intelligence as opposed to just presenting metrics; this will provide a more comprehensive understanding of the data and its implications.

Claire Appleton commented that the Team were dealing with some significant challenges related to delays and the limitations of the current data extraction methods. There was still a lot of work to be done to improve the coding structures and data availability.

Members found that the new format with the streamlined structure made it easier to identify and focus on key priority areas, which was crucial for effective decision-making and governance.

Bethan Evans asked how far developed the iteration of the new format was, and were there any other updates the that the Team was working on to have included in the report. Wendy

Herbert explained that the Trust was focusing on how to enhance patient experience and prevent patient harm, to achieve this, required comprehensive and accurate information. She added it was crucial to strike a balance between providing comprehensive information and ensuring that the key points remained clear and actionable.

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

10/25 MONTHLY INTEGRATED QUALITY PERFORMANCE REPORT (MIQPR) – NOVEMBER/DECEMBER 2024

Rachel Marsh advised that the Monthly Integrated Quality and Performance Report (MIQPR) presented at the meeting was the same as reviewed at Trust Board last week, and drew the committee's attention to the following areas:

In December, the average response time for Amber 1 patients was 33 hours, with some patients waiting even longer. A major factor affecting response times was the handover lost hours, which exceeded 25,000 hours in December 2024.

The report outlined various actions being taken to address these issues, including the Clinical Model Transformation Programme and investments in remote clinical capacity and frontline resources.

Rachel Marsh acknowledged the presence of Joint Commissioning Committee (JCC) colleagues at the meeting, and emphasised the importance of reducing ambulance delays, aligning with the Cabinet Secretary's target of the number ambulances being delayed over an hour by the end of next year.

Rachel also mentioned the ongoing issue of patients cancelling their ambulance requests due to long response times, which likely led to harm as these patients may deteriorate while making their own way to an Emergency Department.

Liam Williams added there has been a small increase in the number of flagged safeguarding reports for children, and a slight deterioration in the number of reports for adults. While the numbers were not necessarily significant, it was important to note the considerable work the safeguarding team was doing to address internal safeguarding issues and support the wider community.

RESOLVED: The Committee considered the November/December 2024 Integrated Quality & Performance Report and actions being taken and acknowledged that it provided sufficient assurance.

11/25 FOCUS ON CLINICAL INDICATOR – STROKE

Jonathan Chippendale provided the committee with a presentation which focused on the points below:

1. Measurement and Importance: Jonathan explained the four clinical indicators for stroke care: Face, Arm, Speech, Time (FAST) test, blood glucose measurement, blood pressure, and GCS (Glasgow Coma Scale). Each indicator was crucial for diagnosing and managing stroke patients effectively.

2. Data Quality and Reporting: Jonathan highlighted the importance of accurate data recording and the challenges faced in ensuring data quality. He mentioned that the automated data often showed lower compliance compared to manual data checks.

3. Performance Trends: Jonathan presented performance trends from April 2022 to December 2024, showing an improvement in compliance with the stroke care bundle, which was closely linked to the recording of the fast test.

4. Improvements and Next Steps: Jonathan discussed the interventions made since April 2024, including changes to EPCR (Electronic Patient Care Record) scripting, clinician education, and the introduction of nudge tools to remind clinicians to complete necessary documentation.

5. Clinical Indicator Recovery Plan: Jonathan referenced the ongoing Clinical Indicator Recovery Plan, which aimed to further improve compliance and data quality with regards to the Stroke related clinical indicators

Rhiannon Beaumont-Wood asked of the ongoing provision of data to clinicians to drive improvement from the bottom up. She was curious to understand if the approach of providing data to clinicians would continue. Jonathan clarified that the responsibility for monitoring and improving clinical indicators has been transferred to the Clinical Intelligence Assurance Group (CIAG), which will continue to oversee these efforts.

RESOLVED: The Committee noted the presentation on the Stroke Clinical Indicator.

12/25 RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK

Due to the reporting cycle, Julie Boalch explained that the data presented today was the same as presented to the Board on 29 November 2024.

Julie Boalch provided an overview of the 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*) with the scoring of 25 remaining unchanged. The two risks continue to be dynamically reviewed to provide assurance to the Committee.

It was noted that the discussions today have highlighted the work being done to mitigate the highest rates risks; as detailed in various reports, standards and frameworks.

The Trust was also exploring new ways to manage mitigations within its control, such as consulting on nurse attendance levels and implementing the clinical navigator role and winter desk.

Ceri Jackson sought assurance on the trajectory of consult and close and any challenges. Lee Brooks commented there was a need to refine the data as the consult and close data was related to the Emergency Communication Nurse System (ECNS) deployment for 111. An approach has been developed and was awaiting verification. The unverified data shows a positive trend regarding consult and close, but formal verification was needed before it can be included in the reports.

Trish Mills commented there were key initiatives underway to address the highest-rated risks (223 and 224) that have been on the risk register at a rating of 25 for some time. The goal was to better visualise and understand what the Trust Board has control over, and how far along it was in managing these risks.

Liam Williams added that the Trust was working on creating improvement trajectories to address significant unmet needs, particularly within the amber cohort of patients. The focus was on making things safer rather than completely safe, which was a realistic approach given the circumstances.

Jacqueline Maunder highlighted the importance of the ongoing dialogue with Trish Mills and Julie Boalch due to the synergies between the top scoring risks of both the Trust and the Joint Commissiong Committee. She emphasised the need for a whole system approach to manage these mitigating actions.

RESOLVED: The Committee noted the contents of the report.

13/25 CANCELLED CALLS POTENTIAL IMPACT ANALYSIS

Jonathan Chippendale provided the Committee with a presentation which looked at a retrospective data analysis of a 12-hour period during an "app perfect day" in the Swansea Bay Health Board area. The aim was to understand the system impact of increased utilisation of Advanced Paramedic Practitioners (APP) and one Palliative Care Paramedic (PCP). He highlighted that on this day, there were 149 calls related to 104 incidents, with additional incidents already on the stack and ambulances waiting to hand over at the hospital. The analysis focused on the outcomes and system impact of managing patients in the community and reducing conveyance rates.

During the "APP perfect day" analysis, it was found that a significant portion of calls were cancelled by patients who then self-presented at the Emergency Department (ED). He noted that approximately 50% of these cancelled calls likely resulted in patients going to the ED on their own. This was identified as a major issue, as it indicated unmet care needs and a significant impact on the ED's workload. The analysis showed that despite efforts to manage patients in the community, a substantial number of patients still ended up seeking care at the ED.

On a specific Thursday, February 15, Swansea Bay went into a Business Continuity Incident, leading to significant changes in hospital operations, such as placing senior clinical decision-makers at the front doors. This day saw the lowest average handover time for any Thursday that year, suggesting that coordinated efforts between the hospital and ambulance service

made a noticeable impact. The new clinical model and urgent care response service were expected to further enhance these efforts in the future.

Liam Williams acknowledged that the information contained in the presentation was comprehensive and detailed. Liam Williams suggested it would be beneficial for a more comprehensive evaluation and benefits realisation report be presented to the Committee. It was therefore agreed that Liam Williams would consult with Rachel Marsh and Andy Swinburn to undertake this task.

RESOLVED: The Committee noted the presentation on the cancelled calls potential impact analysis.

14/25 CLINICAL AUDIT PLAN 2025/26 AND ACTION TRACKER

Jonathan Chippendale advised that following a review by Audit Wales of the Trust's Quality Governance Arrangements, one of the recommendations was for the Clinical Audit Plan to be submitted to the Quality, Experience and Patient Safety Committee (QuEST) for scrutiny and approval ahead of each financial year, and then monitored on a quarterly basis.

Jonathan confirmed that the 2025/26 Clinical Audit Plan has been developed in consultation with the Clinical Intelligence Assurance Team (CIAT), the Clinical Intelligence and Assurance Group (CIAG), and senior clinical and non-clinical managers within the Trust.

The plan included 10 new audits including the Electronic Patient Care record (ePCR) and Drug Administration documentation. The plan will be updated quarterly, and the ongoing monitoring of clinical indicators will continue through the CIAG. The Committee was asked to approve the Clinical Audit Plan for 2025/26.

Rhiannon Beaumont-Wood asked if there is a system to consider medical devices auditing within the Clinical Audit Plan. Andy Swinburn advised it was not contained in the Plan and was monitored separately by a different area within the Clinical Team in the Trust. Following discussion, the Committee approved the Clinical Audit Plan for 2025/26 and noted the update given regarding the progress against the 2024/25 Clinical Audit Plan, within the associated Tracker.

RESOLVED: The Committee APPROVED the Clinical Audit Plan for 2025/26 and NOTED the Action Tracker update against the Clinical Audit Plan for quarter three of 2024/25.

15/25 ANNUAL INFECTION PREVENTION CONTROL SERVICE REPORT – 2023/24

Liam Williams advised that the report provided an overview of the current challenges facing the Infection Prevention and Control (IPC) Team and outlined the Strategic Plan for service enhancement during the 2025-26 financial year.

Over the past year, the IPC Team has navigated several challenges influenced by factors such as workforce changes, leadership transitions, staffing shortages, and a reduction in training opportunities.

Penny Durrant highlighted several points:

1. The report indicated improved compliance with hand hygiene, Personal Protection Equipment (PPE) use, and environmental cleaning, though there was still room for improvement.
2. There has been significant collaboration with internal and external partners, including health and safety, occupational health, Public Health Wales, and national IPC leads.
3. There were challenges in Respiratory Protection Equipment (RPE) provision which were being addressed, and the work was nearing completion.
4. Strengthened governance with policy reviews and updates was ongoing, and there was a focus on improving risk management and training standardisation.
5. A comprehensive IPC training program was being developed in collaboration with training colleagues to align staff competencies with national standards.
6. A Board Assurance Framework was being formalised to enhance policy compliance, accountability, and performance reporting.
7. There were ongoing efforts to recruit into key IPC positions to ensure service stability and continued collaboration across the Trust. There was a push to champion Infection Prevention Control (IPC) quality leads within operational teams and comprehensive IPC training programs aligned with national standards.

Liam Williams emphasised the significant work completed in the Respiratory Protective Equipment (RPE), highlighting the rollout of Powered Air Purifying Respirators (PAPR) across most of Wales and the expansion into the Southeast as soon as it becomes available. Jonny Sammut noted there were efforts to identify digital audit tools and potential collaboration with other services to mitigate funding risks.

RESOLVED: The Committee received the 2023/23 Annual Infection and Prevention report.

16/25 INTERNAL AUDIT REPORT: PATIENT EXPERIENCE COMMUNITY INVOLVEMENT

Liam Williams explained that the Patient Experience and Community Involvement (PECI) Report provided the Committee with a clear and comprehensive view of the Trust's efforts to embed public engagement into its governance and operational structures.

The report gave a reasonable assurance opinion, which reflected the progress made in PECI while highlighting areas for further improvement.

Leanne Hawker noted the launch of the new People's Experience Framework, which aimed to strengthen the duty to promote listening and learning from patient feedback, aligning with several regulations and acts.

Additionally, the PECI Team's Work Plan will be refined to align more closely with operational priorities and transformation goals. This includes introducing a population

health-based approach to analysing feedback and reporting variations in outcomes across Wales.

The Committee held a discussion which focused on the importance of building on the foundations laid and continuing to improve the PECI involvement in the delivery of the Trust's services.

RESOLVED: The Committee NOTED the Internal Audit outcomes, recommendations, management responses, and next steps.

17/25 AUDIT TRACKER 2.0 DECEMBER 2024 (Q3)

Trish Mills explained that the report provided 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).

Of those internal audit recommendations relevant to this Committee, two have been closed in quarter of a total of eleven (18%). There were five recommendations which have had a change in date proposed (marked in blue). There were two open actions on their third revised date: action 604 (Pain Management internal audit) and action 683 (Electronic Patient Clinical Records (ePCR) Clinical Compliance internal audit).

In terms of the external audits relevant to this Committee, none have been closed in quarter of a total of three. One of the external audit actions has a new revised date proposed (marked in blue) taking it to the third revised date; 139 National Review of Patient Flow – A Journey Through The Stroke Pathway.

RESOLVED: The Committee:

(1) Noted there were no Internal Audits and Audit Wales reviews within their remit
(2) Monitored management actions to address recommendations in the Tracker, noting any revised dates for actions (in blue).

18/25 POLICIES FOR APPROVAL/NOTING

The following policies were presented the Committee for approval:

1. Safeguarding Children and Adults at Risk of Harm Policy;
2. Violence Against Women, Domestic Abuse and Sexual Violence 'Ask and Act' Policy.

The Committee acknowledged that the policies had been through internal governance processes and consultation and through Executive Leadership Team. There were no issues and the policies were approved, as presented.

RESOLVED: The Safeguarding Children and Adults at Risk of Harm and the Violence Against Women, Domestic Abuse and Sexual Violence 'Ask and Act' policies were approved.

19/25 COMMITTEE PRIORITIES AND CYCLE OF BUSINESS MONITORING REPORT

The Committee Priorities and Cycle of Business Monitoring Report was received.

RESOLVED: The Committee noted the update.

20/25 KEY MESSAGES FOR THE BOARD

These would be articulated on the Committee's Highlight report.

RESOLVED: The Committee noted that the key messages for the Board would be articulated through the Committee highlight report

21/25 REFLECTIONS AND SUMMARY OF DECISIONS/ACTIONS

Bethan Evans summarised the decisions and actions as follows:

1. Clinical Transformation Model: The QIA discussion was moved to a Closed session for further work.
2. Committee Effectiveness Review: Conducted differently this time, with feedback to be emailed for the Draft Annual Report and priorities for 25/26. Amendments to the Terms of Reference were also agreed upon.
3. Patient Story: Provoked discussions on digital accessibility improvements, with Jonny Sammut tasked to develop further.
4. People and Culture Committee: They will monitor progress on accessibility, especially for deaf people and others with barriers.
5. Quality Governance Review: Agreed to take forward conversations offline to improve governance.
6. Duty of Quality Implementation Plan: A closure report will be brought back to the next meeting as a consent item.
7. Datix Recovery and Improvement Plan: Jonny Sammut to update Jayne Beeslee, with ELT reviewing timelines. It will return to the Committee if significant risks emerge.
8. PTR Report: New format welcomed, with a focus on supporting wider system decommissioning work.
9. Cancelling of Calls: Further work to be done outside the Committee, with feedback to be provided later.
10. Clinical Audit Plan for 25/26: Approved, recognising the need for flexibility.
11. Policies Approved:
    - Safeguarding Children and Adults at Risk of Harm Policy
    - Violence Against Women, Domestic Abuse, and Sexual Violence 'Ask and Act' Policy

Reflections:

The time allocations for items throughout the meeting were challenging, however the difficulty of managing such a comprehensive agenda was acknowledged. The Chair was commended for effectively conducting the meeting. Related to this point, there was consideration of how the meeting arrangements could be adjusted to allow for a more comfortable flow, including where it could be helpful to have pre-meeting discussions on more technical matters.

Rhiannon Beaumont-Wood, Non-Executive Director on the Trust Board, was welcomed to her first meeting of the committee. Additionally, there were several observers ranging from internal Trust staff, Health Improvement Wales, Internal Audit, and NHS Wales Joint Commissioning Committee (JCC) colleagues for the risk discussions.

The Committee acknowledged the work of Kevin Webb, Head of Clinical Intelligence and Assurance, a valued member of the WAST Team who was retiring in the coming weeks. Kevin Webb has been instrumental in the Trust's clinical audit work and a note of thanks was recorded for all his contributions.

Date of Next meeting: 9 May 2025

Meeting concluded at 15:30

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	27 March 2025
Committee Meeting Date	4 February 2025
Chair	Bethan Evans

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. **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. Approximately 10,000 patients per month are cancelling their ambulance requests due to long response times, likely leading to harm and them potentially make their own way to emergency departments. The Trust's focus is to implement a change in how it responds to patient demand through the **Clinical Transformation Programme (CMT).** The committee reviewed the Quality Impact Assessment for the CMT in closed session and received an update on the programme.

2. A theme which ran through a number of items at this meeting included the **importance of data** as intelligence to drive continuous improvements for patient safety**,** as well as digital to support technology advancements/innovation. The need to prioritise digital projects, including the integration of Datix and other systems, to ensure alignment with organisational needs and available resources was emphasised. This is currently underway as part of the development of the IMTP 2025-2028.

3. The **Datix 'Once for Wales' Concerns Management System** contains incident reporting data for patient, staff, and contractor safety concerns, as well as other bespoke modules. Challenges have been identified and a recovery and improvement plan was reviewed which address the key issues and risks which include:

   - Reliance on wider system stakeholders for intelligence on incidents with moderate or higher levels of harm.
   - Data linkage through the National Data Repository owned by Digital Health and Care Wales
   - Reduction of unnecessary data fields and improve data flow for actionable insights.
   - Clear governance and accountability arrangements, and connection with other platforms.
   - Resource constraints impacting system management and data cleansing.
   - Capacity to support the Recovery and Improvement Plan.
   - Current configuration and maintenance lacks structure and requires review.

- Volume and quality of reports causing duplication and variance in outcome data.

The plan was noted, with concerns raised as to deliverability timescales and the resource to implement the plan. The committee will receive updates by way of exception reporting where there are significant risks posed to matters in the remit of this committee.

ADVISE

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

4. Members expressed thanks to service user **Gemma, for sharing their experience as a profoundly deaf British Sign Language (BSL) user in accessing healthcare**. Gemma experienced significant communication barriers, leading to distressing situations in her interactions with the Trust and other public services. Gemma noted that there can often be miscommunications and language barriers, as BSL has its own grammar and sentence structures and is different from English. Also, Gemma advised that BSL users do not necessarily understand or speak English. Gemma indicated that there is often limited access to suitable sign language interpreters for BSL, especially in urgent or emergency situations.

   The committee heard that there is a need for increased education and awareness among healthcare staff regarding the deaf community's needs, and that the existing systems for accessing 111 or 999 to not adequately support the deaf community's needs. Members acknowledged the recurring nature of such patient stories and noted the clear deficiencies in the systems. They discussed what measures could be taken to better support deaf users. In addition to improving the education and awareness of colleagues in the Trust of the needs of the deaf community, the use of technologies to support this activity and improve the user experience were discussed. The relevant legal context and accessibility requirements / information standards were noted. Members acknowledged the commitment of the Trust to improving the user experience for the deaf community and sought support from the Chair of the People and Culture Committee to ensure a continued focus on this area.

5. The Committee received **an update following the patient story from Sian Davies-Kumar** at the last meeting and noted that the Palliative Care Paramedic model 3-year initial trial phase has now ended. The committee heard that the Trust is considering what the model should look like going forward.

6. The Committee received the **Operational Update for Q3 2024/25,** and of note**:**

   - The December critical incident was called due to high call volumes and extended handover delays at emergency departments. The proactive media engagement was noted as helpful in managing the situation. The debrief of that incident will look at the issues of ambulance release requests. Non-Executive Directors who visited staff during this time commended their resilience and commitment despite ongoing pressures.

   - Initial results from the changes made to the mental health service with the addition of a response vehicle, introduced in November, show encouraging rates of enhancing the ability of WAST to manage patients within their setting and not deploy an emergency ambulance or transfer them to

an emergency department. Work is ongoing to ensure the most effiecent and effective model is developed for remote and vehicle based response; to note when not attending a face to face incident, the mental health practitioner is contributing to remote assessment.

- There has been an increase in red activity related to breathing problems with analysis revealing more activity on the 06E01 MPDS code originating from 111 rather than 999, which was flagged as unusual given the nature of this code. Further clinical validation processes were implemented for patients in the 0-4 age group, leading to a reduction in red activity from 111 to 999. Work continues to consider trigger words between CPSS and MPDS, and on the hand-off process from a 111 call handler to 999 call handler. The clinical validation process will be considered for potential standardisation.

7. The **2025/26 Clinical Audit Plan** was approved.

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

- Safeguarding children and adults at risk of harm policy
- Violence against women, domestic abuse and sexual violence policy

9. Members received a presentation on **cancelled calls potential impact analysis** and were assured that the CMT and ongoing improvements in data analysis and reporting could help address challenges in providing timely ambulance responses affected by high demand and ongoing hospital handover delays.

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

- The time allocations for items throughout the meeting were challenging, however the difficulty of managing such a comprehensive agenda was acknowledged. The Chair was commended for effectively conducting the meeting. Related to this point, there was consideration of how the meeting arrangements could be adjusted to allow for a more comfortable flow, including where it could be helpful to have pre-meeting discussions on more technical matters.

- Rhiannon Beaumont-Wood, Non-Executive Director on the Trust Board, was welcomed to her first meeting of the committee. Additionally, there were a number of observers ranging from internal WAST staff, Health Improvement Wales, Internal Audit, and NHS Wales Joint Commissioning Committee (JCC) colleagues for the risk discussions.

- The committee acknowledged the work of Kevin Webb, Head of Clinical Intelligence and Assurance, a valued member of the WAST Team who is retiring in the coming weeks. Kevin Webb has been instrumental in the Trust's clinical audit work and a note of thanks was recorded for all of his contributions.

ASSURE

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

11. An update was given against the Trust's approach to assessment against the **Health and Care Quality**

Standards (2023) with the self-assessment template being received. A maturity matrix approach to assess compliance with the Standards has been taken, and members were assured of the progress with the development of this framework and look forward to future progress updates.

12. A revised **Putting Things Right (PTR) Report** for Q3 2024-25 has been restructured to be more succinct and focused, with a clear presentation of data and visualisations like heat maps. Feedback on the new format was positive, with members appreciating the clarity and ease of finding information. The board will note:

    - Delays and high demand continue to shape the PTR and legal services agenda, impacting both emergency and non-emergency transport.
    - Improvements in complaints management were noted, with better response times and more face-to-face meetings with patients and families.
    - The report includes thematic learning from complaints, emphasizing areas like attitude and behaviour, and the importance of showing empathy.
    - There has been a significant rise in the number of cases being considered at the Serious Case Incident Forum.
    - Additional metrics and changes are planned for future reports, including more detailed themes and legal services data.

13. The **Monthly Integrated Performance Report (MIQPR)** was received, with members noting that the board received and discussed the MIQPR at its meeting the previous week (30 January). Handover delays remain significant as noted in the alert section above. The Cabinet Secretary's target to eliminate handover delays over an hour by the end of the year was noted and the Trust continues to work with Health Bords to support this goal and reduce patient harm.

14. The MIQPR shows a small increase in the number of **safeguarding** children reports and a slight decrease in the number of adult safeguarding reports. Additionally, there was a deterioration in the time taken to complete referral. The safeguarding team is currently managing internal issues related to safeguarding staff and the wider community, which impacts their capacity to handle external safeguarding reports.

15. The **Audit Wales Quality Governance Follow Up Review report** was received and presented by Audit Wales. Progress in implementing recommendations from the 2022 quality governance review was acknowledged, noting that some recommendations were not fully complete. The responses to both the re-opened 2022 and 2024 recommendations were reviewed, with the specificity on evidence to close the actions welcomed.

    Overall, the discussions highlighted the Trust's commitment to continuous improvement, the importance of realistic timelines for management actions, and the need for better data sharing and collaboration with system partners to enhance quality governance. The report is attached at **Annex 1** and will have been reviewed at the Audit, Risk and Assurance Committee ahead of the board meeting in March.

16. Committee received a presentation on the **clinical indicator related to stroke** noting an improvement in performance, with compliance increasing from 65-70% to almost 90%. Members discussed potential

reasons for the decline in the number of stroke patients being recorded noting that patients self-presenting at emergency departments may be a factor. An investigation is needed to understand the reason for the decline; however, members were assured that the Clinical Audit and Assurance Group (CAAG) monitor the indicators noting the importance of local leadership and clinical supervision in maintaining and further improving performance against them.

17. The **Clinical Audit Plan and Action Tracker update for Q3 2024/25** was received with no escalations.

18. The **Infection Prevention and Control Annual Report** for 2023/24 was received, emphasising improved compliance with hand hygiene, PPE use, and environmental cleaning, though there is room for improvement. The report highlights strengthened governance, policy reviews, and updates, as well as workforce development efforts. The changes in the team and challenges around recruitment were noted with further work required to formalise people into posts, enhance policy compliance, accountability, and performance reporting. Some persistent challenges remain, particularly in areas that are typically difficult for the ambulance sector, such as healthcare-acquired infections. Despite this, members commended the team in the role out of Respiratory Protection Equipment (RPE) across Wales as an important development to giving us the best protection for our people and our patients. The Executive Director of Quality and Nursing will develop IPC metrics for regular oversight for this committee's consideration.

19. The internal audit on **Patient Experience and Community Involvement** was received. This was a reasonable assurance audit, reflecting the progress made in patient experience and community involvement. The report highlighted both the strengths of the current patient experience initiatives and areas where further improvements are needed.

20. An update was received on the **Audit tracker** with 18% (23% last quarter) of committee related internal audit actions (due in quarter) closed in quarter. The committee was assured however that appropriate plans were in place to address those actions overdue.

21. The Committee's **annual effectiveness review** was held, with a revised approach taken across all committees. A discussion was facilitated to consider what changes and improvements could be made to the Committee's operations. The draft Annual Report was reviewed, however the final Report for submission to the Audit, Risk and Assurance Committee, and the revised Terms of Reference for 2025/26, will be circulated for approval by Chair's Action after the meeting.

22. Members received the Committee **Cycle of Business Monitoring Report** and progress against the **Committee's priorities** for 2024/25.

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.

Colleagues from the JCC were in attendance highlighting the work being undertaking in collaboration to

consider a new approach to mitigations of these risks from a whole system perspective, noting that ambulance capacity and performance is the highest scoring risk on the JCC's new risk register. The aim is to consider both risks using a manage and monitor approach alongside work to transfer these risks to the Trust's new Strategic Board Assurance Framework. The Trust remains committed to improving the quality of care and reducing harm; however, projecting improvement trajectories on these risks is difficult due to the extreme pressures and context in which it operates.

Committee received assurance that the risks continue to be dynamically reviewed and within the relevant governance forums noting discussions on the mitigating actions, controls and assurances and mitigating actions are reviewed regularly.

New Risks Identified: Whilst there were no new risks for committee, members noted the risk highlighted as part of the RL Datix system report which captures the challenge in ensuring that the system is structured and accessible for staff to report incidents accurately in addition to resources to address the broader impacting factors. Mitigations include training packages, development of procedures and governance processes and the integration of the Incidents and Concerns module on Datix with other systems to improve data reporting and analysis.

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

COMMITTEE AGENDA FOR MEETING		
Operations Directorate Quarterly Report for Q3 2024/25	Committee effectiveness review	Patient story
Clinical Transformation Programme	Audit Wales Quality Governance Follow Up Review 2024	Duty of quality implementation update
Health and care quality standards self-assessment	Datix Recovery and Improvement Plan	PTR report
Monthly Integrated Quality and Performance Report	Focus on clinical indicator – stroke	Risk management and board assurance framework
Cancelled calls potential impact analysis	Clinical audit	Infection prevention and control service annual report
PECI internal audit	Audit tracker	Policies for approval
Committee cycle of business monitoring report and committee priorities 2024/25		

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]	Hugh Bennett until 2pm	
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

ACTION LOG - UPDATE
QUEST COMMITTEE

Minute Ref	Date	Agenda Item	Action Note	Responsible	Due Date	Progress/Comment	Status
03/25	4 February 2025	Committee Effectiveness Review	As a committee it was agreed that Draft Annual Report: Comments should be forwarded via email for consideration before it goes to the Audit, Risk and Assurance Committee. Priorities for 2025/26: Requested that any ideas around priorities should be sent through by e mail. Terms of Reference: The Committee noted any amendments will be made before finalising and issued via Chair's Action to the committee for endorsement.	Trish Mills Bethan Evans Ceri Jackson Rhiannon Beaumont-Wood	4 March 2025	09/05/2025 This work is complete and is being presented to the ARAC on 1 May 2025	Complete
04/25	4 February 2025	Patient Story	It was agreed that Jonny Sammut would look at what the Trust had in place from a digital perspective, website etc.. in terms of accessibility and how to develop this further and improve accessibility for patients who faced barriers in accessing the service.	Jonny Sammut	9 May 2025	09/05/2025 We have looked and there isn't anything that we already have in terms of approved software - we have engaged with our partners at Microsoft and Apple to start conversations on what technologies may be available and these will be explored (with relevant business cases presented)	Complete
04/25a	4 February 2025	Patient Story	The Chair asked that the People and Culture Committee (PCC) monitor the progress of the wider accessibility initiative, focusing on supporting deaf individuals and others facing barriers to accessing services and engaging with the Trust. It was agreed that as Chair of the PCC, Ceri Jackson would take this action forward.	PCC	9 May 2025	09/05/2025 This action has been transferred to the PCC	Complete
06/25	4 February 2025	The Duty of Quality Implementation Plan - Closure Report	It was agreed that the Duty of Quality Implementation Plan closure report be added as a Consent Item section at the next meeting.	Liam Wiliams	9 May 2025	09/05/2025 Added to the Consent Item section for 6 May 2025 meeting.	Complete
08/25	4 February 2025	Datix Recovery and Implementation Plan	It was agreed that Jonny Sammut would update Jayne Beeslee, the Non-Executive Director (NED), who is the NED Trust Board Digital Champion), with regards to her involvement in the All Wales Digital Network and the issues which are being address through this Improvement Plan.	Jonny Sammut	9 May 2025	09/05/2025 A one to one meeting with the Chair of FPC and the Director of Digital has been arranged in May to discuss this.	Complete
13/25	4 February 2025	Cancelled Calls Potential Impact Analysis	The information contained in the presentation was comprehensive and detailed, Jonathan Chippendale explained that approximately 50% of these cancelled calls likely resulted in patients who then self-presented at the Emergency Department. It was suggested by Liam Williams it would be beneficial for a more comprehensive evaluation and benefits realisation report be presented to the Committee. It was therefore agreed that Liam Williams would liaise with Rachel Marsh and Andy Swinburn to undertake this task	Liam Williams Rachel Marsh Andy Swinburn	9 May 2025	09/05/2025 Liam Williams advised that legally privileged advice had been sought and gained to confirm opportunity for data linkage. The current advice prohibited the Trust from explicitly linking data in the national data repository for this purpose. A submission to Commissioners and Policy advisors to request Cabinet Secretary authority to work consistently with PHW and DHCE has been made.	Complete

OPERATIONS DIRECTORATE
QUARTERLY REPORT FOR COMMITTEES
2024-25 Q4 (January – March 2025)

National Operations & Support

General Update

AACE Ambulance Leadership Forum – Presentation on Community Welfare Responder Project

The National Volunteer Manager was invited to speak at the Ambulance Leadership Forum 2025, providing an overview of the Community Welfare Responder project. This has led to further conversation with NHS Charities Together about potential funding opportunities through 2025/26, for which we will ensure our Head of Charity and other colleagues are involved.

HART Drone Pilot

HART are introducing a drone capability to their list of assets to assist the team and Trust when responding to certain types of incidents. The incidents where the use of a drone will be beneficial are as follows:

- Large incidents to gain spatial situational awareness
- Incidents where operating environments may be hazardous - drone to be used to gain situation awareness and aid in risk assessments (water rescue incidents during nighttime or where daylight is minimal)
- Persons in water (thermal imaging cameras to help identify persons)
- Persons injured in rural areas (able to cover areas and thermal imaging cameras to assist)
- Ability to live stream to incident command rooms through a dedicated and secure server

HART will have 7 pilots (1 per team/watch), along with a Chief Pilot (HART Training Manager) trained to standards in line with the Civil Aviation Authority (CAA). Pilots will receive training in drone operation, pre-flight checks, safety critical process (including pre-flight risk assessments) and how to operate the drone for the incidents listed above.

Training was completed week commencing 31.03.2025 and all operatives successfully passed the course. Plans are in place with the IT Project Management Team to set up some live streaming on an exercise to showcase the capability.

Communications Tactical Advisor (CTA) Courses

The College of Policing delivered a nationally recognised CTA course from March 18th-20th to enhance the CTA cadre within the Trust. Managing Airwave capacity is crucial for coordinated incident response. The Trust has been able to provide funding to achieve a situation whereby all NILOs have achieved this accreditation and therefore the Trust can now demonstrate 24/7 on-call capability. However there remains an operational need to deliver training for key identified roles to bring CTA cover to the 'on-duty' as well as access to the supporting software platform 'Insight'. This is not within the operating budget of WAST to deliver and as such there is a dependency upon additional funding from commissioners. This funding request has been submitted to JCC and a decision is anticipated in Q2/3 of this financial year.

Manchester Arena Inquiry (MAI) Scrutiny

Following the submission of WAST's consideration to the MAI recommendations in August 2024 to commissioners with a copy to the NHS Executive, a series of scrutiny workshops have taken place with commissioners over March and April. These sessions have allowed the commissioners, who called upon the expertise of EPRR leads from Health Boards, to scrutinise the detail in the submission before considering and providing their formal response which expected back to the Trust in August 2025.

Resourcing, EMS Coordination and Quality

Challenges

Life X/Control Room Solution

On 23rd January 2025, there was a significant national outage of the Control Room Solution (CRS), utilised by all Ambulance Trusts in England, Scotland and Wales, which impacted on our radio and control room telephony solutions. In response to this outage, WAST implemented business continuity plans that resulted in very little impact on our operations. Consequently, we did not need to declare an incident, such was the effectiveness of our business continuity arrangements.

One of the issues raised during the outage was the lag in time for the system to switch to the fallback data centre, which is a concern for any future fallback arrangements. This prompted the Ambulance Radio Programme (ARP) to instigate a full investigation into the circumstances and root cause of the outage with Frequentis, the software supplier. ARP are working with NHS England who are undertaking external assurance regarding the incident and will be reviewing the plans and actions so that there is external scrutiny on the incident and the response.

A further outage occurred on the 10th March 2025 and again our business continuity arrangement were instigated. The lessons learned from the first outage in January 2025 were implemented and this time the time to recovery of the functionality was far more efficient. However, this has raised concerns regarding the stability and reliability of the system. As a result, ARP senior management are briefing Westminster Ministers and Senior representatives from within the Department for Health and Social Care to ensure that there is suitable scrutiny applied to the supplier to ensure appropriate prioritisation and associated resourcing is in place to help resolve the underpinning issues. ARP are briefing Trusts via the National Digital Leads Group, which our Director of Digital, is a member.

EMSC Sickness

Sickness absence remains an area of focus across the EMSC centres including an approach to support our people to be in work. Following a workshop undertaken with the EMSC leadership team, trade union partners and People Services, the team agreed key areas to focus on, especially around wraparound support for new Call Handlers. The Managing Attendance Policy has been appropriately applied, a new career structure has been deployed, and working environments are being improved. It has been pleasing to see some signs of improvement however focus shall remain in the foreseeable future.

SORT

Since the Trust received confirmation of the SORT enhancement funding, work has been underway to roll out the associated plans. The two band 7 posts have now been recruited and post holders commenced in their roles in March 2025. Some of the equipment items have also been sourced at a cost less than originally anticipated. However, the remainder of the revenue spend remains on track. We were unable to source vehicles from the capital aspect of the case in time for the end of the year and funding was subsequently returned. We anticipate funding of £290,000 to be subsequently returned to us and work is actively underway in relation to vehicle specification, conversion and securing of vehicle chassis. We do anticipate that the capital funds may not cover the full vehicle costs but are unable at this point to provide exact costs for the vehicles until final quotes are received. However, we are actively engaged with WG capital finance colleagues in this respect.

Overdue investigations

Operations Quality continues to experience challenges in completing and returning investigations for concerns and coroners. There are now 95 outstanding concerns investigations of which 66 have breached the Welsh Government Tier 1 target, and 55 outstanding coroner's statements of which 20 have breached the HMC return date. There continues to be challenges in obtaining information critical to investigations in relation to clinician input (Clinical Support Desk). The teams are working together to expedite required information wherever possible and dynamically prioritise coroner's statements when requested by Legal Services. Audit has been identified as a bottleneck; however it is also important to set out that more audits have been completed than before. The issue is one of capacity to absorb activity, and there are plans for auditor growth in the coming months.

IMTP

Culture

The culture plan was developed in partnership and significant amount of work has been achieved to date, signalling a positive shift. Monthly time-to-talk in all centres are well attended which allows opportunities for increased staff engagement as well as actioning some ideas and concerns from colleagues. Monthly sway newsletter has also been developed to better communicate with our people. People Services have provided learning events for the managers and supervisors in application of managing attendance at work and occupational health processes, policies and procedures.

Estates

Llangunnor estate refurbishment has almost been concluded which will support the wellbeing of our people by providing a fantastic environment that includes training suites and so forth.

The moving of North EMSC from Bryn Tirion to Ty Elwy remains on track with great progress being made. The OCP has concluded in March 2025. Relocation transition is commencing w/c 28th April for Ambulance Care and the resource centre with EMSC moving on the 8th May 2025. The Chief Executive and Executive Director of Operations will join the team on 8 May. There is no requirement for others to attend as plans for a formal opening of the new Centre will follow.

Electronic Timesheets

The project board, team and supporting task and finish groups have now been established, terms of reference, project initiation document and project core principles agreed.

Resourcing Functional Model

Phase 1 of the transition to a functional resourcing model has commenced with the alignment of JCC Pan Wales and NET Centre resourcing aligned to one team (previously aligned to regions). Discussions have taken place to align NEPTS CW with NEPTS North which will be implemented from April.

General Update

EMSC Restructure and Reconfiguration

This is now embedding well with positive feedback from our people. The Operations Manager role has signalled a positive impact on some of our performance measures with real time supportive performance management in place.

MPDS Version 14

All emergency calls received by the Trust are prioritised using MPDS. This system is licensed and regulated by the International Academies of Emergency Dispatch (IAED) which provides the system with an overarching and robust clinical governance structure.

Version 14 of MPDS was successfully implemented in March 2025, this was a seamless transition. The enhancement to specific protocols will enhance patient care at the point of accessing our 999 services and the advice provided.

The implementation of Version 14 introduced substantial updates to the 'Pregnancy/Childbirth/Miscarriage' protocol. Notable changes include the removal of the cord pulse check instructions, the elimination of guidance on tying the umbilical cord with a shoelace, and the incorporation of recommendations to maintain appropriate warmth for both the newborn and the environment. These updates align with ongoing advancements in thermoregulation practices and underscore the Trust's active role in shaping global standards, particularly through its representation on the IAED's Obstetrics Council, ensuring the Trust's influence in these international revisions.

Additional updates include the revised protocol for honey administration in cases of button battery ingestion and enhanced instructions for cardio-pulmonary resuscitation, among other refinements.

Business Continuity Plan revised and updated

Following the implementation of Rapid Clinical Screening, the plans were updated to reflect those changes. Workshops were undertaken with Integrated Care colleagues to ensure robustness of the plans. These were tested during a planned C3 CAD server upgrade outage on the 31st March 2025 which tested the new plans and proved to be fit for purpose with a debrief planned for further learning and enhancement to the plans. This is a good example of the types of procedural or plan changes required as the Integrated Clinical Services Model evolves.

Emergency Medical Service

Challenges

Clinical Model Transformation

Work in progress to review affected SOPs and plan and develop training plans in preparation for implementation 1st July 2025 in line with the Welsh Governments announcement regarding the review of our current red targets and performance metrics and the 12-month trial shifting the emphasis from response times to patient outcomes.

Red Performance

Our ability to respond to the sickest patients remains difficult with the continued level of wider system pressures including handover delays at hospitals. Red performance remains below the 65% target and has done so for the past 12 months

Hospital Handover Delays

Patient transfer of care at the Emergency Departments has continued to be a significant challenge this last quarter. Work continues at both national and local level to improve this position where possible. Following the release of the Welsh Government WHC – Ambulance Patient Handover Guidance, meetings have now been held within the four Service areas with NHS Wales Executive, Health Boards and WAST Head of Service(s) to discuss actions against this guidance and future plans to support patient transfer of care.

IMTP

Advanced Paramedic Organisational Change Process

The APP OCP process is complete and the required number of Senior APPs (SAPP) in place. This saw the SAPP transition from Ops to the Clinical Directorate for management purposes, though the APPs remain within Operations. The remaining APPs throughout the Trust have now been aligned to a SAPP team where clinical leadership and mentorship will be provided. Ongoing APP recruitment against funded and approved vacancies will continue over the coming months.

DOM Roster Review

The final adjustments have been made to the DOM Roster Review process, and this will be completed soon with a concluding paper submitted to SOT & SLT.

General Update

Emergency Ambulance Practitioner (EAP) Training

Throughout this reporting period the EAP training courses have progressed at pace. Across the Trust there have been 6 completed courses and a further 3 ongoing that commenced on 24th March 2025. This means that circa 96 members of staff have completed their EAP course within this period and a further circa 48 actively ongoing.

The general uptake from staff to get allocated to a course date has been extremely encouraging with most staff being allocated to their first-choice course. Most staff who have attended the course have completed it, with a limited number requiring to leave the course for personal reasons. These will be allocated onto a future course to allow them to complete the EAP course objectives. Initial feedback from staff is that they are finding the course enjoyable and now wanting to commence the new EAP role operationally.

Glangwili Hospital End of Shift POD

Following an initiative through our Estates Department we have now opened the newer and larger end of shift handover POD at Glangwili Hospital. This newer POD compliments the PODS already in place in Morriston and YGC Hospitals and now has a capacity of 5 stretcher patients to further promote staff wellbeing and timely end of shift finishing.

To further support end of shift overruns planning has taken place to run a series of workshops in partnership with the aim of jointly determining methods of improving the

position and improving staff wellbeing. The first workshop is scheduled to take place on 1st April 2025.

Ambulance Care

Challenges

NEPTS Roster Review

The NEPTS roster review Working Parties have commenced with all areas completing the first 2 working parties of the 4 scheduled. The working parties are planned every 4 weeks to allow for information to be presented and allow station representatives to return to operational teams to discuss and input into the roster design process..

Through the working party process we have received a significant amount of feedback on both the process, rationale for change, methodology and data in addition to the outputs of local engagement for consideration. In addition, several respect and resolution requests were received from a number of staff groups, and a collective respect and resolution from trade unions.

Upon reflection of this feedback, we have decided that rather than continuing to progress upon the existing plan timelines, we need to review the feedback and adjust the timeline to ensure the most optimal methodology is in place to keep the review moving forward.

Further engagement will also be completed with our data modelling partner to identify any alternative solutions to address some of the concerns raised and also deliver improvements to our rostering position and service efficiency.

This will mean that the next working party will be delayed to accomodate this work. An additional session will also be introduced to feedback on the outcome of our considerations, set out the way forward, answer any questions that colleagues may have and consider and respond to any additional support requirements .

The additional time in the process will also allow us to respond to the respect and resolution submissions appropriately, hopefully through the utilisation of a single, combined process.

NEPTS Capacity Management Plan (CMP) Cancellations Update

The NEPTS service uses CMP to prioritise and manage situations where capacity exceeds funded resource available. This can result in patient transport being cancelled at late notice.

Over the past couple of years we have seen the number of times the CMP has been used increase reaching a peak in March 2025 when 900 patient journeys were canceled under CMP, the majority of which were for outpatient appointments . This may mean that patients are not able to attend their appointments and has resulted in an increase in concerns from elected members. Dialysis and oncology patients are continually prioritised.

Data analysis has identifed that increases in the acquity of patients, with proportionally more patients now needing an ambulance vehicle and an increase in the complexity and distance of journeys are directly contributing to reduced patient loading and reduced efficicency. High levels of short notice cancellations by patients and Health Boards also significantly impact on available capacity and a number of workstreams are underway to address this.

The service has been engaging with commisioners for some time on this matter and has illustrated the challenges faced and the actions required to address. Whilst progress is being made on the actions within our gift (which include the roster review), limited progress/feedback on actions that require system support has been received. Of particular concern are the levels of late notice cancellations made by Health Boards and patients, which stood at 5,265 for March 25. Late cancellation of journeys significantly impacts upon resource utilisation; if minimised this lost capacity could significantly reduce CMP cancellations.

IMTP

General Update

SMS Communication

2-way SMS communication has been live since the 24th February 2025 which allows service users that have opted in to cancel their transport if required. This reduces the need to call the Net Centre and has seen a positive increase in the number of cancellations prior to the commencement of the planning process. Within the last month Ambulance Care has seen 283 cancellation requests made through the system.
Whilst the initial volumes of cancellations are still very low when compared to the overall level of cancellations, upcoming changes to opt in procedures and additional 2-way text functionality will increase this volume.

Integrated Care

Challenges

Absence: this remains a concern; however, we have seen improvement in some areas. Call taker absence remains high but is decreasing (was 14.82% in Feb and 11.84% in March 25), with further improvements in April. Clinician absence has decreased from 14.2% in January 25 to 10.26% in March 2025.

Call Taking Performance: challenges remain in relation to call taking performance. Recruitment is ongoing through March and April 25. Additionally, there have been periods of extended waiting times for call takers accessing Clinical Advice (via the Clinical Advice Line), which has further impacted on call taking performance. Work is underway to explore pinch points and determine improvements.

Service User Experience: a review of patient experience for a 12-month period has demonstrated some elements of negative feedback. This includes issues with access, timeliness of advice/support and satisfaction. Numbers of returns are low (210 returns) for a 12-month period. The Integrated Care Senior Leadership Team (ICSLT) are meeting alongside colleagues from the Quality Management Group to consider improvement actions because of the feedback. Additionally, we will explore options to improve current returns of feedback, to ensure it is representative of the total demand, to inform future learning.

IMTP

General Update

Care Planning-

In collaboration with the Quality Safety and Patient Experience Directorate, the Integrated Care Team successfully secured continued investment for the LUSCII clinical platform, through Welsh Government funding. This platform is essential for the Care Planning function, so that clinicians can provide remote monitoring for patients accessing 999. The funding through the Small Business Research Initiative was due to end in March 25, but a successful evaluation presented to the Project Board led to continued funding through 25/26. The cross-directorate teams are now considering key metrics, ensuring robust data capture systems and will be working with external organisations to undertake a full evaluation. Further clinicians have also been recruited to continue to build resilience within the Care Planning function. A presentation was delivered at the Ambulance Service

Leadership Forum, highlighting the key evaluation findings along with qualitative feedback from clinicians.

LUSCII Evaluation: An evaluation was completed and shared with WAST and the SBRI programme board in March 2025, in relation to the LUSCII clinical dashboard. The evaluation report examined patient outcomes, final dispositions, staff experience feedback and care home staff feedback. The team were able to examine outcomes for incidents which did not require an ambulance response (dealt with by Care Planning) and those incidents which required a response to scene. A total of 291 patients were onboarded onto the LUSCII dashboard from the 22nd of August 2024 to the 13th January 2025, measured by LUSCII. A total of 143 patients were able to be further examined and outcomes captured from the WAST CAD system. A total of 52 incidents (36%) did not require a response to scene. A total of 67% of incidents not requiring a response, were dealt with by the Care Planning Desk function. Data demonstrated an increased clinician confidence, along with higher numbers of referrals to GP in hours/out of hours because of increased clinical intelligence. Care Home staff provided positive feedback, explaining that the LUSCII solution often helped residents to access services, which helped to avoid unnecessary admission to the Emergency Department.

External Evaluations: The team have supported the external evaluation of the Extended Clinical Hub and WAST SICAT. The evaluations are being completed by the South Central and West Commissioning Support Unit and will be available in April 25. The Integrated Care Team along with Insights and Data Services worked to consider metrics, capture appropriate data and provide the insights to support the wider evaluation.

Emergency Communication Nurse System (ECNS)

It was reported to SLT and ELT in January 2025 via a paper prepared by colleagues in Integrated Care to highlight the need for auditing within Integrated Care, specifically for the Call Prioritisation & Streaming System (CPSS) and the Emergency Communication Nurse System (ECNS)

The paper highlights the necessity of audits to ensure the quality and effectiveness of patient assessments. The Clinical Support Desk (CSD) holds the 'Accredited Centre of Excellence' (ACE) standard, which requires strict audit compliance. As CSD transitions to the Remote Integrated Care Service (RICS), it must meet these standards. Currently, there are insufficient audit resources to meet the required standards for CPSS and ECNS.

All Call Handlers use CPSS, and Clinicians use ECNS to assess patients remotely. Audits are essential to maintain service quality and inform individual practice. The CSD must audit 2.5% of all calls, with 93% compliance. At the time of preparing the report, each clinician was receiving an audit however rates of non-compliance were too high.

The introduction of CPSS and ECNS in the 111-service necessitated dedicated auditors. The current audit rate is below the required baseline, and this is inhibiting the Academy from establishing compliance standards.

The paper outlined three options for auditing, considering financial constraints, and subsequently the SLT and ELT agreed that it should sustain an ambition to attain and maintain centre of excellence accreditation standards. There are plans to grow auditors with financial investment this year and prioritise volume of audit ahead of improving the quality of feedback and response to audit outcomes.

Operations – Quarterly Sub-Report
Quality and Support Day Key Insights and Developments

Integrated Care

Quality & Support days continue to be a key focus in Integrated Care. These dates are planned well in advance to free up our managers, allowing them to have quality time in face-to-face meetings with staff. This dedicated time is used to listen to staff in a safe space about issues and concerns raised.

We begin each session with a consistent set of wellbeing questions, focusing on wellbeing scores and ways to improve them. By prioritising how staff feel right from the start, we establish a rapport and emphasize their wellbeing, rather than seeking data that only serves the Trust's interests.

The results provide trackable reported wellbeing scores, which we can compare month on month. This should provide earlier awareness of any deterioration in staff morale or increased issues coming to the forefront. These insights are invaluable as they allow us to learn about the underlying factors affecting staff wellbeing and morale. By understanding these factors, we can tailor our support and interventions more effectively.

We utilise themed questions that allow us to deeply dive into specific areas of learning, choosing metrics that align with our objectives.

1. **Communication Styles and Preferences**: Understanding how staff prefer to communicate helped us improve our internal communication strategies and ensures everyone feels heard and understood.
2. **Staff Wellbeing and Morale**: Focusing on the overall wellbeing and morale of staff allowed us to identify areas where support is needed and implement measures to boost morale based on direct feedback from staff at ground roots level.
3. **Sexual Safety at Work**: Addressing the sexual safety topic ensured that staff feel safe and respected in their workplace, which is crucial for a healthy work environment. It allowed space to have conversations around culture, which was prominent in the media at the time of the Quality and Support Day. We were able to identify staff who felt they wanted more training on this topic and utilised the time to signpost to appropriate resources.

4. **You Said – We Did (Feedback Day)**: This theme allowed us to show staff that their feedback is valued and acted upon, fostering a culture of continuous improvement, trust and demonstrating effective listening to our staff.
5. **Christmas Wellbeing**: Focusing on wellbeing during the holiday season helps us address any challenges staff may face during this time of increased pressures and ensures they feel supported. We have been able to establish ideas for improvement on next year's Christmas planning.

These themed days (Item 5.1a) allow us to really probe into how staff feel about particular topics and provided direction and guidance when considering future Quality and Support Day themes. We have been able to link in with other groups such as the Wellbeing Cell, Christmas Planning team and Communications colleagues to work collaboratively, share knowledge, and avoid inundating staff with forms and surveys. We have been able to collate qualitative data that has provided valuable insights into the effectiveness of our initiatives, by learning from these insights, we can continuously improve our approach to staff wellbeing and create a supportive and responsive work environment.

EMS Response

The latest Quality & Support Day took place on 13th February 2025 and saw EMS managers, including DOMs, LMs, SMs & HoS engaging with as many on-duty operational staff as possible. The key focus areas for this particular day were:

- Dyson Bladeless Fans

- Respiratory Protective Equipment (RPE) – Versaflow Hoods

- Use of Shorelines at Hospitals

- Vehicle Security

- Vehicle Communications

An MS Form was designed covering the above subjects to ensure a consistent and transparent approach Trust wide. A total of 85 crews were engaged with at either hospital sites or ambulance stations covering the 7 Health Board areas.

The discussions with crews focussed on raising awareness, promoting appropriate use of equipment and following best practice, and to generally have a supporting two-way discussion. The newly introduced Dyson Bladeless Fans and the vehicle based RPE were extremely topical and timely for the appropriate level of discussion.

Some key learning and future workstream requirements came out of the QSD in relation to vehicle communications. An audit has been completed which showed a depletion in communication devices on board our vehicles. This has obviously initiated some further digging in relation to the locations, connectivity requirements and how we communicate in

2025 in comparison with when the mobile devices were purchased in 2015. A working group lead by the Service Manager, North EMS will be initiated to look into alternative options of communication, firstly at nil cost, but then considerations will be given to other options for completeness. We consider this as a potential risk to the organisation so priority will be given to this piece of work.

We will also be revisiting the Dyson bladeless fans topic once all have been installed at ED sites pan Wales. We felt the data did not represent a true picture of the user experience due to the limited number of fans in situ at time of data collection.

The attached presentation slides (Item 5.1b) summarise the crews' responses to the MS Form feedback which is generally very positive and again demonstrates that the Quality & Support days are very effective tools in increasing manager visibility and providing support to staff.

Ambulance Care

On February 25th, the Quality Support Day focused on enhancing the operational efficiency and safety of ambulance services, particularly through the lens of Shift Start and Vehicle Security during shifts. This initiative aimed to ensure that staff are well-prepared, and vehicles are properly checked before commencing their duties.

Key Areas of Focus

1. **Shift Start SOP Awareness:**

The survey revealed that approximately 25% of staff were not aware of the Shift Start Standard Operating Procedure (SOP). This highlights a significant gap in communication and training, suggesting that more efforts are needed to ensure all staff are familiar with these crucial guidelines.

2. **VDI Completion:**

Vehicle Daily Inspection (VDI) processes showed variability, with 50% of staff completing paper-based forms alongside MDVS (Mobile Data Vehicle System) acknowledgments, while the other 50% relied solely on MDVS acknowledgments. This inconsistency points to the need for a standardised approach to VDI completion to ensure thorough and uniform checks.

3. **Understanding VDI Requirements:**

There was confusion among staff regarding the correct procedure for completing a VDI for a cold vehicle. Responses varied from 5 to 30 minutes, whereas the correct procedure stipulates 15 minutes. This indicates a need for clearer instructions and training to ensure staff are aware of the proper protocols.

Proposed Interventions

Based on the survey results, three focused interventions have been identified to address these issues:

1. **Aligning the Shift Start SOP:**

Minor adjustments are needed to better align the Shift Start SOP with the needs of NEPTS (Non-Emergency Patient Transport Services) teams. This will help ensure that all staff, regardless of their specific roles, are on the same page regarding shift commencement procedures.

2. **Improving VDI Completion:**

Efforts will be made to standardize the VDI completion process, ensuring that all staff follow the same procedures and understand the importance of thorough vehicle inspections. This may involve additional training and clearer guidelines**.**

3. **Reviewing MDVS Functionality:**

The functionality of the MDVS will be reviewed to prevent duplication of VDI checks and streamline the process. This will help make the system more efficient and user-friendly, reducing the likelihood of errors and ensuring that all necessary checks are completed.

The Quality Support Day (presentation Item 5.1c) has provided valuable insights into the current practices and areas for improvement within ambulance care. By addressing the identified gaps and implementing the proposed interventions, the goal is to enhance the overall efficiency, safety, and preparedness of ambulance services. These changes will not only benefit the staff but also ensure better care and service for patients.

NB:

To streamline meeting materials, a 'reading room' has been established in Ibabs. This digital space hosts documents for additional information, not essential for scrutiny or decision-making. Annexes 5.1a, 5.1b and 5.1c are available there. Access to the reading room is through the documents/shared folder in Ibabs' main menu. Documents in the reading room will not be posted on the Trust's website with committee papers; however, copies can be provided upon request

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

AGENDA ITEM No	**7**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**4**

STRATEGIC QUALITY PLAN 2025-2028

MEETING	Quality, Patient Experience and Safety (QuESt) Committee
DATE	09 May 2025
EXECUTIVE	Liam Williams, Executive Director of Quality & Nursing
AUTHOR	Kate Blackmore, Assistant Director of Quality Governance
CONTACT	Kate.blackmore@wales.nhs.uk

EXECUTIVE SUMMARY

1. **Quality Strategy Review:** The current Quality Strategy was extended until April 2025 to facilitate the development of a new Strategic Quality Plan that aligns with the Trust's long-term strategy. This plan aims to improve quality outcomes within existing financial constraints.

2. **Stakeholder Engagement:** Feedback was gathered from various stakeholders, including patients and community members, to inform the development of the Quality Plan. This input was essential in shaping a plan that reflects the needs and expectations of those served by the organisation.

3. **Strategic Quality Plan for 2025-28:** The plan outlines a comprehensive approach to enhancing healthcare services provided by the Trust focussing on key areas such as population health, value-based healthcare, person-centred care, and the integration of technology and innovation. The strategy emphasises building capability and capacity within teams, leveraging data and insights for evidence-based decision-making, and strengthening system partnerships to align services with broader health and care objectives across NHS Wales. It highlights the importance of quality management systems and continuous improvement, ensuring inclusivity and equity so that all patients receive compassionate and personalised care.

4. **Implementation Considerations:** The plan emphasises the importance of resource availability and outlines the need for a clear implementation strategy to ensure achievable delivery of quality services. It acknowledges the challenges posed by financial and capacity constraints within the public sector.

RECOMMENDATION, That Quality, Patient Experience and Safety Committee (QuESt) approve the Quality Plan.

KEY ISSUES/IMPLICATIONS
1. **Financial Constraints:** The plan aims to achieve improved quality outcomes within the existing financial envelope, recognising the challenging financial position within public sector spending and the NHS in Wales. 2. **Capacity Constraints:** The plan takes a pragmatic approach to enhancing the quality of healthcare services provided by the Trust, acknowledging the capacity constraints of the organisation as it moves through its transformation journey. 3. **Leadership and Governance:** Leadership development and effective governance are highlighted as essential for delivering high-quality patient care. The strategy aligns with the "Our WAST Way" principles and the Health & Care Quality Standards 2023, emphasising the need for clear direction, accountability, and a culture of continuous improvement.

REPORT APPROVAL ROUTE
Clinical & Quality Governance Group - 14 April 2025 Executive Leadership Team - 23 April 2025 Quality, Patient Experience and Safety Committee - 9 May 2025

REPORT APPENDICES
ANNEX 1 – SBAR providing background information ANNEX 2 – DRAFT Strategic Quality Plan 2025-2028 ANNEX 3 – DRAFT Implementation Plan ANNEX 4 - EQIA

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

SITUATION

1. The Quality Strategy was due for review in 2024 a paper presented to the Quality, Patient Experience and Safety Committee (QuESt) dated 13 August 2024 set out the approach, framework and timeline for developing a new 'Quality Plan' than aligns with the Trust's long-term strategy.

2. QuEST approved an extension of the current strategy until 1 April 2025 to allow the development of a robust Strategic Quality Plan for 2025-2028.

3. This paper sets out the approach to developing the Strategic Quality Plan and seeks approval of the content of the plan and the development of an associated implementation plan.

BACKGROUND

4. Key legislation and statutory guidelines were considered when developing the approach to the review of the Strategic Quality Plan 2025-2028. Consideration was also given to alignment of the plan with the updated Strategic Clinical Plan.

5. To understand the expectations and experiences of our key stakeholders, a range of feedback opportunities were provided. The Patient Experience and Community Involvement teams collaborated with members of the People & Community Network to explore their vision for a high-quality ambulance service. Quality Leaders also engaged with directorate leads through established governance forums to gather insights on what quality means within their areas of responsibility and what they believed should be reflected in the Strategic Quality Plan. Additionally, a survey was distributed to staff to capture their views and experiences of quality in practice. All feedback was collated and thematically analysed to identify strategic opportunities aligned with stakeholder priorities.

6. Strategic direction on key areas for development of the organisation was provided by the Executive Director of Quality & Nursing aligned with our statutory and regulatory responsibilities.

7. The original intention was to align the development of the Strategic Quality Plan with the revision of the Strategic Clinical Plan. While the Clinical Directorate actively contributed feedback and shaped elements of the Quality Plan, the Clinical Plan was not sufficiently developed to enable full alignment at this stage.

ASSESSMENT

8. The Quality Governance Follow Up review undertaken by Audit Wales and issued in September 2024 provided updated recommendations for the Trust when considering Quality Governance. Recommendation 1 (2024) states "As the Trust develops a new Quality Plan in 2024, it should ensure that delivery is achievable within the resources available. The plan should clearly detail the funding required, the risks of under-delivery (due to capacity and resource constraints) and be underpinned with an implementation plan."

9. Given the challenging financial position within public sector spending and the NHS in Wales as a whole, the aim of the Strategic Quality Plan for 2025-2028 was to achieve improved quality outcomes within our existing financial envelope. Whilst it is acknowledged that it is the desire of the organisation to go further with our quality agenda it is important to recognise not only the financial constraints but the capacity constraints of the organisation as we move through our journey of transformation.

10. Accordingly, the Quality Plan adopts a pragmatic approach to enhancing the healthcare services provided by the Trust. It focuses on developing the necessary infrastructure, intelligence, capability, and capacity to meet our statutory and regulatory responsibilities, while also responding to stakeholder feedback and advancing our understanding of the Trust's role in population health and the delivery of value-based healthcare.

11. The plan looks to recognise the valuable contributions of other strategic plans in delivering this capability viewed through a quality lens. System Matter Experts from across the organisation have supported the drafting of content for their relevant areas to ensure that it achieves the desired outcomes for shared strategic objectives.

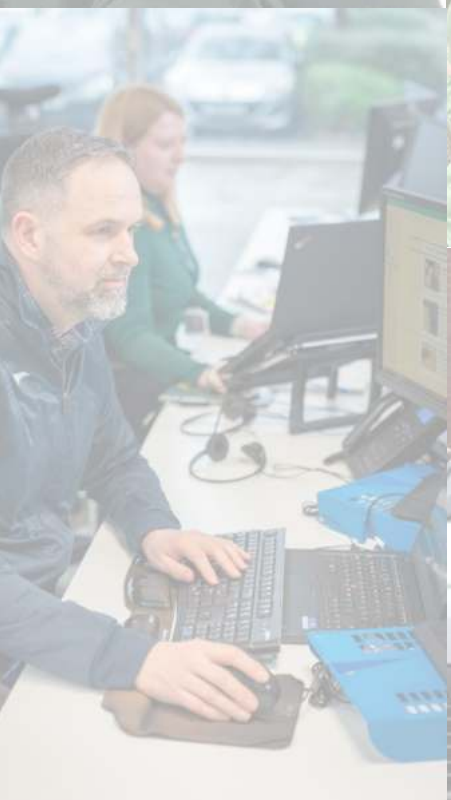
12. The plan supports the Trust's strategic transformation into a trusted provider of quality care—ensuring patients consistently receive the right advice and treatment, in the right place, at the right time. It sets out clear initiatives to improve population health, reduce health inequalities, and promote prevention and healthier lifestyles. Central to the plan is the intelligent use of data and system integration to drive clinical excellence and deliver measurable improvements in patient outcomes.

13. Leadership development and effective governance are highlighted as essential for delivering high-quality patient care. The strategy aligns with the "Our WAST Way" principles and the Health & Care Quality Standards 2023, emphasising the need for clear direction, accountability, and a culture of continuous improvement. The plan includes actions to embed compassionate leadership practices, develop leaders at all levels, and build effective partnerships.

14. The strategy also focuses on quality governance, quality management systems, and quality improvement, ensuring that all functions within the organisation are aligned with the goal of delivering high-quality services and compassionate person-centred care. It includes actions to develop training and specialist expertise within teams, build organisational capacity for improvement, and celebrate individual and team contributions.

15. The Integrated Medium-Term Plan identifies the need for a detailed implementation plan for the Strategic Quality Plan during 2025/26. To support the approval process, a high-level draft has been developed, demonstrating clear alignment with other strategic priorities and the allocation of executive leads. While delivery timescales are currently being finalised, the draft provides a strong foundation for phased implementation and is included as an annex to this paper.

Strategic Quality Plan 2025-2028



Published: DD/MM/YYYY

Contents

Introduction

Our Strategic Quality Plan for 2025-28 outlines a comprehensive and forward-thinking approach to enhancing the quality of healthcare services provided by the Welsh Ambulance Services University NHS Trust. It is designed to address the evolving needs of our population, ensuring that our services are not only efficient and effective but also equitable and inclusive.

Our vision is to deliver excellence in healthcare by focusing on key areas such as:

By building capability and capacity within our teams and leveraging data and insights for evidence-based decision-making, we aim to strengthen system partnerships to ensure that our services are aligned with the broader health and care objectives across NHS Wales.

The strategy emphasises the importance of quality management systems and continuous improvement, highlighting our commitment to inclusivity and equity, ensuring that all patients receive compassionate and personalised care. Additionally, the document outlines our approach to corporate parenting, leadership development, and community involvement, demonstrating our dedication to supporting the health and wellbeing of our staff, volunteers and the communities we serve.

A key aspect of this strategy is its co-produced approach, developed through listening to our people, the broader organisation and our community networks. By engaging with our People and Community Network, we have included insights from lived experiences and community feedback, ensuring that our strategy aligns with the needs and preferences of those we serve. To ensure our Strategic Quality Plan remains relevant and effective, it is important to maintain an open dialogue with all stakeholders to gather insights and suggestions on how we can adapt to changing

environments. The implementation of this strategy will facilitate open communication to build trust and ownership of the quality of our services.

Through this strategy, we will enhance our ability to deliver high-quality care, improve patient outcomes, and drive innovation in healthcare. Our long-term vision is to transform the Welsh Ambulance Services University NHS Trust into a trusted provider of high-quality care, ensuring that patients receive the right advice and care, in the right place, every time.

Population Health

As a Trust, we aim to ensure our daily interactions with our patients, the public and our people improve health and wellbeing. Our Quality Plan aims to promote key initiatives to combat population health challenges in Wales by preventing ill-health, reducing future risks, and advocating healthy lifestyles and choices, helping our patients, staff and volunteers to stay healthy.

> A quality ambulance service will deliver a **population health approach**, which aims to "improve physical and mental health outcomes and promote wellbeing, whilst reducing health inequalities within the population" (Buck *et al.* 2018).

The Association of Ambulance Chief Executives (AACE) recognises the opportunity of strengthening the role of the ambulance sector in **reducing health inequalities**, and it has developed an implementation toolkit setting out how ambulance services could approach this through four key enablers:

Work has already started on how we can focus on those enablers within Wales. In April 2024, we completed a 'maturity matrix' to identify our current

achievements against the four key enablers and identified gaps and opportunities for our future population health approach.

1. Building Public Health Capacity and Capability:

A quality health service includes prevention. It is important that all of us recognise our role in promoting prevention and the opportunities around supporting our patients, ourselves, our colleagues and our communities to live healthy lives. Identifying opportunities to support our people to have key skills in this, as well as input from public health specialists, will support WAST in delivering a service with population health embedded within it.

2. Data, Insights, Evidence, and Evaluation:

A quality driven health service uses data and insights to deliver an evidence-based approach, with regular monitoring and evaluation to ensure that it is delivering the right service to meet the needs of the population. We are facing a changing population, with an increasing ageing population and higher levels of complex health conditions. By turning data into knowledge, we will understand the level of health needed in the population now and for the future. As we better understand health inequalities, we can better deliver and adapt services to meet the aims of a population health approach.

A quality health service needs to be well-connected and able to access the right information at the right time. When healthcare providers share data safely and effectively, it helps tailor care to individual needs and improve outcomes. Our Digital Plan for 2024-29 outlines how we will use data, information, and insights to support better decision-making and enhance the care we provide. We have already started this work—for example, through the Welsh Demographic Service (WDS) lookup, which links patient records using NHS numbers. This important step helps us better understand the full journey of care, supporting more joined-up services and moving us closer to a value-based approach that puts patient outcomes first.

3. Strategic Leadership and Accountability:

A quality health service will have population health embedded within strategy and policy, with senior leadership support and advocacy. Within WAST, our strategy 'Delivering Excellence, Our Vision for 2030' highlights the importance of population health and delivering equitable care, but more can be done to strengthen this approach and increase accountability for everyone in the organisation to consider how we can support our patients, and our people, to have the best health outcomes and wellbeing we can.

4. System Partnerships:

A quality health service will work with other health and care providers to support the best health outcomes throughout a patient's journey, with everyone working to the same population health objectives. Aligned with the Health and Care Quality Standards 2023, we will continue our journey towards a 'Whole Systems Approach', understanding how the decisions we make impact our system partners across NHS Wales and the emergency services. We will collaborate with system partners to identify improvements, innovations, and transformations that consistently and sustainably meet the changing needs of our service users and achieve positive

Value Based Health Care

Our long-term strategy emphasises the importance of achieving optimal health outcomes for our patients by delivering services in the most efficient and **value focused** manner. Value can be considered across four pillars:

- Appropriate care to achieve a patient's personal goals (personal value)
- Achievement of best possible outcomes with available resources (technical value)
- Equitable resource distribution across all patient/client groups (allocative value)
- Contribution of healthcare to societal participation and connectedness (societal value)

We are committed to embedding the principles of **personal value** by measuring the outcomes that matter to people and using data and intelligence to drive innovation, improvement and learning for us as an organisation. Embedding co-production and lived experience methodologies within our planning and innovation design principles, through engagement with our People and Community Network, will provide insights into how we can improve the personal value of our population.

In evaluating **technical value**, the principles of value-based healthcare ensure that available resources are utilised in an equitable, sustainable, and transparent manner to achieve better outcomes and experiences for our population, and that we optimise our contributions to research and innovation to deliver and evaluate evidence-based practice and share our learning with the wider ambulance sector. When considering patient outcomes, it is essential to account for both clinical results and patient-reported outcomes, which include the experiential and relational impacts of the services received. Striking a balance between these factors will enable us to provide a high-quality service that is focused on value, ensuring responsible use of public funds to deliver enhanced patient outcomes.

Building on the work of the Digital Plan 2024-2029 and population health, with a focus on data insights and intelligence, and the deliverables from our long-term vision for 2030 'Delivering Excellence', we will strengthen how we use our data as intelligence to inform how resources are distributed to add **allocative value,** promoting and monitoring for equity of services both through what we deliver, and using our intelligence to inform the wider health and social care system where inequities or gaps are found.

We play a vital role in delivering **societal value,** not only through the way we provide care to patients and the public, but also by how we engage with communities, support wellbeing, and create employment, volunteering, and development opportunities for people across Wales. Set out in our well-being objectives, as a

newly named organisation under the Well-Being of Future Generations (Wales) Act 2015 and aligning with our strategic population health and long-term strategy for 2030 objectives, we will continue to provide quality by being a socially responsible and inclusive employer, as well as continuing our work through engaging with volunteers and communities across Wales.

In pursuit of delivering value in healthcare across Wales, the Welsh Value in Health Centre's *Strategy to 2024* underscores the importance of a whole-system approach encompassing prevention, early and accurate diagnosis, timely intervention, ongoing care, and end-of-life support. Aligned with this vision, we will continue to embed value-based principles across our directorates and workstreams, working in partnership with system leaders and identifying the unique and meaningful contributions that our ambulance service can offer to the broader health and care landscape in Wales.

Person Centred Care

Communication

Feedback from our service users reinforces that person-centred care means being respectful and responsive to each individual's preferences, needs, and values. Patients consistently highlight the importance of empathetic, caring, and communicative staff and volunteers who can offer reassurance during often stressful situations—whether in person or over the phone. This must be complemented by clear, high-quality communication that treats patients as equal partners and supports shared decision-making. As we progress on our transformation journey, it is essential that we equip our people with the skills and training to strengthen compassionate communication, ensuring meaningful engagement with all communities and meeting patient needs and preferences wherever possible.

This commitment extends to how the organisation responds when things have not gone well. We recognise that how we communicate with individuals who have had negative experiences is crucial to rebuilding trust in our service and ensuring meaningful learning. Our approach will increasingly incorporate restorative practices, focusing on personalising our responses to complaints, patient safety incidents, claims, and redress ensuring we address the aspects that matter most to those affected and fully explore opportunities for improvement.

In line with the Duty of Candour, we will continue to build on our practices of being open and transparent when helping patients and their loved ones understand how their care was delivered, and where changes will be made to provide better care or an improved experience in future. We will continue to build our culture of candour in all our work through education and training, increasing our people's confidence in offering meaningful apologies and holding sensitive conversations. Whilst it is the Patient Safety Team who lead on enacting and monitoring the implementation of the Duty of Candour we must all understand our responsibilities.

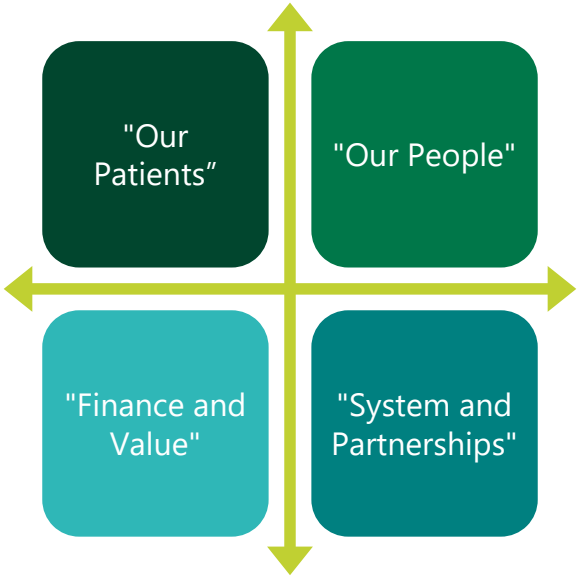
Hearing our Citizen's Voice

Ensuring that patient impact is at the heart of all decision and discussions we will take a collaborative approach to quality discussion both internally and with our service users and system partners. We will review our governance processes to include an annual review of the actions we have taken based on our Citizen's Voice and ensure that we continually improve our approach to learning in this way.

We have a shared commitment to delivering the best possible service to the public, including learning from poor experiences and outcomes, and fostering a culture of continuous improvement.

Traditionally, we have used time-based metrics for our three services (111, 999 and Ambulance Care) to gauge patient safety and clinical outcomes. We recognise the need for a more balanced assessment involving patient safety measures, experiential measures, and the relationship between process (lead) and outcome (lag) measures. In March 2025, the Welsh Government announced the creation of a new purple category which we will introduce for responses to life-or-death cardiac and respiratory arrests. The associated changes to the response targets will focus on outcomes with links to the chain of survival metrics for cardiac arrest and an intention of linking our data with health board intelligence to create the national cardiac database.

Through our Clinical Model Transformation (CMT) Programme, we will implement this new purple category. Supported by a Metrics Workstream, the programme will develop a scorecard approach aligned with our Quality and Performance Management Framework balanced across the four quadrants:



This more balanced approach ensures that performance is assessed through a wider lens moving beyond time-based metrics to include key factors such as safety, experience, and relational aspects of care. While further development of these measures is ongoing, our Quality and Performance Management Framework is designed to promote this broader perspective

In support of this, the CMT programme will undergo a collaborative and independent evaluation to assess its impact within the Quality and Performance Management Framework.

Community Involvement

The Trust's People and Community Network offers members of the public a platform to engage in and contribute to our work. We are committed to expanding the network to better reflect the full diversity of the communities we serve. Plans are in place to grow membership with a particular focus on age, geography, diversity, equity, inclusion, and Welsh language representation. These plans, developed through a population health lens and aligned with the Trust's Integrated Medium-Term Plan, aim to strengthen meaningful community involvement and ensure all voices are heard in shaping our services.

Through our continuous engagement cycle with patients and the public, we will work to provide assurance on compliance with the Health and Social Care Quality Engagement Act by increasing the reporting of impacts and outcomes of our engagement activities and ensuring that experiences and feedback are considered to inform service change.

Corporate Parenting

> Corporate parenting refers to the "collective responsibility of partners when a child enters care...to safeguard and promote the rights and life chances of care-experienced children and young people". (*Welsh Government 2023, Corporate Parenting Charter - A Promise from Wales.*)

We are committed to our responsibilities as a Corporate Parent and are dedicated to addressing the specific needs of care-experienced children and young people. This

means ensuring their voices are heard, their views are considered, and they are actively involved in decisions that affect them, while keeping them informed throughout. Our communication must be clear, compassionate, and tailored to support their understanding and confidence. To truly fulfil these commitments, we must adapt our systems and ways of working. With this in mind, we have identified key actions to support meaningful and lasting change.

5 Key Actions:

- Identify care-experienced children and young people accessing the Trust's services.
- Collaborate with children, young people, and partner agencies to understand their needs.
- Adapt systems and processes to meet these needs once identified.
- Provide additional training for WAST staff and volunteers to better support care-experienced individuals.
- Ensure the voices and wishes of care-experienced children and young people are actively considered in all decisions.

Leadership and Governance

Leadership Development

Empowering leadership and effective governance are essential for delivering high-quality patient care and as such, our Quality Plan aligns with our People and Culture Plan and is guided by the "Our WAST Way" principles and the Health and Care Quality Standards 2023. The Quality Plan highlights the need for clear direction, accountability and a culture of continuous improvement.

A culture of learning and growth flourishes when staff and volunteers feel valued, respected and supported. When leaders embrace compassionate, inclusive practices, they create an environment where people are confident to speak up, challenges are constructively addressed, teamwork thrives, and innovation is encouraged. This in turn empowers staff and volunteers to deliver compassionate and patient-centred care.

Investing in leadership development equips leaders with the skills for collaboration, accountability and innovation. By building effective partnerships and seeking continuous feedback, we ensure services remain relevant and effective, creating a cycle of improvement that benefits our staff, volunteers, patients and communities.

We will:

- Embed compassionate leadership practices at all levels, ensuring leaders model inclusivity and create environments where staff and volunteers feel supported, valued, and empowered. *(Culture)*
- Develop and support leaders at all levels to integrate quality into daily decision-making and uphold high standards of care. *(Capability)*
- Build effective partnerships with trade unions, internal teams and external networks to co-produce and collaborate on key initiatives. *(Capacity)*
- Strengthen change management capability to drive innovation, transformation and efficiency, while embracing new models of care and service delivery. *(Capability)*
- Continue to pursue a holistic mature health and safety culture to enable our staff and volunteers to work as reasonably practicable whilst providing excellent care to our patients.

By committing to these actions, we will establish a culture where leadership inspires quality, collaboration and continuous improvement.

Quality Governance

Our quality governance structures provide integrated forums where feedback, intelligence and collaboration is embraced, and specialists are aligned with local leaders to create an environment of continuous improvement. By growing these relationships and embedding the Health and Care Quality Standards 2023 into how we monitor and evaluate our transformation, innovation and improvement we can identify and mitigate risks, driving quality into everything we do. We will review our Quality Impact Assessment processes to ensure that they are proportionate and user-friendly, supporting the professional judgement of our leaders as a developing tool to identify risks and consequences of our proposals. Embedding assessments at every level of improvement and transformation will create an environment that is focused on quality and safety.

To turn data into knowledge, we use Datix Cymru, our electronic concerns management system to record, monitor, and investigate incidents, feedback, claims, inquests and mortality reviews. The quality of our insights depends on the accuracy of the data, its alignment with service areas, and our ability to theme findings for learning and improvement across the organisation. We will enhance the governance and configuration of our information platform to ensure user-friendliness and provide accessible training materials. These improvements will enable timely learning and support our continuous improvement journey.

Quality Management Systems

Quality is at the heart of the NHS in Wales, and as such, quality management systems are essential for ensuring that our healthcare services are safe, effective and continuously improving. They provide a structured framework for monitoring and evaluating the quality of care, identifying areas for improvement and supporting the implementation of necessary changes.

A robust quality management system brings all information surrounding quality together to implement effective change and improvement in care. Our commitment to continually developing our quality management systems will ensure that all functions within the organisation are aligned with the goal of delivering high quality services and compassionate person-centred care.

Quality Control

As part of our operational activity, it is important to have clear quality control processes. These daily management processes are designed to monitor the quality of the services we deliver and ensure sustainable results by creating and maintaining the culture and processes for those closest to the work to act and to keep the system in control, escalating when appropriate. Quality control processes are an integral part of our quality management systems and are not restricted to our frontline service delivery.

Through the work of our Quality and Performance Steering Group, we will support all teams to assess their quality management systems and identify opportunities for improvement, ensuring that all functions have robust quality control processes in place. Insights gained from these activities will be shared through our quality governance structures, promoting a culture of continuous learning and improvement across the Trust.

Our approach to learning is a maturing one as we seek to learn from what routinely goes well in addition to adverse events. Our quality control analysis should also promote 'double loop' learning, encouraging us to question underlying assumptions about the traditional role of the ambulance service. This reflective approach enables us to challenge established ways of working, fostering innovation and transformation to better meet the evolving needs of our population.

Quality Improvement

A robust quality management system relies on effective improvement processes to ensure the consistent delivery of safe, high-quality care, alongside efficient resource use and productivity gains driven by innovation and technology. Embedding a culture of continuous quality improvement requires a balance between sound change management principles and the application of proven quality improvement methodologies. These methodologies are essential for helping teams fully understand the root of a problem before designing and implementing meaningful change. To embed this approach across the organisation, we must create the conditions and build the capacity for our people to think differently and drive improvement. This includes developing training and specialist expertise, and providing experiential learning, coaching, and mentorship—empowering staff and volunteers at all levels to lead and deliver effective quality improvement initiatives.

Organisational improvement should address both immediate issues as well as longer-term strategic changes, enabling agile change in response to specific goals or risks but also addressing systems-based improvement, seeking to understand and influence complex, interconnected healthcare systems. We will take a systemic view through quality improvement methodology, considering our operational complexities, to create a supportive environment for change through co-production methods with those who need, use and deliver our services.

Creating a culture of inclusivity and equity we will focus on delivering compassionate, patient-centred care through strengthening communication, fostering empathy, and encouraging openness within and between departments which is vital for achieving continuous quality improvement.

By celebrating individual and team contributions and embedding collaborative approaches, we will enhance our cultural competence and address diverse needs effectively.

- Quality improvement methodology: Build an organisational improvement methodology around the Institute for Healthcare Improvement (IHI) principles and frameworks.
- Building capacity and conditions: Develop the capacity and conditions for staff and volunteers to think differently and balance change management principles with quality improvement
- Quality improvement training: Provide training that includes data analysis which equips staff with necessary skills for continuous improvement and creates a supportive system of improvement.
- Systemic view of improvement: Utilise quality improvement methodologies to take a systemic view, considering complexity and co-production methods involving all stakeholders.
- Developing skills and empowerment: Develop skills for staff at all levels to deliver quality improvement projects and become empowered to drive change.
- Demonstrating impact: Develop systems to demonstrate the impact of improvements at national, regional, and local levels, including small projects to large-scale interventions.

Quality Assurance

Our quality assurance systems ensure that the care and services we provide to our patients and service users is safe and meets the standards we require. These standards are aligned to the Health and Care Quality Standards 2023. Through quality assurance, we monitor our processes and procedures ensuring that we are identifying opportunities for learning and improvement in the services we deliver, following quality improvement initiatives that monitor activity to ensure improvement has been achieved. Assurance comes in many forms including internal and external audit, inspection, peer review or statutory/regulatory reporting. It may even be in the form of feedback from our patients and service users.

In line with the Duty of Quality, we are committed to ensuring we have robust quality management systems across all functions of our organisation, and we continue to

support our teams in developing and continually improving their quality assurance processes. This means we will work with teams across the organisation to ensure we have clear quality statements in place to describe what quality means for each function. We will support quality assurance self-assessments to identify improvements we can make in our internal processes and will support the development of information and intelligence data to help us monitor our services in line with the Health and Care Quality Standards 2023. Our quality impact assessments will guide our monitoring and evaluation standards, providing assurance that we have achieved the improvements set out, therefore we will continue to develop our quality impact assessments processes to make it clearer and easier for leaders and innovators to consider the impacts of our decisions on our people, our patients and our stakeholders. Through the continual improvement of our quality assurance processes, we will help to reduce risks, improve results and build public trust.

Quality Planning

The Quality and Performance Management Framework offers a consistent approach for improving service quality and patient outcomes by monitoring and enhancing performance across individual, team, and organisational levels.

Central to the framework is the role of effective planning in driving improvement. This includes strategic plans aligned with the Trust's overarching purpose, Integrated Medium-Term Plans (IMTPs), and more detailed programmes or directorate-level strategies. The framework also ensures alignment at the individual level through personal development reviews, connecting staff contributions directly to organisational goals.

The Quality and Performance Management Steering Group will support teams in evaluating their quality management systems, identifying areas for improvement, and embedding robust quality control processes. Insights from these activities will be shared through our quality governance structures to drive continuous learning and improvement across the organisation.

Implementing a quality planning approach ensures compliance with the Health and Care (Quality and Engagement) Wales Act, facilitating strategic decision-making that considers the 12 health and care quality standards. As an organisation, we will evaluate our performance against these standards to identify opportunities for improvement, foster learning, and establish monitoring mechanisms. Furthermore, we will enhance our quality impact assessments processes to provide clarity and simplicity, enabling leaders and innovators to assess the impacts of our decisions on our people, patients, and stakeholders.

'Delivering Excellence' is the Trust's long-term strategic framework which sets out the future vision for the organisation up to 2030. The strategy articulates the organisational ambition to shift away from being perceived as a 'traditional ambulance and transport service' to becoming a trusted provider of high-quality care, ensuring patients receive the 'right advice and care, in the right place, every time', with an increasing emphasis of managing and resolving more care closer to home to improve patient outcomes, but being there for patients with a serious injury or illness that require immediate emergency care. The strategy provides a clear vision for the whole organisation and is therefore focused upon the continued evolution of our Clinical Service Model, along with changes across the broader organisation. We will continue to use quality impact assessments to inform our decision-making processes in this domain. These assessments aid in identifying the effects of our transformation efforts, enabling us to mitigate potential harm to patients and staff, as well as to recognise risks affecting our organisation and the broader NHS Wales community.

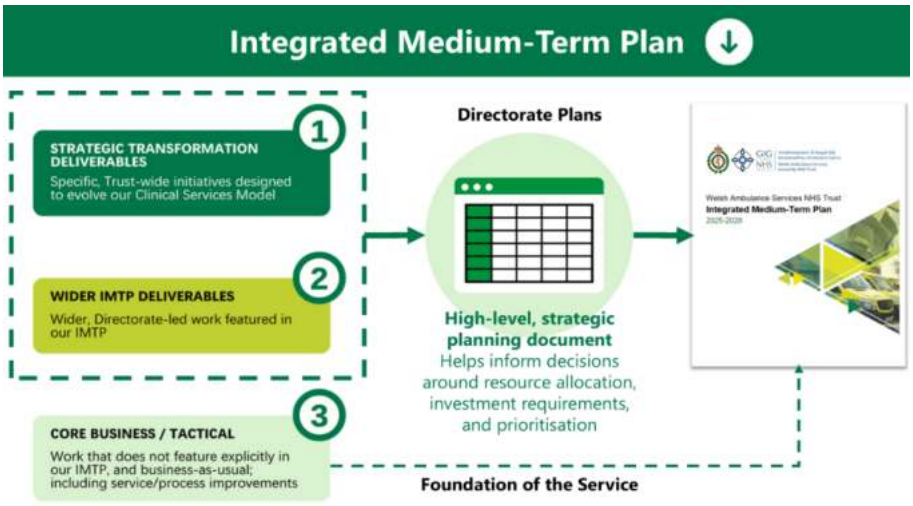
Our long-term strategy was developed with valuable input from staff, service users, and wider health system stakeholders. It addresses key challenges across Emergency Medical Services, Non-Emergency Patient Transport Services, and NHS 111 Wales. Informed by demographic trends and data from Public Health Wales, it also reflects

public expectations and concerns. The strategy aligns with key national policies, including *A Healthier Wales*, the *Well-being of Future Generations (Wales) Act*, the *NHS Wales Quality Framework*, and the strategic priorities of our commissioners.

Over the past three years, the strategy has been re-framed in response to the post-COVID context and is now structured around six strategic objectives. Quality remains central—acting as a key driver in our commitment to being a quality-led and clinically driven organisation. As we reach the midpoint in delivering this strategy, we will begin a formal review of *Delivering Excellence* in 2026/27, engaging with stakeholders to shape our future direction and organisational ambitions.

Our Quality Plan will play a vital role in shaping these future strategic aims. By undertaking a population health needs assessment and considering projected demographic changes, we will ensure our services are designed to meet both current and future health needs across Wales.

Our Integrated Medium-Term Plan (IMTP) delivers our strategic ambitions in a phased approach over a three-year period, aligned with NHS Wales planning guidance and the commissioning intentions of our partners. It includes a defined set of quality-based outcomes and metrics, framed around the questions 'what does good look like?' and 'what will be different?'. These outcomes have informed the development of targeted improvement plans, delivered through transformation programmes, projects, and quality improvement methodologies. This structured approach enables ongoing evaluation of progress against our deliverables and ensures we remain focused on achieving our intended outcomes.



Delivery is driven through our organisational transformation programmes and supported by directorate-level plans. These directorate plans provide opportunities to enhance service quality both internally and externally and can incorporate findings from quality and performance management self-assessments. At an individual level, staff are encouraged to align their personal objectives with both directorate and organisational plans, strengthening the connection between individual contributions and strategic priorities.

Inclusivity and Equity

Inclusivity and equity are fundamental to delivering compassionate, patient-centred care. Compassionate practices are also essential to nurture and support a healthy workforce to deliver our services. Our Quality Plan aims for all quality initiatives to align with the overarching objectives of our Strategic Equality Plan which reflect the diverse needs of our workforce and patients, creating equity in access, outcomes and experiences.

Through the embedded use of quality impact assessments and by embedding a collaborative approach to transformation and improvement we will consider the needs of our staff and our service users. More detailed equality impact assessments will be undertaken to ensure that all our strategic decisions consider the potential impacts upon people who are disadvantaged. This includes our service users with a protected characteristic, unpaid carers, Welsh speakers, veterans, and people who are impacted by socioeconomic disadvantage. Feedback from people with lived experience, carers and those with complex needs tell us the importance of personalised care particularly when linked to assessment protocols.

Recognising and celebrating individual and team contributions builds a culture of inclusion, where everyone feels valued and can drive continuous quality improvement. A diverse workforce that reflects the communities we serve enhances cultural competence and allows us to better understand the individual needs and challenges of our service users.

We will:

- Ensure that our policies and plans meet the needs of all our services users and the people we rely upon to deliver these services by undertaking robust impact assessments *(Capability / Design Equitable Services)*
- Implement support mechanisms to attract and retain a diverse workforce that reflects the communities we serve by promoting inclusivity and offering equitable opportunities for growth and success *(Capacity / Be an Employer of Choice)*
- Build cultural competence through targeted training, helping staff and volunteers to understand the barriers faced by diverse patient groups e.g. those from ethnic minority backgrounds, those with sensory loss, learning disabilities, or other physical and social challenges *(Capability / Create Allyship)*
- Celebrate diversity and create fair opportunities for all staff and volunteers to contribute, thrive, and feel a sense of belonging *(Culture / Lead by Example)*

By embedding inclusivity and equity into all aspects of leadership and service delivery, we will create an organisation where every individual, patients and staff alike, feel valued, respected, and empowered to contribute to quality outcomes.

Technology and Innovation

Our Digital Plan describes the Trust's commitment to quality digital technologies in supporting clinical decision making, facilitating a seamless patient experience, and underpinning excellent service delivery. In the UK, emergency services like the Welsh Ambulance Service are often considered 'data rich but information poor' – with effort often spent more on sharing data outside of the organisation to commissioners, partners and stakeholders for monitoring performance and downstream decision making, leaving limited capacity to interpret the rich sources of data to better understand operational and clinical quality and impact. However, aligned with Welsh

Government and Digital Health and Care Wales ambitions of a centralised National Data Resource, the Trust's Digital Plan explains how we will assure the data we collect, ensures compliance with information standards, and securely, ethically and confidentially shares data with decision makers and partners to enable better insight of patient experience, outcomes, and risk across NHS Wales.

As the Trust evolves to become even more evidence-based in its decision making and approach, it is essential we maintain trust in the quality of the information and technology that enable these decisions.

Following the introduction of the electronic patient care record (ePCR), we are now bringing together the operational, clinical and wider system data to triangulate intelligence and understand patient safety and outcomes. Additionally, ePCR information has value to our clinical workforce, helping individuals identify areas for professional development and understand the impact of their decisions on quality care. We will review our ePCR configuration to ensure that it better supports our clinical workforce whilst providing a rich source of data intelligence to support our endeavours in understanding our role in health inequality. As part of this work, we will also explore how we can improve visibility of clinical assessment and decision making to inform treatment plans and care planning, to ensure our actions are efficient and effective.

The Digital Plan also explains how our approach to digital foundations, digital transformation and digital innovation is centred on meeting the diverse needs of our communities (patient, public and workforce) in more accessible and responsive ways. Many of the projects in our five-year Digital Plan directly demonstrate the commitment to quality services, care and decision making, for example:

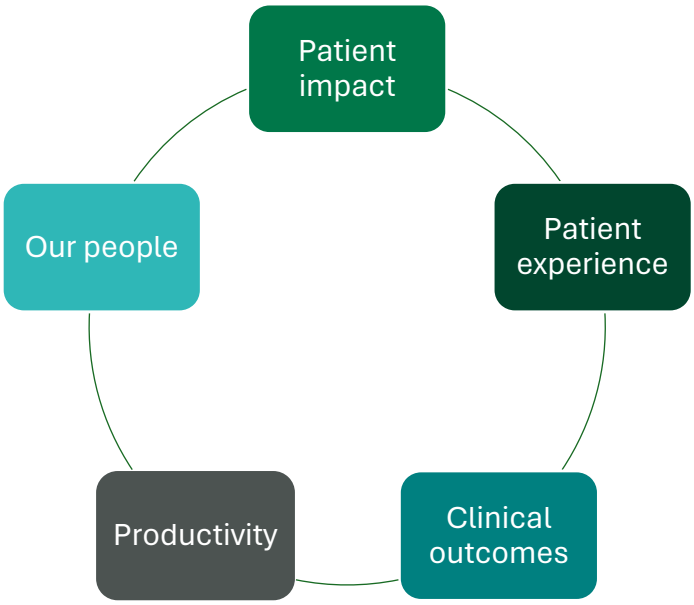
- Promoting digital skills for our workforce - fostering a digitally literate and confident workforce for now and future generations.
- Measuring impact through quantitative and qualitative data, as well as public engagement - supporting the evolution of the Quality and Performance Management Framework as well as collaborations across NHS Wales for Health Protection and Population Health Management.
- Adopting system-wide interoperability standards to ensure patient information and journeys flow seamlessly, such as the integrations with Welsh Clinical Portal and Welsh Demographic Service.

Monitoring a Quality Service

The Trust is a commissioned service, with its three main services: NHS 111 Wales, Emergency Medical Services (999) and Non-Emergency Patient Transport Service (NEPTS), all commissioned by the Joint Commissioning Committee.

Each of these three services is commissioned along a five-step patient pathway, which ensures we take a focused person-centred approach to monitoring the quality of services we provide. However, we recognise that the data monitored through these pathways is almost exclusively time based, supported with some clinical indicators which measure the application of "bundles" i.e. clinical process.

As the Trust moves through its Clinical Model Transformation, we will review our metrics to ensure a continued and improving focus on:



It is particularly important that we align with our Digital Plan to ensure we:

- Have linked patient data across NHS Wales
- Understand the patient outcomes across the entire patient pathway and not just the five steps which are integral to us as an ambulance service.

To achieve this, we will liaise with our commissioners on proposed changes ensuring that we work collaboratively and are supported by a more nuanced set of data.

The Joint Commissioning Committee was newly established in April 2024 and as such, continues to develop its governance mechanisms. An expected area of development is the creation of a Quality and Safety Committee with which the Trust will provide intelligence on the patient pathways beyond time-based metrics. By fostering a collaborative relationship between the Trust, the Joint Commissioning Committee and the health boards across NHS Wales, we can move to a more integrated approach to patient care, addressing not just the immediate medical needs but also the experiences of our patients to positively impact on our relationship with our population.

Project name Strategic Quality Plan Implementation
Plan owner Kate Blackmore
Project start date
Project finish date
Duration
% complete 0%
Exported on 01/05/2025

Task number	Outline number	Labels	Name	Bucket	Assigned to	Start	Finish	Duration	% complete	Priority	Depends on	Dependents (after)	Milestone	Notes	Completed
1	**1**		**Population Health**						**0%**	**Medium**			**Yes**		
2	**1.1**		**Building Public Health capacity & capability**						**0%**	**Medium**			**Yes**		
3	1.1.1		Scope public health development opportunities	Population Health					0%	Medium			No		
4	1.1.2		Raise awareness of health inequalities and prevention	Population Health					0%	Medium			No		
5	1.1.3		Explore the development of a 'public health' training programme in WAST	Population Health					0%	Medium			No		
6	1.1.4		Explore options for ongoing public health expertise	Population Health					0%	Medium			No		
7	**1.2**		**Data Insights, Evidence & Evaluation**						**0%**	**Medium**			**Yes**		
8	1.2.1		Introduce public health metrics or intelligence	Population Health					0%	Medium			No		
9	1.2.2		Strengthen partnerships with Public health Wales for data linkage	Population Health					0%	Medium			No		
10	1.2.3		Promote the inclusion of health inequalities as part of evidence based practice and evaluation	Population Health					0%	Medium			No		
11	1.2.4		Explore medium-term actions for partnership and intelligence growth	Population Health					0%	Medium			No		
12	**1.3**		**Strategic Leadership & Accountability**						**0%**	**Medium**			**Yes**		
13	1.3.1		Explore introduction of Population Health Champions across all levels	Population Health					0%	Medium			No		
14	1.3.2		Develop mechanisms for inclusion of population health principles in decision making	Population Health					0%	Medium			No		
15	1.3.3		Direct and support embedding of principles of prevention in practice	Population Health					0%	Medium			No		
16	**1.4**		**System Partnerships**						**0%**	**Medium**			**Yes**		
17	1.4.1		Use population intelligence from local and national partners to support our work	Population Health					0%	Medium			No		
18	1.4.2		Identify ongoing membership in the AACE reducing Health Inequalities group	Population Health					0%	Medium			No		
19	1.4.3		Explore and advocate for increasing contribution to population health across whole system	Population Health					0%	Medium			No		
20	**2**		**Value Based Health Care**						**0%**	**Medium**			**Yes**		
21	**2.1**		**Embedding the principles of Personal Value**						**0%**	**Medium**			**Yes**		
22	2.1.1		Measure outcomes that matter to people using data and intelligence to drive innovation	Value Based Health Care					0%	Medium			No		
23	2.1.2		Embed co-production and lived experience methodologies within our planning design principles	Value Based Health Care					0%	Medium			No		
24	2.1.3		Provide insights from People & Community Networks to improve the personal value of our population	Value Based Health Care					0%	Medium			No		
25	**2.2**		**Evaluate technical value**						**0%**	**Medium**			**Yes**		
26	2.2.1		Optimise our contributions to research and innovation to deliver and evaluate evidence based practice	Value Based Health Care					0%	Medium			No		
27	2.2.2		Develop and enhance PROMs/PREMs to balance against clinical outcomes.	Value Based Health Care					0%	Medium			No		
28	**2.3**		**Add Allocative Value**						**0%**	**Medium**			**Yes**		
29	2.3.1		Strengthen how we use data as intelligence to inform resource distribution	Value Based Health Care					0%	Medium			No		
30	2.3.2		Promote and monitor equity of service to inform the wider health and social care system	Value Based Health Care					0%	Medium			No		
31	**2.4**		**Deliver societal value**						**0%**	**Medium**			**Yes**		
32	2.4.1		Develop key activities aligned with the Well-being of Future Generations Act	Value Based Health Care					0%	Medium			No		
33	2.4.2		Continue to review and develop opportunities to provide employment and volunteer opportunities to the people of Wales	Value Based Health Care					0%	Medium			No		
34	**3**		**Compassionate Communication**						**0%**	**Medium**			**Yes**		
35	3.1		Formalise & Strengthen the offer of listening discussions in line with updated PTR Regulations	Person Centred Care	Claire Appleton				0%	Medium			No		
36	3.2		Expand our communication channels to prevent queries being routed into concerns	Person Centred Care	Claire Appleton				0%	Medium			No		
37	3.3		Enhance outward facing resources to emphasise service user needs and communication preferences	Person Centred Care	Leanne Hawker				0%	Medium			No		
38	3.4		Collaborate with teams to promote compassionate, open & transparent communication	Person Centred Care	Leanne Hawker				0%	Medium			No		
39	3.5		Develop educational resources focussed on the impacts of compassionate communication	Person Centred Care	Jo Kelso				0%	Medium			No		
40	3.6		Explore the development of a compact with the public to outlines how we will engage and communicate with service users	Person Centred Care	Leanne Hawker				0%	Medium			No		
41	**4**		**Hearing our Citizens voice**						**0%**	**Medium**			**Yes**		
42	4.1		Develop localised PREMs for monitoring through governance forums	Person Centred Care	Leanne Hawker				0%	Medium			No		
43	4.2		Expand and embed annual review of actions taken to improve services based on user voices	Person Centred Care	Kate Blackmore				0%	Medium			No		
44	4.3	CMT	Through CMT workstreams Develop Data linkage and new metrics to better understand our service user experiences	Person Centred Care	Leanne Smith				0%	Medium			No		
45	4.4	CMT	Through CMT workstreams undertake collaborative and independent evaluation to ensure continuous improvement	Person Centred Care	Hugh Bennett				0%	Medium			No		
46	**5**		**Community Involvement**						**0%**	**Medium**			**Yes**		
47	**5.1**		**Community Network Growth**						**0%**	**Medium**			**Yes**		
48	5.1.1		Expand network to ensure it is representative of diverse communities	Person Centred Care	Leanne Hawker				0%	Medium			No		
49	**5.2**		**Continuous Engagement Cycle**						**0%**	**Medium**			**Yes**		
50	5.2.1		Establish Continuous engagement cycles with patients and public	Person Centred Care	Leanne Hawker				0%	Medium			No		
51	5.2.2		Develop partnership approach with Health Board engagement teams	Person Centred Care	Leanne Hawker				0%	Medium			No		

52	5.2.3		Explore partnership approach with grassroots teams to strengthen continuous engagement	Person Centred Care	Leanne Hawker	0%	Medium		No
53	5.2.4		Adopt a population health approach to foster involvement within the community served ensuring engagement activies are inclusive and representative.	Person Centred Care		0%	Medium		No
54	5.2.5		Enhance reporting on the impacts and outcomes of engagement activities	Person Centred Care		0%	Medium		No
55	**6**		**Corporate Parenting**			**0%**	**Medium**		**Yes**
56	6.1		Identify those accessing WAST Services	Person Centred Care	Vicky Maxwell	0%	Medium		No
57	6.2		Collaborate to understand their needs	Person Centred Care	Vicky Maxwell	0%	Medium		No
58	6.3		Adapt systems & Processes	Person Centred Care	Vicky Maxwell	0%	Medium		No
59	6.4		Training	Person Centred Care	Vicky Maxwell	0%	Medium		No
60	6.5		Consider voices in decision making	Person Centred Care	Vicky Maxwell	0%	Medium		No
61	**7**		**Culture**			**0%**	**Medium**		**No**
62	7.1	People & Culture Plan	Embed compassionate leadership practices at all levels	Leadership & Governance	Sara Mills	0%	Medium		No
63	7.2		Continue to pursue a holistic mature health & safety culture	Leadership & Governance	Nicola White	0%	Medium		No
64	7.3	Strategic Equality Plan	Celebrate diversity and create fair opportunities for all our people	Inclusivity & Equity	Kathryn Cobley	0%	Medium		No
65	**8**		**Capability**			**0%**	**Medium**		**No**
66	8.1	People & Culture Plan	Develop & support leaders to integrate quality into daily decision making & uphold high standards of care	Leadership & Governance	Sara Mills	0%	Medium		No
67	8.2	People & Culture Plan	Strengthen change management capability do drive innovation, transformation & efficiency	Leadership & Governance	Sara Mills	0%	Medium		No
68	8.3	Strategic Equality Plan	Through Strategic Equality Plan ensure that our policies & plans meet the needs of all our service users by undertaking robust impact assessments	Inclusivity & Equity	Kathryn Cobley	0%	Medium		No
69	8.4	Strategic Equality Plan	As part of creating allyship Build cultural competence through target training	Inclusivity & Equity	Kathryn Cobley	0%	Medium		No
70	**9**		**Capacity**			**0%**	**Medium**		**No**
71	9.1	People & Culture Plan	Build effective partnerships to coproduce and collaborate on key initiatives	Leadership & Governance	Sara Mills	0%	Medium		No
72	9.2	Strategic Equality Plan	Implement support mechanisms to attract and retain a diverse workforce	Inclusivity & Equity	Kathryn Cobley	0%	Medium		No
73	**10**		**Quality Governance**			**0%**	**Medium**		**Yes**
74	10.1		Grow partnership relationships with quality leaders to create an environment of continuous improvement	Leadership & Governance	Kate Blackmore	0%	Medium		No
75	10.2		Embed Health & Care Quality Standards into monitoring & evaluation processes	Leadership & Governance	Kate Blackmore	0%	Medium		No
76	10.3		Review QIA processes to ensure that they are proportionate & user friendly	Leadership & Governance	Caroline Miftari	0%	Medium		No
77	10.4		Embed assessments at every level of improvement and transformation	Leadership & Governance	Caroline Miftari	0%	Medium		No
78	**10.5**		**Datix Recovery & Improvement Plan**			**0%**	**Medium**		**Yes**
79	10.5.1		Enhance the governance and configuration of Datix Cymru	Leadership & Governance	Caroline Miftari	0%	Medium		No
80	10.5.2		Provide accessible training materials and guides to support our teams	Leadership & Governance	Caroline Miftari	0%	Medium		No
81	10.5.3		Turn data to knowledge through accessible dashboards providing thematic intelligence to support continuous improvement	Leadership & Governance	Caroline Miftari	0%	Medium		No
82	**11**		**Quality Control**			**0%**	**Medium**		**No**
83	11.1	QPM Steering Group	Through QPM Steering Group we will support all teams to assess their quality management systems	Quality Management Systems	Hugh Bennett	0%	Medium		No
84	11.2		Develop processes to support 'double loop' learning to support innovation and transformation	Quality Management Systems		0%	Medium		No
85	**12**		**Quality Improvement**			**0%**	**Medium**		**Yes**
86	12.1		Develop Organisational Improvement Methodology around IHI principles	Quality Management Systems	Christopher Evans	0%	Medium		No
87	12.2		Build Capacity & Conditions for our people to balance change management principles with QI methodology	Quality Management Systems	Christopher Evans	0%	Medium		No
88	12.3		Provide and support Quality Improvement Training including data analysis for our people	Quality Management Systems	Christopher Evans	0%	Medium		No
89	12.4		Develop Systemic View of Quality Improvement Methodology to support co-production	Quality Management Systems	Christopher Evans	0%	Medium		No
90	12.5		Develop Skills for our people at all levels to become Empowered to drive change and improvement	Quality Management Systems	Christopher Evans	0%	Medium		No
91	12.6		Develop systems to demonstrate the impact of improvements	Quality Management Systems	Christopher Evans	0%	Medium		No
92	**13**		**Quality Assurance**			**0%**	**Medium**		**Yes**
93	13.1		Support teams to develop clear Quality Statements that describe what quality means for each of our functions	Quality Management Systems	Caroline Miftari	0%	Medium		No
94	13.2		Support teams to undertake Quality Assurance Self Assessment to support the development of robust quality management systems	Quality Management Systems	Caroline Miftari	0%	Medium		No
95	13.3		Support and guide the development of information & Intelligence data to monitor our services in line with H&C Quality Standards 2023	Quality Management Systems	Caroline Miftari	0%	Medium		No
96	13.4		Develop processes and environments for monitoring and evaluation of QIA outcomes	Quality Management Systems	Caroline Miftari	0%	Medium		No
97	**14**		**Quality Planning**			**0%**	**Medium**		**No**
98	14.1	QPM Steering Group	Through QPM Steering Group we will support all teams to assess their quality management systems	Quality Management Systems	Hugh Bennett	0%	Medium	83SS	No
99	14.2		H&C Quality Standards Self Assessment	Quality Management Systems	Kate Blackmore	0%	Medium		No
100	14.3	CMT	Through CMT workstreams we will ensure our transformative decisions are supported by Quality Impact Assessments which include robust monitoring and evaluation indicators	Quality Management Systems	Heather Holden	0%	Medium		No
101	14.4		Support the review of the long term strategy through a quality lens	Quality Management Systems	Kate Blackmore	0%	Medium		No
102	14.5		Undertake a Population Health Needs assessment to ensure the long term strategy refresh in 2030 is designed to support current and future population health needs	Quality Management Systems		0%	Medium		No
103	14.6		Support the development of Directorate Plans to include QPMF improvement workplans and use of H&C Quality Standards	Quality Management Systems	Alexander Crawford	0%	Medium		No
104	**15**		**Inclusivity & Equity**			**0%**	**Medium**		**No**

105	15.1	Strategic Equality Plan;P	As part of designing equitable services ensure that our policies & plans meet the needs of all our service users by undertaking robust impact assessments	Inclusivity & Equity	Kathryn Cobley, Sara Mills	0%	Medium	68SS	No
106	15.2	Strategic Equality Plan;P	As an employer of choice implement support mechanisms to attract and retain a diverse workforce	Inclusivity & Equity	Kathryn Cobley, Sara Mills	0%	Medium	72SS	No
107	15.3	Strategic Equality Plan;P	As part of creating allyship Build cultural competence through target training	Inclusivity & Equity	Kathryn Cobley, Sara Mills	0%	Medium	69SS	No
108	15.4	Strategic Equality Plan	Leading by example we will celebrate diversity and create fair opportunities for all our people	Inclusivity & Equity	Kathryn Cobley, Sara Mills	0%	Medium	64SS	No
109	**16**		**Technology & Innovation**			**0%**	**Medium**		**Yes**
110	16.1	Digital Plan	Through the Digital Plan assure the data we collect and create data linkage for better insight of patient experience, outcomes and risk	Technology & Innovation	Leanne Smith	0%	Medium		No
111	16.2	Digital Plan	Through the Digital Plan review our ePCR configuration to ensure that it better support our clinical workforce	Technology & Innovation	Keith Dorrington	0%	Medium		No
112	16.3	Digital Plan	Through the Digital Plan review ePCR configuration to provide a rich source of data intelligence to understand our role in health inequalities	Technology & Innovation	Keith Dorrington	0%	Medium		No
113	16.4	Digital Plan	Through the Digital Plan improve visibility fo clinical assessment and decision making to inform treatment plans and care planning	Technology & Innovation	Keith Dorrington	0%	Medium		No
114	16.5	Digital Plan	Through the Digital Plan promote digital skills for our workforce	Technology & Innovation	Aasha Cowey	0%	Medium		No
115	16.6	Digital Plan	Through the Digital Plan Measure impact through quantitative, qualitative and engagement data	Technology & Innovation	Leanne Smith	0%	Medium		No
116	16.7	Digital Plan	Through the Digital Plan adopt system-wide interoperability standards	Technology & Innovation		0%	Medium		No
117	**17**		**Commissioning & Monitoring**			**0%**	**Medium**		**Yes**
118	17.1	CMT	Through CMT workstreams review our metrics to ensure an improving focus across a broad range of factors	Commissioning & Monitoring	Hugh Bennett	0%	Medium		No
119	17.2	Digital Plan	Through data linkage understand patient outcomes across the entire patient pathway (not just 5 steps)	Commissioning & Monitoring		0%	Medium		No
120	17.3		Work collaboratively with commissioners to develop a nuanced data set for monitoring & evaluation	Commissioning & Monitoring	Hugh Bennett	0%	Medium		No
121	17.4		Foster a collaborative relationship with the commissions Quality & Safety committee	Commissioning & Monitoring	Hugh Bennett	0%	Medium		No

View results

Respondent

41 Kate Blackmore

00:03
Time to complete

About this EQIA

1. Name *

Kate Blackmore

2. Job Title *

Assistant Director for Quality Governance

3. Email Address *

kate.blackmore@wales.nhs.uk

4. Team / Directorate *

Quality Governance - Quality, Safety & Patient Experience (QSPE) Directorate.

5. Executive Lead for this work *

Liam Williams

6. Governance Approval Route *

Quality, Patient Experience and Safety (QuESt) Committee/Trust Board

7. What are you impact assessing? (Insert document title) *

Strategic Quality Plan 2025-2028

8. What type of document are you impact assessing *

- ( ) Policy / Procedural Guidelines
- (•) Strategic Plan
- ( ) Business Case / Service Development
- ( ) Service Change / Closure

9. Who has been involved in undertaking this EQIA? *

Head of Inclusion & Engagement
Welsh Language Service Manager
Trade Union Representative

10. EQIA Start Date *

4/24/2025

11. Provide an overview of what you are impact assessing *

Please describe the overall aims and objectives and who will benefit. How will you achieve this and measure any outcomes and success. Please include any timeframes for this work.

Our Strategic Quality Plan for 2025-28 outlines a comprehensive and forward-thinking approach to enhancing the quality of healthcare services provided by the Welsh Ambulance Service University NHS Trust. It is designed to address the evolving needs of our population, ensuring that our services are not only efficient and effective but also equitable and inclusive. The plan creates a linkage between other strategic plans and will be published on our website. The plan will be supported by an implementation plan that sets out clear actions and objectives including the responsible leaders and the timelines for delivery.
Oversight of assurance will be provided through our Quality Governance infrastructure through to QuESt committee.

Links to objectives and other areas of work

12. Does this work link to the WAST Behaviours? (please tick each relevant behaviour)

For further information on WAST behaviour please click here: The Culture Champions Network (sharepoint.com)

- [x] Take ownership
- [x] Broaden our understanding
- [ ] Respect others
- [ ] Show belief in each other
- [ ] Practice ethically
- [x] Continually improve our service
- [ ] Be inclusive of the whole team

13. Does this work help to achieve the Strategic Equality Plan Objectives? (please tick each relevant objective)

- [x] We will design equitable services
- [x] We will lead by example
- [ ] We will be an employer of choice
- [ ] We will create allyship

14. Does this work help to achieve the Wellbeing Goals of the Wellbeing of Future Generations Act? (please tick each relevant option)

For further information on the Wellbeing Goals please click here: The Well-being of Future Generations | GOV.WALES

- [ ] A Prosperous Wales
- [ ] A Resilient Wales
- [x] A More Equal Wales
- [x] A Healthier Wales
- [ ] A Wales of Cohesive Communities
- [ ] A Wales of Vibrant Culture and Thriving Welsh Language
- [ ] A Globally Responsible Wales

15. Human Rights: The Human Rights Act contains 15 Articles (or rights), all of which NHS organisations have a duty to act compatibly with and to respect, protect and fulfil. The 6 rights that are particularly relevant to healthcare are listed below. For further information on the Human Rights Act, please click here: Human rights in health and social care | EHRC (equalityhumanrights.com)

Tick whether this work applies to any of the following:

- [x] Article 2: The right to life
- [ ] Article 3: The right not to be tortured or treated in an inhuman or degrading way
- [ ] Article 5: The right to liberty
- [ ] Article 6: The right to a fair trial
- [ ] Article 8: The right to respect for private and family life, home and correspondence
- [ ] Article 11: The right to freedom of thought, conscience and religion

16. Is this work aligned to the FREDA Principles?

- [ ] Fairness
- [x] Respect
- [x] Equality
- [x] Dignity
- [ ] Autonomy

17. Does this work link to any other policies, plans or related areas of work?

Please list any other documents that need to be read in conjunction to what you are impact assessing.

People & Culture Plan
Strategic Equality Plan
Digital Plan
Health & Social Care (Quality & Engagement) (Wales) Act 2020
Integrated Medium Term Plan
Organisational Strategy: Delivering Excellence 2030

Consultation and Engagement

18. Please provide details of any consultation and engagement that you have done

This could include consultation and engagement with specific staff groups, community groups and individuals. If you have engaged with people with a protected characteristic, please provide details here.

Patient Experience and Community Involvement teams engaged with our People & Community Networks to understand their expectations of WAST as a Quality service.
All directorates were engaged with through their cycle of business to provide feedback on their expectations of the Quality Plan and WAST as a quality organisation.
A survey was issued to all staff to provide feedback to the same questions that were asked to our People & Community Networks to understand their expectations of WAST as a Quality service provider and what that means to them.
Attendees at the WAST Quality Event in July 24 were provided with an opportunity to engage on the development of the plan through a Menti survey informed by table group work.
Following feedback a cross directorate Task & Finish Group was set up to consider the emerging themes and design the strategic plan including engagement with a Public health Wales Registrar to provide specialist advice in this area.

19. Were there any emergent themes from the consultation and engagement?

Overarching themes:
1. Leadership & Governance:
Emphasize the importance of strong leadership and clear direction to maintain high quality patient care. Linking this to the People & Culture plan and 'Our WAST Way' as well as the Health & Care Quality standards 2023. The importance to set clear goals and foster an environment where all staff understand their roles in maintaining standards. Particular focus on supporting leadership at lower levels (band 6/7) to drive quality into their leadership and everything they do.

2. Developing and implementing QMS that are safe and effective across the organisation. Creating capacity and conditions for people to think differently and balance change management principles with quality improvement principles. The need for continuous improvement through robust quality management systems. Quality improvement methodology and training that includes analysis of data, equipping people with the rights skills and capacity to use those skills in the endeavour of continuous improvement.

3. Patient Centred Care
Ensuring that patient impact is at the heart of all decision and discussions with a collaborative approach to quality discussion. A shared commitment to delivering the best possible service to the public, including learning from mistakes and fostering a culture of continuous improvement. Ensuring that information regarding experiential and relational measures are used when evaluating our service with equal importance alongside time-based metrics

4. Communication & Collaboration
Strengthening communication across the organisation by creating open feedback channels and enhancing cooperation with hospitals and community services. (integration with health boards, other UK ambulance services and blue light partners) Encouraging openness within and between departments and teams with clarity of strategy, purpose and roles. Emphasize the importance of seeking continual feedback for improvement and reinforcing the good practices that support quality. Fostering a culture of empathy and clear communication within the service through training to enhance compassionate communication.

5. Inclusivity & Equity
Ensuring that quality initiatives are inclusive of everyone considering age, physical or social needs and other demographic factors. Addressing the needs of specific groups, such as patients with sensory loss or learning disabilities to provide equitable care.

6. Technology & Innovation
Leveraging technology to enhance service delivery and patient experience including real-time updates through mobile application and better post call communication via text or email. The importance of data and information standards with a focus on improving data utilisation across the organisation which measures patient outcomes alongside operational performance.

Service User Feedback Themes:
1.Timeliness and Responsiveness :
2. Empathy and Communication:
3. Capacity and Resources:
4. Expertise and Specialized Care:
5. System Efficiency and Coordination:

6. Technology and Innovation:
7. Equity and Access:

Staff Feedback Themes:
1. Leadership and Governance:
2. Employee Well-Being and Support:
3. Training and Development:
4. Operational Efficiency:
5. Communication and Collaboration:
6. Quality and Continuous Improvement:
7. Patient-Centred Care:
8. Recognition and Reward:
9. Work-Life Balance:

20. Have you made any changes or amendments as a result of the consultation and engagement?

The strategic quality plan was designed as a co-produced document. Engagement was undertaken pre-emptively and feedback was collated & themed to identify strategic opportunities to align with the visions of our stakeholders.

21. Do you plan to undertake any further consultation and engagement? Please provide details

The task & finish group including trade union partners was utilised to identify the strategic opportunities based on the feedback received and following the drafting of the plan it was shared with CQGG and ELT for comment. The associated action plan is also being created through the T&F group collaboratively with content leads.

22. How will the outcome of the final decision be shared?

The strategic quality plan will be shared internally on our quality sharepoint pages and externally via our Duty of Quality website presence. it will be publicised through events such as the WAST quality event in July 2024 and will be referenced in our Duty of Quality Annual Report.

23. Please provide details of any further evidence that you have used to inform your plans?

This could include external research, population data, etc

External research and engagement with Public Health registrar to support the development of strategic change for organisational understanding of Population Health and Value Based health Care.
Other health board Quality Strategies that coincide with timelines
Legislation requirements.

EQIA

Use this section to identify any potential impact your plans may have upon people with a protected characteristic and other community groups. You can learn more about the Equality Act 2010 and the protected characteristics here: Protected characteristics | EHRC (equalityhumanrights.com)

For further guidance and video tutorials on equality impact assessment, please visit this page on SIREN:
Equality Impact Assessments (sharepoint.com)

PLEASE NOTE: You may identify a potential positive and a negative impact against some of the protected characteristics. If this happens, you should tick both the 'positive' and 'negative' options and provide your narrative for each in the box below.

AGE

Think about older people, children and young people, young adults, etc, and how your plans may affect them differently.

24. What impact will your plans have upon people within different age groups *

- (●) Positive Impact
- ( ) Negative Impact
- ( ) No Impact

25. Please state why you have selected the above options *

The intention of the Strategic Quality Plan is to improve the quality of services that we provide as an organisation. This plan includes a strong theme of understanding our role in population health and impacting on health inequalities. The objectives around data linkage and recording particularly for health inequalities will help identify quality improvement initiatives for this group of staff.

26. If you have identified potential negative impacts, please state what actions you plan to take to mitigate against them *

n/a

Disability

This includes disabilities affecting mobility, sensory loss, long-term health conditions, hidden disabilities, learning disabilities, mental health conditions and neurodiversity. Further detail on disability and the Equality Act can be found here - Disability: Equality Act 2010 - Guidance on matters to be taken into account in determining questions relating to the definition of disability (HTML) - GOV.UK (www.gov.uk)

27. What impact will your plans have upon people with a disability? *

- [x] Positive Impact
- [ ] Negative Impact
- [ ] No Impact

28. Please state why you have selected the above options *

The intention of the Strategic Quality Plan is to improve the quality of services that we provide as an organisation. This plan includes a strong theme of understanding our role in population health and impacting on health inequalities. The objectives around data linkage and recording particularly for health inequalities will help identify quality improvement initiatives for this group of staff.

29. If you have identified potential negative impacts, please state what actions you plan to take to mitigate against them *

n/a

Sexual Orientation

30. What impact will your plans have upon LGBTQ+ people? *

- [x] Positive Impact
- [ ] Negative Impact
- [ ] No Impact

31. Please state why you have selected the above options *

The intention of the Strategic Quality Plan is to improve the quality of services that we provide as an organisation. This plan includes a strong theme of understanding our role in population health and impacting on health inequalities. The objectives around data linkage and recording particularly for health inequalities will help identify quality improvement initiatives for this group of staff.

32. If you have identified potential negative impacts, please state what actions you plan to take to mitigate against them *

n/a

Gender Reassignment / Gender Identity

This includes people who identify as a gender which may be different to their sex assigned at birth. This includes people who are trans or non-binary.

33. What impact will your plans have upon people due to their gender reassignment or gender identity? *

- (●) Positive Impact
- ( ) Negative Impact
- ( ) No Impact

34. Please state why you have selected the above options *

The intention of the Strategic Quality Plan is to improve the quality of services that we provide as an organisation. This plan includes a strong theme of understanding our role in population health and impacting on health inequalities. The objectives around data linkage and recording particularly for health inequalities will help identify quality improvement initiatives for this group of staff.

35. If you have identified potential negative impacts, please state what actions you plan to take to mitigate against them *

n/a

Sex

Think about how your plans may impact men and women differently

36. What impact will your plans have upon people due to their sex? *

- [x] Positive Impact
- [ ] Negative Impact
- [ ] No Impact

37. Please state why you have selected the above options *

The intention of the Strategic Quality Plan is to improve the quality of services that we provide as an organisation. This plan includes a strong theme of understanding our role in population health and impacting on health inequalities. The objectives around data linkage and recording particularly for health inequalities will help identify quality improvement initiatives for this group of staff.

38. If you have identified potential negative impacts, please state what actions you plan to take to mitigate against them *

n/a

Race and Ethnicity

Think about how your plans may impact upon people from Black, Asian and Minority Ethnic backgrounds.
This includes Gypsy, Roma, Traveller Communities and could include White people from a non-British background.

39. What impact will your plans have upon people due to their Race and Ethnicity? *

- [x] Positive Impact
- [ ] Negative Impact
- [ ] No Impact

40. Please state why you have selected the above options *

The intention of the Strategic Quality Plan is to improve the quality of services that we provide as an organisation. This plan includes a strong theme of understanding our role in population health and impacting on health inequalities. The objectives around data linkage and recording particularly for health inequalities will help identify quality improvement initiatives for this group of staff.

41. If you have identified potential negative impacts, please state what actions you plan to take to mitigate against them *

n/a

Religion and Belief

Think about how your plans may affect people who practice a specific religion or live their life according to a set of beliefs.

42. What impact will your plans have upon people due to their religion or beliefs? *

- [x] Positive Impact
- [ ] Negative Impact
- [ ] No Impact

43. Please state why you have selected the above options *

The Quality Plan is to improve the quality of services that we provide as an organisation. This plan includes a strong theme of embedding inclusivity and equity into all aspects of leadership and service delivery, we will create an organisation where every individual, patients and staff alike, feel valued, respected, and empowered to contribute to quality outcomes. The plan links specifically to our strategic equality plan.

44. If you have identified potential negative impacts, please state what actions you plan to take to mitigate against them *

n/a

Pregnancy and Maternity

Think about how your plans may impact upon people who are pregnant or on maternity

45. What impact will your plans have upon people who are pregnant or on maternity? *

- [ ] Positive Impact
- [ ] negative Impact
- [x] No Impact

46. Please state why you have selected the above options *

The intention of the Strategic Quality Plan is to improve the quality of services that we provide as an organisation. There are no specific wellbeing initiatives within the plan but there is a strong link to our people & culture plan particularly around leadership.

47. If you have identified potential negative impacts, please state what actions you plan to take to mitigate against them *

n/a

Marriage and Civil Partnership

Think about how your plans may impact those who are married or in a civil partnership and those who are not.

48. What impact will your plans have upon people who married or in a civil partnership and people who are not *

- [ ] Positive Impact
- [ ] Negative Impact
- [x] No Impact

49. Please state why you have selected the above options *

The intention of the Strategic Quality Plan is to improve the quality of services that we provide as an organisation. There are no specific wellbeing initiatives within the plan but there is a strong link to our people & culture plan particularly around leadership.

50. If you have identified potential negative impacts, please state what actions you plan to take to mitigate against them *

n/a

Unpaid Carers

An unpaid carer is someone who provides help and support to a family member, friend or neighbour who cannot manage without the carer's help.

51. What impact will your plans have upon unpaid carers? *

- [ ] Positive Impact
- [ ] Negative Impact
- [x] No impact

52. Please state why you have selected the above options *

The intention of the Strategic Quality Plan is to improve the quality of services that we provide as an organisation. There are no specific wellbeing initiatives within the plan but there is a strong link to our people & culture plan particularly around leadership.

53. If you have identified potential negative impacts, please state what actions you plan to take to mitigate against them *

n/a

Armed Forces Covenant

Consider members of the Armed Forces and their families, whose health needs may be impacted long after they have left the Armed Forces and returned to civilian life.

Consider their unique experiences when accessing and using public services compared to the general population. Think about their unfamiliarity with civilian life, frequent moves around the country and the subsequent difficulties in maintaining support networks.

54. What impact will your plans have upon people who belong to the Armed Forces Community? *

- [ ] Positive Impact
- [ ] Negative Impact
- [x] No Impact

55. Please state why you have selected the above options *

The intention of the Strategic Quality Plan is to improve the quality of services that we provide as an organisation. There are no specific wellbeing initiatives within the plan but there is a strong link to our people & culture plan particularly around leadership.

56. If you have identified potential negative impacts, please state what actions you plan to take to mitigate against them *

n/a

Welsh Language Impact Assessment

For further information on the requirements of the Welsh Language Standards and Welsh Language Impact Assessment, please click here:
https://ambulance.nhs.wales/about-us/welsh-language-standards/
Or please contact Melfyn.Hughes@wales.nhs.uk for further advice.

57. Will your plans ensure that patients and carers can choose to live and receive services through the medium of Welsh? *

- ( ) Yes
- ( ) No
- (•) Not applicable

58. Please provide an explanation and evidence to support your answer. What actions will be taken to mitigate any negative impacts or better contribute to positive impacts: *

There is no specific content related to language preferences for service users as part of strategic plans to improve the quality of our services however the plan does include the importance of compassionate communication without specifying the language in which this communication is undertaken.

59. What impact will your plans have upon the opportunities for people to use the Welsh language? *

- [ ] Positive Impact
- [ ] Negative Impact
- [x] No Impact

60. Please provide an explanation and evidence to support your answer. What actions will be taken to mitigate any negative impacts or better contribute to positive impacts: *

n/a

61. Will your plans encourage staff to use Welsh in the workplace and provide opportunities for staff to learn and improve their Welsh language skills? *

- ( ) Yes
- ( ) No
- (•) Not applicable

62. Please provide an explanation and evidence to support your answer. What actions will be taken to mitigate any negative impacts or better contribute to positive impacts: *

n/a

63. Will your plans encourage Welsh language cultural awareness, activity and integration? *

- ( ) Yes
- ( ) No
- (•) Not applicable

64. Please provide an explanation and evidence to support your answer. What actions will be taken to mitigate any negative impacts or better contribute to positive impacts: *

n/a

65. Will your plans increase the Trust's ability to deliver services in the medium of Welsh? *

- ( ) Yes
- ( ) No
- (•) Not applicable

66. Please provide an explanation and evidence to support your answer. What actions will be taken to mitigate any negative impacts or better contribute to positive impacts: *

n/a

67. Do your plans treat the Welsh language no less favourably than the English language? *

- ( ) Yes
- ( ) No
- (•) Not applicable

Socioeconomic Duty

The Socioeconomic Duty aims to improve outcomes for people who experience socioeconomic disadvantage. This may include people on low incomes, lone parents, students, the homeless, etc. People who live in rural and urban areas can be affected by socioeconomic disadvantage in different ways. For example, consider the impact of fuel poverty, wifi poverty, job opportunities, unemployment rates, access to health and social care systems, etc.

When assessing the impact of your plans, please consider the following domains:

Education:
Consider the impact of education on the local population, children and adults with additional learning needs, basic literacy levels and those less likely to have access to training opportunities and qualifications
Think about how careers support, including apprenticeships and volunteer work placements can be promoted to support young people furthest from the job market.

Health:
Consider the expected health outcomes of the local population. What are the current health needs and what action can be taken to increase access to healthcare for those who experience socio-economic disadvantage? Have the costs of transport and travel been taken into account? Think about the design of the built environment on the physical and mental health of patients, staff and visitors.

Living Standards:
Consider the impact of poverty and deprivation. Are there groups who may be disproportionately impacted by poverty e.g. disabled people / lone parents / unemployment / homelessness. This domain includes issues of accessibility of transport, healthy food, leisure activities, road safety and the quality and safety of play areas and open spaces.

Work:
Welsh Ambulance Services NHS Trust provides numerous opportunities for people to access work. Will this plan impact on employment / apprenticeship / volunteering opportunities? What are the implications of the proposal for people on low income, those who are economically inactive, unemployed, and people who are unable to work due to ill-health. Consider people living in work poverty.

Justice and Personal Security:
Consider local crime rates and feeling safe. Think about people who live in less safe areas and those more likely to be victims of domestic violence and abuse. Evidence suggests that domestic violence incidents are becoming more complex and serious, with higher levels of physical violence and coercive control.

Participation:
How is participation enabled, how is engagement sustained with people with lived experience of socio-economic disadvantage and how has this informed your proposal? Think about digital exclusion and digital poverty, people living in rural areas and those unable to access services and facilities.

For a comprehensive guide to the Socio-Economic Duty in Wales and supporting resource please see https://gov.wales/more-equal-wales-socio-economic-duty

68. What impact do your plans have upon those who are affected by socioeconomic disadvantage? *

- [x] Positive Impact
- [ ] Negative Impact
- [ ] No Impact

69. Please state why you have selected the above options *

The intention of the Strategic Quality Plan is to improve the quality of services that we provide as an organisation. This plan includes a strong theme of understanding our role in population health and impacting on health inequalities. The objectives around data linkage and recording particularly for health inequalities will help identify quality improvement initiatives for this group of staff.

70. If you have identified potential negative impacts, please state what actions you plan to take to mitigate against them *

n/a

EQIA Outcome Decision

71. Using the information provided in this assessment, are you able to proceed with your plans?

- (●) Yes
- ( ) No

72. What are your next steps? Please provide details of any required changes, further changes and consultation, decisions, etc. *

Plan is scheduled for approval at QuESt committee on 9th May and will be submitted with an associated executive summary on how the plan was created as well as a draft implementation plan of the detailed actions associated with delivering the strategic context. The implementation plan will be monitored regularly with updates shared to senior leadership and committee governance infrastructures. This regular monitoring of the plan will allow for dynamic prioritisation, reprioritisation and update based on insights and intelligence from across our organisation.

Thank you for completing this EQIA.

Please ensure that you tick the box which allows you to edit your EQIA after submission. This will allow you to make any necessary updates as required.

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

Quality Impact Assessment (QIA): Clinical Model Transformation: Urgent Community Response	
MEETING	**Quality, Patient Experience and Safety Committee**
DATE	**9 May 2025**
EXECUTIVE	Andy Swinburn (Director of Paramedicine)
AUTHOR	Gareth Taylor (Senior Project Manager) Richard Ashby (Project Manager) Jonathan Chippendale (Assistant Director of Clinical Development)
CONTACT DETAILS	Gareth.taylor3@wales.nhs.uk
CORPORATE OBJECTIVE	Providing the right care or advice, in the right place, every time.
CORPORATE RISK (Ref if appropriate)	223 – The Trust's inability to reach patients in the community causing patient harm or death (Score – 25) 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 (Score – 25)
QUALITY THEME	**Governance Leadership and Accountability**
Quality Health & Care Standards 2023 **Domains**	**Safe** **Timely** **Effective** **Efficient** **Equitable**

	Person Centred Care	
Quality Health & Care Standards 2023 Enablers	**Leadership** **Culture** **Workforce** **Information** **Whole System** **Learning Improvement and Research**	
REPORT PURPOSE	**1. For Assurance**	
CLOSED MATTER REASON	**N/A**	
REPORT APPROVAL ROUTE		
WHERE	**WHEN**	**WHY**
CQGG	**14th April 2025**	To provide governance, clinical leadership, and accountability in support of a transition from a clinical response model to clinical service model, within which an element consists of a review of urgent community-based response models.
UCR Workstream Board	**23rd April 2025**	To provide governance, clinical leadership, and accountability in support of a transition from a clinical response model to clinical service model, within which an element consists of a review of urgent community-based response models

Annex 2 – Part 1 QIA Screening Tool & Part 2 Full QIA

Governance, Leadership & Accountability	
Title of service change/proposal	**Urgent Community Response Workstream**
Date of QIA assessment:	29th January 2025
Date logged on central QIA digital repository. (For all completed part one and part 2)	TBC
Project overview (summary)	**Situation and Background** • Within the Welsh Ambulance Services University NHS Trust (WAST), our mission is to continuously enhance our services, ensuring that we provide safe, effective, and patient-centred care. Our aim is to meet the evolving healthcare needs of our patients while improving their outcomes and experience. In 2024, WAST began evolving its 2015 Clinical Response Model into a more integrated Clinical Service Model, known as the Clinical Model Transformation (CMT) programme. • The following infographic illustrates how the future CMT programme intends to bring 111 and 999 closer together and process patients through their systems. • The CMT programme is a strategic response to the increasing demands on Welsh healthcare services, driven by an ageing population and the growing complexity of health care needs. These challenges have been compounded by workforce shortages within NHS Wales. The CMT programme is designed to address these demands by optimising the use of WAST resources and improving patient care across the system. • WAST envisions itself as a gateway to urgent and emergency care across Wales. Through the CMT programme, we seek to enhance clinical capabilities, improve integrated care pathways,

and reduce avoidable hospital conveyances. By focusing on alternative care settings and fostering greater collaboration between healthcare providers, we aim to deliver more efficient care pathways and better patient outcomes.

- Urgent and emergency care are terms frequently used interchangeably, this can cause confusion to care providers and service users. To provide clarity on this, Welsh Government has defined urgent and emergency care, within their document *Right care, right place, first time Six Goals for Urgent and Emergency Care 2021-2026* as,

CMT Programme Overview

The CMT programme will be implemented in three phases:

Phase 1: 6-Month Priorities (June 2024 – December 2024)

- Initiated to ensure readiness for Winter 2024, this phase focuses on six critical projects under interim governance arrangements.
- Formal governance structures were established during this phase to support programme management and delivery.

Phase 2: Service Alignment (July 2024 – July 2025)

- Focused on aligning existing services for future integration, this phase works towards ensuring service alignment by June 2025.
- Formal governance arrangements continue to guide the projects initiated during Phase 1.

Phase 3: System Integration (July 2025 – April 2027)

- The comprehensive integration of WAST's services will take place during this phase, accompanied by a period of evaluation and iterative development through to April 2027.
- The transformation also builds on WAST's strategy, "Delivering Excellence," which envisions the ambulance service as a gateway to urgent and emergency care across Wales. By enhancing its clinical capability and focusing on integrated care pathways, WAST seeks to play a more

pivotal role in reducing avoidable conveyance to hospital and facilitating access to alternative care settings.

WAST aspires to collaborate with the seven health boards across Wales to provide a 24/7, 365-day service that supports patients' urgent care needs. However, this goal presents workforce challenges for both WAST and the health boards.

To address these challenges, WAST has developed and implemented a workforce recruitment plan for advanced practice, enabling an increase in remote telephone triage service delivery while maintaining an advanced practice response capability. Additionally, other WAST services aligned with the UCR have been introduced or expanded to support this vision. These services will operate in isolation when HB partners are unable to provide teams to work alongside these staff groups, however this may reduce their ability to access alternative care options to address the patient's needs in the most appropriate setting.

Key Objectives of the CMT Programme

1. **Clinically Led Service:** Implementing a clinically led model that focuses on integrated, patient-centred care across multiple services.
2. **Seamless Healthcare Experience:** Enhancing collaboration between healthcare providers to ensure efficient and seamless care pathways.
3. **Reduction in Hospital Conveyance:** Reducing avoidable hospital conveyances by improving access to alternative care settings.

Future Clinical Service Model

Summary of Proposed Changes to the Clinical Service Model

Urgent Community Response (UCR)

- A key component of the CMT programme is the Urgent Community Response (UCR). WAST is committed to developing a national service that enables patients to receive treatment at home or their normal place of residence. This is crucial for improving outcomes, preventing unnecessary hospital admissions, and aligning to the strategic priorities within NHS Wales.
- The CMT programme will continue to prioritise calls made to the 999 service, particularly for life-threatening cases. However, for less-urgent cases, a clinician within Rapid Clinical Screening will determine whether the patient requires an Emergency Medical Service (EMS) response or a Remote Integrated Care Service consultation, to better understand the patients care needs (as seen in the 'ASSESMENT' section of the infographic in the introduction) and signpost them to services listed within a directory of services.

- Remote Telephone Consultations will provide opportunities for WAST clinicians to identify care at home or signpost to alternative services and address the patient's needs, on a national footprint. If neither outcome is suitable, the patient will be passed on to the 'RESPONSE' service within the CMT programme. Within this service area Urgent Community Response (UCR) will have the ability to remotely review the call, the services within UCR will be working at a local level with awareness of alternative options to address the needs of the patient within their area.

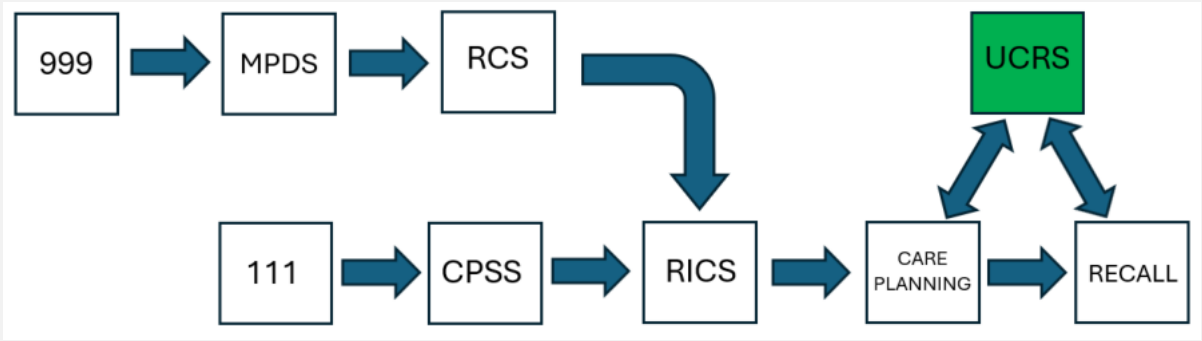
- The UCR will operate at a local level and often be integrated into a Multi-Disciplinary Team (MDT) with specialist clinical skills. This model allows clinicians to further assess the patient's needs using various information systems (e.g., Vision, PARIS, Welsh Clinical Portal) establishing a shared care approach with our health board partners when required. This localised approach offers several benefits, including better knowledge of available services and the ability to consider alternative pathways for patient care supported within an MDT setting. It is intended that UCR will review the calls that have had an opportunity for the patients' needs to be addressed within the 'Assessment' service of the CMT, but the patient's needs are deemed unsuitable to be supported within this area of service delivery on a national footprint.

- The MDT working at a local level will have an awareness and referral opportunity above the availability of a national service. These teams will be 'Welsh NHS Body' and therefore the Welsh concerns, complaints and redress arrangements 2011 will apply in the event of any concerns that are brought against the service. Concerns raised within this service area may fall under Regulation 17 of these arrangements, which sets out the responsibilities of each party, further information on these matters can be accessed in the MoU.

- The services that operate within the UCR will be specific to the individual health boards based on their commissioning model. Understanding the various operating models of these multiple services, that may not be operating 24 hour 365 days a year is complex. Each model will have their own wrap around services available to them and the capacity of these services will differ across the country. It is for this reason that the benefit of having a local involvement (local footprint) in these schemes is deemed most suitable in meeting the care needs of the patient. Examples of services within UCR, but not available in each health board currently, would be the palliative care paramedics (PCP), level 2 falls response service working with a health board

therapist, APPNAV (Advanced Paramedic Practitioners Navigators) within a health board team and stand alone at times, mental health response vehicles and the Clinician Triage assessment & Streaming (CTAS, previously PTAS).

- The UCR will review calls that have progressed from ‘Assessment’ and into ‘Response’, these calls will become visible on the regional RECALL stack and the Care Planning Desk stack as seen in the diagram below. The clinician working within the UCR will subjectively identify calls from the stack and ‘Pull’ them through the call gateway for a further review to address the patients care needs. The outcome may be made by the WAST clinician in isolation or receive an MDT shared care approach, with the intention of altering the patient’s outcome away from the Emergency department and when appropriate away from a hospital visit, avoiding a WAST resource dispatch.
- Patients that have been deemed suitable for an UCR review by the care planning desk, can be ‘pushed’ to the UCR clinician. There is a requirement for the two services to communicate and review the call, this should determine if the call is suitable and there is capacity to manage the care needs of the patient within UCR area. UCR has the ability to schedule calls for a specialist resource when none are available, and the patient’s presentation had been deemed suitable. However, the functionality of delivering UCR scheduling is not fully understood and requires further discussions to ensure patient safety and best practice in delivery of this service.



Delivery

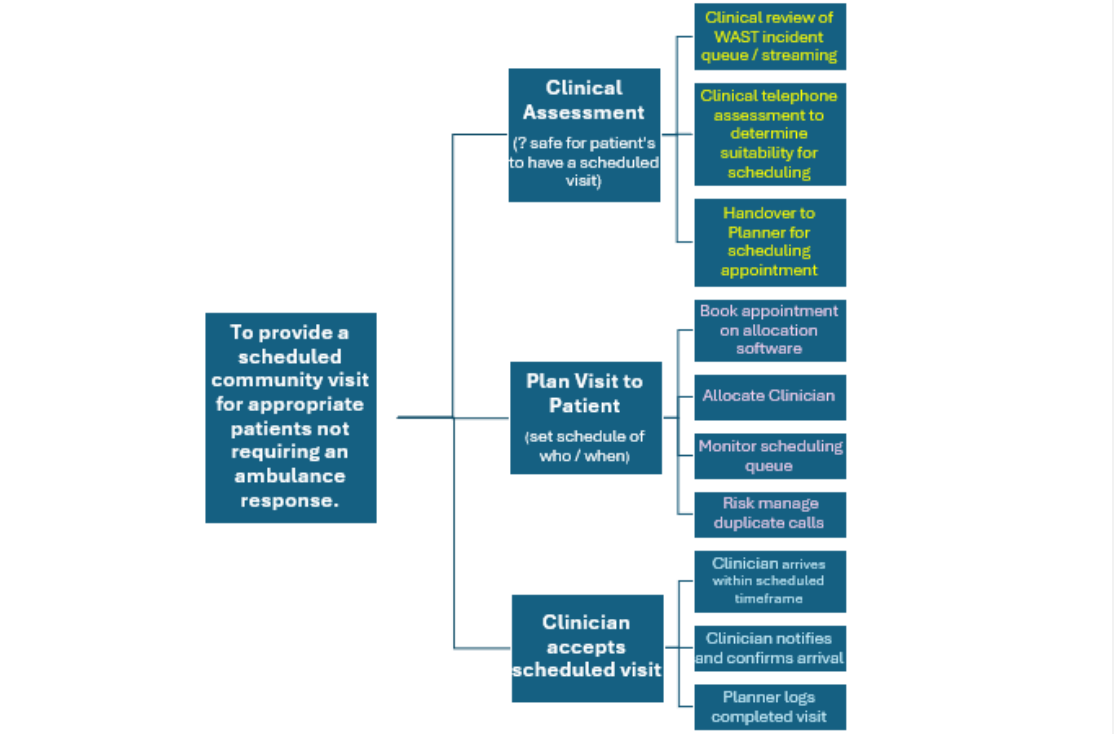
- For the CMT to succeed it is important that WAST has pathways that by-pass the emergency department or avoid a hospital attendance when appropriate to avoid unnecessary pressure on hospital departments. The patients calling 999 or 111 will be reviewed for either an immediate response or selected to undertake a remote telephone triage by a WAST clinician. patients that can have their care needs addressed by a RICS clinician, on a single point of triage, should not progress further and be closed. However, there are patients who's care needs are more complex and may require multiple contacts from a WAST clinician to understand the more complex care needs whilst ensuring patient safety. This approach will be supported within the care planning desk and/or the UCR.
- Patients may be 'held' within the care planning service and remotely monitored to understand the progression of their presentation. Clinical conditions that could be remotely monitored by the care planning desk could include;
    - A new or acute problem such as an infection

- An exacerbation of a chronic condition where the condition can be safely treated out of hospital, but its functional consequences may mean that the individual is at risk of hospital admission
- Serious illness where treatment at home is in keeping with the person's wishes as part of a pre-agreed treatment escalation plan, such as A patient in receipt of palliative care who may be in a crisis and wishes to be treated at home or their usual place of residence as part of a pre-agreed treatment escalation plan rather than be admitted to hospital. This will be with the full understanding that the same level of diagnostics and support may not be provided in the community.

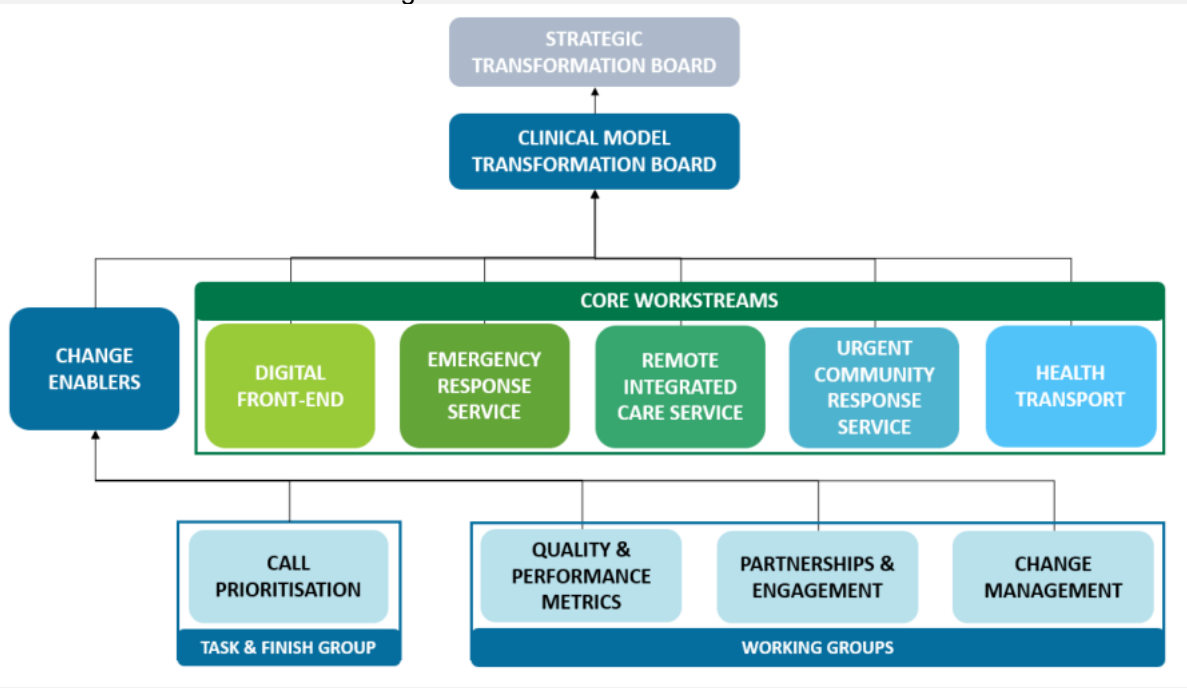
- There are patients described here that will require additional support to prevent their deterioration, on these occasions the care planning desk has the ability to work closely with the UCR and together they should support the patient and avoid a hospital conveyance whenever possible, a 'Push' model. This will require close communication between the services and when identified the UCR should aim to provide a response to the patient within two hours of 'seeing' the call.
- The UCR clinician will also be reviewing the RC Stack within their area to identify calls that have been passed for a response to the dispatch desk, either selected for immediate dispatch or have undertaken a RICS triage and the care needs of the patient has not been addressed. The UCR clinician will be able to 'Pull' calls for review and either manage the needs of the patient remotely or arrange a face-to-face visit of a specialist resource with a scope of practice deemed appropriate to manage the patient's presentation. The resource could be a WAST resource or part of the health boards multi-disciplinary team.
- To ensure the patient receives the most appropriate resource to manage their needs, there is an opportunity to schedule calls for the UCR specialist resource, this is important in aligning the scope of practice of the clinician to the perceived patient needs.

Scheduling

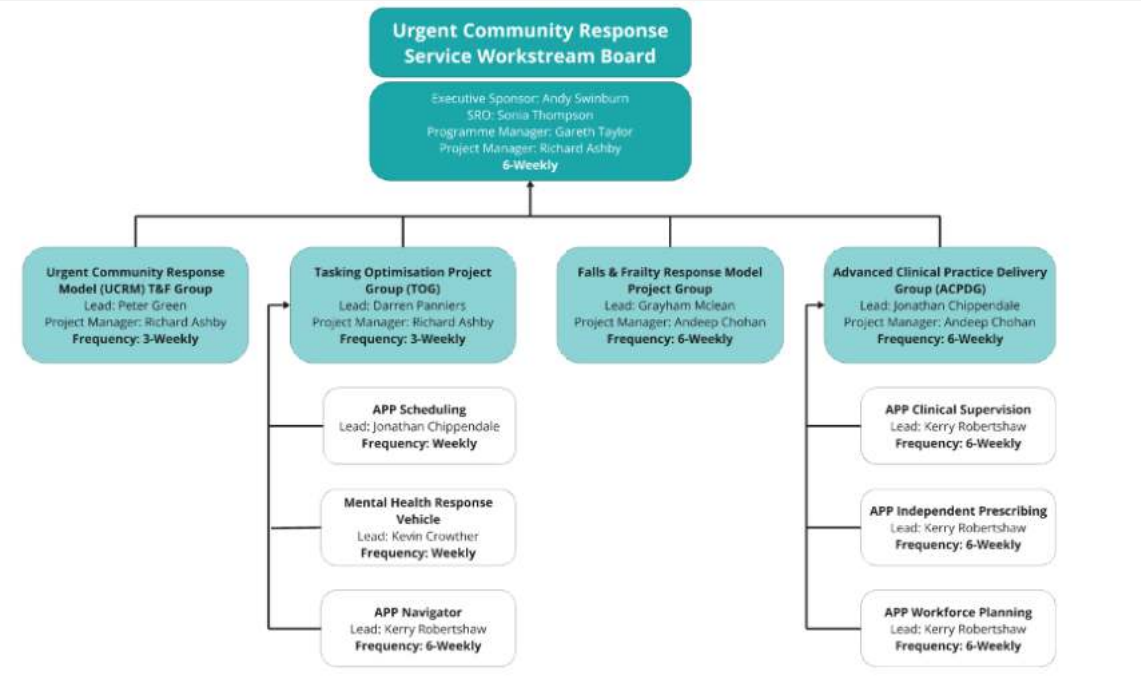
- WAST has successfully integrated Advanced Paramedic Practitioners (APPs), whose clinical expertise allows them to manage patients in the community. The APP Navigator schemes have demonstrated significant benefits since their inception in 2022, with a notable increase in the number of patients managed at home or referred to non-emergency hospital departments, thus avoiding emergency department (ED) attendances and at times avoiding the need to dispatch a WAST resource to the scene.
- To further optimise the impact of resources, WAST has been testing the scheduling of 999 calls for operational APPs and Palliative Care Paramedics (PCP). The aim was to maximise the value of their clinical skills by ensuring that appropriate cases are directed to them, allowing for safe alternatives to ambulance conveyance wherever possible as seen in the following driver diagram.



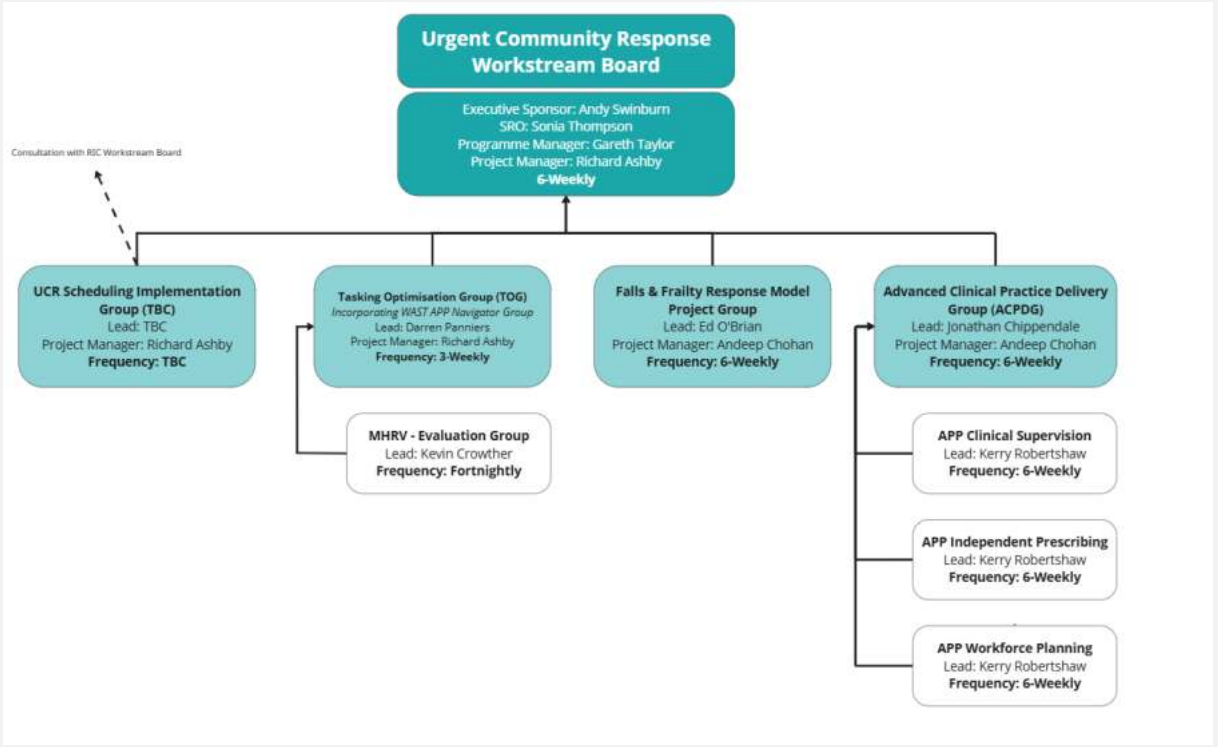
- The aim of scheduling calls within the UCR for the operational resources is to maximise the utilisation of specialist resources in 'See and Treat' of suitable patients within community settings, to reduce demand on the Emergency Department 'front door' and increase available capacity within EMS. The outcomes and benefits of scheduling include:
    - Improved patient outcomes aligned to the Six Goals of Urgent and Emergency Care.
    - Enhanced patient experience.

	• Increased health system efficiency. • Reduced handover delays. • Increased emergency ambulance capacity. • Improved job satisfaction by aligning patient presentations with the advanced practice scope of practice and skill set.
Reporting route (oversight group of QIA and monitoring of quality measures)	Urgent Community Response Workstream Board Clinical Model Transformation Programme Board 

WORKSTREAM REPORTING STRUCTURE (PHASE ONE)



WORKSTREAM REPORTING STRUCTURE (PHASE TWO)



Projects and Task & Finish groups report into regular Workstream Boards with Highlight reports (HLR1), these separate reports are then captured onto a Workstream Highlight report (HLR2) which is then presented at the Clinical Model Transformation Board. (Examples shown below)

Tasking Optimisation

Report Date:	Current RAG	Previous RAG	For Noting:	Project Lead:	Darren Panniers
20/01/25	Green	Green	APP Scheduling – process to be presented and discussed at CMT Workshops 22-24/01/25. MHRV – Operationally Live. APP Navigator – 6 out of 7 health boards now have an APPNAV model at various stages of operation, with 49 ECNS trained APPs over 7 HBs by end of January.	Project Manager	Richard Ashby
Scope:	Designing the optimum configuration of our Urgent Community Responders, ensuring efficient tasking of the most appropriate resource to meet the patients' needs. Implementation of phase 1 objectives deliverables through Task & Finish groups defined to implement MHRV in South-East area and demonstrate how scheduling would be implemented for the APP workforce.				

Task / Milestone	RAG Status	RAG Trend	Current Position	Forward View
TASK & FINISH GROUPS – Key Updates				
APP Scheduling	Green	↔	• Face to face meeting held on 03/12 to map out scheduling process. • Scheduling process to be presented at CMT workshops 22-24/01/25 to discuss, get feedback and plan next steps.	• Next steps to be discussed at UCRS Workstream board and wider CMT engagement sessions. • Consider if Task & Finish group has met its objective, should it now be closed down and then if the plan is to implement scheduling, then establish a new group? • APP AQM will need to go back to CPAS for approval before implementation phase.
Mental Health Response Vehicle	Green	↔	• MHRV operationally live as of the 4th November 2024. Operating 1300-0100 with focus on the South-East. • Process designed to ensure robust pool of staff available. Looking to recruit 'bank' staff to cover shortfalls, working on a co-ordinated roster and vehicle markings. • MHRV Power BI dashboard now operational via Launchpad.  Mental Health Car Dashboard - Power BI	• Continued noting of feedback in order to evaluate and undertake lessons learnt • Ongoing discussions with HI to 'fine tune' dashboard. • HI to attend next meeting to discuss data definitions in order to determine performance and evaluation measures • Data sources for quality measures currently being confirmed, for example working with PECI on patient feedback.
APP Navigator	Green	↔	• Powys Teaching Health Board launched the APPNAV model on the 09/12, with positive feedback from APP and Ops reps. • BCU model currently undergoing a 'soft launch' involving 2 APPNAV's co-locating with SICAT. Exploring options to co-locate in an alternative location. • By end of January there should be 49 ECNS trained APPs over 7 HBs, which has risen from the October figure of 21 APPs in 3 HBs. • To provide quality assurance we now have a further 5 auditors who have undertaken the necessary ECN-Q auditing course.	• 6 out of 7 health boards now have an APPNAV model at various stages of operation, with Aneurin Bevan discussions currently underway with the ask to launch possibly March/April 25.

Urgent Community Response Service
Workstream Update

Report Date:	Current RAG	Previous RAG	For Noting:	Executive Sponsor:	Andy Swinburn
Jan-25	Green	Green	Draft WAST Falls plan & Exec summary ratified by FFRM for onwards approval. Draft Level 1 Falls Service Specification ratified by FFRM for onwards approval. Proposal Advanced Practice education pathway for staff with an interest in palliative care awaiting final approval at formal SOT on 14/01/25	SRO:	Sonia Thompson

Project/Working Group	In Scope	RAG Status	RAG Trend	Summary Position
Urgent Community Response Model	Development of Service Specification to deliver a consistent community urgent care response pan-Wales	Green	↔	• Draft of Service Specification has been written, circulated throughout group for comment and will be presented at UCRS Workstream Board for discussion.
Falls & Frailty Response Model	Review the impact of existing falls and frailty services with the purpose of designing efficient and sustainable urgent care service models that provide timely, appropriate, and effective care for patients across Wales.	Green	↑	• Draft Level 1 Falls Service Specification supported by FFRM 06/01/25. • Proposal regarding an Advanced Practice education pathway for staff with an interest in palliative care has been developed. Acknowledge this will impact the development of the Palliative Care Response Service Specification. FFRM Project Group supported the proposal on 25/11/24 and it was approved at Field Ops 18/12/24. • All Wales Falls Framework approved at 6G Programme Board in October. WAST Falls Plan developed (in alignment to All Wales Falls Framework). Draft version of Exec summery and plan supported at FFRM on 06/01/25 • Draft QIA developed 18/12/2024 and reviewed at FFRM on 06/01/24
Tasking Optimisation	Designing the optimum configuration of our Urgent Community Responders, ensuring efficient tasking of the most appropriate resource to meet the patients' needs	Green	↔	• Face to face meeting held on 03/12 to map out scheduling process. Scheduling process to be presented at CMT workshops 22-24/01/25 to discuss, get feedback and plan next steps. • MHRV operationally live as of the 4th November 2024. Operating 1300-0100 with focus on the South-East. • Process designed to ensure robust pool of staff available. Looking to recruit 'bank' staff to cover shortfalls, working on a co-ordinated roster and vehicle markings. • MHRV Power BI dashboard now operational via Launchpad. • Powys Teaching Health Board launched the APPNAV model on the 09/12, with positive feedback from APP and Ops reps. • BCU model currently undergoing a 'soft launch' involving 2 APPNAV's co-locating with SICAT. Exploring options to co-locate in an alternative location. • By end of January there should be 49 ECNS trained APPs over 7 HBs, which has risen from the October figure of 21 APPs in 3 HBs.
Advanced Practice Delivery Group	Developing an APP workforce with the skills, training, and clinical supervision to perform their roles effectively	Green	↑	• Organisational approval received to recruit 36 FTE APPs in 2024/25 to take establishment to 120.FTE. Currently at 109FTE. • APP Restructure OCP commenced on the 12th November. Due to end w/c 13th Jan 25. • Modelling undertaken to indicate APP recruitment numbers/areas (All Wales) for 2025/26. • Proposed APP education pathway for staff with an interest in palliative care (Funded by 6G & Marie Curie) approved at Field Ops 18th Dec. Will only be available as a part time education programme. • Senior APPs areas of specialism confirmed (APPNAV/Primary Care/Palliative). **Determined 8a roles are geographically disproportionate in certain areas which will impact plans going forward.** • Standard training TAPP and APP Primary Care Service Level agreement (including SOP) developed and approved for implementation. • Standard APPNAV MOU (including SOP) developed and approved for implementation. • End dates for current primary care rotations determined. Discussions ongoing with Primary Care Academies to support continuation and introduce standard Service Level Agreement.

How will quality measures be obtained? (Full QIA only)

Performance Measures
Operational performance of live initiatives will be monitored via Power BI and associated dashboards. Service performance

Quality Measures
The quality measures attached to the UCR Workstream have been identified via the development of a Logic Benefit Map (attached). These align with the benefits and outcomes identified in the specification above and include

- More patients are cared for at, or closer to home
- Patients receive a timelier falls response
- Patients receive a more personalised response
- Patients receive a more planned response within an appropriately agreed timeframe

	- Improved utilisation of UCR responders Several methods will be utilised to obtain this data, including Health Board and patient feedback, job cycle data, PLICS costings, and performance metrics.
Executive lead	Andy Swinburn (Director of Paramedicine)
Project lead(s)	UCR Workstream – Sonia Thompson (Project Manager - Richard Ashby) APP Scheduling Group – Peter Green (Project Manager - Richard Ashby) Tasking Optimisation – Darren Panniers (Project Manager - Richard Ashby) Advanced Clinical Practice Delivery Group – Kerry Robertshaw (Project Manager - Andeep Chohan) Falls & Frailty – Ed O'Brien (Project Manager - Andeep Chohan)
Outcome of QIA (screen only or full QIA)	**Full**
Comments (including brief rationale for not progressing to full QIA if appropriate) Log commencement on central QIA digital repository	Full QIA required for adverse risks associated with Patient Care, Effective Care, Timely Care, and Workforce domains.
Date submitted to Clinical Quality Governance Group (full QIAs) and inclusion on QIA Database (all QIAs) by CQGG secretariat. **Quality.amb@wales.nhs.uk**	Monday 7th April 2025

Annex 2 – Part 1 QIA Screening Tool continued

Health & Care Standards Domains 2023	Potential / Actual Impact Question	Potential Impacts? Positive (P), Neutral (N), Adverse (A)	Likelihood Score	Consequence (impact) Score	Score Likelihood X consequence	Score 8 & above. = Full QIA

Safe **1 Patient Safety** Our healthcare system is a high quality, highly reliable and safe system that avoids preventable harm, maximising the things that go right and learning from when things go wrong to prevent them occurring again. People's health, safety and welfare are actively promoted and protected; risks are identified and monitored and where possible, risks to safety are reduced or prevented. We promote and protect the wellbeing, and safety of children and adults who become vulnerable or at risk at any time. Where children or adults may be experiencing or are at risk of abuse or neglect, we take appropriate, timely action and report concerns.	Could the proposal impact on any of the following? Impact on serious incidents, their reporting and learning, systems in place to safeguard patients /staff and prevent harm?	**(P) Positive** • UCR expects to deliver a positive impact on patients' outcomes and treatment, namely increased timeliness across services such as falls response, and more appropriate responses such as APPs or Mental Health to enable a safer outcome such as close and treat at scene or closer to home. **(A) Adverse** • As noted in the CMT QIA, the complexity and scale of model reconfiguration may indirectly affect clinical outcomes. To assess and collate learning, Datix incidents will be recorded where applicable and appropriate. **(A) Adverse** • Patients traditionally closed at Point of Care (CSD or Consult & Close, or Transport), may now be held to facilitate onwards referral or case closure over a period of time where the patient is monitored to ensure no deterioration in condition. This may also reflect a positive impact such as awaiting the opening hours of the most appropriate referral point	N/A 3 4	 3 3	 **9** **12**	**Screening Only** **Full QIA Required** **Full QIA Required**
Effective Care	Could the service change impact on evidence-based practice, clinical standards	**(P) Positive** • Following several PDSA Tests of Change, the UCR workstream has	N/A	N/A	**N/A**	**Screening Only**

Our healthcare system ensures decision-making, care and treatment reflects evidence-based best practice, to ensure that people receive the right care to achieve the optimal and possible outcomes that matter to them. We design transformative, evidenced-based, whole-of-life pathways that cover prevention, care and treatment, rehabilitation and embed these into local service delivery.	(NICE/JRCALC), clinical leadership and/or engagement?	developed a robust evidence base to support the assertion of a more personalised and appropriate care package through scheduling resources. • Transitioning the model from a response model to a service model, provides an evidence -based opportunity to implement a system that best suits the developing needs of our patients based on the principles of right care right time.				

Efficient Our health care system takes a value-based approach to improve outcomes that matter most to people in a way that is as sustainable as possible and avoids waste. We make the most effective use of resources to achieve best value in an efficient way. We only do what is needed and undertake treatments that ensure any interventions represent the best value that will improve outcomes for people.	Does this proposal increase waste? Does this proposal improve value- based approach? Financial implication of the proposal	**(P) Positive** • The UCR workstream expects to evidence improved utilisation of several key resources, including (but not limited to) reduced EA handover delays, reduced EA time at scene, and reduced EA conveyance. • Tasking resources will support the determination of the most appropriate care pathway, ensuring the most efficient allocation of resource based on clinical presentation. • It is anticipated that this will lead to an increase of incidents closed at scene and/or signposted to the most appropriate care provider, reducing patients presenting at Emergency Departments (EDs) by ambulance, and increasing resource availability for patients that need an art scene response. **(P) Positive** • Increased availability of EAs (most expensive resource for patients who access the service and require conveyance	N/A	N/A	**N/A**	

Equitable Our healthcare system provides everyone with an equal opportunity to attain their full potential for a healthy life which does not vary in quality by organisation providing care, location where care is delivered or personal characteristics (such as age, gender, sexual orientation, race, language preference, disability, religion or beliefs, socio-economic status, political affiliation). We embed equality and human rights in our health care system.	Could the proposal impact on patient choice, dignity and respect, service user experience? Could the proposal impact on eliminating discrimination, on eliminating harassment and or on promoting good community relations /positive attitudes?	**Adverse (A)** • Several initiatives are being rolled out in phases, and it cannot be evidenced that patients nationwide will receive an equitable service until service are upscaled to a consistent standard across Wales. For example, patients in the southeast will initially receive a dedicated mental health service that is not available to patients across the rest of Wales until both funding is identified and value is evidenced. Palliative and Falls (Falls Responder and Enhanced Falls Response) are also example services that are not yet standard pan-Wales	3	5	**15**	**Full QIA Required**
Person-centred Our health care system meets people's needs and ensures that their preferences, needs and values guide decision-making that is made in partnership between individuals and the workforce. We care about the well-being of individuals, their families, carers, and our staff. We ensure that everyone is always treated with kindness, empathy and compassion and we respect their privacy, dignity, and human rights. We are committed to working better together to put people and their families at the centre of decisions, seeing them as experts working alongside professionals to get the best outcome and experience.	For example, if people could be treated differently in terms of race, religion, disability, gender, sexual orientation pregnancy, gender reassignment, civil partnerships, or age. (This can be a separate assessment, but the outcome recorded in the QIA)	**(P) Positive** • The UCR workstream can be considered person-centred, with the listed quality measures and objectives reflecting the desire to deliver a service that delivers for the patient at or closer to home. The specification for the service has been designed and developed with the patient at the centre.	N/A	N/A	**N/A**	**Screening Only**

Timely Care Our healthcare system ensures people have access to the high-quality advice, guidance and care they need quickly and easily, in the right place, first time. We care for those with the greatest health need first, and where treatment is identified as necessary, we treat people based on their identified and agreed clinical priority.	Could the proposal impact on care being provided in a timely way?	**Positive (P)** • Tasking resources will support the determination of the most appropriate care pathway, ensuring the timeliest response for the patient.	N/A	N/A	**N/A**	
		Adverse (A) • If operational APPs (or other similar specialist resources) are kept available for responding to Red calls whilst also being scheduled, there is a chance that if a Red call is received and allocated then there will impact on scheduled responses not being able to meet their target time slots which would result in delays of care and the breakdown of the scheduling principles. **Adverse (A)** • Alternatively, if all or a proportion of operational APPs (or similar) are reserved for scheduling then this may have an effect on the Trust's ability to respond to Red calls in a timely manner which would potentially lead to patient harm.	4	4	**16**	**Full QIA Required**

Workforce Our healthcare system recruits, retains, develops, and extends roles to ensure we have enough, confident people with the right knowledge and skills available at the right time to deliver safe care. We value our people and the commitment and resilience they demonstrate in the care they provide. We care about their wellbeing, protect their rights, and support them to feel well and happy at work; and provide them with the tools, systems, and environment to work safely and effectively. Our workforce planning focuses on investing in our people and nurturing, growing, and transforming our workforce to create a sustainable workforce for the future.	Could the proposal impact on staff satisfaction and/or sickness retention and recruitment skill and knowledge to undertake the proposal. Public perception of the Trust or its services? Wellbeing Safe systems at work to safeguard staff and prevent harm? serious incidents & reporting and learning?	**Adverse (A)** • As noted in the CMT QIA, there is risk of substantially harming workplace morale and disrupting the existing workplace culture by implementing further operational service changes. The Trust has undergone significant developmental and transformational work over recent years with all teams having been impacted by Organisational Change Processes, Model for Improvement Testing and introductions of new systems of work. There is a risk, by introducing a new way of working, that staff may struggle with additional system changes and experience episodes of burnout, and stress, resulting in increased sickness rates during the busiest period of the year.	2	4	**8**	**Full QIA Required**
		Adverse (A) • While delivering community-based responses, there is a risk of lone workers being subjected to violence and aggression incidents, or placed in a situation where they may be at risk.	2	2	**4**	

Summary rating = highest individual risk score						**9**

Health and Care Standard Enablers- no requirement to score only to reference any impact.

Enabler	Potential impact	Narrative
Leadership Our health care system has visible and focused leadership at all levels, with its activities driven by the organisations' vision and values for quality. Our leaders and managers take a long-term, stakeholder-centric view to develop a clear organisational vision. They have the appropriate skills and capacity to create the conditions for a functioning quality management system. We ensure our governance, leadership and accountability is effective in sustainably delivering care.	**Could the proposal impact.** • **Leadership of the service** • **Trust Quality Management System** • **Governance arrangements**	Leaders have been offered change management training in preparation for large scale transformation and have had the opportunity to engage over the proposed transformation and design of a Clinical Service Model. Opportunities to engage have included Leadership symposiums, CEO Roadshows and internal planning workshops. Whilst there will be no direct impact on leadership arrangements, leaders involved in the Clinical Model Transformation (CMT) programme in addition to business-as-usual operational leadership requirements and wider Local Development Plan activities may feel increased pressure. The impact on workforce will also create increased activity and challenging working environments for leaders as they support their teams through large and continuing periods of transformational change. Prioritisation of the CMT programme as part of the winter plan for operational service delivery may also lead to de-prioritisation of other key work deliverables including the introduction of robust quality management systems supported by QPMF self-assessment. Introduction of new key performance indicators aligned with the chain of survival will require leadership support through roll out and

		management of quality management systems and learning/feedback for team members.

Culture Our healthcare system creates the right climate and culture to nurture and encourage quality and system safety, valuing people in a supportive, collaborative, and inclusive workplace so that our people feel psychologically safe to raise concerns and try out new ideas and approaches. Relationships within teams and with the people we serve are effective and based on transparency, accountability, ethical behaviour, trust and just culture, where people can thrive.	**Will the proposal effect the culture of the Trust?**	There is acknowledgment of potential impacts on staff culture, particularly as operational changes will be occurring within a system of continued operational changes, and external pressures. The Trust aims to embed a culture of sustainable learning and improvement; however, it must be conscious of the pressures associated with continuous redesign. Attention must be given to supporting colleagues adequately through change, both in terms of internal pressures and potential external pressures. There is also a wider risk associated with the Trust's reputation. Should any of the work result in negative public perceptions, the subsequent impact on staff will also be negative. A change management approach has been adopted in relation to the CMT programme, with Change Management leads participating in relevant project groups and workshops. Additionally, a Change Management working group has been established to: a. Support leaders and managers at all levels across WAST to facilitate change and lead their teams through large-scale transformation b. Support colleagues impacted by change to deal with uncertainty and embrace change, in order to proactively contribute in WAST's transformation journey c. Offer a robust change management approach that contributes to successful adoption of transformed ways of working and benefits realisation

		d. Ensure change-related lessons learned during this programme are incorporated into WAST's change approach for future transformation programmes e. Align change management approach with WAST's culture as much as possible.
Whole System Approach Our healthcare system ensures safety in healthcare goes beyond individual patient safety. We will look within and beyond our organisational boundaries to learn how we can continually, reliably, and sustainably meet the evolving needs of people. We will strengthen relationships and work with all our partners to achieve good outcomes. Our policies incorporate the broader ambitions within the seven well-being goals and five ways of working in the Well-being of Future Generations Act.	**Are we working with external as well as internal partners as part of the proposal?** **Does it impact on the Trust Policies i.e.? Well-being goals and five ways of working in the Well-being of Future Generations Act.**	This work has been and will continue to engage with internal and external partners, with Trade Union and Commissioning colleagues having been part of the two workshop discussions to date. Welsh Government have also been made aware via the commissioners of the intention to transition from response to service model, however the political considerations of revised categories and subsequent performance monitoring have also been factored into the project risks.

Information Our healthcare system ensures information is available and shared appropriately for all who need it. We turn data to knowledge by triangulating quantitative and qualitative performance, experience, and outcome measures to understand the quality of services, efficacy of improvement work and impact of decisions made. We monitor, report, and escalate indicators through our governance structures to ensure that appropriate action is taken at every level in terms of learning, improvement, and accountability.	**Will the proposal data to knowledge by triangulating quantitative and qualitative performance, experience, and outcome measures to understand the quality of services, efficacy of improvement work and impact of decisions made?**	Data is a key enabler, and the evidence base utilised for further implementation will be available where appropriate. Given the scale of changes to existing service models and the associated impact on performance and quality measures, a CMT Quality & Performance Metrics group has been established with Executive Sponsorship from the Executive Director of Strategy, Planning, and Performance and cross-Directorate membership. This group is responsible for ensuring that the impact on current reporting is fully understood and that outcome measures associated with UCR service changes.

Learning Improvement and Research Our healthcare system creates the conditions and capacity for an organisation and system-wide approach to continuous learning, quality improvement and innovation, which it actively promotes. We use new knowledge to influence improvements in practice and to inform our decision-making. We ensure our learning and improvement activity is linked to our strategic vision to deliver transformational, organisation-wide change. We commit to participating in research because research-active organisations provide improved quality of care and outcomes for people.	**Does the proposal evidence continuous learning, quality improvement and innovation?**	The Clinical Model Transformation Programme is the result of, and dependent on, continuous learning and development to create not only an effective and efficient service for the patient whereby they receive the most appropriate care in the right place but also ensures long-term sustainability in an increasingly challenging climate.

Annex 2 – Part 2 Full QIA Tool

To be completed for each Quality Health and Care standard Domain that has an adverse score of >8.

QIA Part 2: Health & Care Quality Standards 2023 Domain: PATIENT CARE								
		Initial Risk Rating (No mitigations)				Mitigated Risk Rating (Residual)		
Reference number	Brief Description & Actual / Potential Adverse Impacts	Likelihood	Impact	Initial Risk Score	Key controls / assurances established. (What is already in place?)	Likelihood	Impact	Residual risk score
1.	**Equity of access.** If WAST continue to use APP Navigators (APPNAVs) as the conduit to schedule APP resources, then areas or regions where there is currently no APPNAV scheme will be disadvantaged which will lead to inequitable access to APP scheduling MHRV is also to be rolled out in phases and will operate during pre-determined hours. Until a 24/7 pan Wales service is developed, there can be no confirmation of equitable access to services.	5	3	**15**	• Continue to work with Health Board partners to develop/implement APPNAV services or similar. • Ongoing TAPP/APP recruitment to increase numbers to support current or new APPNAV schemes. • As of January 2025, 6 of 7 Health Board areas operate an APPNAV scheme with ongoing discussions with the remaining HB. • Aim to standardise APPNAV operation with all current and new schemes. • Measure of success will be delivery of IMTP ambitions by stated timelines • Mitigation score based on full rollout as desired	1	3	3
2.	**Patient Holding** Patients traditionally closed at Point of Care (CSD or Consult & Close, or Transport), may now be held to facilitate onwards referral or	4	3	**12**	• Dedicated monitoring is in place to ensure capture of potential deterioration. • This includes remote monitoring (via specialist teams)	2	3	**6**

	case closure over a period of time where the patient is monitored to ensure no deterioration in condition. This may also reflect a positive impact such as awaiting the opening hours of the most appropriate referral point							

Quality measures (monitoring unintended consequences and positive impacts)-

- What are the quality outcome measures?
- What is the source data for the quality metrics?
- How often will they be monitored?
- Where will they be reported for monitoring and discussion?
- How will you capture patient feedback?
- How will you capture staff feedback?

Any further mitigations planned (with accountabilities and timescales)?

- Applicable mitigations noted in assurances and controls

Comments

QIA Part 2: Health & Care Quality Standards 2023 Domain: EFFECTIVE CARE				
		Initial Risk Rating (No mitigations)		Mitigated Risk Rating (Residual)

Reference number	Brief Description & Actual / Potential Adverse Impacts	Likelihood	Impact	Initial Risk	Key controls / assurances established. (What is already in place?)	Likelihood	Impact	Residual risk score
3.	**How will patients be prioritised during the scheduling process?** If scheduling is based on time order of call received, then this may not be the most efficient or patient centred method of providing care which would lead to sub-optimal use of APPs (or similar) and the ability to respond to emerging clinical risk.	3	4	**12**	• During the tests of change a prioritisation process has been developed and tested. • Patients will be placed in the appropriate call category following a detailed clinical assessment and patient will be monitored by referring clinician prior to scheduled appointment. (Not noted in screening due to mitigation in place following Tests of Change) **Waiting Time Priorities** **High priority - 2 hour (H2)** **Medium priority - 4 hour (M4)** **Low priority - 6 hour (L6)**	1	4	**4**

Quality measures (monitoring unintended consequences and positive impacts) - How will you source these metrics?

- What are the quality outcome measures?
- What is the source data for the quality metrics?
- How often will they be monitored?

- Where will they be reported for monitoring and discussion?
- How will you capture patient feedback?
- How will you capture staff feedback?

Any further mitigations planned (with accountabilities and timescales)?

- Applicable mitigations noted in assurances and controls

Comments

QIA Part 2: Health & Care Quality Standards 2023 Domain: TIMELY CARE

		Initial Risk Rating (No mitigations)				Mitigated Risk Rating (Residual)		
Reference number	Brief Description & Actual / Potential Adverse Impacts	Likelihood	Impact	Initial Risk Score	Key controls / assurances established. (What is already in place?)	Likelihood	Impact	Residual risk score
4.	**What effect will scheduling have on Red calls and Red calls have on scheduled calls?** If operational APPs (or other similar specialist resources) are kept available for responding to Red calls whilst also being scheduled, then if a Red call is received and allocated then thus will impact on scheduled	4	4	**16**	• Tests of change have been carried out on the scheduling process and on a process to notify patients in advance with SMS messaging of appointment time, when the clinician is mobile and of any changes/delays. • Further PECI involvement is planned regarding patient feedback of scheduling process.	2	4	**8**

	responses not being able to meet their target time slots which would result in delays of care and the breakdown of the scheduling principles. Alternatively, if all or a proportion of operational APPs (or similar) are reserved for scheduling then this may have an effect on the Trust's ability to respond to Red calls in a timely manner which would potentially lead to patient harm.				• Some modelling has been carried out to look at impact of 'removing' APP resources from Red response, however this is currently based on the existing 'red' category and would have to be remodelled following implementation of arrest/emergency categories. **For every 25% increase of APPs not responding to RED call, there is a reduction in 8 minute success rate of 1%.**			

Quality measures (monitoring unintended consequences and positive impacts)-

- What are the quality outcome measures?
- What is the source data for the quality metrics?
- How often will they be monitored?
- Where will they be reported for monitoring and discussion?
- How will you capture patient feedback?
- How will you capture staff feedback

Any further mitigations planned (with accountabilities and timescales)?

- Applicable mitigations noted in assurances and controls

Comments

QIA Part 2: Health & Care Quality Standards 2023 Domain: WORKFORCE

		Initial Risk Rating (No mitigations)		Mitigated Risk Rating (Residual)

Reference number	Brief Description & Actual / Potential Adverse Impacts	Likelihood	Impact	Initial Risk Score	Key controls / assurances established. (What is already in place?)	Likelihood	Impact	Residual risk score
5.	**What effect will scheduling have on Red calls and Red calls have on scheduled calls?** If operational APPs (or other similar specialist resources) are kept available for responding to Red calls whilst also being scheduled, then if a Red call is received and allocated then thus will impact on scheduled responses not being able to meet their target time slots which would result in delays of care and the breakdown of the scheduling principles. Alternatively, if all or a proportion of operational APPs (or similar) are reserved for scheduling then this may have an effect on the Trust's ability to respond to Red calls in a timely manner which would potentially lead to patient harm.	2	4	**8**	• A robust executive-led communication approach over a series of years as the possibility of movement to a clinical service model was explored. This included opportunities to discuss with executives as part of recurrent CEO roadshows. • Regular and consistent updates of progress from the transformation teams will help team members feel informed and involved in the change process. • Transparency of decision making with internal and external stakeholders. • Embedding and upskilling colleagues regarding approaches to change management. In August 2023, Change Management training was made available to all staff. • Change Management approach to the Clinical Model Transformation (CMT) programme supported by a dedicated Change Management Working Group to share and embed best practice. • Robust wellbeing arrangements are in place with access to wellbeing services and shared information for external providers to support individual needs. • Involvement with representatives from key internal stakeholder groups as part of design workshop	1	4	**4**
	Staff Workload and Culture The scale of Transformation in addition to delivering core responsibilities may present a significant burden to staff with regards to capacity and ability to deliver	2	4	**8**	• The additional damage to workplace culture may be mitigated via continuous feedback loops, extending through to staff from Workstream Board. The existing hierarchy allows for feedback from Board to be looped via Heads of Service, DOMs, and LMs, as	1	3	**3**

					well as back up the chain. Positive or negative feedback from staff will act as an indicator.			
	Lone Worker Risk Colleagues may find themselves in a situation at risk of violence and aggression during episodes of community-based care	2	2	**4**	• Key mitigations are already in place for this risk, monitored and assured via the Lone Worker Policy, Violence and Aggression Training Module, as well as line-manager de-briefs and associated wellbeing checks or via standard clinical supervision. Measures of success will be noted via incidents recorded during the period of transformational change.	2	2	**4**

Quality measures (monitoring unintended consequences and positive impacts)-

- What are the quality outcome measures?
- What is the source data for the quality metrics?
- How often will they be monitored?
- Where will they be reported for monitoring and discussion?
- How will you capture patient feedback?
- How will you capture staff feedback

Any further mitigations planned (with accountabilities and timescales)?

- Applicable mitigations noted in assurances and controls

Comments

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

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/profession intervention. Requires time off work 4-14 days. Increased hospital stays 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 many 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 (> 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.	ocal media coverage - short-term reduction in public confidence/trust. hort-term negative social media. ublic expectations not met.	Local media coverage - long-term reduction in public confidence & trust. Prolonged negative social media. Reported in local media.	National media coverage <3 days, service well below reasonable public expectation. Prolonged negative social media, reported in national media, long-term reduction in public confidence & trust.	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.

				Increased scrutiny: inspectorates, regulatory bodies and 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 several 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.

Annex 3 – Questions and Prompts for QIAs

Safe Care

- What is the impact on partner organisations and any aspect of shared risk?
- Will the proposed scheme impact on the organisations duty to protect children, young people, and adults?
- What is the impact on patient safety?
- What is the impact on preventable harm?
- Will it affect the reliability of safety systems?
- How will it impact on systems and processes for ensuring that the risks of healthcare acquired infections to patients is reduced?
- What is the impact on clinical workforce capability care and skills?

Equitable and Person-Centered Care

- Has consideration been given to patients, carers, the public and stakeholder engagement in line with the Welsh Equality Duties including Welsh language?
- What is the impact on race, sex, gender reassignment, age, disability, sexual orientation, religion, or belief (including those with no belief), marriage or civil partnership and pregnancy/ maternity for individual and community health access to services and experience?
- What is the likely impact on self-reported experience of patients and service users? (Response to concerns & feedback from service users).
- How will it impact on the patient choice agenda?
- How will it impact on the compassionate care and personalised care agenda?

Effective & Timely Care and Workforce

- What is the impact on implementation of evidence-based practice?
- What is the impact on leadership?
- Does it reduce or have a negative impact on variations in care provision / equal to all groups?
- Does it affect supporting staff to stay well / staff experience?
- Does it promote self-care for people with long terms conditions?
- Does it impact on ensuring that care is delivered in the most clinically and cost-effective setting?
- Does it eliminate inefficiency and waste by design?
- Does it lead to improvements in care pathways?

Annex 4 – Examples of monitoring measures (not exhaustive)

Safe Care:

- incidents including Never Events
- concerns, claims & service user feedback.
- staffing levels and skill mix
- clinical audit results
- harm free care data
- internal audit results

- Outcomes of external reviews.

Effective & Timely

- clinical outcomes
- clinical audit results
- activity data
- contract performance
- Implementation of national guidance.

Equitable & Person-Centered Care

- patients, carers, and public feedback
- Patient Voice feedback
- Concerns data.

Workforce

- staff feedback
- sickness / absence
- turnover
- appraisal rates
- mandatory training uptake
- National surveys.

Annex 5 - Stakeholders & partners (not exhaustive)

- NHS Wales Delivery Unit
- Welsh Government
- GPC Wales
- Executive Medical Directors
- Executive Nursing Directors
- Executive Directors of Therapies & Health Science
- Primary Care Reference group
- Mortality Review Steering Group
- Patient Safety / Risk Managers
- Welsh Risk Pool - Once for Wales Concerns Management System
- Assistant Directors for Primary Care & Community Care

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

AGENDA ITEM No	**9**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**5**

PUTTING THINGS RIGHT REPORT
QUARTER 4 2024/25, JANUARY - MARCH

MEETING	Quality, Patient Experience & Safety Committee
DATE	9 May 2025
EXECUTIVE	Liam Williams, Executive Director of Quality & Nursing
AUTHOR	Wendy Herbert, Deputy Director of Quality and Putting Things Right Claire Appleton, Assistant Director - Putting Things Right
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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 4 2024/25 highlights:

- The impact of high demand across Trust Emergency and Non-Emergency Services
  - harm due to extensive response times in the community for emergency care
  - distress caused by cancellations of pre-booked transport
  - large volume of high harm cases shared with Health Boards for joint investigation.
  - increase in Nationally Reportable Incident (NRI) reporting and Duty of Candour cases
- Challenges in providing timely complaint responses; (reducing percentage of complaints responded to in 30 working days and high number of open overdue responses.
- Two Public Interest Reports published by the Public Service Ombudsman for Wales.
- The findings of the Annual Welsh Risk Pool Concerns Assessment.

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

KEY ISSUES/IMPLICATIONS

(i)	The deterioration in complaints investigation requires organisational leadership, capacity and ongoing case level priortisation across Directorates. Current performance is likely to reduce further over coming months while additional capacity is secured which will lead to increased family concerns and potential regulator inquiry.
(ii)	The Trust is committed to completing the Action Plans developed in response to the Public Services Ombudsman for Wales (PSOW) and Welsh Risk Pool (WRP) Reports.
(iii)	Patient safety risks and learning opportunities may not be identified in a timely way if the number of open, uninvestigated incidents is not addressed.
(iv)	Online training for the Duty of Candour is now a mandated learning subject for all Trust staff.

REPORT APPROVAL ROUTE	
Clinical and Quality Governance Group	14 April 2025 (Virtual)
Quality, Patient Experience & Safety Committee	9 May 2025

REPORT APPENDICES
ANNEX 1 - SBAR Report
ANNEX 2 - PTR & Legal quarterly data
ANNEX 3 - Welsh Risk Pool Annual Concerns Assessment
ANNEX 4 - Public Service Ombudsman for Wales Section 23 Report 202302966 and 202307480
ANNEX 5 - Public Service Ombudsman for Wales Section 23 Report 202306104

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

REPORT ABBREVIATIONS			
ACS	Ambulance Care Service	MPDS	Medical Prioritisation and Dispatch System
CAG	Clinical Advisory Group	NRI	Nationally Reportable Incident
CCP	Complex Case Panel	PFD	Prevention of Future Deaths
CMT	Clinical Model Transformation	PSOW	Public Service Ombudsman for Wales
CSD	Clinical Support Desk	PTR	Putting Things Right
CSP	Clinical Safety Plan	QMG	Quality Management Group
CQGG	Clinical Quality Governance Group	SCIF	Serious Case Incident Forum
HSSIB	Health Services Safety Investigations Body	WRP	Welsh Risk Pool
LFER	Learning From Events Report		

SITUATION

1. This Putting Things Right Report covers the period from 1 January 2025 - 31 March 2025. 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 also lead on the learning from mortality agenda, this is covered within the separate twice-yearly Learning from Mortality Report to this Committee.

BACKGROUND

2. The Report consists of two elements:

ANNEX 1: The Report has been structured to provide a succinct overview of three core areas; Assurance, Performance and Learning. The narrative is drawn from the data provided in **ANNEX 2** as well as qualitative organisational intelligence flowing through the Trust's Quality and Safety Governance Groups.

ANNEX 2: PTR and Legal data reporting. It includes a compliance heatmap (enabling focused attention on statutory requirements), assurance overview (a more detailed picture of statutory and regulatory functions), performance overview (indicative of potential risks to future assurance) and a thematic visual presentation of themes and learning (areas that are informing organisational development and improvement).

ASSESSMENT

ASSURANCE

(i) ***External Assurance***

3. The Annual WRP Concerns Assessment was received during Quarter 4 for fieldwork undertaken on case management during Quarter 4 2023-24. The Report is included in **ANNEX 3** and the findings outlined in Table 1 below.

Table 1

Management of Concerns (Incidents)	LIMITED ASSURANCE
Management of Concerns (Complaints & Enquiries)	LIMITED ASSURANCE
Redress Case Management	SUBSTANTIAL ASSURANCE
Claims Case Management	SUBSTANTIAL ASSURANCE
Inquest Case Management	SUBSTANTIAL ASSURANCE
Organisational Learning & Learning from Events	LIMITED ASSURANCE
WRP Reimbursement Process	LIMITED ASSURANCE

4. The assessment states that organisational procedures are robust however performance with LFERs and reimbursement and data quality issues within complaints management have reduced the assessed assurance score of these areas. The Report highlights that processes for legal case management are considered to be an exemplar arrangement and notes the compassionate nature of the Trust's complaint responses.

5. A comprehensive Action Plan has been developed in response to the findings and will be monitored through the Trust's Audit Tracker.

6. The PSOW has published two Section 23 Public Interest Reports involving the Trust during March 2025 (one issued jointly to the Welsh Ambulance Services University NHS Trust (WAST) and Swansea Bay University Health Board). The Reports are included as **ANNEXES 4 and 5** for review, as per the recommendation by the Ombudsman.

7. Report 202302966 and 202307480 (joint report reference numbers issued for Swansea Bay University Health Board and WAST) details a missed opportunity for clinical review from CSD and a poor standard of complaint investigation. Report 202306104 identifies issues with clinical record-keeping and aspects of the complaints handling process; delays in information sharing and a lack of completeness within the investigation.

8. Throughout the PSOW investigation and publication, our thoughts remained with the families who had lost loved ones, and the additional distress caused that must have been caused by unsatisfactory responses from the Trust. The Trust contributed to the collaborative development of the Ombudsman's recommendations. The recommendations have largely already been undertaken, with evidence of completion being provided to the PSOW.

9. No Regulation 28 PFD Reports were received during Quarter 4.

(ii) **Compliance heatmap**

10. The overdue number of NRI investigations has remained static. While it is recognised that this is not acceptable, the consistency in volume demonstrates an ongoing commitment to maintaining control over this number in the face of increased demand and new reports being generated. The overall number of NRIs open with the NHS Wales Executive has increased to 53, reflective of the number reported in the last quarter.

11. Complaint acknowledgement times remain consistently high, notwithstanding the increase in volume, with only a very few cases missing the acknowledgement target. However, compliance to complaint response times are once again becoming a cause of concern due to increased complexity of investigations within the Trust, an increased volume of incidents that may have arisen from planned changes in the Clinical Safety Plan that increased the Trust risk on behalf of the wider NHS system and the need to recruit additional staff to support audit of the different interventions now in place across the Clinical Contact Centres; Clinical Navigators within Emergency Medical Service (EMS) and Emergency Communication Nurse System (ECNS) within 111Wales Integrated Care.

12. An expected reduction in complaint response times performance was identified in the last report to the Quality, Patient Experience & safety Committee (QuESt) due an increasing number of submitted and open overdue complaints. The Trust has approved increased investment within the Operations Auditing Team and the Remote Care Education Team to support the PTR Recovery Plan previously noted by QuESt. This investment is being used to recruit new colleagues and is expected to start impacting in Quarter 2.

13. The Trust has complied with the five working day target for issuing Duty of Candour initial letters after the 'in-person' notification on all but one occasion which was overdue by a small number of days.

14. The Trust continues to achieve target levels of compliance with National Patient Safety Alerts and Notices and its response times for PFD Regulation 28 Reports.

(iii) **Assurance profile**

15. The rates of NRI reporting have increased during the last quarter and similarly, there are a historically high level of cases shared under joint investigation processes.

16. As previously indicated, a number of potential drivers have been identified for these increases; significantly high levels of seasonal pressures and operational activity during the winter period; embedding of the Medical Examiner process; changes made to the WAST CSP that led to the Trust holding risk on behalf of the wider NHS system that would previously have been deferred back into the community through the No Send Policy.

17. Service area and Corporate Teams are experiencing challenges in respect of CMT changes due to the complexity of patient pathways and increased number of call management touchpoints, meaning the amount of audit work and expertise required to review cases has increased, contributing to lengthening response timescales. As colleagues and teams become more familiar with the new processes the audit process will become more intuitive again and changes to the CAD will also ensure that the delineation between interventions is clearer within the sequence of events.
18. The Trust's CCP continues to review all complaints and incidents where the Redress provisions may be engaged. The proportion of cases triggering the WRP Learning from Events process has remained consistently low.

19. The number of open claims is gradually reducing over time, a reflection of increased investment in team capacity.

20. The number of Medical Examiner Referrals received breached the upper control limit in January 2025 but dropped again in February 2025. Year on year comparison will be possible going into the next financial year. Commencing in April 2025, the Medical Examiner (ME) Service will begin to send a monthly list of cases referred to WAST for us to cross-reference for assurance that no cases have been overlooked. The ME Service will also begin requesting monthly feedback on outcomes for these cases.

(iv) **Performance**

21. The number of patient safety incidents reported on Datix Cymru that have not undergone a management review has increased during the quarter despite this aspect of incident management being regularly reviewed at QMG. The Patient Safety Team screen all incidents to assess levels of harm and ensure statutory requirements and mandatory processes for serious incident management are met. However, patient safety risks may not be identified in a timely way and limited learning undertaken if the number of open, uninvestigated incidents is not addressed.

22. The increasing number of open complaints and the proportion of which are overdue presents a challenging picture of future performance. There continues to be challenges in obtaining information critical to investigations in relation to clinician input (CSD). Additional Auditors for CSD are due to start in post over coming months and the service now has a complete senior management structure who are considering the delivery structure and resourcing for the PTR/Legal work across the service.

23. In addition to delays incurred through awaiting CSD Audits, the Operations Quality Team Report that the increased volume of calls requiring audit is also impacting on MPDS Audits compliance/responses. As of mid-April, they report 192 call audits awaiting completion that are associated with potential adverse incidents, 134 associated with complaints and 18 associated with coronial investigations.

24. The complaints management process itself is well-assured, with families continuing to receive regular contact from the Trust. However, the delays in completing investigations contribute to the distress and frustration felt by many complainants and affects the well-being of staff who are supporting them. There is the potential of future PSOW findings against the Trust for cases where our response timescale is unreasonably lengthy.

25. Medical Examiner Level 1 triage occurs regularly, ensuring prompt recognition of cases where learning and/or potential harm are identified. The Level 2 Medical Examiner Learning Panel is now effectively managing cases, as demonstrated by

the number closed during this financial year, but the frequency of Panels is being increased to enable more timely review of cases and to address the number still outstanding.

26. As of the end of March, there were 15 deferred LFERs. Fourteen of these were Amber deferred cases, including 3 that had been resubmitted and were awaiting the outcome of the Learning Approval Panel. There was one Red deferred case.

27. The number of Coronial approaches has increased in Quarter 4 in comparison to Quarter 3. The workload of the team remains high due to the large number of statements being requested, an increase in the use of jury inquests and increased number of witnesses being called. The Legal Services Team provides individualised preparation and support to all Trust staff.

(v) **Learning And Improvement**

HSSIB Report: *12 lead electrocardiograms (ECGs) in Ambulance Services: paramedic education, training and competence*

28. In October 2024, through the monitoring of concerns, and feedback provided by Paramedics during their ride-out shifts with their Senior Paramedic, an emerging theme was recognised in relation to electrocardiograms (ECG) interpretation by Trust Clinicians and work commenced explore educational standards and obtain staff feedback on barriers to effective interpretation.

29. The Trust's Review has overlapped with the launch of a HSSIB investigation into pre-hospital interpretation of electrocardiograms (ECG) in Ambulance Services in England, the first part of which was published in March 2025. The scope of the HSSIB review includes the undergraduate and vocational training of Paramedics in conducting an ECG and interpreting its results; the professional training and support available to Paramedics in maintaining competence in ECG practice; the approach adopted in education and training in considering differences in ECG interpretation across protected characteristics.

30. The Trust's own review provides assurance relating to incident management and individual learning following a small number of patient safety incidents and also evidences that the HSSIB findings are replicated in a Welsh context. Findings demonstrate opportunities for improvement in education standardisation and provision which have been reviewed by our Learning and Development Team and will be driven forward through an organisational assurance plan monitored in the Ambulance Practice Steering Group.

(vi) **Duty of Candour**

31. Figures from the last quarter demonstrate improvement in our ability to identify cases which fall beneath the NRI threshold but still trigger the Duty of Candour (cases where Moderate harm may be linked to healthcare provision). This is as a result of investment and development of the Patient Safety Team and increased capacity for detecting patient outcomes from data sources outside of the Trust.

32. The Trust, and the two PTR teams (Patient Safety and Patient and Family Relations) in particular, have reflected deeply on the principles of candour and openness following the two PSOW Public Interest Reports. While the statutory Duty was not in place at the time of those cases, delays with information sharing or a lack of completeness in investigations compounded the poor experience and lack of trust experienced by the families involved. In at least one of the cases, the monitoring and reporting associated with the statutory implementation of the Duty will prevent recurrence and the Trust has proactively proposed further developments within the Datix Cymru Platform to enhance oversight. The Trust has also driven the resolution of technical issues within the Duty of Candour electronic Training Module, and this will become mandatory training for all Trust staff.

33. In conjunction with the development of a national Joint Investigation Module, the Trust is enhancing data sharing with the NHS Wales Executive Quality Assurance & Performance Team in respect of Duty of Candour enactment. It is hoped that this will facilitate broader national oversight beyond NRI reporting, and lead to clarification of responsibilities for Duty of Candour enactment in cases that are unlikely to result in a qualifying liability.

(vii) **Strengthening approaches to organisational learning**

34. Following the Trust's participation in the All Wales Enhancing Learning Programme, local scoping work has identified opportunities to strengthen organisational approaches to learning from events. Through the leadership of the QMG, a Task and Finish Group is currently engaged in considering the potential of a centralised learning repository alongside the adoption of the All Wales Learning from Events Framework. It is anticipated that this work will improve the Trust's LFER performance.

35. Service developments during the winter period associated with the CMT Programme have required a need for agile and highly responsive learning to identify and mitigate risks effectively and recognise benefits at an early stage of change. Rapid Learning Teams have been established to do this, bringing together service leads and patient safety to rapidly review patient pathways and

service interfaces. The Clinical Advisory Group is also being reframed to ensure that the processes adopted are as effective and efficient as possible These activities demonstrate a shift towards improving our safety management system and a desire to undertake proactive and prospective patient safety assurance. Learning from these activities is channelled through the CAG, CQGG and into CMT Board.

36. The Patient Safety Team has also been supporting the use of 'Safety II' approaches through the creation of a template to formally recognise & feed back good practice identified through SCIF Case Reviews.

(viii) **Joint investigations**

37. 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.

38. The pilot phase for the joint investigation module within Datix Cymru has been completed with Cardiff and Vale University Health Board with further piloting needed but with national engagement receiving a positive response. If national agreement on its structure, adoption and associated governance can be achieved, it will provide a national learning repository for joint investigations.

(ix) **National Reportable Incidents**

39. The incidents that have been reported as NRIs this quarter related to:

Call management - incorrect call categorisation and/or prioritisation, welfare call policy not being followed, missed ineffective breathing descriptors, incorrect address/location recording, inappropriate closure of call between 111 and CSD
Remote clinical care - lack of recognition/response to a deteriorating patient with sepsis, inappropriate clinical downgrade from Red to Amber 1.
Clinical care - inadequate assessment of diabetic symptoms, inadequate assessment of head injury, staff acting outside of scope of practice.

(x) **Horizon Scanning**

40. The upcoming changes to call categorisation will require dedicated support from the PTR Teams in terms of identification and collation of intelligence related to the changes we have been asked to introduce.

41. The Trust is undertaking a pilot using Generative AI to analyse patient safety incidents. This project remains at the early stages to ensure that all information governance requirements are carefully adhered to, and updates will be provided in future Committee Reports.

42. The Trust continues to await updated Guidance from Welsh Government regarding proposed changes to the Concerns Regulations and the Putting Things Right Guidance process. No formal timescale has been confirmed for an implementation date and updates will be provided as information becomes available.

Welsh Ambulance Services University NHS Trust

PTR & Legal Services – Quarterly data

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

PTR & Legal Services – Quarterly data
Version 1.0
Released: April 2025

by Claire Appleton
Assistant Director of PTR & Legal Services

Compliance Heatmap - *how well are we meeting national legislation & regulation?*

Assurance Profile - *what does our PTR & Legal Services data tell us about quality and safety in the Trust?*

Performance Profile - *how effectively are we managing the Putting Things Right & Legal Services functions?*

Thematic Learning – *where should we target our improvement efforts?*

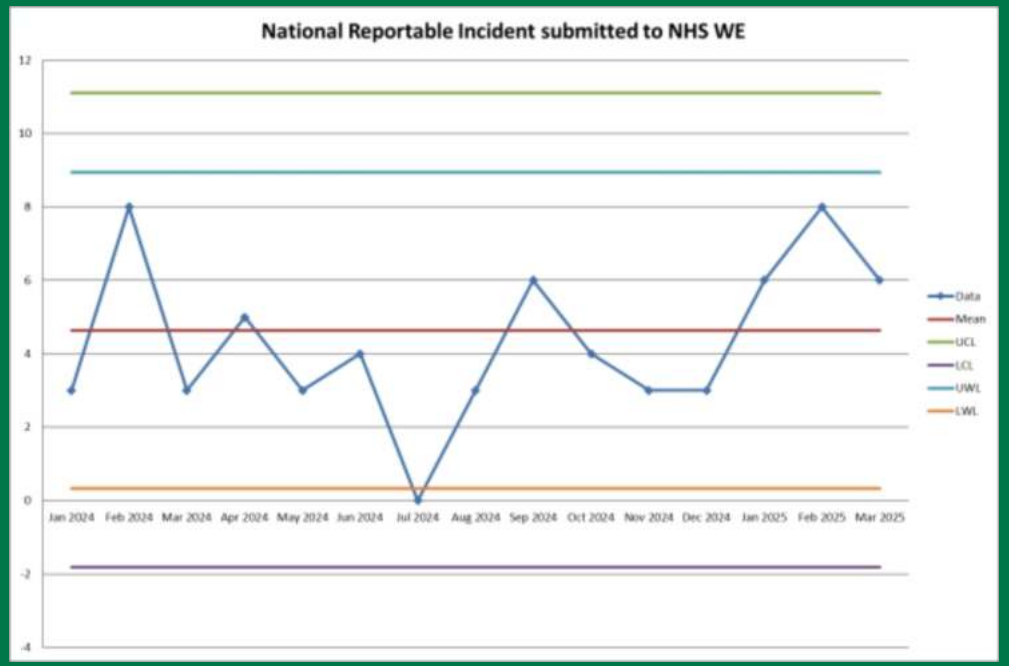
Data contained within this report is accurate at the time of reporting.

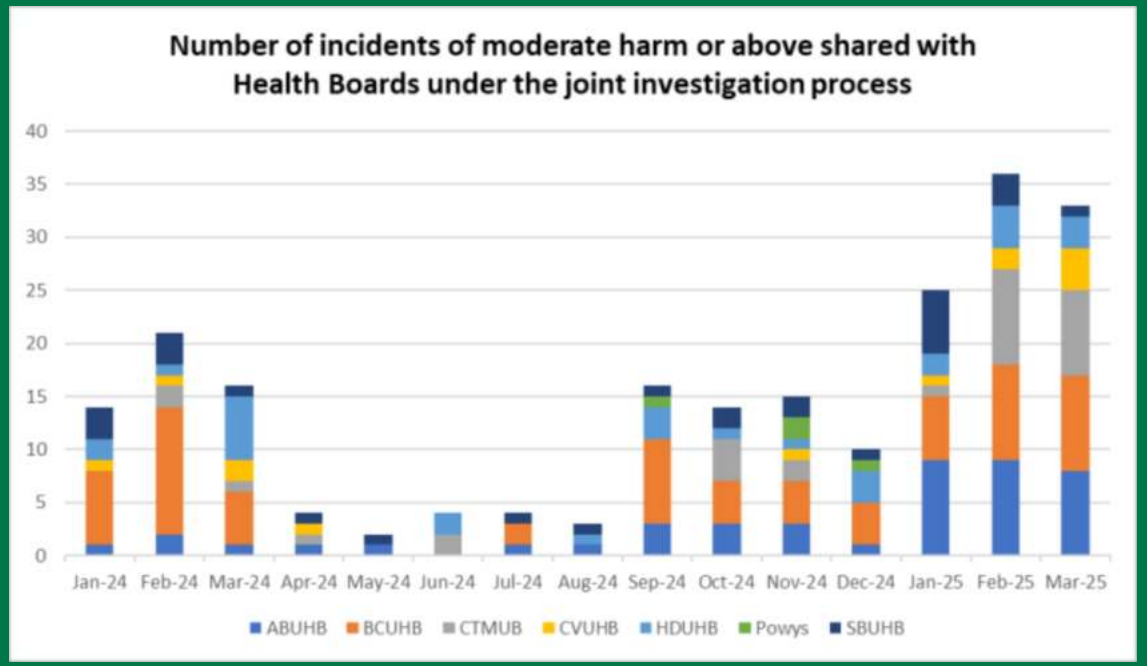
Data may be subject to change following validation, retrospective reviews and audits and ongoing clinical governance processes including regrading of incidents.

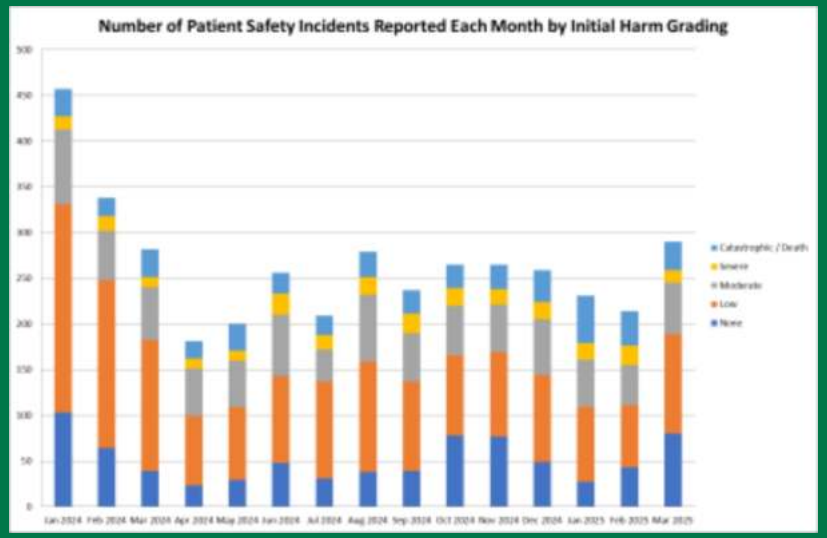
Compliance heat map

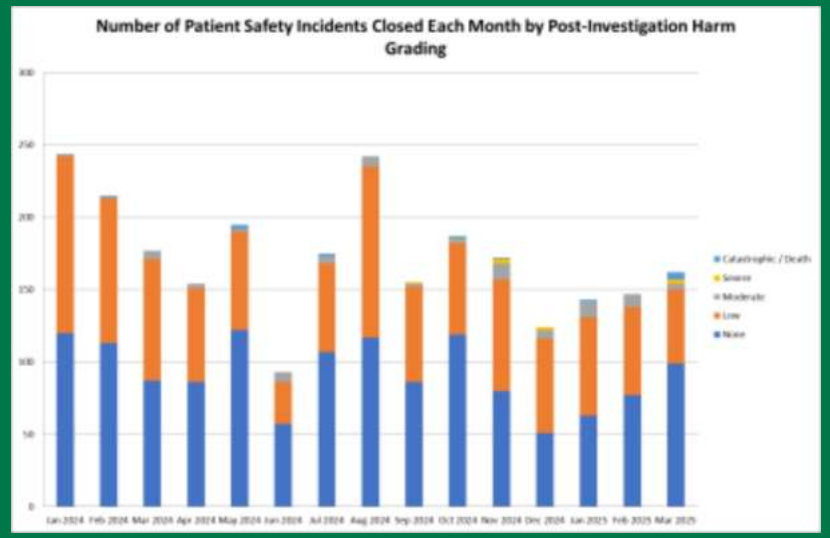
MEASURE	Scoring	Q4 2023-24			Q1 2024-25			Q2 2024-25			Q3 2024-25			Q4 2024-25		
		Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Overdue NRIs	R: 10 A: 1 G: 0									40	34	29	30	28	29	29
Patient Safety Alerts/Notices overdue	R: 2 A:1 G: 0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Complaints ack'd within 5 working days	R: 80% A: 90% G: 98%	99%	95%	99%	62%	87%	98%	100%	100%	100%	99%	95%	98%	99%	98%	100%
Complaints responded to within 30 working days	R:<65% A: 65% G: 75%	53%	35%	56%	62%	50%	88%	70%	40%	46%	65%	72%	73%	64%	52%	55%
Duty of Candour letters issued within 5 working days	R: NO G: YES	YES	YES	YES	NO	NO	YES	NO	YES	YES	NO	YES	YES	NO	YES	YES
Regulation 28 PFD reports responded to on time	R: NO G: YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Public Interest reports published by the PSOW	R: >1 A: 1 G: 0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2

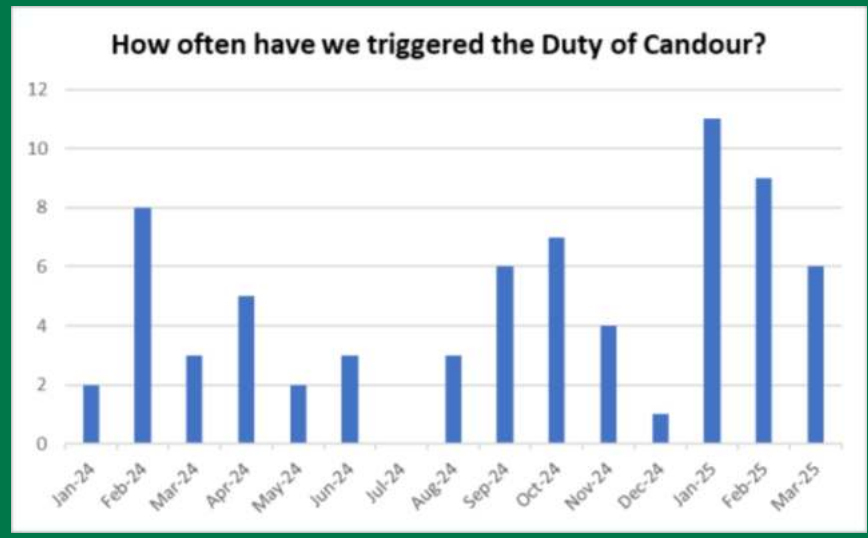
Assurance Profile – Incidents & Duty of Candour



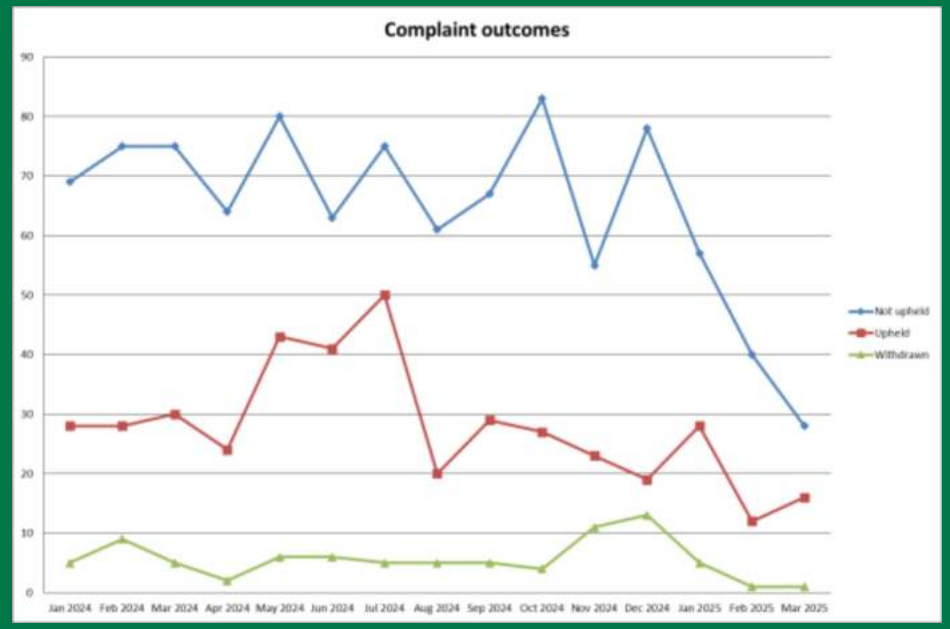


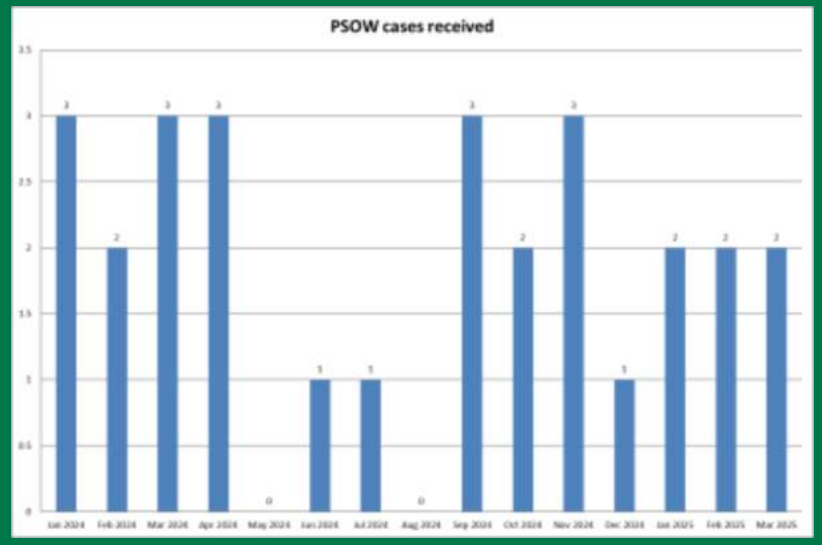


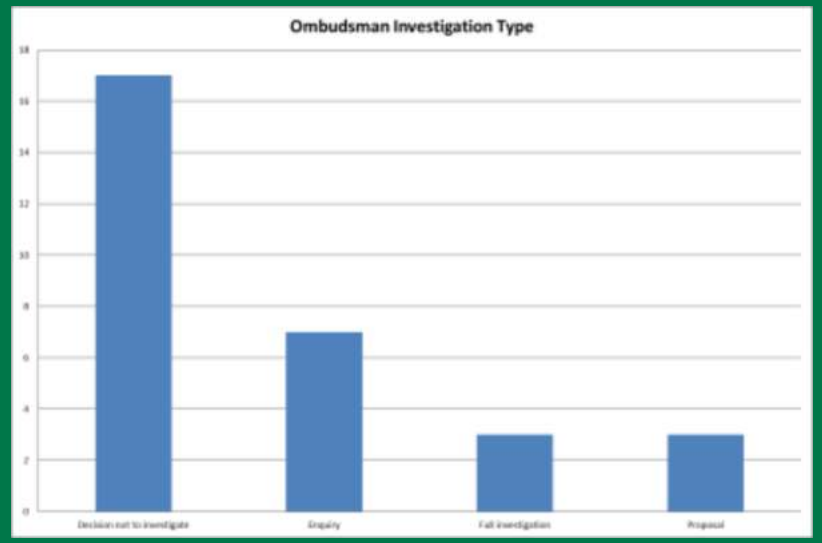


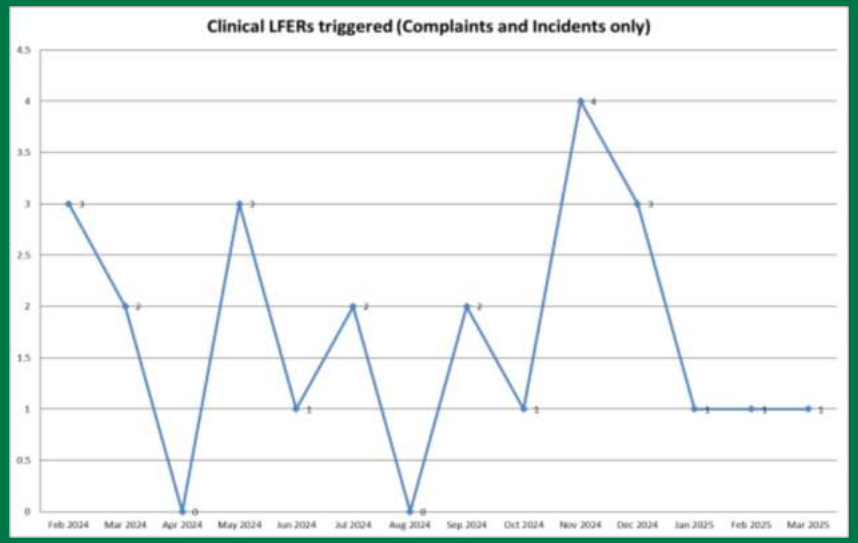


Assurance Profile – Complaints, PSOW and PTR outcomes





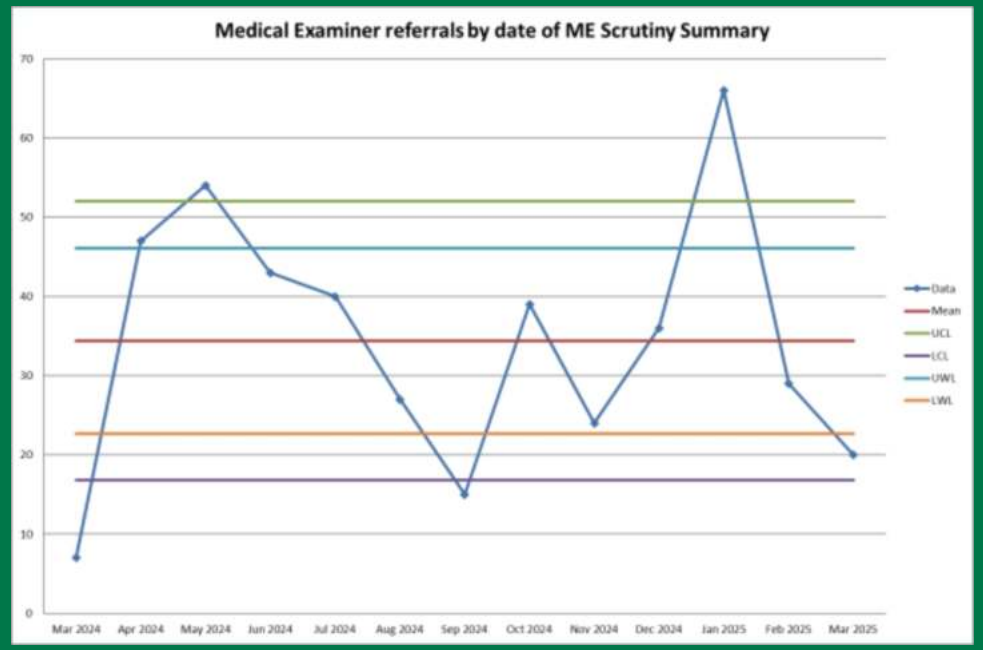


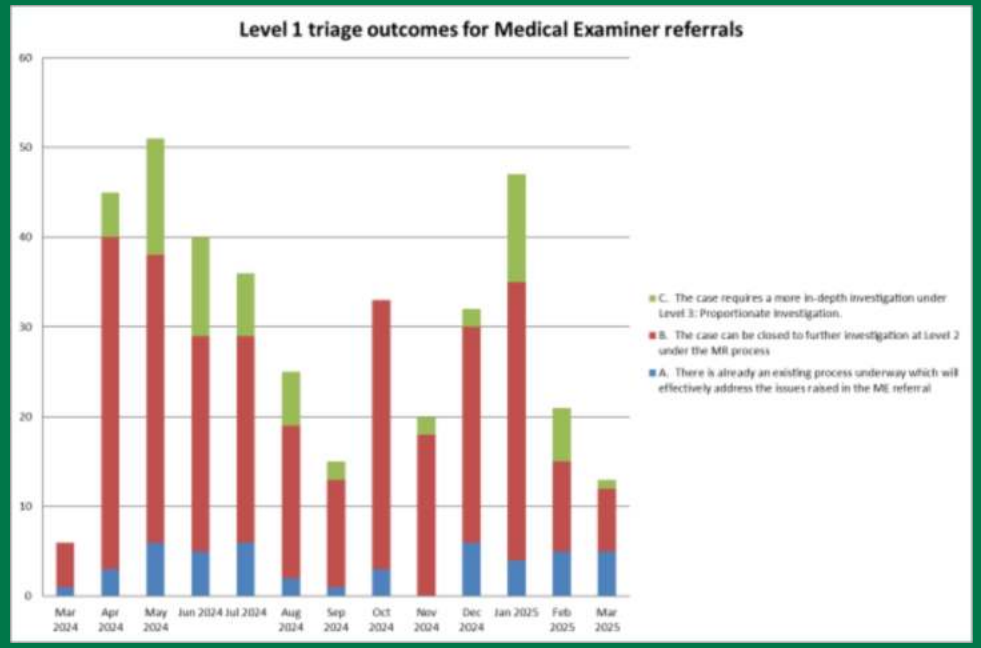


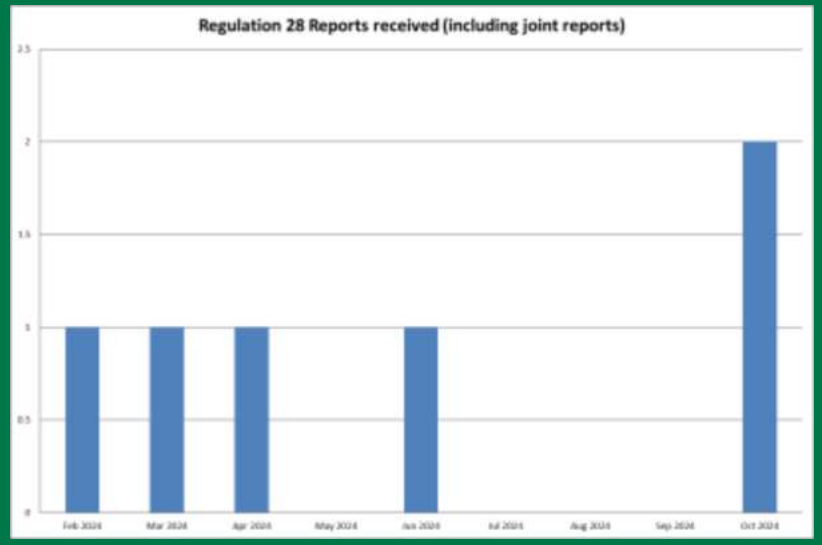
Assurance Profile –Legal Services

		Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Claims opened	Personal Injury (PI)	*			2	0	1	1	2	0	3	1	2	4	2	2
	PI Road Traffic Accident	*			1	0	0	4	0	2	0	1	0	2	0	1
	Clinical Negligence	7	5	5	4	2	2	3	6	0	5	2	3	1	4	3
	Road Traffic Accident	*			19	23	19	14	30	14	26	16	14	23	11	19
	Damage to property	*			9	4	2	6	2	3	5	1	4	3	3	3
Claims closed	Personal Injury (PI)	*			0	0	0	0	0	2	0	6	8	9	2	0
	PI Road Traffic Accident	*			0	0	0	0	1	1	1	0	5	8	0	0
	Clinical Negligence	0	1	0	0	1	3	0	0	1	3	0				
	Road Traffic Accident	*			17	13	13	18	29	43	30	27	9	12	27	11
	Damage to property	*			1	0	4	1	17	1	6	11	2	2	5	5
Claims open at the end of the month	Personal Injury (PI)	*		84	86	86	87	86	90	88	93	85	78	73	73	75
	PI Road Traffic Accident	*		63	64	64	64	68	67	68	67	56	51	45	45	46
	Clinical Negligence	161	162	167	171	172	172	175	181	180	182	184	186	186	189	178
	Road Traffic Accident	*		228	230	240	248	249	255	228	225	211	216	227	217	225
	Damage to property	*		29	30	34	33	37	22	24	23	13	14	15	18	16
				571	***581***	***596***	***604***	***615***	***615***	***588***	***590***	***549***	***545***	***546***	***542***	***540***

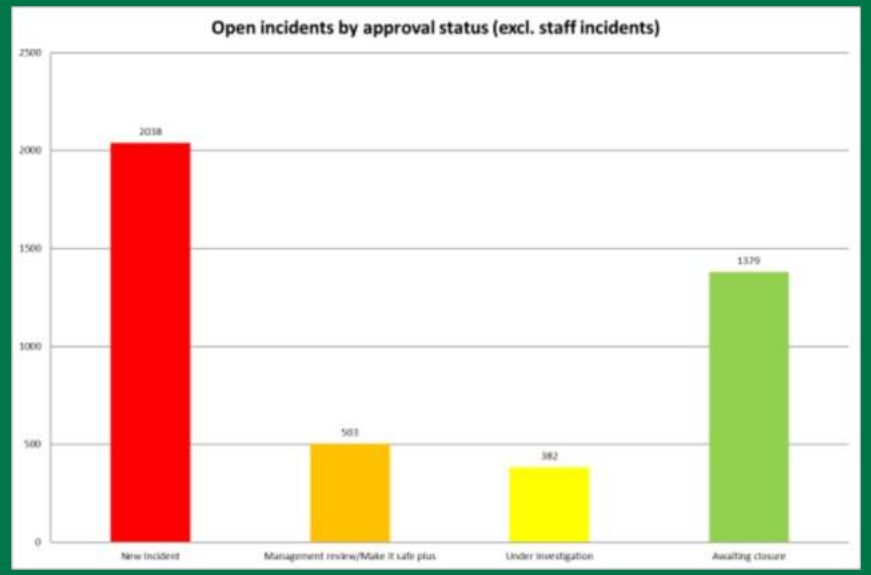
Assurance Profile – Mortality governance

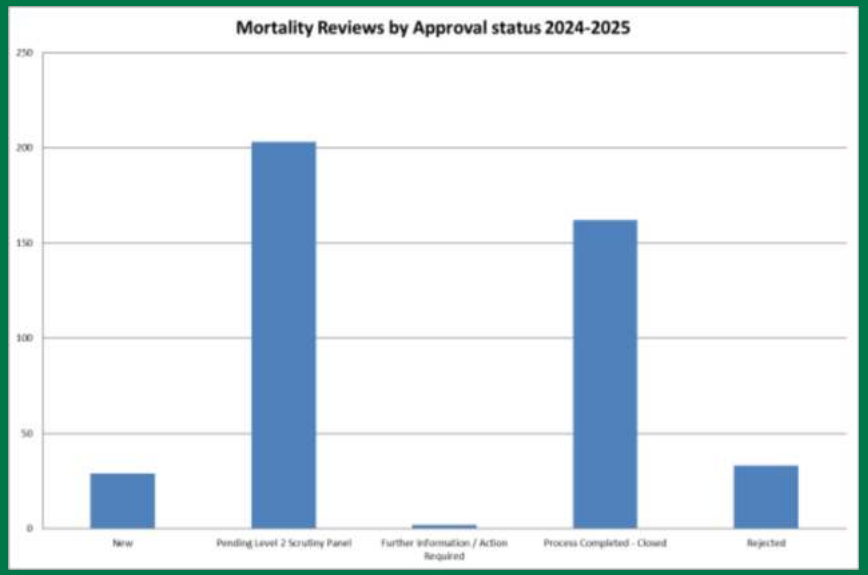


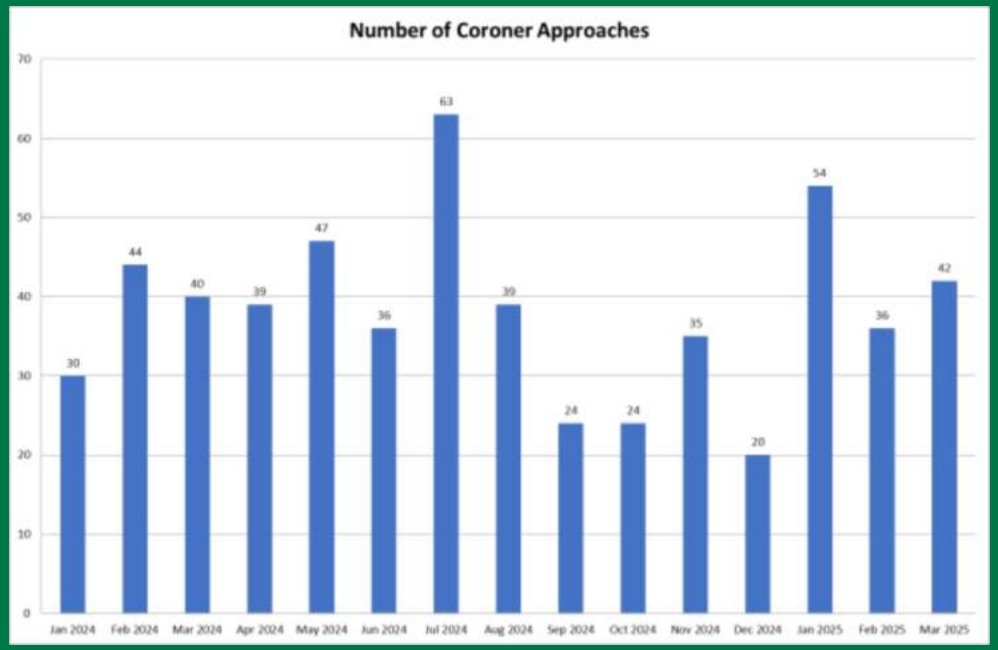




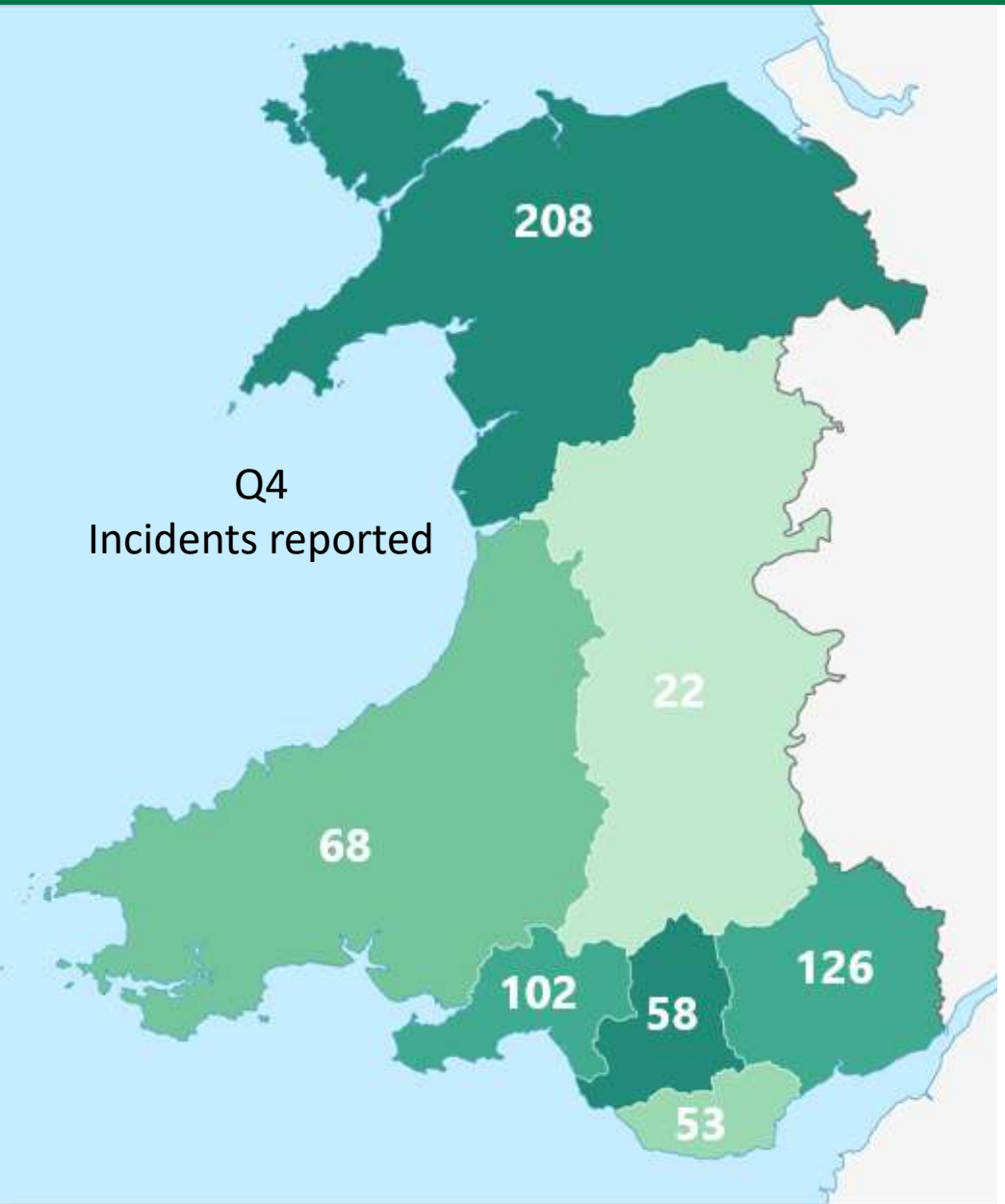
Performance Profile







Thematic Learning - Incidents



111 Contact Centre	89
Ambulance Care Service	151
999 Coordination Centre	260
Emergency Medical Services	238

Thematic Learning -Incidents

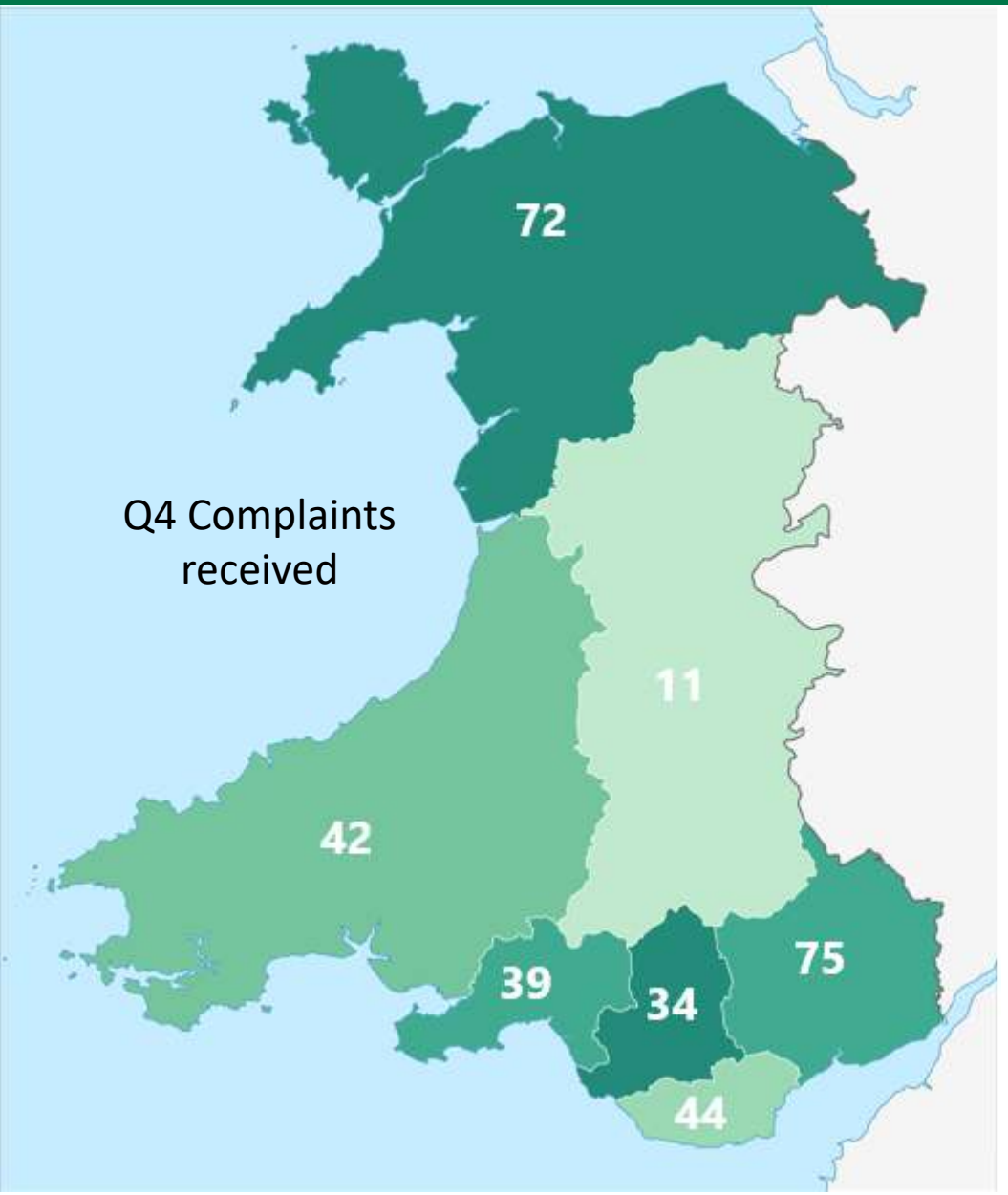
ACCESS & ADMISSION
Approximately 50% of incidents reported related to delays in admission, appointments, transfer or transport.

COMMUNICATION
Competing priorities & pressures on healthcare staff – at points of handover, delayed transport

TREATMENT & PROCEDURE
Different thresholds and professional opinions relating to referral appropriateness / service access.

ASSESSMENT, INVESTIGATION AND TREATMENT
Incidents often originating from external sources – Health Boards, complaints, Medical Examiner

Thematic Learning -Complaints



111 Contact Centre	23
Ambulance Care Service	146
999 Coordination Centre	99
Emergency Medical Services	49

Thematic Learning - Complaints

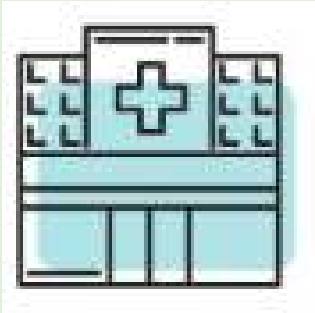
ACCESS TO SERVICES
40% of our complaints related to not being able to access care when people felt they needed it

UNMET NEEDS AND EXPECTATIONS
Our complaints reveal that sometimes the care or service people receive is not what they expect or feel is right for them.

There is learning about how we explain and inform to educate about clinical decision-making, service provision or alternative referral pathways

CLINICAL TREATMENT & ASSESSMENT
Non-conveyance features heavily in this thematic area along with individualised care not being understood

APPOINTMENTS
Challenges around timeliness for non-emergency transport arrangements



GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Cronfa Risg Cymru
Shared Services Partnership
Welsh Risk Pool Services

Welsh Risk Pool Concerns Assessment

A Report by the Welsh Risk Pool Safety and Learning Team

Welsh Ambulance Service Trust

Final Report February 2025

Gwella Diogelwch Trwy Ddysgu
Improving Safety Through Learning

WRP Concerns Assessment

A Report by the Welsh Risk Pool Safety and Learning Team

February 2025

About this Report

his report is intended to support health bodies within NHS Wales to continuously improve the operation of their Putting Things Right processes and provide assurance in relation to current policies, procedures and practice.

This report outlines the findings in relation to each area for assessment following field work and matter scrutiny undertaken by the independent assessment team. The report has been circulated for comments, factual accuracy considerations, and the development of actions arising from recommendations.

The report identifies a number of proposed recommendations. The organisation has developed an action plan which addresses the findings and supports the prioritisation of improvement activity in this sector. A copy of the organisation's action plan, addressing the recommendations, is embedded within this report to ease future analysis.

Along with the draft report, each Health Body has received a separate summary which detailed the analysis of the matters scrutinised as part of the assessment process. This enables the organisation to consider the comments in the context of the information that the reviewers analysed.

This report is now finalised and will be shared with the Welsh Risk Pool Committee.

Assessment Field Work	May - Jun 2024
Matter Scrutiny	May - Aug 2024
Draft Findings shared	Dec 2024
Action Plans Received	Feb 2025
Final Report Published	Feb 2025

Version

WAST WRP Concerns Assessment Report VFinal1

WRP Concerns Assessment

A Report by the Welsh Risk Pool Safety and Learning Team

February 2025

CONTENTS

1.0 Outline of Review

1.1 The Welsh Risk Pool (WRP) undertakes assessments of member organisations' policies, procedures, and practice as part of its oversight duties – with the aim of gathering assurance on local processes for the WRP Committee, Welsh Government and the NHS Wales Executive; and to provide recommendations to support organisations in continuous improvement in this important area of governance.

1.2 The WRP Assessment is used by the WRP Committee when determining members' contributions to the fund as part of the risk sharing agreement. The risk sharing calculations for *Managing Concerns* and *Lessons Learned* will include a measure which ranks organisations in each area of assessment.

1.3 The WRP Assessment process provides a framework for the analysis of an organisation's compliance with the WRP Reimbursement Procedures, the requirements of the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011, the Health & Social Care (Quality & Engagement) (Wales) Act 2020 and other national policies & procedures related to the PTR sector. Following a review in 2023, the 2024 programme of WRP assessments includes a specific area for assessment in relation to Inquests - in acknowledgement of the increased work in this area.

1.4 The review involves analysis of individual case management against both legal requirements and policy criteria. It also examines compliance with the application of the Once for Wales Concerns Management System workflows and essential data fields.

1.5 The review further facilitates analysis of the efficacy of the Learning from Events process within the organisation and examines how a Health Body shares and implements good practice across the Health Body and more widely.

1.6 The methodology for assessment has evolved during the last few years in line with national policies. The approach is focussed on peer-review, with senior leaders within the PTR sector in other organisations joining staff from the WRP in conducting the assessment.

1.7 Specialist advisors and legal experts have been invited to join the Assessment Team

as required. This approach is considered to promote sharing of best practice and enable the Assessment Team to recognise the application of the areas for assessment in operational practice.

1.8 For each area for assessment, the Assessment Team considers the available evidence and reports assurance to the organisation using the NHS Wales Internal Audit Assurance Framework. Details of the framework are shown in Appendix 1.

2.0 Scope of Review

2.1 The review considers a number of areas for assessment, each focussed on a different aspect of the PTR process.

- Management of Concerns (Incidents)
- Management of Concerns (Complaints & Enquiries)
- Redress Case Management
- Claims Case Management
- Inquest & Coronial Inquiry Management
- Organisational Learning
- WRP Reimbursement Process

2.2 The report considers the same period for each Health Body that underwent a WRP Assessment. The periods used within the assessment were selected and agreed with the assistance of the Head of Patient Experience Safety & Learning Network.

2.3 The period used for the assessment related to policies and procedures in force and matters opened, under investigation, or closed between 1st January 2024 to 31st March 2024. This period was chosen as it is considered that cases would be sufficiently progressed from initial report and commencement of investigations to facilitate a thorough review but remain relatively current at the time of the assessment. When considering the *performance of quality* data in respect of compliance with the WRP Reimbursement Procedures, data from the financial year 2023/24 was used.

2.4 The WRP recognises that the most frequently occurring clinical specialties seen in claims and redress cases are *Maternity Services*, *Care in Emergency Departments & Units* and *Trauma & Orthopaedics.* The Assessment Team have focussed on these specialties, where they are provided by the health body, as part of the drive towards continuous improvement in relation to the NHS Wales litigation profile. In addition to the clinical specialties which have been subject to enhanced focus, the Assessment Team have selected other matters on a random basis to ensure that assurance is provided across as broad range of areas as possible.

3.0 Assessment Team

3.1 The WRP Assessments are conducted by a small group of specialist practitioners who are drawn from the PTR sector.

3.2 The Coordinator for each Assessment is a member of the WRP Team, with the Chair of the Assessment Team drawn from a member of the Heads of Patient Experience Safety & Learning Network – providing realistic advice on the practicalities in achieving the standards in practice.

3.3 To provide specialist advice in relation to compliance with the legislation, a lawyer from the Legal & Risk Service is included in the Assessment Team and this colleague focusses on compliance with redress case handling.

3.4 As the assessment process focusses greatly on the use of the Datix Cymru system, a member of the Once for Wales Concerns Management System central team is included in the Assessment Team.

3.4 The Assessment Sponsor coordinates the formation of fieldwork teams and oversees any queries which arise, along with signing off the Assessment Report.

3.5 The Assessment Team for this review was:

Sponsor: Jonathan Webb, Head of Safety & Learning
Welsh Risk Pool

Field Work: Zoe Ashman, Assistant Director of Quality and Safety
Powys Teaching Health Board

Gemma Cooper, Senior Solicitor
Legal & Risk Services

Rachel Roberts, Solicitor
Legal & Risk Services

Christine Buckland, Safety & Learning Advisor
Welsh Risk Pool

Maria Stolzenberg, Principal Systems Lead
Once for Wales Concerns Management System

Gethin Bateman, Serious Clinical Incident Investigation Manager
Digital Health & Care Wales

Eleri Wright, Safety & Learning Advisor
Welsh Risk Pool

4.0 Previous Findings

4.1 Summary of the 2023 WRP Assessment

4.1.1 During 2023, a programme of assessments was conducted, and the report was accepted by the Health Body. This report contained a number of recommendations, to which the Health Body developed an action plan. The Assessment Team have sought evidence for progress with, or completion of, the proposed actions and this is shown in Table1.

Table1: Update on Actions from 2023 Assessment Report

REF	Recommendation 2023	Position Update	Status
R01	WAST should ensure that investigation outcomes for incidents are recorded accurately on Datix Cymru.	The Assessment Team found evidence that steps had clearly been taken to address this, there are still opportunities to do this more robustly and incident outcomes remain inconsistently recorded.	Ongoing
R02	WAST should introduce a Key Performance Indicator (KPI) for incident reporting and regularly review and scrutinise cases to ensure that they are closed efficiently and do not remain open on the system longer than necessary.	The Assessment Team found that there was a commitment to do this, a KPI was not yet established and reported at service and corporate level.	Ongoing
R03	WAST should ensure that all Datix Cymru records are the subject of a validation process, as a minimum of closure of the record, to ensure all information and data fields are completed comprehensively.	No evidence of an internal quality assurance (QA) process for closing complaints or incidents was noted. The findings of the 2024 assessment together with information from National Complaint Data submissions (which are validated by WRP) would indicate there is still no robust QA process in place. This should be reviewed as a matter of priority.	Outstanding
R04	The process for obtaining consent for release of information arising from a concern should be reviewed and produced in a structured procedure, with arrangements for recording circumstances where consent is not required or appropriate.	In respect of complaints, WAST have advised that they give 10 days, then a reminder with further 10 days and a final 5 days. This was reported as being under review. WAST will take this to the Complaint Network for discussion and guidance. No procedure was noted as being in place by the Assessors.	Ongoing

R05	WAST should ensure all documents including staff statements and detailed investigation reports are uploaded to the Datix Cymru system.	There is now good evidence of all relevant documents and information being saved to Datix.	Complete
R06	It is expected that both the Actions Module in Datix Cymru and the Yorkshire Contributory Framework is utilised and applied efficiently and correctly to ensure appropriate review of investigations in accordance with the All-Wales approach.	The Assessment Team found evidence that steps had clearly been taken to address this, however, there remain inconsistency in the effective use of these tools.	Ongoing
R07	WAST should train and skill the cadre of Investigating Officers in considering Breach of Duty and Qualifying Liability as part of their investigation process.	Several new members of staff have been appointed to the Team with training to take place imminently with the support of Legal and Risk Services.	Complete
R08	WAST should consider issuing an Interim Regulation 26 response to avoid delays when the investigation has concluded that there is a Breach of Duty.	WAST have kept this issue in mind but have rationalised going straight to a Regulation 33 response as complainants/families are kept in contact within the lead up to the Regulation 33 and WAST considers this works well given the nature of the Complaints.	Complete
R09	WAST should ensure subject and sub-subject codes for all records in the Datix Cymru systems are completed consistently and comprehensively and are subject to validation checks.	The 2024 assessment has identified that this still is not happening. The Trust told the Assessors that they felt more unique codes specific to the organisation were rejected by the Once for Wales national workstream. The Assessment Team felt that the available codes could be used comprehensively to provide all Wales data, which is the view expressed by the All-Wales workstream. The Assessors encourage WAST to use the available codes.	Outstanding
R10	WAST should ensure the description field in the feedback module is completed correctly on the Datix Cymru system and that these are subject to validation checks.	The 2024 assessment has identified that this still is not happening.	Outstanding

5.0 Organisational Performance

5.1 Performance data - Management of Concerns & Lessons Learned

5.1.1 As part of the information gathered with each Health Body data relating to the performance against the standards and timescales outlined in the WRP Reimbursement Procedures is collated.

Table 2: Timeliness of LFER submission – 2023/24					
No of LFERs submitted	No of missed standard deadlines	% missed standard deadlines	No of extensions granted	No of missed revised deadlines	% missed revised deadlines
39	31	79.49%	0	0	0%

Table 3: Approval of Learning by Learning Advisory Panel – 2023/24						
No of LFERs considered	No Approved	% Approved	No Amber Deferred	% Amber Deferred	No Red Deferred	% Red Deferred
51	29	56.86%	14	27.45%	8	15.69%

Table 4: Timeliness of CMR submission – 2023/24					
No of CMRs submitted	No of missed standard deadlines	% missed standard deadlines	No of extensions granted	No of missed revised deadlines	% missed revised deadlines
16	6	37.50%	0	0	0%

6.0 Review Findings

6.1 Management of Concerns (Incidents)

6.1.1 The Assessment Team noted that there were 1077 incidents reported in the period 1st January 2024 to 31st March 2024.

6.1.2 The Assessment Team met with the Head of Patient Safety, Concerns and Learning and were made aware of several changes that had both been implemented and were still ongoing as part of an Organisational Change Programme within the organisation. This included the outstanding recruitment into some posts, which the Assessors considered would add considerable value to the PTR function.

6.1.3 The Assessment Team were provided with evidence of a clear incident management framework contained within the Adverse Incident Reporting Policy and Procedure which was drafted in April 2023.

6.1.4 This document provides clear guidance on the Trust's arrangement for the management of incidents covering their reporting, review, and escalation and is reflective of the changes in the NHS Wales National Incident reporting policy from the NHS Wales Executive and the implementation of the Duty of Candour (DoC).

6.1.5 The framework provides comprehensive guidance on the implementation of the DoC along with support for both families and staff members involved in incidents with a suite of reference documents contained within the appendices.

6.1.6 The Assessment Team were pleased to note that there are clear and established links between the central quality and safety team and the area/locality teams which manage incidents.

6.1.7 The Patient Safety Managers have regular meetings with the Locality Managers and Health Board Clinical Leads (HBCL's). The scope of these meetings is to review and support any patient safety incidents that are either under investigation or can be closed by the incident manager. The aim is to continue reduction in closure of open incidents.

6.1.8 Each of the Locality Managers, Service Managers and HBCL's have dashboards within their Datix Cymru permissions to allow them to monitor and review the incidents within their area of responsibility.

6.1.9 There is a robust process in place for the rapid review of incidents and escalation of potential Nationally Reportable Incidents (NRIs) to a Serious Case Incident Forum (SCIF).

6.1.10 Rapid review meetings are held regularly (thrice weekly ensuring that a review is taken place within 72 hours). The scope of these meetings is for the Patient

Safety Team to review incidents that have been identified via the Datix notification system as potentially requiring progressing to the SCIF.

6.1.11 Whilst these are generally Moderate and above incidents, all of the notifications are reviewed by the Patient Safety Team and shared with the Deputy Patient Safety Managers if a case outside of moderate and above is considered to require review.

6.1.12 The weekly Quality Management Group (QMG) meets weekly, and each week has a different operational and corporate focus. At that meeting a real time Dashboard is shared which allows for focussed discussion and feedback to the representative(s) from the chosen service area around themes and trends of incidents, NRI's or any other issues.

6.1.13 The Assessment Team scrutinised the detail of 10 incident records on the Datix Cymru system and noted the following: -

- 80% of incidents were reported within 48hrs of the event and the only exceptions were noted to be cases that were reported within Health Boards and then shared with WAST.
- Only 1 of the 10 incidents reviewed had not had an Initial Management Review undertaken.
- It was however noted that there was a significant variation in the timeliness of the Initial Management review- on some occasions this may not have been completed as a Rapid review or SCIF was held, and in these cases, documentation was uploaded to reflect the meeting and outcome – which was considered as good practice.
- In the majority of cases, when required, a focussed review was undertaken however there were 2 cases where it was felt by the Assessment Team that a focussed review was required but not undertaken and no information was entered onto the record to clarify the rationale for this.
- There was good evidence within the records (where required) that the incident was subject to a Rapid Review and/or SCIF.
- Where the progress of an incident appeared to have stalled there was evidence in the progress notes of intervention from the central team to support the investigating officer(s).
- In many incidents there was clear documentation of a rationale for the change in harm grading either during initial management review or upon investigation closure.
- In some reports there was excellent usage of progress notes and/or the communications field to provide expanded commentary on actions, decisions, escalation and de-escalation of issues.
- In one case there was significant good practice in providing a robust investigation and the utilisation of this to support concerns handling.

6.1.14 The previous WRP Assessment identified a number of recommendations intended to improve the incident management performance. These included a process to ensure that investigation outcomes should be recorded accurately, the need for a KPI for incident management and the requirement for a validation process for incident records. The Assessment Team found evidence that whilst steps had clearly been taken to address these recommendations, there remained a number of actions which are incomplete. There was found to still be considerable inconsistency in the completion of data and no evidence of consistent validation was found.

6.1.15 The Assessors are confident that the new organisational structure which has been implemented is the right approach for the Trust in respect of its patient safety and PTR processes. With the outstanding actions and the inconsistency in data, the assurance rating remains as *Limited Assurance*. However, the Assessors are confident that as the changes which are being implemented take effect, there will be sufficient evidence to increase the assurance rating.

Management of Concerns (Incidents)		
LIMITED ASSURANCE		The organisation can take **limited assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. More significant matters require management attention with moderate impact on residual risk exposure until resolved.

6.2 Management of Concerns (Complaint and Enquiries)

6.2.1 The Assessment Team noted that there were 324 complaints opened in the period from 1st January 2024 to 31st March 2024.

6.2.2 The Assessment Team reviewed the current PTR Policy in place which had been reviewed and ratified in April 2023. The Policy was noted to be very detailed and sets out the principles for the Trust's Management of concerns in compliance with the PTR Guidelines.

6.2.3 The Assessment Team analysed a number of records and scrutinised the detail of 5 matters opened in the relevant period on the Datix Cymru system and noted that further training is required to ensure appropriate use of the system and fields are completed appropriately. WAST have separately accessed assistance with training of the Complaints Team following a major Organisational Change Programme and the Assessment Team consider that this will help support the correct use of the system for the benefit of the wider organisation.

6.2.4 The Assessors noted that additional contacts were being added to some records. It is good practice to include key persons involved in the complaint (e.g., person providing care – other than the investigator or handler who are recorded separately). There was evidence of these contacts being recorded in some WAST complaints and this should be encouraged and applied consistently.

6.2.5 Evidence of links to other complaint records by same complainant was seen in some records. This is recognised as good practice and should be encouraged if complaints are related.

6.2.6 It was noted that the organisation does not routinely include the standard paragraphs regarding (BoD) and (QL) in their response letters. Following discussion with the Team, it was explained that they do not respond in relation to BoD and QL in their responses to complaints. A response is not sent until they have confirmation from their Complex Case review whether or not BoD or QL exists. This indicates a lack of compliance with the requirement to issue Regulation 26 letters in appropriate cases and should be reviewed.

6.2.7 One of the matters selected for a review was a complaint progressing as a legal case. The response letter was a Regulation 24 as it was expected to exceed the current limit of redress. The Response letter advised the complainant on next steps. However, a Redress record was generated from the Complaint in Datix Cymru and the complainant (wife) was entered as the Claimant. There is no documentation from any legal representative attached and it was therefore unclear why this Redress record was created and what the internal process is for such matters. This suggests ineffective record management as this was identified as a potential clinical negligence claim, not a Redress Case. The recommendation from the previous assessment, introducing a record review on closure, would significantly improve such issues.

6.2.8 It is imperative that when a complaint sub type is changed (e.g., from 'Early Resolution' to 'Managed under PTR', or vice versa) that the complainant chain is reset. Likewise, if the *Date Received* is changed in the system, the Complainant Chain will need to be reset. If the Complainant Chain is not reset, the dates showing may be inaccurate resulting in Investigation Support Officers working to incorrect deadlines. Following discussion with the Team, assurance was provided that complainant chains are now used appropriately and updated as necessary. A subsequent review shows a marked improvement with this issue.

6.2.9 It was noted that further work is required in relation to capturing reopened complaints in Datix Cymru. The Assessors reviewed some reopened complaints which were managed appropriately but some records on Datix Cymru had been incorrectly completed. A structure piece of work to address this is recommended and assistance can be obtained from colleagues in the Complaints Network.

6.2.10 As was the case during last year's assessment there was evidence noted in which the description of the complaint was entered in the 'details of complaint raised'. Details of complaint is to record main points/questions to be addressed. The main body of the complaint should be documented in the description field with 'Details of complaint raised' being used to precis the points to be investigated. Audits of records will facilitate improvement in this area.

6.2.11 The Assessors were pleased to note comprehensive response letters detailing investigation findings and providing an explanation of how to progress cases which was noted as good practice.

6.2.12 Overall, the quality of response letters was generally felt to be to a good standard, but the use of the system and the associated data is poor. It is recognised that a holistic review of the use of the wider Datix Cymru system has been commissioned to ensure it is of maximum benefit to the organisation. If this produced results as anticipated, it is expected that the assurance level will increase in future assessments.

Management of Concerns (Complaints & Enquiries)		
LIMITED ASSURANCE		The organisation can take **limited assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. More significant matters require management attention with moderate impact on residual risk exposure until resolved.

6.3 Redress Case Management

6.3.1 WAST continues to have one Redress Lead in post with a mixed portfolio which includes the management of inquests and claims. The Redress Lead explained that the organisation is currently reviewing how the workload is managed and structures within the team as part of a wider ranging Organisational Change Programme. A new administrative colleague had been appointed and a review was due to take place to determine whether claims and redress cases could be managed by some of the Claims Co-ordinators. It was noted that the workload has been difficult to manage but it was hoped that it would improve following the review.

6.3.2 The Assessment Team were pleased to note that there is good evidence of all relevant documents and information being saved to the Datix Cymru system - with the Redress section being completed comprehensively. It was noted however, that there was a lack of completion of the Quantum page. The Team does have a shared folder of precedents and guidance, which has not been reviewed during this assessment apart from the guidance documents, leaflets and process documents.

6.3.3 During the previous Assessment the Assessment Team noted that a number of cases reviewed proceeded straight to issuing a Regulation 33 response, where the Trust had conclusions regarding both BoD and Causation. It was noted that the organisation has kept this issue in mind but have rationalised going straight to a Regulation 33 response. Complainants and families are kept in contact within the lead up to the Regulation 33 and it is believed this works well given the nature of the Complaints. Nonetheless it is a departure from the statutory guidance for PTR and should be reviewed by the organisation and decisions to continue to deviate from expected practice recorded at executive level – which will be particularly important as the revisions to the PTR process are introduced in 2025.

6.3.4 The Trust explained that work is ongoing to improve the management of joint cases with Health Boards and this is an area of focus going forward.

6.3.5 The Assessment Team scrutinised the detail of 3 cases on the Datix Cymru System within the reference period of the review. Good use of Datix Cymru was

noted and in particular use of the Redress page. It was however noted that it was somewhat difficult to follow the chronology of documents as a number were uploaded on the same day. The Redress Lead explained that as the documents have been transferred from the complaint file on the day the Redress file was opened, often there is not always capacity to save emails and documents to the file on the relevant day which means that documents are not uploaded on the day but when time allows.

6.3.6 The Assessment Team were pleased to note however that all relevant documentation had been saved to Datix Cymru, save one case that was not a traditional Redress matter, and the Assessor deemed this as appropriate given the circumstances of the case.

6.3.7 Of particular note was the completion of Progress notes – which were sufficient and useful, along with some use of the Redress Tracker. This is excellent practice and is recognised by the assessors.

6.3.8 The Quantum page however was noted to not be completed, even where offers have been made and settlement has been achieved. The Redress Lead explained that unfortunately they felt they have no capacity to complete this section as this information is also input into other applications. Unfortunately, this means that the data reports which can be obtained are limited and this will have an impact as the WRP moves to an automated process. This approach should be reviewed and rectified.

6.3.9 The Assessors noted good engagement with clinicians and families during the course of investigations. There was also evidence of well drafted final response letters - which were appropriately compassionate & sensitive, with enough detail, but not overwhelming. The result is concise and clear response letters for redress cases. The correct description of legal tests and terminology was also noted within the communications.

6.3.10 The process for investigation and scrutiny was outlined to the Assessors. It was explained that the Patient Safety Managers responsible for the investigations bring the case to the Panel and the Redress Lead then manages the case once part 6 is triggered and the Panel has approved the way forward.

6.3.11 Good communication was noted between the Redress function and Incidents & Complaints investigators. Where a Regulation 26 is drafted, this is completed by the Incidents and Complaints Teams reflecting what the Complex Case Panel conclusion was. It then comes to the Redress Lead and the Regulation 33 is drafted. The Response is then sent via the Quality and Safety Team to the Assistant Director of Quality & Nursing; and there are good communication links between all parties with no delays experienced.

6.3.12 The Complex Case Panel sits once a month. The chair can call extraordinary meetings if necessary and these are undertaken virtually. There was evidence of good early communication with the Complex Case Panel and Complainant and/or their Solicitor.

6.3.13 The Assessment Team saw very little evidence of any delays in Redress cases. However, it must be recognised that the Redress function is a team of one - who facilitates various other functions. However, the Assessment Team noted that Redress is managed efficiently, and final responses are often served many months in advance of the deadline. Increasing the diversity of personnel skilled in this area would reduce the risk of delays and disruption through unavoidable absence.

6.3.14 It was noted that there was no evidence of consideration of value at the outset of an investigation. The Redress Lead explained that consideration is being undertaken however it is currently not recorded. The minutes from the Complex Case Panel are saved in the shared folders which will have comments on value if over £25k but not on individual cases. The PTR team will approach the Legal Services Team if they believe the matter could be over £25k. The Redress Lead does have experience and understanding of case values as she sits on the Serious Clinical Incidents Forum which discusses NRI's, which allows staff to be aware early, of the background and position of each Claimant from a likely value perspective. Any decisions on value of cases are ratified by the Redress Panel.

6.3.15 The Assessors would recommend that a brief consideration of value be noted on Datix Cymru at the outset of every stage of a complaint or claim. It is also recommended that a record of settlements is kept advising other colleagues of previous decisions.

6.3.16 In summary, WAST has a good Redress case management structure, with documents and guidance in place to manage Redress cases with minimal input from Legal & Risk Services. Cases are generally managed efficiently, and more support staff are being recruited, so that full compliance with Datix Cymru can be achieved and there is less reliance on one member of staff. Whilst there are a small number of recommendations to further enhance processes, data quality and consistency, this does not detract from an exemplar area for assessment.

Redress Case Management		
SUBSTANTIAL ASSURANCE		The organisation can take **substantial assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Few matters require attention and are compliance or advisory in nature with low impact on residual risk exposure.

6.4 Claims Case Management

6.4.1 The Assessment Team noted that there were 14 claims opened in the period 1st January 2024 to 31st March 2024. This is the caseload which is managed through the Legal & Risk Services and does not include WAST-specific legal matters which are handled in-house (which are subject to separate review procedures).

6.4.2 The Assessment Team were pleased to note that there was good evidence of clear claims management processes in place for both Clinical Negligence and Personal Injury Claims. The Assessors reviewed the Management of Compensation Claims Policy but noted that it was overdue for review. However, as the organisation has been undergoing a recent review and reorganisation it was noted that the Policy was due to be updated in the coming months. A detailed Standard Operating Procedure (SOP) was also in place, and this had been updated in April 2024.

6.4.3 The Assessment Team reviewed 6 matters on the Datix Cymru system handled during the relevant period. Increased use of Datix Cymru compared to previous assessments was noted and during discussions with the Trust Solicitor further use was planned which would include the uploading of relevant documents.

6.4.4 The Assessment Team noted good use of progress notes and documents were uploaded on the cases reviewed. The Trust continue to use their server files for the management of their matters which works well but further use of the Datix Cymru system was recommended to improve tracking and efficacy of case management. Completion of claim details and current stage on matters would allow for detailed and accurate reports to be run directly from the system.

6.4.5 The process for the application of Standing Financial Instructions was reviewed in 2022 with the Trust's Solicitor able to agree damages and costs up to £10,000 however most claims require authority from the Board and a detailed report is submitted for each matter. This does not appear to be resulting in significant delays.

6.4.6 As part of the claims governance process, the Trust Solicitor continues to attend the Board meeting and provides a summary of all ongoing claims and highlights any significant issues which ensures all relevant staff are cited on current matters. Good practice was also noted by the submission of Claims Reports for the Executive Management Team highlighting any issues with Clinical Negligence and Personal Injury Claims.

6.4.7 The Assessment Team were pleased to note that there is a clear and efficient process in place for the referral of relevant matters to Legal & Risk Services and for the receipt of advice in a matter from Legal and Risk Services which are actioned in a timely manner following receipt and in accordance with requests of the protocol. The Legal and Risk Services Referral form is utilised accordingly.

6.4.8 There is no formal training package in place for claims. However, the detailed SOP is a useful tool for new staff, and they are also provided a one-to-one induction which includes claims, complaints, and incidents. The organisation also works closely with Legal & Risk Services with training provided on an ad hoc basis for legal topics.

6.4.9 In summary, WAST has clear claims management processes in place and cases are managed efficiently and the Board updated as necessary in terms of any ongoing issues. The liaison with Legal & Risk Services is robust and effective. Whilst relatively minor improvements can be made in record completion, the overall process for claims management is substantially assured.

Claims Case Management		
SUBSTANTIAL ASSURANCE		The organisation can take **substantial assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Few matters require attention and are compliance or advisory in nature with low impact on residual risk exposure.

6.5 Inquest Case Management

6.5.1 Inquest matters are managed in-house within the organisation by the Trust Solicitor together with a senior member of the Team who assists with the review of statements and ensuring they are served on time to HM Coroner. As a national service, the Trust engages with the majority of coronial services across Wales.

6.5.2 The Assessors were pleased to note that inquest matters are maintained on the Datix Cymru System in addition to information being stored on the Trust's server. The Assessment Team scrutinised the detail of 10 matters saved on the Datix Cymru system and noted that generally there was good use of the relevant fields with documents uploaded and progress notes updated accordingly. The current stage is not always updated, and the statement sections are not always completed however, as relevant documents were uploaded and progress notes completed it allowed the Assessment Team to review the matters without difficulty.

6.5.3 The Assessment Team noted an induction process in place for inquests with a central dedicated email address to ensure matters are actioned efficiently and not missed. Ad-hoc training is also in place and undertaken by the Trust Solicitor both in person and virtually. There is a detailed SOP in place detailing all steps required following receipt of correspondence from HM Coroner which the Assessors noted as good practice. A flowchart was also provided for the management of WAST Coroner Inquests & Police Information requests which was very detailed but was dated December 2014 and should be reviewed to ensure it remains valid.

6.5.4 Inquest matters are risk assessed upon receipt and managed according to their category whilst also being reviewed throughout the investigation process.

6.5.5 The Assessors were pleased to note that staff are offered a meeting to discuss the inquest process and are supported throughout the course of the matter.

6.6.6 As part of the WRP Assessment process, the WRP invited all Coroners in Wales to contribute information to support the review of this area for assessment. The South Wales Central coroner's office outlined that WAST were generally very responsive, and information provided within the timescales. The number of

Section 5 notices (formally requesting information, usually issued due to delays) is very low.

6.6.7 The South Wales Central Coroner's Office also highlighted that there is commonly a delay in receipt of the Patient Report Form in a case. It would be advantageous to enable decisions to be made by the Coroner if this clinical information could be provided more promptly when required.

6.6.8 A further query highlighted by the Coroner's service was whether the Recognition of Life Extinct form could be made electronically available and the WRP agreed to highlight this to the Trust.

6.5.9 In summary, the organisation has a robust and efficient inquest management process in place. Whilst there are learning points to increase data accuracy, the process is substantially assured.

Inquest Case Management		
SUBSTANTIAL ASSURANCE		The organisation can take **substantial assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Few matters require attention and are compliance or advisory in nature with low impact on residual risk exposure.

6.6 Organisational Learning and Learning from Events Reports

6.6.1 The Assessors were advised that there is currently a clear focus on learning across the organisation. At the time of the review, the locally-adapted 'All Wales Learning from Events Framework' had not yet been approved through the Trust's governance processes but there was a draft document in place. The organisation is also considering the importance of psychological safety to being a learning organisation and a Freedom to speak up guardian has also been recruited.

6.6.2 At the time of the fieldwork, the Claims & Redress Team were responsible for drafting the Learning from Event Report's (LFER's) which are then signed off by the Trust Solicitor with the involvement of the Executive Management Team. It is understood that responsibility for this action will transfer to the Patient Safety Team. The Assessors were pleased to note that senior staff are involved in all legal matters and the learning process from the outset. It was noted that the SOP associated with this process will require further updating to reflect the new arrangements.

6.6.3 The Assessment Team noted that there was a large percentage of cases submitted after the deadline despite a tracking system in place. The Trust Solicitor has an efficient tracking system in place with local services contacted and chased as necessary. However, deadlines have unfortunately been missed for some Redress cases and the Assessment Team would recommend that the Datix Cymru System is utilised further by inputting the relevant trigger dates to avoid being person-dependant.

6.6.4 A quarterly report is provided to the Board on lessons learnt. LFER's for Personal Injury cases are presented at the Health Board Safety meeting and LFER's for clinical cases are presented at Quality, Patient, Experience and Safety Committee.

6.6.5 As was the findings of the previous assessment, the corporate arrangements for capturing, reviewing, and presenting learning impresses the Assessors, however, there remains delays in the process with local teams having to be chased causing delays in submission of appropriate learning.

6.6.6 The performance data for submission of LFER's (with almost 80% submitted after the deadline) would usually result in a finding of *No Assurance*, the risk of penalties being applied by the WRP Committee and will incur a greater contribution to the WRP fund through the risk sharing agreement cost drivers. However, with the clear process reviewed during the fieldwork, involvement of the senior team in promoting learning, and the fact that some of the exceeded deadlines have been missed by only a small margin, a finding of Limited Assurance is justified as the leadership team have committed to reviewing the associated instances to drive improvement. Relatively simple data management processes could avoid the risk of penalties needing to be applied by the WRP Committee and would see the assurance rating rise to Substantial.

Learning from Events		
LIMITED ASSURANCE		The organisation can take **limited assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. More significant matters require management attention with moderate impact on residual risk exposure until resolved.

6.7 Reimbursement Process

6.7.1 The Assessment Team were assured that there remains a close working relationship with the Finance Department who support the Claims Team and the reimbursement process. All payments are cross-checked with Datix to ensure an accurate record is in place and Legal & Risk Services are also contacted prior to closure to ensure cases are not submitted inappropriately.

6.7.2 The number of U5 request for reimbursement in closed matters was noted to be very low.

6.7.3 Whilst the review has found that there is an efficient process in place, it was noted that deadlines had been missed in the submission of Case Management Reports (CMR's), all relating to Redress case files. Almost 40% of all submissions for reimbursement were submitted past the four-month deadline within the WRP procedures. This is likely to result in the application of penalties by the WRP Committee and will incur an increased contribution to the risk sharing agreement. This would also usually be associated with a finding of *No Assurance*. However, with the clear process established during the review and the commitment to improve the position, a finding of Limited Assurance is justified.

6.7.4 The Assessment Team would emphasise the importance of utilising the Datix Cymru system for the tracking of CMR trigger dates to enable accurate reports to be run for the monitoring of cases to avoid deadlines being missed and the process being dependant on a person.

Reimbursement Process		
LIMITED ASSURANCE		The organisation can take **limited assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. More significant matters require management attention with moderate impact on residual risk exposure until resolved.

7.0 Areas of Good Practice

7.1 Good Claims management structure in place with effective in-house leadership.

7.2 Effective communication channels with the Executive Team to provide escalation where necessary.

7.3 Legal and Risk Services contacted prior to closure and submission of cases for reimbursement.

7.4 Detailed SOP in place for the management of Inquests.

7.5 Good support provided to staff throughout the inquest process.

7.6 Good practice identified where complaint records were linked.

8.0 Assurance Summary

Management of Concerns (Incidents)	LIMITED ASSURANCE	
Management of Concerns (Complaints & Enquiries)	LIMITED ASSURANCE	
Redress Case Management	SUBSTANTIAL ASSURANCE	
Claims Case Management	SUBSTANTIAL ASSURANCE	
Inquest Case Management	SUBSTANTIAL ASSURANCE	
Organisational Learning & Learning from Events	LIMITED ASSURANCE	
WRP Reimbursement Process	LIMITED ASSURANCE	

NOTES

The overall position is that the procedures in place for *Learning* and *Reimbursement* should result in substantial assurance. However, the performance data in these areas of assessment is so poor that the assurance rating is reduced significantly, and relatively simple measures can be applied to change this.

The processes for legal case management is considered to be robust. This is an exemplar arrangement.

The process for complaints is clear and well documented, with compassionate response letters seen in the matters reviewed. However, the overall data quality and accuracy is poor leading to a reduced assurance rating.

9.0 Recommendations

2023-R01 WAST should ensure that investigation outcomes for incidents are recorded accurately on Datix Cymru.

2023-R02 WAST should introduce a KPI for incident reporting and regularly review and scrutinise cases to ensure that they are closed efficiently and do not remain open on the system longer than necessary.

2023-R03 WAST should ensure that all Datix Cymru records are the subject of a validation process, as a minimum of closure of the record, to ensure all information and data fields are completed comprehensively.

2023-R04 The process for obtaining consent for the release of information arising from a concern should be reviewed and produced in a structured procedure, with arrangements for recording circumstances where consent is not required or appropriate.

2023-R06 It is expected that both the Actions Module in Datix Cymru and the Yorkshire Contributory Framework is utilised and applied efficiently and correctly to ensure appropriate review of investigations in accordance with the All-Wales approach.

2023-R09 WAST should ensure subject and sub-subject codes for all records in the Datix Cymru systems are completed consistently and comprehensively and are subject to validation checks.

2023-R10 WAST should ensure the description field is completed correctly on the Datix Cymru system and that these are subject to validation checks.

R01 WAST to ensure that inclusion of additional contacts, where appropriate, is undertaken in relevant complaint records. An audit process may provide assurance of this.

R02 WAST to undertake further training in relation to capturing reopened complaints in Datix Cymru.

R03 WAST to consider noting a brief consideration of value on Datix Cymru at the outset of every stage of a complaint or claim.

R04 WAST to review the current exclusion from relevant complaint letters of standard paragraphs for Breach of Duty and Qualifying Liability.

R05 WAST should ensure Quantum fields in Datix Cymru are completed within Redress records.

R06 WAST to consider developing a record of settlements to assist and advise other colleagues of previous decisions.

R07 WAST should ensure the Management of Compensation Claims Policy is updated and subject to periodic reviews.

R08 WAST to continue to increase its use of the Datix Cymru system for the management of matters utilising the current stage and claim details fields as much as possible.

R09 WAST to update the flowchart for the management of inquests and police information requests.

R10 WAST to continue to increase its use of the Datix Cymru system with regards to inquest matters to include the fields for both current stage and statements.

R11 WAST to update the Learning from Event Report Standard Operating Procedure to reflect the new process that is being implemented.

R12 WAST to fully utilise the Datix Cymru System for the tracking of both Learning from Event Reports and Case Management Report submission deadlines and the introduction of an assurance and tracking process to offer visibility to this.

10.0 Health Body Action Plan

10.1 The Health Body has developed an action plan which addresses the findings of the report and responds to the recommendations made. A copy of this is provided for future reference.

REF	RECOMMENDATION	Organisational comments	Actions	Timescale
2023-R01	WAST should ensure that investigation outcomes for incidents are recorded accurately on Datix Cymru.	WAST's Quality and Safety Committee has recently approved a Datix Recovery and Improvement Plan (Page 134) https://ambulance.nhs.wales/files/committee-meetings/quality-patient-experience-and-safety-committee-files/papers-4-february-2025/ The Plan recognises that the volume and quality of reports generated within the RL Datix Cymru Platform is adding to the lack of structure surrounding the system, creating duplication and introducing variance in outcome data. A Workshop of key stakeholders has been completed to identify a Recovery and Improvement Plan for the Trust to provide confidence in the reporting and learning outcomes provided from investigation utilising these platforms.	Make additions to Adverse Incident SOP so that responsibilities for QA upon closure of incident records is clear. Self-assessment for each service area should be built into their Departmental Quality Performance Management Framework.	Apr-25
			Work with the Once for Wales Central Team to design listing reports which can be cascaded to service areas identifying records which need to be reopened and adjusted or additional information provided.	Apr-25
			Develop and deploy Robotic Process Automation to identify incomplete/ inappropriately completed records and report this information by exception report to the Quality Management Group to monitor performance.	Dependent on in-year Digital priorities
2023-R02	WAST should introduce a KPI for incident reporting and regularly review and scrutinise cases to ensure that they are closed efficiently and do not remain open on the system longer than necessary.	As referenced above, the Datix Recovery and Improvement Plan will facilitate this as work to review and amend profiles is completed, enabling more accurate access for incident managers. The establishment of a Datix User Group will also support the upskilling and confidence of incident managers.	Make additions to Adverse Incident SOP to ensure that timescales for reviewing new incidents, undertaking investigatory work and closing records is clear for all staff.	Apr-25
			Heads of Service to develop Improvement trajectories for incident closures which will be monitored through service focus area Quality Management Group	May-25
2023-R03	WAST should ensure that all Datix Cymru records are the subject of a validation process, as a minimum of closure of the record, to ensure all information and data fields are completed comprehensively.	Senior WAST staff identified during mid 2024 that not all user accounts had mandatory fields activated. This meant that records were able to be saved without having all necessary information completed.	Switching on of mandatory fields in all user accounts should have addressed this issue from part-way through 2024/25.	Complete

2023-R04	The process for obtaining consent for the release of information arising from a concern should be reviewed and produced in a structured procedure, with arrangements for recording circumstances where consent is not required or appropriate.	A SOP was drafted with input from multiple stakeholders 'Dealing with Consent in relation to Complaints'. This was not formally approved owing to changes in staff during an OCP. Enhanced leadership in Patient Safety and Patient and Family Relations teams has increased the senior expertise available to guide staff on consent.	SOP to be reviewed for current accuracy and then approved by Senior Quality Team.	Apr-25
			Commence Quarterly Complaints Audit to provide assurance that SOP is being followed.	Jul-25
2023-R06	It is expected that both the Actions Module in Datix Cymru and the Yorkshire Contributory Framework is utilised and applied efficiently and correctly to ensure appropriate review of investigations in accordance with the All-Wales approach.	WAST is not currently using the Actions module for incidents requiring multi-person oversight as the module does not support full extraction for oversight and monitoring purposes. Action plans which require completion by a range of individuals or service areas, such as NRI action plans, are held in MS Teams and managed by service areas.	The actions module is used by individuals in the Corporate Patient Safety team to ensure appropriate review of any incidents which could be Moderate harm or above. Corporate use commenced in approximately October 2025.	Complete
			Senior Quality Team to undertake options appraisal of digital action planning software to enhance organisational assurance in respect of action plan completion.	Sep-25
		Although YCFF has now been included in the Adverse Incident SOP, the majority of staff have a training need relating to understanding of the framework and its application to WAST services (parts of the Framework are heavily focused on an acute secondary care setting).	In order to set an achievable target within a continuous improvement journey, focus in the next year will be prioritised on how YCFF are being included in NRI completion. This will include reviewing organisational investigation templates and provision of training to the Corporate Patient Safety team, to then be cascaded to NRI investigators in service areas.	Mar-26
			WAST to support workplan for OfWCMS Incident Workstream to provide enhanced definitions and guidance for YCFF and ensure ambulance leaders can utilise it more confidently.	Mar-26
2023-R09	WAST should ensure subject and sub-subject codes for all records in the Datix Cymru systems are completed consistently and comprehensively and are subject to validation checks.	This recommendation was addressed through the development of a Complaints Validation SOP. The SOP has taken time to embed due to OCP and recruitment across the PTR & Legal Services Department.	Commence Quarterly Complaints Audit to provide assurance that SOP is being followed.	Jul-25

2023-R10	WAST should ensure the description field is completed correctly on the Datix Cymru system and that these are subject to validation checks.	This recommendation was addressed through the development of a Complaints Validation SOP. The SOP has taken time to embed due to OCP and recruitment across the PTR & Legal Services Department.	Commence Quarterly Complaints Audit to provide assurance that SOP is being followed.	Jul-25
R01	WAST to ensure that inclusion of additional contacts, where appropriate, is undertaken in relevant complaint records. An audit process may provide assurance of this.	Training on why and how to attach additional contacts was provided by Central OfWCMS team in November 2024 as part of a day-long training offer to all of the Patient and Family Relations team on the use of the Feedback module.	Commence Quarterly Complaints Audit to provide assurance that training is being embedded in practice.	Jul-25
R02	WAST to undertake further training in relation to capturing reopened complaints in Datix Cymru.	Training from the OfWCMS team included a section on how to manage Reopened complaints.		
R03	WAST to consider noting a brief consideration of value on Datix Cymru at the outset of every stage of a complaint or claim.		Develop a guidance flowchart to assess whether cases will breach the Redress threshold	Sep-25
R04	WAST to review the current exclusion from relevant complaint letters of standard paragraphs for Breach of Duty and Qualifying Liability.	WAST recognises the potential for changes to the approach around how legal information is provided to complainants as part of the revised PTR Guidance and Concerns Regulations.	WAST will review the information it provides on Breach of Duty and Qualifying Liability within its complaints responses. A review paper will drafted for the Executive Team due to the statutory requirement for this information to be provided.	Apr-25
R05	WAST should ensure Quantum fields in Datix Cymru are completed within Redress records.	This is now being completed on every case	Development of QA dashboard in Datix to monitor field completion	Apr-25
R06	WAST to consider developing a record of settlements to assist and advise other colleagues of previous decisions.		Repository in shared folder to be created using Datix listing report of past cases	Sep-25
R07	WAST should ensure the Management of Compensation Claims Policy is updated and subject to periodic reviews.	WAST recognises the potential for changes as part of the revised PTR Guidance and Concerns Regulations	Policy has been drafted but needs to be placed into appropriate template, track changes, consultation with TU and rescheduled for Policy Group	Dec-25

R08	WAST to continue to increase its use of the Datix Cymru system for the management of matters utilising the current stage and claim details fields as much as possible.		Designate the fields that require completion to provide clarity to staff.	Feb-25
			Development of QA dashboard in Datix to monitor field completion	Apr-25
			Development of regular BI report to provide assurance	TBC - dependent on automated extraction work
R09	WAST to update the flowchart for the management of inquests and police information requests.		Inquest Management SOP to be developed to supersede flowchart (Police information requests are now managed by Records)	May-25
R10	WAST to continue to increase its use of the Datix Cymru system with regards to inquest matters to include the fields for both current stage and statements.		Designate the fields that require completion to provide clarity to staff.	Mar-25
			Development of QA dashboard in Datix to monitor field completion	Apr-25
			Development of regular BI report to provide assurance	TBC - dependent on automated extraction work
R11	WAST to update the Learning from Event Report Standard Operating Procedure to reflect the new process that is being implemented.	Management of LFERs has transferred from Legal Services to Patient Safety team under OCP arrangements. It is anticipated that this will bring significant benefits in terms of more timely and comprehensive completion, although 'legacy' cases may still present some challenges during the transition period. A SOP is under development as part of the new arrangements.	SOP to be finalised & approved by SQT	Apr-25
R12	WAST to fully utilise the Datix Cymru System for the tracking of both Learning from Event Reports and Case Management Report submission deadlines and the introduction of an assurance and tracking process to offer visibility to this.		Designate the fields that require completion to provide clarity to staff.	Mar-25
			Development of QA dashboard in Datix to monitor completion	Apr-25
			Development of regular BI report to provide assurance	TBC - dependent on automated extraction work

Appendix 1
NHS Wales Assurance Framework

The WRP Assessment Programme utilises the NHS Wales Internal Audit Framework for Assurance:

SUBSTANTIAL ASSURANCE		The organisation can take **substantial assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Few matters require attention and are compliance or advisory in nature with low impact on residual risk exposure.
REASONABLE ASSURANCE		The organisation can take **reasonable assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved.
LIMITED ASSURANCE		The organisation can take **limited assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. More significant matters require management attention with moderate impact on residual risk exposure until resolved.
NO ASSURANCE		The organisation has **no assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Action is required to address the whole control framework in this area with high impact on residual risk exposure until resolved.

Appendix 2

WRP Concerns Assessment – Areas for Assessment

The WRP Assessment Programme uses a series of Areas for Assessment to guide the Assessment Team in the aspects and criteria to be examined. These cover the areas of activity which directly impact on matters which may cause a request for reimbursement from the Welsh Risk Pool.

The Areas for Assessment provide a framework for the Assessment Team to gather information, evidence and collate data to support the identification of findings and the establishment of recommendations.

Assessment Criterion

AREA FOR ASSESSMENT	
A	Management of Concerns (Incidents)
B	Management of Concerns (Complaint and Enquiries)
C	Redress Case Management
D	Claims Case Management
E	Inquest Case Management
F	Organisational Learning and Learning from Events Reports
G	Reimbursement Process

Area for Assessment A:	
Management of Concerns (Incidents)	
A1-01	Is the timescale between index events and incident reporting reasonable?
A1-02	Did the incident have a Management Review?
A1-03	Is the timescale between reporting and Management Review reasonable?
A1-04	Did the incident have a proportionate investigation completed, where appropriate?
A1-05	Was the incident record closed within 30 days? If not, is there information to explain the reason for any delays or actions being taken?
A1-06	Was the incident reportable as a Nationally Reportable?
A1-07	Did the post incident investigation indicate there was harm caused and that Qualifying Liability was considered?
A1-08	Based on the reporters view of harm (moderate or above) have the Duty of Candor fields been completed and if not is a rationale provided for the non-completion?
A1-09	Is there training for staff reporting and investigating incidents?

Area for Assessment A:	
Management of Concerns (Incidents) Policy and Procedure	
A2-01	Is there a policy or procedure in place for Incident Management within the Health Body? Is it in date? Is there a review date? How is it reviewed/ratified?
A2-02	Does the policy or procedure cover the requirements as set out in PTR guidance and associated national policy?

Area for Assessment A:	
Management of Concerns (Incidents) Information, Reporting & Governance Arrangements	
A3-01	Are there effective governance arrangements for the management of incidents?
A3-02	Is there a screening process in place for monitoring accuracy of information submitted in incident reports? Is it timely?
A3-03	How are incidents reported within the Health Body and to what meetings/ committees are they reported? Are they reported at Board level or Sub-Committee? Are these arrangements proportionate?

Area for Assessment B:	
Management of Concerns (Complaint and Enquiries)	
B1-01	Does the record include details of the 'Person Providing Feedback' (Complainant) and has the Complainant Chain been triggered
B1-02	Have details of the original contact with the Complainant been recorded and supporting information available for review. This may be an email or letter from the Complainant or notes from a telephone discussion.
B1-03	If the complaint is in relation to a third party, has consent been requested
B1-04	Does the Date received (Complainant Chain) match the date the Complaint was first received (Key Dates)
B1-05	Have the following essential data fields in Datix Cymru been completed accurately and up to date: • Is the Complainant Chain available and completed where possible • Has an investigator been identified
B1-06	Has the type of complaint been changed? If yes, has the Complainant Chain be reset to meet the PTR Reg timescale of the new type of complaint
B1-07	Does the Description field contain identifiable information i.e. names of persons or locations
B1-08	Have all the relevant points raised in the complaint been recorded in the 'Complaint Subjects' section
B1-09	If applicable, has a holding letter been sent to the Complainant
Closed records only:	
B1-10	Where a complaint was dealt with as Early Resolution, is this appropriate?
B1-11	Has a response been provided to the person notifying the concern within 30 days. Where it has not been possible to provide the report within 30 days, has the person notifying the concern been advised within 30 working days, an explanation provided, and a proposed timescale agreed?
B1-12	Did the response respond to all the relevant points raised in the complaint and the investigation outcome of each point recorded
B1-13	If no response letter has been sent, has the reason why no response letter was sent provide an adequate explanation eg evidence of verbal discussion with

	complainant
B1-14	If a Regulation 26 or Regulation 33 Response has been sent, has a Redress record been created and have the records been linked
B1-15	Does the complaint response comply with the content requirement as set out within the guidance? - Reg 24 response prepared for the concern reviewed which has been investigated and in respect of which the Responsible Body considers there is no QL in tort? - Reg 24 response prepared for the concern which has been investigated and in respect of which the Health Board considers the claim to be over £25,000 in value? (no reference to BOD and QL if considered over £25,000 and advice re Solicitors etc?) - Reg 26 response prepared advising may be BOD & QL with explanation provided regarding Redress and next steps - Reg 33 response prepared advising there is/was BoD & QL explanation provided regarding Redress and offer made
B1-16	Has the Complainant Chain been fully completed and is the date of response accurately recorded in the Complainant Chain

Policy and Procedure	
B2-01	Is there a policy or procedure in place for Complaint Management within the Health Board? Is it in date? Is there a review date? How is it reviewed/ratified?

Information, Reporting & Governance Arrangements	
B3-01	What are the governance arrangements for the management of complaints and enquiries?
B3-02	How are complaints reported and monitored within the Health Body and to what meetings/Committees are they reported? Are they reported at Board level or Sub-Committee?
B3-03	Is there a training package in place for staff for complaints handling?

Area for Assessment C:	
Redress Case Management	
C1-01	Is there an appropriate process for determining when a matter should be handled by Redress specialists? Is there a clear process for transition from incident teams and complaints teams?
C1-02	Is the redress record complete? Is all correspondence, advice and supporting information available for review?
C1-03	Is there evidence of the case being screened for potential value at the outset?
C1-04	Has an interim report (Reg 26 letter) for the concern reviewed and investigated been prepared where the Health Body considers there may be a QL?
C1-05	Has the interim report been provided to the person notifying the concern within 30 days?
C1-06	Does the response letter comply with the content requirement set out in the Regulations & associated Guidance? E.g., explaining QL, advice re Solicitors, addresses all concerns raised etc
C1-07	In circumstances where a Reg 26 interim response was provided, have independent experts been instructed? Has this been done in line with the requirements in the Regulations (ie jointly) and appropriately?
C1-08	Has a Regulation 33 report been sent for every concern reviewed and investigated in respect of which the Responsible Body has not sent a Regulation 24 response?
C1-09	Has the Regulation 33 report been provided within a maximum of 12 months of the concern being notified to it?
C1-10	Does the Regulation 33 Response comply with the requirements of the Guidance? Eg clearly sets out the basis for the final decision as to QL and the offer made.
C1-11	Where financial compensation has been paid, has an appropriate contract been entered into between the recipient of the financial compensation and the organisation?
C1-12	Has Legal and Risk Advice been requested? Was this request proportionate?
C1-13	Who authorised QL and on what basis? Was this appropriate?
C1-14	Have all essential data fields been completed correctly within the case management record?

WRP Held Data Review	
C1-14	How many LFER's submitted in relevant period?
C1-15	How many requests for reimbursement submitted to WRP?
C1-16	What is the performance for WRP submission deadlines?
C1-17	How may extensions were requested for submission to WRP?
C1-18	How many cases were approved at the first Learning Advisory Panel?

Policy and Procedure	
C2-01	Is there a policy or procedure in place for Redress Case Management within the Health Board? Is it in date? Is there a review date? How is it reviewed/ratified?
C2-02	Is there a clear process for the application of Standing Financial Instructions and authorisation of admissions & settlement of matters?
C2-03	Is there a process in place to review admission/denial decisions?

Information, Reporting & Governance Arrangements	
C3-01	What are the governance arrangements for the management of redress cases?
C3-02	How are they reported within the Health Board and to what meetings/Committees are they reported? Are they reported at Board level or Sub-Committee?
C3-03	Is there a training package in place for staff?
C3-04	There is a system for learning lessons from events including concerns (incidents, complaints, claims under redress) compensation claims, claims reviews etc which are used to improve services

Area for Assessment D:	
Claims Case Management	
D1-01	Is there an effective process for receiving and processing requests for disclosure of medical records in matters where a claim is being considered against the health body?
D1-02	Where disclosure of records is requested, is there a process to ensure appropriate release of information is managed and redaction of relevant information undertaken as required?
D1-03	Is there an effective process for the oversight of disclosure of information in matters where a claim is being considered against the health body?
D1-04	Is there a clear process for referral of relevant matters to Legal & Risk? Is the referral to Legal & Risk being utilised? Is the timescale for referral of claims to Legal & Risk appropriate?
D1-05	Is there a clear process for receipt of advice in a matter and analysis of requests for instructions? Are the timescales for receiving advice and providing instructions appropriate and proportionate?

Policy and Procedure	
D2-01	Is there a policy or procedure in place for Claims Case Management within the Health Board? Is it in date? Is there a review date? How is it reviewed/ratified?
D2-02	Is there a clear process for the application of Standing Financial Instructions and authorisation of admissions & settlement of matters?

Information, Reporting & Governance Arrangements	
D3-01	What are the governance arrangements for the management of claims cases?
D3-02	How are they reported within the Health Board and to what meetings/Committees are they reported?
D3-03	Are they reported at Board level or Sub-Committee?
D3-04	Is there a training package in place for staff responsible for managing claims?

Area for Assessment E: Inquest Case Management	
E1-01	Is there an effective process for receiving and processing requests from the Coroner?
E1-02	Where staff statements are requested, is there a process to ensure appropriate release of information and statements drafted correctly?
E1-03	Is there an effective process to support staff who are asked to provide statements for the Coroner and to attend the Inquest?
E1-04	Is there a clear process for referral of relevant matters to Legal & Risk? Is the referral to Legal & Risk being utilised? Is the timescale for referral of inquests cases to Legal & Risk appropriate?
E1-05	Is there a clear process for review of Regulation 28 notices from the Coroner? How are staff and Services informed? What is the process for monitoring the request for information and ensuring it is actioned and information submitted in time?

Policy and Procedure *To be completed by Assessors*	
E2-01	Is there a policy or procedure in place for Inquest Management within the Health Board? Is it in date? Is there a review date? How is it reviewed/ratified?

Information, Reporting & Governance Arrangements	
E3-01	What are the governance arrangements for the management of inquest matters?
E3-02	How are they reported within the Health Board and to what meetings/Committees are they reported?
E3-03	Are they reported at Board level or Sub-Committee?
E3-04	Is there a training package in place for staff responsible for managing inquests?

Area for Assessment F:	
Organisational Learning	
F1-01	Has the locally adapted 'All Wales Learning from Events Framework' been approved through the Health Body's governance processes?
F1-02	Is the Health Body progressing the implementation of the locally adapted 'All Wales Learning from Events Framework'?
F1-03	Is the Health Body considering the importance of psychological safety to being a learning organisation?
F1-04	Are there effective governance arrangements in place to enable oversight by the Health Body's Board and Board subcommittee's that the approach to organisational learning is improving?
F1-05	Are there effective governance arrangements in place to enable oversight by Directorates / Divisional / Groups senior management teams that local learning is improving?
F1-06	Are staff, service users, families and stakeholders involved in determining what the learning should be following an event?
F1-07	Has it been determined how staff across the organisation wish to receive learning?
F1-08	Is the organisation able to demonstrate examples of organisational learning from events (examples may include what goes well, incidents, complaints, claims, inquests, ombudsman, internal reviews, networks, external independent reviews, and Public Inquiries) being discussed from Operational level to the Health Body's Board?
F1-09	Is there a clear process relating to the approval of the Welsh Risk Pool (WRP) Learning from Events Reports locally and corporately prior to submission to the Welsh Risk Pool, including the provision of additional information if the case is deferred?
F1-10	In respect of organisational learning what is the Health Body's approach to knowledge management (practice of organising, storing and sharing vital information) so that everyone can benefit from its use?
F1-11	What proportion of LFER reports were submitted in accordance with the WRP Reimbursement Procedures? E.g. timeliness, completeness, extension requirements?
F1-12	What proportion of LFER reports were approved by the Learning Advisory Panel?

Area for Assessment G:	
Reimbursement Process	
G1-01	Does the Health Body have in place a defined and formalised process or procedure through which it sets out its objectives and provides assurance for the accounting of losses & special payments which are subject to WRP Reimbursement?
G1-02	Does the Health Body have a process for tracking and ensuring submission to WRP for reimbursement? E.g. timeliness?
G1-03	Does the Health Body have a process for identifying and submitting post-closure reimbursement requests in a timely manner?

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The investigation of a complaint against Welsh Ambulance Services University NHS Trust and Swansea Bay University Health Board

A report by the
Public Services Ombudsman for Wales
Cases: 202302966 and 202307480

Contents	Page

Introduction

This report is issued under s.23 of the Public Services Ombudsman (Wales) Act 2019.

We have taken steps to protect the identity of the complainant and others, as far as possible. The names of the complainant and other involved people have been changed. The report therefore refers to the complainant as Mr B.

Summary

Mr B complained about a lack of care and treatment provided to his late mother, Mrs C, by the Welsh Ambulance Services University NHS Trust ("the Trust") and Swansea Bay University Health Board ("the Health Board") in September 2022. The Ombudsman's investigation considered whether the triaging of the emergency calls, and the priority they were allocated by the Trust, was reasonable and appropriate. The investigation also considered whether the advice provided by Trust staff during the calls was reasonable and appropriate. Finally, the investigation considered whether Mrs C was appropriately assessed and managed by the Health Board following her arrival at the Emergency Department of Morriston Hospital on 15 September.

The Ombudsman found that the emergency calls were correctly triaged and prioritised by the Trust's emergency call handlers. However, a clinician on the Clinical Support Desk ("CSD" – a team of clinically trained practitioners who work as part of the Trust's control room) should have reviewed Mrs C's case, identified that she was at serious risk and then considered escalating the ambulance response category. If this had happened, an ambulance may have been allocated to Mrs C sooner. This might have reduced the time she spent lying on the floor, which would have been extremely distressing, painful and undignified for her. This complaint against the Trust was upheld.

The Ombudsman was concerned that the Trust missed several opportunities to identify this service failure, and that it only acknowledged failings after she shared the views of her Paramedic Adviser in April 2024. The Ombudsman considered that this raised serious concerns about the robustness of the Trust's investigations of the complaints it receives, particularly as this was not the only case in which she had identified deficiencies in the Trust's complaints investigation process.

In respect of the advice provided by the Trust's staff, particularly the advice not to move Mrs C, the Ombudsman found that this was clinically appropriate because moving her could have worsened her injuries and caused her more pain. This complaint against the Trust was not upheld.

The Ombudsman found that Mrs C received appropriate care, investigations and treatment whilst she was in the ambulance outside the Emergency Department and after she was admitted to Morriston Hospital. Although there was a missed opportunity to have stopped the administration of nephrotoxic medication (medication that can damage the kidneys) at an earlier stage, there was no suggestion that this caused Mrs C harm or affected her outcome. This complaint against the Health Board was not upheld. However, the Health Board was invited to share this report with the relevant staff and consider how it could improve the training its clinicians receive in recognising and managing patients at high risk of acute kidney injury.

The Ombudsman made a number of recommendations, which the Trust accepted. These included:

- An apology to Mr B, an explanation about the shortfalls in the investigation process and payments totalling £2,750 for the distress, loss of dignity and uncertainty caused and for Mr B having to pursue his complaint.

- To share the report with the Trust's complaint investigation team to review the conduct of its investigation in line with the Duty of Candour and identify learning points to ensure that similar failings are not missed in the future.

- To share the report with the Trust's Quality and Patient Safety Committee to consider my findings and include its learning from these recommendations in its Annual Report on the Duty of Candour.

- To share the report with all appropriate staff and remind them of the importance of fully reviewing information recorded in the Command & Dispatch system at the time of the call.

The Complaint

1. Mr B complained about the care and treatment provided to his late mother, Mrs C, by the Welsh Ambulance Services University NHS Trust ("the Trust") and Swansea Bay University Health Board ("the Health Board"). The investigation considered the following:

a) Whether the triaging of the emergency calls and the priority they were allocated by the Trust was reasonable and appropriate in the circumstances.

b) Whether the advice provided by Trust staff during the calls was reasonable and appropriate.

c) Whether Mrs C was appropriately assessed and managed by the Health Board following her arrival at the Emergency Department of Morriston Hospital on 15 September 2022.

Investigation

2. My investigator obtained comments and copies of relevant documents from the Trust and the Health Board and considered those in conjunction with the evidence provided by Mr B. They also obtained clinical advice from 2 specialist advisers, Mr Tom Burns, a paramedic ("the Paramedic Adviser") and Dr Robert Barker, a consultant in acute medicine and geriatrics ("the Consultant Adviser").

3. The Advisers were asked to consider whether, without the benefit of hindsight, the care or treatment had been appropriate in the situation complained about. I determine whether the standard of care was appropriate by making reference to relevant national standards or regulatory, professional or statutory guidance which applied at the time of the events complained about.

4. I have not included every detail investigated in this report, but I am satisfied that nothing of significance has been overlooked.

5. Mr B, the Trust and the Health Board were given the opportunity to see and comment on a draft of this report before the final version was issued.

Relevant guidance

6. National Institute for Health and Care Excellence ("NICE") Guideline NG148, "Acute kidney injury: prevention, detection and management", December 2019 ("the NICE Guidance").

7. An agreement exists between the Trust, Welsh health boards and the Welsh Government which states that the handover of patient care at hospitals should take no more than 15 minutes (Welsh Government NHS Wales Hospital Handover Guidance, issued 5 May 2016).

8. The Medical Priority Dispatch System ("the MPDS") is used by the Trust to dispatch the most appropriate medical resource to an incident. Emergency calls are answered by the Trust's emergency call handlers, who process calls using the MPDS. The software generates a questioning script based on the medical issue described by the caller and determines the most appropriate response based on the answers to these questions. A response code is then allocated to the call:

- Red, the highest priority response for immediately life-threatening situations (for example, respiratory or cardiac arrest).
- Amber 1, high clinical priority for potentially life-threatening emergency calls.
- Amber 2, for incidents considered serious but not immediately life threatening.
- Green 2, for not clinically serious or life-threatening.
- Green 3, for calls deemed suitable for clinical telephone assessment.

9. The Trust's Clinical Safety Plan version 1.1.1, January 2022 ("the CSP"). This provides a framework for the Trust to respond to situations when the demand for its services is greater than its available resources. The CSP "provides a set of tactical options that are flexible and immediate so that [the Trust] can dynamically react to situations to ensure those patients with the most serious conditions or in greatest

need according to their presentation remain prioritised to receive services." Section 5 of the CSP, "Reducing Risk", states that the Clinical Support Desk ("the CSD" – a team of clinically trained practitioners who work as part of the Trust's control room) should be tasked with reviewing the ambulance queue to identify high-risk patients. As part of the review of high-risk patients, CSD clinicians conduct clinical triages of waiting calls and are able to change the priority of ambulance responses according to the outcome of these assessments.

10. The National Health Services (Concerns, Complaints and Redress Arrangements (Wales) Regulations 2011, often referred to as the Putting Things Right Regulations ("the PTR Regulations"), provide guidance to Health Boards and NHS Trusts on how to effectively handle concerns about NHS treatment and services.

11. The NHS Wales Duty of Candour was introduced in Wales on 1 April 2023. The overriding principle (set out in accompanying Welsh Government Guidance) is that "being open with service users and their representatives when things go wrong in their care is the right thing to do". This is in addition to any professional duty of candour a healthcare professional will be subject to under their own professional practice regimes and specifically applies when a healthcare provider is responding to complaints about a service.

The background events

12. At around 19:00 on 13 September **2022** Mrs C, aged 93, fell at her home address and was unable to get up. The fall went unnoticed until approximately 13:00 on 14 September when her family visited and found her on the floor. Mrs C complained of pain to her right leg and buttock.

13. Mrs C's family made 6 emergency calls to the Trust between 13:00 on 14 September and 04:27 on 15 September. The first 3 calls were categorised as Green priority calls. During the fourth emergency call at 21:20 Mrs C's family reported that she was no longer completely alert. Calls 4, 5 and 6 were categorised as Amber 1 priority. An ambulance arrived at Mrs C's address at 04:49 on 15 September. This was around 16 hours after the first emergency call was made and almost 34 hours after Mrs C fell.

14. Mrs C was taken to Morriston Hospital ("the Hospital") and arrived at 06:44. Due to a lack of available beds in the Emergency Department ("the ED") Mrs C waited in the ambulance outside the Hospital. Whilst in the ambulance, Mrs C was reviewed by an advanced nurse practitioner. A diagnosis of a fall with a long lie (when a person falls and spends over 1 to 2 hours on the floor because they are unable to get up) was made and a hip or knee fracture was queried. Mrs C underwent investigations and treatment with intravenous fluids ("IV fluids" – liquids given to replace water, sugar and salt that are administered directly into a vein through a drip).

15. Mrs C remained in the ambulance outside the Hospital for around 14 hours. She was transferred to the ED at 21:00 on 15 September. By this time around 50 hours had passed since her fall. On 16 September Mrs C was diagnosed with a fractured right knee, a chipped bone in her right hip and rhabdomyolysis (the breakdown of muscle tissue that leads to the release of muscle fibre contents into the blood, caused by direct or indirect muscle injury) that led to her developing an acute kidney injury ("AKI" – a sudden reduction in kidney function). Despite treatment with fluids, Mrs C's kidney function worsened, and she stopped passing urine.

16. Mrs C sadly died on 20 September. The inquest into her death determined the cause of death to be pneumonia and acute kidney injury second to rhabdomyolysis caused by a fall and long lie at home on 13 September, contributed to by a delayed ambulance response.

Mr B's evidence

17. Mr B said that his mother's wait for an ambulance and then outside the ED was unacceptable and shocking. He said that the information his family were given about ambulance arrival times was misleading and that if they had been given transparent advice, they could have taken Mrs C to hospital themselves. Mr B said that the advice not to move their mother and to wait for an ambulance caused her to develop pneumonia (inflammation and fluid in the lungs that is usually caused by an infection) and an AKI, which ultimately led to her death. Mr B said that the poor care Mrs C received deprived her of dignity and left him and his family deeply traumatised.

18. Mr B said that the joint complaint response provided by the Trust and the Health Board was totally inadequate as it failed to address any of his concerns or take any accountability for Mrs C's death. He said that the response was written in jargon and concerned how the Trust and the Health Board intended to respond to problems in the future rather than addressing why they had failed Mrs C.

The Trust's evidence

19. In its response to Mr B's complaint, the Trust explained that its call handlers are not medically trained, so they must follow call scripts and provide instructions generated by the MPDS to ensure that all patients receive consistent assessment and responses. It said that having reviewed the calls made about Mrs C, it was satisfied that its call handlers provided the correct advice to Mrs C's family. It said that the instruction "do not move her unless she's in danger" was provided to Mrs C's family in line with MPDS instructions to reduce the risk of Mrs C experiencing further injury.

20. The Trust said that at the time Mrs C was awaiting an ambulance it was experiencing an increase of high priority emergency calls and severe delays in handovers at hospital, so its response times were significantly protracted. Between 14 and 15 September 2022, the longest handover time at the Hospital was 16 hours and 7 minutes.

21. The Trust said that all calls made by Mrs C's family were correctly prioritised and that there were no missed opportunities to have responded differently or attended sooner to Mrs C.

22. Following receipt of advice from the Paramedic Adviser, my investigator asked the Trust further questions about the role of the CSD, how it reviewed patients and how it managed Mrs C's clinical risk. The Trust said that upon further review, it had identified failings in the care provided. The Trust said that the CSD clinician reviewing the calls made about Mrs C ("the CSD Clinician") decided not to undertake a full clinical review of the information provided during the second call, and this decision was based on the information from the first call. The Trust said that the clinician should have undertaken a telephone triage following the second call. Had this taken place, on the balance of probability, the call

would likely have been escalated to an Amber response. This might have resulted in an ambulance being allocated to Mrs C sooner. The Trust said that this was an individual human error and not indicative of a wider issue with its processes.

23. The Trust could not say why this failing was missed during its investigation. It said that at the time, the CSD did not have an internal process for managing its investigations. Since then, it has developed an internal process of managing concerns, including audits, individual clinical feedback, action plans and reviews of practice, with dedicated clinical staff responsible for identifying learning opportunities. It said that future investigations would be more robust and monitored as a result of these developments.

24. The Trust explained that in May 2024 it began making considerable changes to how it responds to emergency calls. It said that the changes aim to ensure that all patients, except those in extremely high acuity cases (where patients require high levels of medical care or monitoring because their condition cannot be easily managed, such as patients in cardiac arrest), are clinically triaged over the phone before an ambulance is sent. The Trust said that these changes will address the issue of low acuity calls (where patients have conditions that are less severe and not immediately dangerous) that result in patients experiencing long lies while awaiting an ambulance response.

The Health Board's Evidence

25. The Health Board said that on 15 September, the Hospital was on escalation level 4, the highest level of escalation below business continuity. This is where an event or occurrence causes normal service delivery to fall below acceptable levels, and special arrangements have to be put into action to ensure it can still deliver critical services. At escalation level 4, the Health Board experiences:

- delays of over an hour in releasing the Trust's crews from hospital
- patients waiting over an hour for triage

- 12 hour waits for patients in the ED.

At this level, the matter is escalated for oversight by senior managers in the Health Board and steps are taken, such as diverting patients to other facilities and cancelling all meetings, study days and non-urgent elective appointments and surgery, so staff can be used in acute care areas to manage demand.

26. The Health Board said that it was at escalation level 4 on 15 September because of the high level of patients being admitted to the Hospital with significant health problems and the high demand experienced by the ED on that day. Between 15 September and the early hours of 16 September, there were up to 13 ambulances waiting outside the ED unable to handover patients.

27. The Health Board said that all patients awaiting handover would have been triaged, assessed and admitted to the ED in order of clinical priority. It explained that it took actions to reduce waiting times for patients requiring admission to the ED, including re-directing patients to other hospitals in the area and reviews of potential patient discharges.

28. The Health Board said that when Mrs C arrived at 06:44 on 15 September there were already 9 ambulances outside the ED waiting to handover patients. It said that Mrs C remained in the ambulance for 15 hours because it was not possible for her to be transferred from the ambulance at an earlier point. The Health Board said that despite her wait in the ambulance, Mrs C was appropriately triaged, assessed and managed following her arrival at the ED.

29. The Health Board said that Mrs C underwent investigations while she remained in the ambulance. It said that Mrs C's blood test results showed that her creatine kinase (a protein in the blood that can indicate muscle damage) was raised and her kidney function was slightly abnormal, so treatment with IV fluids started while she was in the ambulance. The Health Board said that it did not feel that the delay Mrs C experienced in being transferred from the ambulance to the ED significantly affected the level of care she received or her eventual outcome.

Professional Advice

The Paramedic Adviser

30. The Paramedic Adviser explained that to ensure the reliability and accuracy of the MPDS, call handlers must follow the questioning script word for word so that questions are not asked incorrectly or misinterpreted. This ensures that call handlers give appropriate advice, and the correct triage category is allocated to a call.

31. The Paramedic Adviser said that the advice provided by the Trust's staff during the calls, especially the advice not to move Mrs C, was clinically appropriate. He said that Mrs C needed to be assessed by a clinician before being moved as she was complaining of pain in her leg and knee. It would not have been appropriate to advise Mrs C's family to move her or arrange alternative transport to hospital as doing so could have worsened her injuries.

32. The Paramedic Adviser said that during all the calls made by Mrs C's family, the correct questions were asked by the Trust's emergency call handlers and the appropriate triage categories were reached, in keeping with the MPDS. He said that although Mrs C appeared to be deteriorating during the wait for an ambulance, the information provided during the second and third calls did not suggest that her condition at the time had become urgent, immediately or potentially life-threatening. Accordingly, the MPDS system would not have escalated the response from Green to Amber or Red.

33. The Paramedic Adviser said that during the fourth call made at 21:20 it was noted that Mrs C was not fully alert, so the MPDS escalated the response to Amber 1, indicating that her condition had become serious and potentially life-threatening. The Adviser said that escalation to this triage category was appropriate given the time Mrs C had spent on the floor and her gradual deterioration. It was also appropriate that the fifth and sixth calls did not trigger an escalation to a Red response as there was nothing to indicate that Mrs C's condition had deteriorated to the point that it was immediately life-threatening.

34. The Paramedic Adviser said that the Trust's records show that the first call made about Mrs C was placed in both the ambulance response queue and in the CSD queue for a call back and re-assessment by one of the Trust's clinicians. He explained that these concurrent actions are taken to ensure that the patient receives help or re-assessment if an ambulance response or clinician call back are delayed.

35. The Paramedic Adviser said that the CSD Clinician identified that Mrs C required an ambulance response and a face-to face clinical assessment, so removed the call from the CSD call back list. The Paramedic Adviser said that by not keeping the call on the list for a clinician review as well as an ambulance response, the opportunity for further review and identification of risk factors by a clinician was removed. The Paramedic Adviser stated that it would be reasonable to expect that a CSD clinician reviewing Mrs C's case (93 years old, long lie of 18 hours) would have identified that she was at serious risk and considered upgrading the call triage category to a more time critical level. He stated that this is especially relevant when considering that there were already severe delays in responding to potentially life-threatening emergency calls.

36. The Paramedic Adviser described the decision making in respect of the most suitable care pathway for Mrs C as transactional, in the sense that it did not consider that Mrs C would have benefited from clinician contact and subsequent escalation to an emergency response at an earlier stage. The Paramedic Adviser said that the actions taken by the Trust to minimise the clinical impact of the ambulance delay were not sufficient and there was a missed opportunity for Mrs C to have received improved care.

The Consultant Adviser

37. The Consultant Adviser said that despite the circumstances, Mrs C received triage, assessment and appropriate investigations whilst she was in the ambulance outside the ED. He said that Mrs C received pain relief and fluids and underwent regular reviews and pressure area checks in line with guidance. The Consultant Adviser said that whilst the overall standard of care was appropriate, there was a failing in respect of the management of Mrs C's risk of AKI.

38. The Consultant Adviser explained that Mrs C would have been at high-risk of developing an AKI as she was diabetic, over 65, on medication and had experienced a long lie with poor fluid intake. It was noted that her serum creatinine level (a blood test used to check how well the kidneys are filtering the blood), which was above the normal upper limit upon her admission to the ED, rose during her time in hospital. On 16 September her blood pressure level, which was originally within the normal range, became low.

39. Despite being at high risk of an AKI, Mrs C continued to receive her regular medications to treat blood pressure and diabetes until they were stopped on 18 September. The Consultant Adviser noted that continuing to administer these potentially nephrotoxic medications (medication that can damage the kidneys) was contrary to the NICE Guidance. This states that advice should be sought from a pharmacist about optimising medicines and drug dosing in adults with or at risk of AKI. The Consultant Adviser said that there was an opportunity to have stopped the administration of these medications earlier in Mrs C's admission, but that it is unlikely that doing so would have had an effect on her outcome.

40. The Consultant Adviser said that due to Mrs C's frailty and existing health conditions, her deterioration and death were likely to have been unavoidable. He said that even without the delay in an ambulance attending, Mrs C's outcome may have been the same as she had already spent a long time on the floor before she was found, and an ambulance was called.

Analysis and conclusions

41. In reaching my conclusions, I must consider whether there were failings on the part of the Trust and the Health Board, and if so, whether those failings caused an injustice to Mrs C or her family. In doing so, I have considered whether the actions of the Trust or the Health Board met appropriate standards rather than best possible practice. I have had regard to the advice I have received, which I accept. However, the conclusions reached are my own.

42. This report considers the care and service provided to Mrs C by the Trust and Health Board, and the likely impact of shortfalls in that care. My investigation has also considered whether anything could or should have been done differently to manage Mrs C's wait for an ambulance and clinical risk.

43. I would like to extend my sincerest condolences to Mr B and his family for the sad loss of Mrs C.

Whether the triaging of the emergency calls and the priority they were allocated by the Trust was reasonable and appropriate in the circumstances

44. I accept the Paramedic Adviser's advice that all 6 emergency calls were correctly triaged and prioritised by the Trust's emergency call handlers. I share the Paramedic Adviser's view that the CSD Clinician should have reviewed Mrs C's case, identified that she was at serious risk and then considered escalating the ambulance response category.

45. Had the CSD Clinician reviewed the situation, an ambulance may have been allocated to Mrs C sooner. I am satisfied that the failure to review Mrs C represents a significant service failure which caused Mrs C a serious injustice. The time Mrs C spent on the floor waiting for an ambulance would have been extremely distressing, painful and undignified for her, and it would have been upsetting for her family to see her in this condition. This time might have been reduced.

46. I accept the Consultant Adviser's view that even without the delay in an ambulance attending, Mrs C's outcome may have been the same. However, he did not say that this was a certainty and there remains a degree of uncertainty as to whether a quicker ambulance response would have changed Mrs C's sad outcome. I consider this uncertainty amounts to an injustice to Mr B and his family. Accordingly, I **uphold** this element of the complaint.

Whether the advice provided by Trust staff during the calls was reasonable and appropriate

47. I accept the Paramedic Adviser's view that the advice provided by the Trust's staff, particularly the advice not to move Mrs C, was clinically appropriate. This was because Mrs C required a face-to-face clinical assessment before being moved. Advising her family to move her could have worsened her injuries and caused her more pain. As such, I **do not uphold** this element of the complaint.

Whether Mrs C was appropriately assessed and managed by the Health Board following her arrival at the Emergency Department of Morriston Hospital on 15 September 2022

48. I accept the advice I have received that Mrs C received appropriate care, investigations and treatment whilst she was in the ambulance outside the ED and after she was admitted to the Hospital. Although the Consultant Adviser identified that there was a missed opportunity to have stopped the administration of nephrotoxic medication at an earlier stage, there is no suggestion that this caused Mrs C harm or affected her outcome. As such, I **do not uphold** the complaint against the Health Board. However, I **invite** the Health Board to share this report with the relevant staff and consider how it could improve the training its clinicians receive in recognising and managing patients at high risk of AKI.

Complaint handling by the Trust

49. Finally, whilst my investigation did not initially intend to consider the handling of Mr B's complaint by the Trust, in light of the information that has become available during this process, I must address this. The NHS Wales Duty of Candour was introduced in Wales on 1 April 2023. Whilst not in force at the time of the response to Mr B, it was well known that the duty would be implemented, and in any event, the PTR Regulations under which the Trust responded to Mr B's complaint places an obligation upon it to investigate concerns properly, efficiently and openly. The Trust's response to Mr B fell well short of what the duty promotes and is intended to achieve. The Trust had a second chance to identify service failure at the time I started this investigation when my investigator sought its comments on Mrs C's care. It again did not identify the service failure. It was only after

my investigating officer shared the Paramedic Adviser's views with the Trust that it acknowledged, in April 2024, that there had been failings in Mrs C's case.

50. This raises serious concerns about the robustness of the Trust's investigations of the complaints it receives. Concerningly, this is not the only evidence I have seen of deficiencies in the Trust's complaints investigation process. Alongside this report, I am publishing another public interest report[1] in relation to a different complaint received by my office, which highlights similar shortfalls in this respect. The Trust needs to ensure that in the future it responds openly and honestly to complaints, and that staff involved in formulating/feeding into the response also reflect on both the duty, and their own professional standards obligations when doing so. My recommendations therefore take account of this failure.

51. I consider that I cannot adequately address the significant injustice caused to Mr B and his family without recommending financial redress. I stress that this is in no way to be seen as compensation for the family's loss, but rather to reflect the injustice caused. I consider that the level of financial redress I am recommending appropriately reflects the distressing impact that the failings identified in this report will have on Mr B and the rest of Mrs C's family.

Recommendations

52. I **recommend** that the Trust, within **1 month** of the date of this report:

a) Provides a meaningful written apology to Mr B and his family for the failures identified in this report and acknowledge that it missed opportunities to minimise the clinical impact of the ambulance delay and provide improved care for Mrs C. The apology should also include an explanation as to why the Trust's investigation did not identify these failings.

[1] Case reference 202306104

b) Offers Mr B redress of £2,000 in recognition of the distress and loss of dignity Mrs C experienced and the uncertainty caused to Mr B. To further offer Mr B redress of £750 for the significant time and trouble he has been put to in pursuing this complaint to gain answers to his concerns.

c) Shares this report with the Trust's complaint investigation team to review the conduct of its investigation in line with the Duty of Candour and identify learning points to ensure that similar failings are not missed in the future. Any improvements it identifies should be fed back into its complaints handling procedure and shared with my office.

d) Shares this report with the Trust's Quality and Patient Safety Committee to consider my findings and include its learnings from these investigations in its Annual Report on the Duty of Candour.

e) Shares a copy of this report with all appropriate staff and reminds them of the importance of fully reviewing information recorded in the Command & Dispatch system at the time of the call.

53. I am pleased to note that in commenting on the draft of this report **Welsh Ambulance Services University NHS Trust** has agreed to implement these recommendations.

Michelle Morris

Michelle Morris 4 March 2025
Ombwdsmon Gwasanaethau Cyhoeddus | Public Services Ombudsman

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The investigation of a complaint against Welsh Ambulance Services University NHS Trust

A report by the
Public Services Ombudsman for Wales
Case: 202306104

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Introduction

This report is issued under s23 of the Public Services Ombudsman (Wales) Act 2019.

We have taken steps to protect the identity of the complainant and others, as far as possible. The names of the complainant and other involved people have been changed. The report therefore refers to the complainant as Mrs A.

Summary

Mrs A complained about a lack of care and treatment by the Welsh Ambulance Services University NHS Trust ("the Trust") for her son, Mr B, on 14 December 2022. The Ombudsman's investigation considered the handling of 2x 999 calls, the standard of record keeping by the attending paramedic, and whether the earlier arrival of Trust staff would likely have affected Mr B's outcome.

The Ombudsman found a failure to properly manage the 2x 999 calls made in respect of Mr B. The First Call was incorrectly downgraded from "Red" priority to "Green 2". This meant a delay of 32 minutes in an ambulance attending Mr B. The Second Call was also not handled appropriately, with incorrect information given to Mrs A about cardio-pulmonary resuscitation. As a result, Mr B did not receive timely medical attention. Additionally, there was injustice to Mrs A and Mr B's brother, Mr C, as they spent 45 minutes attempting to deliver CPR to Mr B, without instruction or support.

In respect of the standard of record keeping by the attending paramedic, the Ombudsman found that fully accurate information was not entered on the patient clinical record particularly that the information was based on estimation. There was inconsistent reporting by the attending paramedic of what information was obtained from Mr B's family. This lack of clarity about the events of 14 December constituted an injustice to Mr B's family.

In terms of whether earlier attendance by Trust staff could have affected Mr B's outcome, the Ombudsman could not conclude with certainty that the earlier arrival of an ambulance would have made a difference. There was information that was not known, including the point at which Mr B suffered a cardiac arrest. As there was a small possibility of a different outcome for Mr B, this is an injustice to Mrs A and the family.

Whilst the Ombudsman's investigation did not set out to consider the Trust's handling of Mrs A's complaint, information came to light which highlighted concerns about the robustness of the Trust's investigation of the complaints it receives, particularly as this was not the only investigation she had seen which revealed deficiencies in the Trust's complaints

investigation process. Failures in the investigation process have meant Mrs A has unanswered questions about the care provided to Mr B which have left her with deep concerns.

The Ombudsman made a number of recommendations, which the Trust accepted. These included:

- An apology to Mrs A, an explanation about the shortfalls in the investigation process and payments totalling £2,750 for the distress and uncertainty caused and for Mrs A having to pursue her complaint.

- To review its approach to maintaining accurate clinical records to ensure it meets the requirements of The Health and Care Professions Council Standards of Practice.

- To remind all clinicians about the importance of good communication with those present at calls they attend.

- To share the report with the Trust's complaint investigation team to review the conduct of its investigation in line with the Duty of Candour and identify learning points to ensure that similar failings are not missed in the future.

- To share the report with the Trust's Quality and Patient Safety Committee to consider the findings and include its learning from these recommendations in its Annual Duty of Candour report.

The Complaint

1. Mrs A complained about the care and treatment provided to her son, Mr B, by the Welsh Ambulance Services University NHS Trust ("The Trust") on 14 December 2022. The investigation considered:

a) The handling of 2x 999 calls made to the Trust in respect of Mr B.

b) The standard of record keeping demonstrated by the attending paramedic.

c) Whether the arrival of the Trust staff at an earlier point would likely have affected Mr B's outcome.

Investigation

2. My investigator obtained comments and copies of relevant documents from the Trust and considered those in conjunction with the evidence provided by Mrs A. They also obtained clinical advice from 2 specialist advisers, Dr Les Ala, a consultant acute physician ("the Consultant Adviser") and Mrs Sue Pateman, an advanced paramedic and registered nurse ("the Paramedic Adviser").

3. The Advisers were asked to consider whether, without the benefit of hindsight, the care or treatment had been appropriate in the situation complained about. I determine whether the standard of care was appropriate by making reference to relevant national standards or regulatory, professional or statutory guidance which applied at the time of the events complained about.

4. I have not included every detail investigated in this report, but I am satisfied that nothing of significance has been overlooked.

5. Both Mrs A and the Trust were given the opportunity to see and comment on a draft of this report before the final version was issued.

Relevant guidance

6. The Medical Priority Dispatch System ("the MPDS") is used by the Trust to dispatch the most appropriate medical resource to an incident. Emergency calls are answered by the Trust's emergency call handlers, who process calls using the MPDS. The software generates a questioning script based on the medical issue described by the caller and determines the most appropriate response based on the answers to these questions. A response code is then allocated to the call:

- Red, the highest priority response for immediately life-threatening situations (for example, respiratory or cardiac arrest).

- Amber 1, high clinical priority for potentially life-threatening emergency calls.

- Amber 2, for incidents considered serious but not immediately life-threatening.

- Green 2, for not clinically serious or life-threatening.

- Green 3, for calls deemed suitable for clinical telephone assessment.

7. The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011, often referred to as the Putting Things Right Regulations ("the PTR Regulations"), provides guidance to Health Boards and NHS Trusts on how to effectively handle concerns about NHS treatment and services.

8. The NHS Wales Duty of Candour was introduced in Wales on 1 April 2023. The overriding principle (set out in accompanying Welsh Government Guidance) is that "being open with service users and their representatives when things go wrong in their care is the right thing to do". This is in addition to any professional duty of candour a healthcare professional will be subject to under their own professional practice regimes and specifically applies when a healthcare provider is responding to complaints about a service.

The background events

9. On 14 December **2022** Mr B, aged 35, was at home with his brother, Mr C, when he collapsed.

10. At 07:34 Mr C made a call to the Trust via 999 ("the First Call"). He explained to the emergency medical dispatcher ("the First EMD") that Mr B had been unwell the previous night with a cold or COVID-19 and had collapsed that morning. Mr C said he was unable to feel a pulse and did not think that Mr B was breathing. No instructions were provided to Mr C by the First EMD to perform cardiopulmonary resuscitation ("CPR" – an emergency lifesaving procedure performed when the heart stops beating).

11. At 07:35 a "Red" response (immediately life-threatening – the fastest response possible with an aim to respond within 8 minutes, using lights and sirens) was generated by the Trust. An emergency ambulance was allocated with an estimated time of arrival of 13 minutes.

12. At 07:40 it was noted that ProQA Paramount ("ProQA" – the Trust's emergency dispatch software programme) had failed to connect to its Computer Aided Dispatch system ("CAD").

13. At 07:40 the emergency ambulance was stood down after the call priority was downgraded to "Green 2" (not immediately serious or life-threatening with an aim to respond as soon as possible, without lights and sirens). This was as a result of an input code being manually entered by the First EMD into the CAD, which recorded that Mr B was obviously deceased.

14. At 08:11 Mrs A made a second call to the Trust via 999 ("the Second Call"). She explained that Mr B was unresponsive, but she was unaware if he was breathing.

15. At 08:12 the call was prioritised by the EMD ("the Second EMD") as "Red" and at 08:13 an advanced paramedic practitioner ("APP") and an emergency ambulance were allocated, with estimated times of arrival of 12 and 16 minutes respectively. Instructions were provided to Mrs A about performing 'mouth-to-mouth' resuscitation (blowing air into the mouth) on Mr B, but she was not instructed to do chest compressions.

16. At 08:14 the Second EMD was informed that there was black fluid coming from Mr B's mouth. At 08:15 another emergency ambulance was allocated with an estimated time of arrival of 12 minutes.

17. At 08:16 the Second EMD notified the APP that CPR was in progress.

18. At 08:20 the APP arrived at the scene, followed at 08:26 by the emergency ambulance staffed by 2 paramedics.

19. At 08:37 it was confirmed that Mr B had died. Following a postmortem examination, Mr B was found to have died from ketoacidosis, a condition where there is an overproduction of ketones (a type of chemical that the liver produces when it breaks down fats) that causes there to be too much acid in the blood.

Mrs A's evidence

20. Mrs A said that it took the Trust almost 45 minutes to attend to her son. She said this resulted in him not receiving timely treatment, which was vitally important, and could well have changed the outcome for him.

21. Mrs A said that there was no proof that Mr B suffered an immediate cardiac arrest (when the heart stops beating suddenly) at the point of his collapse.

22. Mrs A said that the information recorded on the electronic patient clinical record ("the ePCR") by the APP was fictitious. She said that the ePCR recorded that there had been a 10-minute delay in CPR being commenced, and that Mr B's collapse was not witnessed. However, Mrs A said that Mr C was metres away from Mr B when he collapsed, and Mr C immediately began CPR. She said that the APP was not there, she did not speak with Mr C to ascertain any details and therefore was unaware of the facts. Mrs A said that it was hugely upsetting that a professional person should manufacture details, when they should be reporting what was known as fact.

23. In respect of the communication with the APP, Mrs A reiterated that the APP failed to obtain any information about the events that had occurred prior to her arrival, recorded inaccurate information and demonstrated a complete

lack of basic kindness, which was inexcusable in the circumstances. Mrs A said that the APP failed to pass on information regarding the process and their options for seeing Mr B at the hospital. It was not made clear to them that they would not get the opportunity to see him again, as was the case.

24. Mrs A said that the Trust had been evasive in its dealings with her following Mr B's death. She said that she was not informed about any errors until March 2023, when she requested copies of the recordings of the 999 calls.

25. Mrs A said the information provided by the Trust about the member of staff who was sat with the First EMD during the call ("the Buddy") compounded the family's horror over the poor handling of the 999 calls. She questioned why an account of the events was not obtained from the Buddy at the time. Mrs A stated that the evidence of the Buddy was pertinent, and she is left questioning the authenticity of the Trust's investigation when the staff member was not approached in a timely manner to provide an account.

26. Mrs A questioned why, if the Buddy was experienced and available to assist the First EMD, they did not identify the errors made by the First EMD and intervene. She added that the Buddy would not have needed any additional training as a mentor to detect the errors made.

27. Mrs A said that the loss of her 35-year-old son, who had no significant health issues prior to his collapse, was completely devastating for the whole family.

The Trust's evidence

28. The Trust provided its condolences to Mrs A and her family.

29. The Trust confirmed that it undertook its own investigation into the circumstances surrounding Mr B's death. Its conclusions were communicated to Mr B's family and meetings subsequently took place with them. It said it made every effort to be open and transparent about these matters with Mr B's family.

30. The Trust said that sometimes the link between the CAD and ProQA will fail. When this happens, EMDs follow a 'fall-back process' which involves launching a standalone version of ProQA, not linked to the CAD, and the MPDS code being manually entered into the CAD.

31. The Trust said that its investigation found that the First Call was inappropriately prioritised as a "Green 2", instead of a "Red" response. It said that when the call was initially prioritised, it should have remained as a "Red" response and not been downgraded to a "Green 2" response.

32. As a result, there was a delayed response time of 32 minutes, along with a delay in providing CPR instructions. It said that if the call had remained "Red", an emergency ambulance could have arrived with Mr B within 13 minutes of the First Call being received.

33. In respect of the First EMD, the Trust clarified that they had commenced employment on 7 November 2022 and had undergone a full 3-week induction training programme. It confirmed that the First EMD had further completed approximately 3 weeks of employment during which they were taking 999 calls with supervision. The Trust said that they should have been provided with an appropriately trained mentor on 14 December 2022. Regrettably, due to staff sickness, the First EMD was placed with a member of staff who had not been suitably trained for mentorship, and who had not mentored previously ("the Buddy"). The decision by the supervisor was considered against the risk to waiting 999 calls as a result of the unprecedented service demand faced on that day.

34. In respect of the First Call, the Trust confirmed that the First EMD asked incorrect questions. It said Mr B should have remained as a "Red" priority, and CPR instructions should have been provided to Mr C to perform on his brother. It said that the First EMD failed to correctly assess the information given by Mr C that would have ensured that the call remained a "Red" priority and, had they fulfilled their duties appropriately, the information flow could have been more accurate.

35. The Trust said that it did not consider that chest compressions were carried out during the First Call. It said that it would have been obvious from the call recording if they had been, due to the physical exertion required to undertake them and that a steady rate of conversation would be unlikely to be maintained.

36. The Trust confirmed that the standard of the First Call was not the standard it expects from its call handlers. It assured Mrs A that the First EMD and the Buddy had received further formal training and support, particularly in relation to calls involving cardiac arrest.

37. In respect of the issue with the supervision of the First EMD, the Trust confirmed that it had implemented the following changes:

- Staff are now given more time on scenario work, including more complex scenarios, and knowledge checkers on these are completed.

- Department awareness sessions now include the Patient Safety Team (a team which plays a role in reviewing and learning from incidents to improve service provision).

- Ongoing work to develop the EMD training, and a 4-week induction course was piloted in March 2024.

- Staff are not only mentored by trained mentors, but also by buddies across all 3 sites to support the mentorship period.

- The Trust is seeking to increase the number of mentors as it has recognised that with high employee turnover and a lot of newer staff there are not enough mentors.

- The Trust has a specialist Learning & Development Team for emergency medical services coordination, and arrangements are being made so that this team is able to deliver mentorship training to staff. This training will be provided by the International Academies of Emergency Dispatch ("IAED").

38. In respect of the Second Call, the Trust said that this was also non-compliant, as incorrect information was provided to Mrs A about CPR. It said that during this call, Mrs A was asked to retrieve a defibrillator, but she responded that she felt it was too late. It confirmed as the call was a "Red" priority from the outset, the error in respect of CPR instructions did not cause a direct delay in getting help to Mr B.

39. The Trust added that ketoacidosis tends to produce deep fast breathing as a compensatory mechanism in the body to try and correct the increased level of blood acidity. This means that breathing was likely to be relatively easily detected, even if not appearing normal (it will often be fast, and with deep 'sighs'). It said the fact that during the First 999 call Mr C could not identify any sign of breathing was highly suggestive that these compensatory mechanisms were no longer working, and thus that cardiac arrest had occurred.

40. The Trust said that following its internal investigation and evidence presented for the Coroner's investigation, it did not consider that an ambulance arriving sooner would have changed the outcome for Mr B. This was because once Mr B had suffered a cardiac arrest, he would have had a low chance of survival.

41. The Trust said that it had shared Mr B's postmortem examination report with a consultant in anaesthesia and intensive care medicine. They said that virtually any cause of cardiac arrest would have a low chance of survival once cardiac arrest had actually occurred. It said that in Mr B's case, where the cardiac arrest was due to ketoacidosis, it would generally carry a very low survival chance. It said that the chance would be reduced further if CPR was not commenced immediately. It said that in this instance, the slim chance that Mr B had of survival was reduced to zero, due to the failure to perform CPR due to the coding issue.

42. The Trust said that Mr B's BMI (body mass index – a value derived from the mass and height of a person) indicated that he was underweight.

43. The Trust said that an internal incident report was submitted following Mr B's death and, as a result, an investigation was started. It said that the investigation was started prior to Mrs A raising a concern, and that the outcome of its investigation would have been shared with Mrs A, regardless of her submitting a complaint herself. The Trust did acknowledge that there was a missed opportunity to advise Mrs A that Mr B's case had been reported as a Nationally Reportable Incident ("NRI") to NHS Wales, and it apologised to her for this.

44. Mrs A raised concerns with the Trust on numerous occasions about its openness and transparency in its investigation process. In its response to Mrs A on 15 June 2023, the Trust confirmed that it had adhered to the Duty of Candour principles for many years, despite the legislation not being implemented in Wales until 1 April 2023.

45. In response to my investigation, the Trust confirmed that the initial "Red" priority assigned to the First Call was through the 'pre-alert' process. It explained that when an EMD answers a 999 call, and before processing a call using MPDS, the EMD asks 2 questions which are designed to identify the sickest patients and allow for the immediate dispatch of a resource to these patients: 'is the patient awake?' and 'is the patient breathing?'. This process is followed within the CAD system. These questions were asked in this instance, and it was identified that Mr B was not conscious or breathing. This triggered an initial "Red" priority. As the pre-alert process is an initial review, when an EMD has processed a call in full, the priority can change. This may be if later information indicates that a patient is in fact conscious and breathing, has regained consciousness, or if a patient is obviously beyond any help.

46. The Trust said that sometimes the link between the CAD and ProQA will fail. In these circumstances, the EMD can process the call using a version of ProQA which is not linked to the CAD. This does not impact the MPDS code that the EMD assigns but does impact how the EMD records the MPDS code within the CAD.

47. In this instance, the ProQA failure did not have any causal link with the incorrect MPDS code being assigned to the call. The reason that the call was not assigned the correct MPDS code was because the First EMD

recorded that Mr B was obviously deceased, which was not correct based on the responses to the questions asked. Given that Mr B was described to have just collapsed, there was no indication that resuscitation should not be attempted.

48. For absolute clarity, the Trust said that the 2 systems ("pre-alert" and ProQA) would have resulted in the same call grade had the First EMD not made an error.

49. The Trust informed my investigator that, soon after the incident, the Buddy changed roles. It confirmed that a statement was not obtained from the Buddy at the time, and due to the timeframe that has passed, they are unable to recall the incident.

50. The Trust also confirmed that staff working as buddies do not take their own calls and should either member of staff require a comfort break, no calls are taken during that time. The training received by the Buddy was the training provided to them as an EMD, with no additional training provided. The Buddy had experience of working as an EMD. The Trust confirmed that at the time of the First Call, the Buddy was plugged in to the call (a splitter cable was used to facilitate 2 headsets to a call) and listening at the time the call was taken by the First EMD.

51. The Trust said that the information recorded on the ePCR by the APP about the length of time CPR had been performed was an estimation. In respect of the completion of the ePCR by the APP, the Trust confirmed that it meets the requirements of The Health and Care Professions Council Standards of Practice ("HCPC").

52. The Trust said that when attending a cardiac arrest situation, all Trust staff are asked to undertake actions to support the chain of survival. It confirmed that across the ambulance sector, record-keeping takes place retrospectively rather than at the point of intervention and therefore all timings are estimated to a degree because of the nature of the care undertaken and the environment in which it is provided. It confirmed that it engages with other ambulance sectors across the 4 nations and shares learning and good practice. Any changes to its approach on completion of records would need to be considered as a wider sector to ensure consistency and the practical application of any changes.

53. It said that it did not agree that the APP did not speak with Mrs A or Mr C to obtain information. It provided a statement from the APP, dated 4 December 2023, in which she said, “I informed the family that the Police would be attending and explained the reason for this and spent some time with them in the middle downstairs room.” It said that staff members do not have access to the 999 calls, and only minimal information is shared prior to staff arriving at the scene. All other information recorded on the ePCR was the information supplied to, and observed by, the APP.

54. In a statement provided by the APP for HM Coroner, dated 24 August 2023, which was also supplied by the Trust, the APP did not reference a conversation with the family and stated, “I completed the paperwork, requested attendance of the police as per the ROLE policy. I cleared from the scene and continued with the rest of my shift.”

55. In its complaint response to Mrs A dated 30 October 2023, the Trust confirmed that it had returned to the APP regarding the rationale for entering 10 minutes into the ePCR. They advised the following, “To the best of my recall I believe that it was an estimated time, based upon the information given to me on the day of the time taken from the time of collapse to the patients brother finding [Mr B] on the floor, an assessment and then the movement from the bathroom into the box room where [Mr B] was located on my arrival”.

56. The Trust said during the First Call, which lasted 5 minutes, no CPR was ongoing. Therefore, following the conversation with Mr B’s family, an estimated time of 10 minutes (time to commencement of CPR by bystander) was recorded on the ePCR. This is supported by the First Call received at 07:34. The Trust acknowledged that 10 minutes was an estimated time. It said the medical record is a contemporaneous medical record and there is no requirement to indicate that a time is estimated. The Trust said that its staff are not trained to indicate when a time is estimated. It said on introducing the new ePCR, it liaised closely with other ambulance services within the UK and the requirement to indicate estimated records was not introduced.

57. The Trust confirmed that the inclusion of the word ‘estimated’ on the ePCR would not have changed its opinion about Mr B’s chances of survival.

The Call Recording

58. My Investigator listened to the recording of the First Call which is approximately 4 ½ minutes long. My Investigator noted that Mr C was not directly asked if he was performing CPR, and no instructions were given. They also noted that Mr C does not sound like he is administering mouth-to-mouth resuscitation, as that would likely have impacted on his ability to communicate effectively with the First EMD. The call recording does not confirm whether or not Mr C was carrying out chest compressions. Mr C indicated during the call that Mr B has “just kind of collapsed on the floor.” Mr C made no reference to the collapse having occurred 5 minutes before the First Call was made.

Professional Advice

The Consultant Adviser

59. The Consultant Adviser was asked to consider whether Mr B’s outcome would likely have been different had an ambulance arrived within 13 minutes of the First Call being made.

60. The Consultant Adviser noted that the postmortem examination of Mr B revealed the cause of his death to be ketoacidosis, but that there was no further explanation of the likely cause of this. Mr B was not known to suffer from diabetes, which is one potential cause of ketoacidosis.

61. The Consultant Adviser said that, noticeably, all other findings at postmortem examination were completely normal, and that otherwise, Mr B was a very healthy young man.

62. In respect of Mr B’s BMI, the Consultant Adviser said that whilst he was underweight, with a BMI of 15.5, postmortem examination did not show any cardiac features that you would expect to see in patients who are underweight (e.g. those with anorexia), such as reduced ventricular wall

thickness or reduced heart chamber volumes. The Consultant Adviser confirmed that patients who are underweight have a reduced chance of survival when suffering a cardio-respiratory arrest and confirmed that Mr B's low BMI would have reduced his chances of survival.

63. The Consultant Adviser noted that there was no definitive evidence of exactly when Mr B had suffered a cardiac arrest and said that this would not necessarily have happened at the time of Mr B's collapse.

64. In respect of the likely outcome being different, the Consultant Adviser said that had an ambulance not been delayed, the outcome potentially could have been different for Mr B, particularly in the absence of any other significant natural disease present at postmortem examination. However, he could not conclude with certainty that the outcome would have been different.

The Paramedic Adviser

65. The Paramedic Adviser was specifically asked whether it is clinically appropriate to record information in clinical records without any indication that the information is based on estimation rather than fact.

66. The Paramedic Adviser said that it is not acceptable to record estimated information in clinical records without indicating that it is an estimation. The HCPC Standards of Paramedics Proficiency (section 9 paragraph 9.1) states that paramedics must, "Maintain records appropriately and keep full, clear and accurate records in accordance with applicable legislation, protocols and guidance." The HCPC Standards of Conduct, Performance and Ethics (section 10 paragraph 10.1) states that paramedics must, "Keep records of your work and you must keep full, clear and accurate records for everyone you care for, treat or provide other services to."

67. The Paramedic Adviser confirmed that the HCPC Standards require records to be accurate, and therefore if a time elapsed has not been specifically recorded (such as could be found on a cardiac monitor), it would be a best guess estimate by the clinician, or a rough timing provided by those in attendance from the start of an incident.

68. The Paramedic Adviser said that the delay in starting CPR was not timed by the APP nor any bystander and is therefore unlikely to have been 10 minutes exactly. She added that it would appear from the Trust's investigation that a drop-down box has been used to enter the time before CPR commenced, which does not permit the inclusion of words such as approximate or estimate. She said this could have been recorded as an estimated time, and if there is no facility to put it in a specific field, it could be presented in the free text boxes which are available on ePCR forms. The Adviser reiterated that it is a requirement to distinguish between fact and estimate, and this did not happen in Mr B's case.

69. The Paramedic Adviser was also asked to consider the situation where a paramedic speaks with a person at a scene, whether they should record that the conversation has taken place and/or indicate the source of the information provided.

70. The Paramedic Adviser said that she could not identify any guidance which specifically requires a clinician to record who said what at the scene of any incident, although it would be good practice to do so. She confirmed that identifying where information came from helps with decision making, determining whether it is/was relevant and reliable and whether the information could be considered valuable if any follow up to a case was required. Recording who said what may also aid health care professionals' recollection of events at a later date.

Analysis and conclusions

71. In reaching my conclusions, I must consider whether there were failings on the part of the Trust and, if so, whether those failings caused an injustice to Mr B or his family. In doing so, I have considered whether the actions of the Trust met appropriate standards rather than best possible practice. I have had regard to the advice I have received, which I accept. However, the conclusions reached are my own.

72. This report considers the care and service provided to Mr B by the Trust, and the likely impact of shortfalls in that care. My investigation has also considered whether anything could or should have been done differently to manage Mr B's wait for an ambulance.

73. I would like to extend my sincerest condolences to Mrs A and her family for the sad loss of Mr B.

Complaint (a)

74. The evidence I have received from Mrs A and the Trust confirms that the First Call made by Mr C on 14 December 2022 was not handled appropriately. The call was incorrectly downgraded from "Red" priority to "Green 2" by the First EMD, and no instructions were provided to Mr C in respect of carrying out CPR on Mr B. The downgrading of the call resulted in a delay of 32 minutes in an ambulance attending to Mr B. The Trust identified the incorrect prioritisation and the delay that caused in its response to Mrs A's complaint.

75. I note that the Trust informed Mrs A that the First EMD was not supervised by a suitably trained mentor. The Trust said that the First EMD was supervised by the Buddy, who was not suitably trained to mentor, and who had not mentored previously. The Trust did not inform Mrs A that the Buddy was a fully qualified EMD.

76. Whilst I note the Trust's comments about the Buddy not having received formal training to mentor the First EMD, I do consider that the First EMD would have had an expectation that the Buddy would have intervened in the event of them making an error. I do not consider that the Buddy, being a fully qualified EMD, required any additional training to undertake this task. No explanation has been provided by the Trust for the lack of intervention by the Buddy. The Trust did not obtain a statement from the Buddy immediately following the incident and no explanation has been provided by the Trust for its failure to do so. I consider this to be a failure in its investigation process and its subsequent handling of Mrs A's complaint. As a result, the opportunity to obtain key evidence has been lost and a full account of circumstances surrounding the First Call remains unknown. This is unsatisfactory for Mrs A who, despite investigations by the Trust and my office, still has unanswered questions about the events leading to the death of her son.

77. The Second Call made by Mrs A on 14 December was also not handled appropriately by the Second EMD, with incorrect information provided to Mrs A about CPR.

78. There is no evidence to suggest that any service failure was a result of the failure of the Trust's call handling software.

79. The Trust's failure to properly manage the 2x 999 calls made in respect of Mr B constitutes a service failure. As a consequence of the failure, Mr B did not receive timely medical attention following his collapse. Additionally, both Mr C and Mrs A were caused an injustice due to them spending a period of 45 minutes, where they were attempting to deliver CPR to Mr B, without instruction or support. This must have been incredibly distressing for them both. On this basis, I **uphold** this element of the complaint. As the Trust has already implemented changes to its induction programme (paragraph 36), I have not made any additional recommendations in this respect.

Complaint (b)

80. The evidence I have seen confirms that the ePCR completed by the APP documented that CPR was not commenced for 10 minutes following Mr B's collapse. There is no record that this time was an estimation. The advice I have received is that there was a requirement for the APP to distinguish between factual and estimated information on the ePCR. However, I note that the Trust's position is that in the context of emergency care in a community setting, record-keeping takes place retrospectively rather than at the point of intervention and that all timings are estimated to a degree.

81. I am concerned that there may be other instances involving other patients, for example the timing/administration of medication, when information contained on the ePCR will need to be accurate and not estimated. This could potentially lead to a situation where accuracy of information contained on the ePCR could be misinterpreted. Whilst I cannot adjudicate between the differing views of the Paramedic Adviser and the Trust, I do propose to recommend that the Trust takes appropriate steps to confirm that its approach meets the requirements of HCPC.

82. I have further noted that the statements provided by the APP do not provide consistent evidence about a conversation taking place with Mr B's family. There is no record on the ePCR that any conversation took place. I accept the advice received that it is considered good practice to record

the origin of information provided at the scene of an incident. Mrs A is clear in her evidence that the APP did not speak with her or Mr C to obtain additional information. Nor did the APP provide key information about the process following Mr B's death. I am persuaded by Mrs A's recollection of the incident, as I believe that Mrs A is more likely to have recalled the events in detail in view of the gravity of the situation and because the evidence of the APP has not been consistent. Additionally, the lack of information about the process resulted in Mrs A and her family being unable to see Mr B following his transfer to the hospital mortuary.

83. The failure to enter fully accurate information in the ePCR, particularly that the information was based on estimation, plus the inconsistent reporting by the APP of what information was obtained from the family, has meant a lack of clarity over events that morning. I **uphold** this complaint on that limited basis.

Complaint (c)

84. The Trust said that even if an ambulance had attended in a timely manner, they would have found Mr B in cardiac arrest, and his chance of survival would have remained extremely low. It subsequently said that any slim chance Mr B may have had was reduced to zero by the failure to perform CPR, due to the incorrect call coding.

85. The Trust said that the fact that during the First Call Mr C could not identify any sign of breathing is highly suggestive that cardiac arrest had occurred.

86. The evidence I have seen confirms that during the Second Call, Mrs A said she was unsure of the breathing status of Mr B. However, when advised to retrieve a defibrillator, Mrs B responded that she felt it was too late. There is insufficient evidence to say whether Mr B was in cardiac arrest at that time.

87. Mrs A said that CPR was commenced immediately by Mr C following Mr B's collapse. This was despite the failure of the First EMD to provide instructions. The Trust disputes this fact and said that the recording of the First Call did not evidence that Mr C was performing CPR at that time.

88. During the recording of the First Call, Mr C was not directly asked if he was performing CPR, and no instructions were given. I accept that Mr C does not sound like he is administering mouth-to-mouth resuscitation, as that would likely have impacted on his ability to communicate effectively with the First EMD. I do not consider that the call recording confirms whether or not Mr C was carrying out chest compressions. Mr C indicated during the call that Mr B had "just kind of collapsed on the floor." Mr C made no reference to the collapse having occurred 5 minutes before the First Call was made.

89. There is no definitive evidence to support exactly when cardiac arrest occurred, as there was no medical professional on the scene immediately following Mr B's collapse. There was uncertainty in the Second Call about Mr B's breathing status. I accept the Trust's evidence that once cardiac arrest occurs, chances of survival are low. However, we will never definitively know at what point Mr B suffered a cardiac arrest to be able to conclude, on the balance of probability, at what point his chances of survival decreased.

90. Mrs A said that CPR was commenced immediately. The Trust said that the recording of the First Call evidences that it was not. Given that we do not know at what point cardiac arrest occurred, I do not consider that we can conclude whether a delay of 4 ½ minutes (the duration of the First Call) was significant or not.

91. I fully accept that the possibility of a different outcome may have been remote for Mr B, and I also accept the advice received that we cannot say with certainty that earlier arrival of an ambulance would have changed the outcome. There is information that we simply do not know. On this basis, I consider there was still a possibility, however slim, that the outcome may have been different for Mr B had an ambulance arrived within 13 minutes of the First Call being made.

92. As the effect of the potential earlier arrival of the Trust staff on Mr B's outcome is not certain, this represents an enduring injustice to Mrs A and her family. Taking all of the above into consideration, I **uphold** this element of the complaint.

Complaint handling

93. Finally, whilst 'complaint handling' was not one of the heads of complaint I investigated, in light of the information that has become available during this process, I must address this. The NHS Wales Duty of Candour was introduced in Wales on 1 April 2023. Whilst not in force at the time of the response to Mrs A, it was well known that the duty would be implemented, and in any event, the PTR Regulations under which the Trust responded to Mrs A's complaint places an obligation upon it to investigate concerns properly, efficiently and openly[1]. Additionally, in its complaint response to Mrs A, the Trust confirmed that it had followed the candour principles for many years.

94. I consider that the Trust's response to Mrs A fell well short of what the duty promotes and is intended to achieve. The opportunity to obtain key evidence has been lost and a full account of circumstances surrounding the First Call remains unknown. This is unsatisfactory for Mrs A who, despite investigations by the Trust and my office, still has unanswered questions about the events leading to the death of her son. That has left Mrs A with deep concerns about the care of her son at the end of his life.

95. In addition, and disappointingly, despite the Trust being asked to provide all relevant evidence to my office at the commencement of my investigation, it failed to do so. It provided one of the APP's statements 8 months after my investigation started and a key statement provided for the purposes of the Coroner's investigation was only provided in response to a draft copy of this report. In addition, no information was provided about the absence of key evidence from the Buddy.

96. This raises serious concerns about the robustness of the Trust's investigations of the complaints it receives. Concerningly, this is not the only evidence I have seen of deficiencies in the Trust's complaints investigation process. Alongside this report, I am publishing another public interest report[2] in respect of a different complaint received by my office, which highlights similar shortfalls in this respect. The Trust needs to ensure that in the future it responds openly and honestly to complaints, and that staff involved in

[1] As set out in Regulation 3 of the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 No. 704

[2] Case reference 202302966

formulating/feeding into the response also reflect on both the duty, and their own professional standards obligations when doing so. My recommendations therefore take account of this failure.

97. I consider that I cannot adequately address the significant injustice caused to Mrs A and her family without recommending financial redress. I stress that this is in no way to be seen as compensation for the family's loss, but rather to reflect the injustice caused as a consequence of the failings I have identified. I consider that the level of financial redress I am recommending appropriately reflects the distress caused to both Mrs A and Mr C during the prolonged time they were awaiting an ambulance and the subsequent uncertainty caused to Mrs A and her family.

Recommendations

98. I **recommend** that the Trust, within **1 month** of the date of this report:

a) Provides a meaningful written apology to Mrs A and her family for the failures identified in this report and acknowledge that it missed opportunities to provide timely care to Mr B. The apology should also include an explanation as to why the Trust's investigation did not appropriately consider the role of the Buddy in the handling of the First Call.

b) Offers Mrs A redress of £2,000 in recognition of the distress caused to both her and Mr C during the prolonged time they were awaiting an ambulance and the subsequent uncertainty caused to Mrs A and her family. To further offer Mrs A redress of £750 for the significant time and trouble she has been put to in pursuing this complaint to gain answers to her concerns.

c) Reviews its approach to maintaining accurate clinical records to ensure that it meets the requirements of The Health and Care Professions Council Standards of Practice.

d) Provides a reminder to all clinicians about the importance of good communication with those present at calls they attend.

e) Shares this report with the Trust's complaint investigation team to review the conduct of its investigation in line with the Duty of Candour and identify learning points to ensure that similar failings are not missed in the future. Any improvements it identifies should be fed back into its complaints handling procedure and shared with my office.

f) Shares this report with the Trust's Quality and Patient Safety Committee to consider my findings and include its learning from these recommendations in its Annual Duty of Candour report.

99. I am pleased to note that in commenting on the draft of this report **Welsh Ambulance Services University NHS Trust** has agreed to implement these recommendations.

Michelle Morris

Michelle Morris 4 March 2025
Ombwdsmon Gwasanaethau Cyhoeddus | Public Services Ombudsman

Public Services Ombudsman for Wales
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AGENDA ITEM No	10
OPEN	OPEN
No of ANNEXES ATTACHED	1

MONTHLY INTEGRATED QUALITY & PERFORMANCE DASHBOARD – February 2025/March 2025

MEETING	QUEST
DATE	9th May 2025
EXECUTIVE	Rachel Marsh – Executive Director of Strategy, Planning & Performance
AUTHOR	Georgia Tizzard – Commissioning and Performance Officer Melanie O'Connor - Senior Performance Analyst Mark Thomas – Commissioning & Performance Manager Hugh Bennett - Assistant Director, Commissioning & Performance
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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 **February 2025/March 2025.**

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 for red 8-minute performance was 50.32 % in March 2025, with performance decreasing compared to February 2025, with winter pressures. The Amber 1 median was 1 hour 53 minutes, which was slightly above the 1 hour 48-minute 12-month average. The Trust knows these extended times (the ideal is 18 minutes) 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 (91% in March, slightly

below the benchmark) and fully rolling out the CHARU service (87% in March); whilst also undertaking more transformative actions through the Clinical Model Transformation (CMT) Programme.

5. The Trust lost 21,852 hours to handover in March 2025 (31-days). This level of lost capacity is difficult to compensate for, despite all the actions being taken by the Trust.

6. The 2024/25 budget included 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, but the service did not achieve the 5% abandonment rate in March 2025, and performance decreased to 11.2% from 10.1% in February 2025.

8. Ambulance Care, in particular, Non-Emergency Patient Transport Service's (NEPTS) performance is stable, with both oncology and renal journeys being above target in March 2025. The NEPTS transport roster review has now started, this is 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 7.35% in March 2025. The IMTP ambition is to reach 6%. The Trust will continue its focus on sickness absence. EMS abstractions rose above the 30% benchmark figure in March 2025 to 33.86%.

10. The Trust is continuing to deliver its Clinical Model transformation (CMT) programme at pace. Key parts went live in December, in particular, remote clinical screening (RCS), which was a cultural shift in how the Trust manages 999 demand. There are early indications in the data in this report that the clinical model transformation changes implemented over the winter are having an effect. The new Purple Arrest and Red Emergency categories were announced on 11 March 2025.

RECOMMENDATION

QUEST is asked to: -

i. **Consider** the February 2025/March 2025 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
28.04.2025 - Executive Director of 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 **February 2025/March 2025.**

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:-

Slide Title	Slide Number
Red Performance Indicators	6
Amber Performance Indicators	7
Clinical Indicators	9
Clinical Indicators	10
Patient National Reportable Incidents & Patient Concerns	11
Patient & People Safety Indicators	12
Coroners, Mortality and Ombudsmen Indicators	13
Potential Patient Harm Indicators	16

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

Our Patients – Quality, Safety and Patient Experience

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

6. **999** call answering times improved in March 2025 with the 95th percentile decreasing to 27 seonds, compared to 33 seconds in February 2025. The 65th percentile and median performance remain consistently good, however data quality checks are being undertaken. Work will be undertaken early in Q1 on a demand and capacity analysis of 999 call demand.

7. **111 call answering performance has decreased over recent weeks,** and the call abandonment performance was at 11.2% in March, and still failing to achieve the 5% target. Recruitment has been undertaken to ensure that staff in post reflect the establishment position, and this has seen performance improve, but high sickness levels are having an effect. 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 March 2025 was 16.6% lower than during March 2024. The Trust has procured a third party in January 2025 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 97.5%. Response times for lower priority calls declined, recording 69.6% and 60.9% for P2CT and P3CT respectively. This is consistent with previous years, but needs to be monitored closely over the coming months.

10. **Ambulance Response** (safety / patient experience): the red 8-minute response performance for March 2025 was 50.32%, remaining below the 65% target, and decreasing slightly compared to February 2025. The Trust is reaching more red patients in 8 minutes, but the denominator (demand) has also grown. The Amber 1 median in March was 1 hour and 53 minutes and the Amber 1 95th percentile was 7 hours 53 minutes. The Clinical Safety Plan and CHARUs will protect red demand, but Amber is where the impact of handover lost hours is felt i.e. there is a strong correlation. These long response times have a known impact on avoidable patient harm. New performance arrangements were announced by the Cabinet Secretary on 11 March 2025 which will come into effect on the 1st of July 2025 and will see the introduction of new purple arrest and red emergency categories alongside an increased emphasis on improving patient outcomes.

11. Traditionally the main factors which affect response times are demand and capacity (recruitment and lost hours). EMS production has been good, 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 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 have been implemented over the winter. Areas of focus include: -

- Data quality issues have been identified with APPs and these are currently being addressed.
- Further investment into remote clinical capacity (+28.5 FTEs) and switching on of remote clinical screening (RCS) (completed);
- Recruiting up to 153 CHARU FTEs (91% UHP achieved in February 2025, benchmark 95%).
- Further investment in APPs (+32 APPs) (26 FTEs achieved);
- Development of the remote integrated care service (111 clinicians and CSD clinicians) (initial development completed as part of winter plan);
- Continued focus on a range of responses that support non-conveyance, where it is clinically safe and appropriate to do so: Connected Support Cymru, mental health response pilot, Falls response etc. (MH pilot live).
- Formal reporting of the 2023 collaborative and independent EMS Demand & Capacity review (reported to F&P Committee, but not yet formally reported to the JCC).
- New Purple Arrest and Red Emergency categories (announced on 11 March 2025).

12. As above, the extreme level of lost hours to **handover outside Emergency Departments** remains the critical component of long waiting times and patient safety incidents. 21,852 hours were lost during March 2025. 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 during 2024, Betsi Cadwaladr health board remains significantly high and just above its two-year average figure, with 8,238 hours being lost within the health board during March. 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.

13. Ambulance Care (Patient Experience): Oncology performance in March 2025 was 74.98%, achieving the 70% target. Renal performance improved to 73.76% which was also above target. Advanced discharge & transfer journey performance however decreased minimally to 78% and remains below its 95% target. Overall demand for NEPTS continues to increase and is now above pre-pandemic levels. The Trust has a comprehensive Health Transport transformation

workstream in place, which includes delivering a range of efficiencies and improvements. The Trust is also about to re-roster NEPTS transport (now started) which will better align available capacity with changing demand patterns (on target).

14. **National Reportable Incidents (NRIs) / Concerns Response**: the Trust reported six NRI's to the NHS Executive in March 2025, slightly less than February 2025 (7) and 33 serious patient safety incidents were referred to health boards under the Joint Investigation Framework. In March 2025 complaint response times increased to 55%, compared to the 52% recorded in February 2025, remaining below the 75% target, with cases remaining complex.

15. **Clinical outcomes**: The percentage of suspected stroke patients who are documented as receiving an appropriate stroke care bundle was 91.6% in March 2025, improving but 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 19.8% in March 2025 compared to 23.9% in February 2025.

16. The Trust can report on call to door times for Stroke and STEMI patients. For March 2025, these highlight call to hospital door times of two hours and 41 minutes for stroke patients and two hours and forty-eight minutes for STEMI. Clearly these times are too long and are representative of the longer response times for all calls, as a result of the pressures and issues outlined in this report.

17. In March 2025, 5,950 patients **cancelled** their ambulance (this figure excludes patients who refused treatment), and the Trust sent alternative transport due to the application of the Clinical Safety Plan to approximately 73 callers. Both of these figures are a significant reduction on January 2025 levels, however an increase from February 2025 totals. This reduction is likely to be the impact of switching on RCS through the winter. The Trust believes that 50% (of the pre-RCS switch on figure) of this combined number is unmet demand and is likely to be presenting elsewhere in the system. Anecdotal evidence from health boards suggests that as the Trust has switched on RCS and as the level of patient cancellations has dropped, so has the demand presenting elsewhere in the system. Caution is required at this stage though as a longer run of data is required in order to properly evaluate the changes made. The Trust changed its Clinical Safety Plan in December, removing the "can't send" application, with the option remaining at the strategic commander's discretion in the new plan.

Our People (workforce resourcing, experience, and safety)

18. **Hours Produced**: The Trust produced 118,812 Ambulance Response unit hours in March2025 and delivered an emergency ambulance unit hours production (UHP) of 91%, dropping below the 95% target.

19. **Response Abstractions:** EMS abstraction levels decreased to 33.86% in March 2025, below the 30% benchmark figure. Response sickness abstractions stood at 7.43% (benchmark 5.99%).

20. **Trust sickness absence:** the Trust's overall sickness percentage was 7.35% in March 2025, an improvement on the 7.93% recorded in February 2025. 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 7.35% is above the 2023/24 IMTP ambition of 6%.

21. **Staff training and PADRs:** PADR rates did not achieve the 85% target in March 2025 but improved slightly to 82.38%. Compliance for Statutory and Mandatory training increased slightly to 87.96% and continues to achieve the 85% target.

22. **People & Culture Plan**: the Trust launched its People & Culture Plan in April 2023 and workstreams are being delivered around behaviours, in particular, sexual safety, Freedom to Speak Up, 111 culture review, flexible working, and the introduction of a staff pulse survey tool. The Executive Leadership Team undertook another round of a pan-Wales of CEO Roadshows in early April 2025.

Finance & Value

23. **Financial Balance**: the reported outturn performance at Month 11 is a surplus of £42k and the Trust is forecasting to achieve both its External Financing Limit and its Capital Expenditure Limit.

Partnerships & System Contribution

24. We are not able to 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 is currently validating new data in this area. A one-off Insight & Data Services consult & close graph indicates that the Trust is now achieving a consult & close rate of +20%. IDS have developed a new consult & close definition that requires Executive and Commissioner sign off before formal reporting can restart.

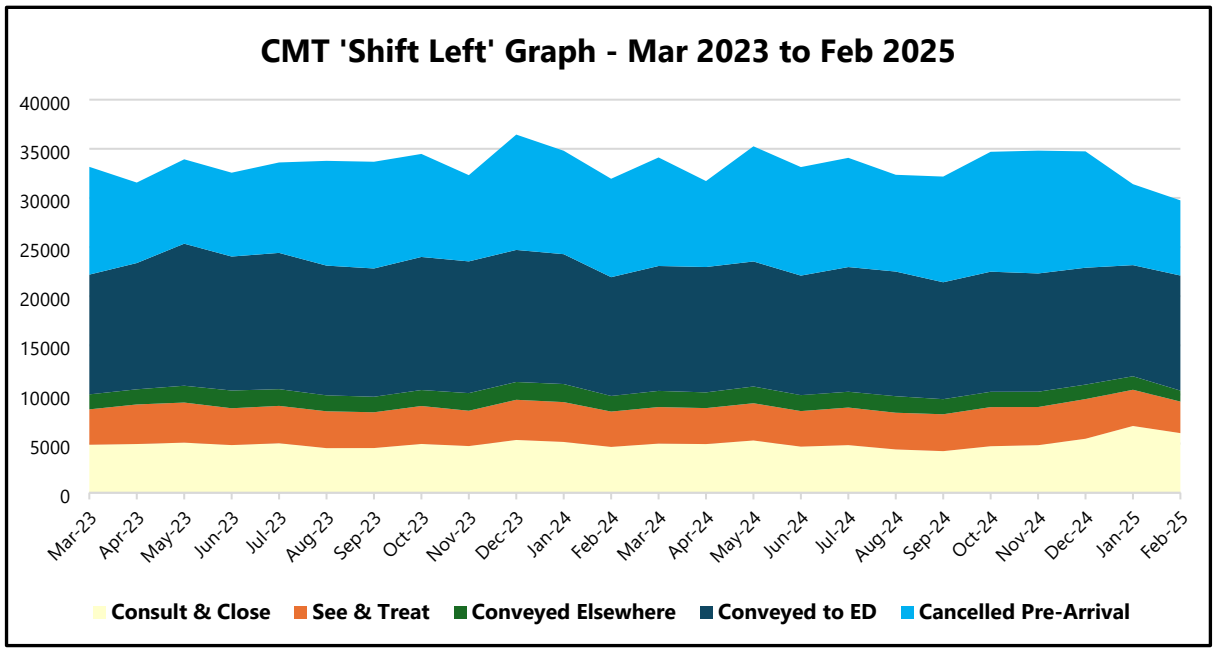
25. Same Day Emergency Care (SDEC) centres continue to only see a low level of ambulance activity and handover levels remain extreme, which makes further transformation of the clinical model a strategic imperative, supported by a

tactical winter plan for 25/26. A winter summit meeting was held with the Cabinet Secretary on 31 March 2025.

Summary

26. The indicators used at this high-level highlight that 111 has been resilient during the winter months, more so than in in previous years. For the 999-emergency pathway, the Trust produced good metrics on what it can control e.g. production, abstractions etc. and managed to turn on new elements of its clinical model transformation programme, which appears to be having a positive effect. However, hospital handover lost hours have increased and remain extreme. These levels give further imperative to continuing with the clinical model transformation. NEPTS performance was stable, with the Trust about to re-roster NEPTS transport.

27. The graph below has been included to show in broad terms what the outcomes (dispositions) are for 999 callers and to track changes. It shows that since December 2024 there has been a drop in the number of patients conveyed to ED and the number of ambulances being cancelled pre-arrival. It also highlights that there has been an increase in the Consult and Close rate over the same period.



RECOMMENDATIONS

QUEST is asked to: -

i. **Consider** the February 2025/March 2025 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

February 2025 / March 2025

Annex 1 – Top Indicator Dashboard

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

Annex 1 – Top Indicator Dashboard
Version 1.0
Released: April 2025

by Commissioning & Performance Team

Section 1: Monthly Indicators / Top Indicator Dashboard

Top Monthly Indicators	Target 2024/25	Feb-25	Mar-25	2 Year Average	RAG
Our Patients					
Timeliness Indicators					
NHS111 Call Handling Abandonment Rates	< 5%	10.1%	11.2%	8.5%	R
111 Clinical Triage Call Back Time (P1)	90%	96.4%	97.5%	97.9%	G
999 Call Answer Times 95th Percentile	00:06	00:33	00:27	00:20	R
999 Red Response within 8 minutes	65%	51.1%	50.3%	49.6%	R
999 Amber 1 Median	00:18	02:00	01:53	01:30	R
Oncology Journeys arriving within 45 mins and up to 15 minutes after appointment time	70%	77.7%	75.0%	72.9%	G
Advanced Discharge & Transfer journeys collected less than 60 minutes after booked time (NEPTS)	90%	80.1%	78.2%	80.0%	R
Clinical Outcomes / Quality Indicators					
Return of Spontaneous Circulation (ROSC)	Increasing Trend	23.9%	19.8%	19.7%	G
Stroke Patients with Appropriate Care	95%	90.1%	91.6%	82.0%	A
Stroke Call to Hospital Door Times	Reduction Trend	02:20	02:41	10.1%	A
ST-Elevation Myocardial Infarction (STEMI) with Appropriate Care	95%	77.8%	70.0%	53.2%	R
National Reportable Incidents reports (NRI)		7	6	4	
Can't Send & Cancelled by Patient Volumes	Reduction Trend	5,815	6,433	8,697	R
Concerns Response within 30 Days	75%	52.0%	55.0%	52.3%	R
Enactment of the Duty of Candour Total		9	6	5	
Our People					
Capacity					
Hours Produced for Emergency Ambulances	95-100%	92%	91%	90%	A

Top Monthly Indicators	Target 2024/25	Feb-25	Mar-25	2 Year Average	RAG
Health & Well-being					
Sickness Absence *(all staff)*	6.0%	7.93%	7.35%	7.84%	R
Mental Health Absence Rates	Reduction Trend	2.68%	2.31%	2.32%	R
Staff Turnover Rate	Reduction Trend	7.98%	8.42%	8.50%	G
Statutory & Mandatory Training	>85%	85.93%	87.96%	77.79%	G
PADR/Medical Appraisal	>85%	79.79%	82.38%	72.96%	A
Number of Shift Overruns	Reduction Trend	3,599	3,839	3,684	R
Inclusion & Engagement / Culture					
NEPTS % of Total Calls Answered in Welsh	Increasing Trend	1.80%	1.90%	1.7%	G
Value					
Financial balance - annual expenditure YTD as % of budget expenditure YTD	100%	100.00%	N/A	100%	G
EMS Utilisation Metric (CHARU)	Increasing Trend	31.7%	30.7%	27%	G
Average Jobs per Shift (All Vehicles)	Increasing Trend	2.55	2.56	2.34	R
NEPTS on the Day Cancellations	Reduction Trend	12.2%	12.9%	13%	R
Partnerships / System Contribution					
Inverting the Triangle					
Successful Consult & Close Outcome	17.0%	N/A	N/A	13.1%	
% Of Total Conveyances taken to a Service Other Than a Type One Emergency Department	Increasing Trend	11.20%	10.48%	11.3%	R
Number of Handover Lost Hours	7,500	18,811	21,852	21,864	R
NHS111					
NHS111 Dental Calls	Increasing Trend	N/A	N/A	7,105	
Consult & Close Volumes by NHS111	Increasing Trend	N/A	N/A	963	

In-Month RAG Indicates =

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

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

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

TBD: Status cannot be calculated (To Be Determined)

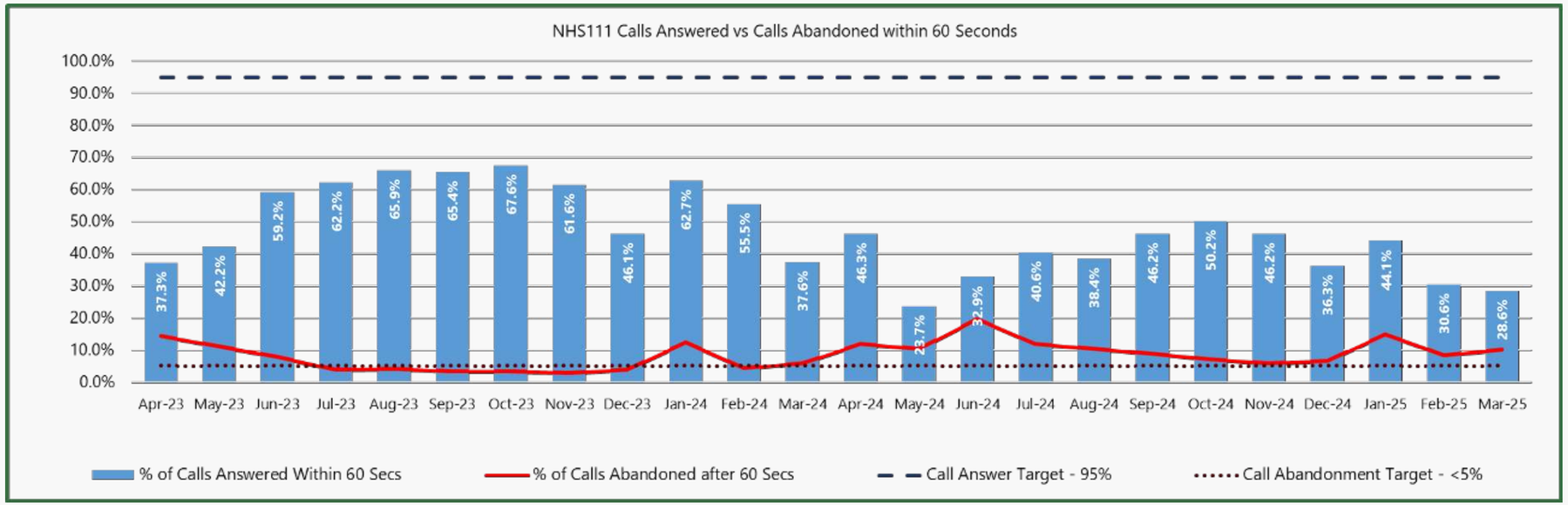
Our Patients: Quality, Patient Safety & Experience
111 Call Answering/Abandoned Performance Indicators

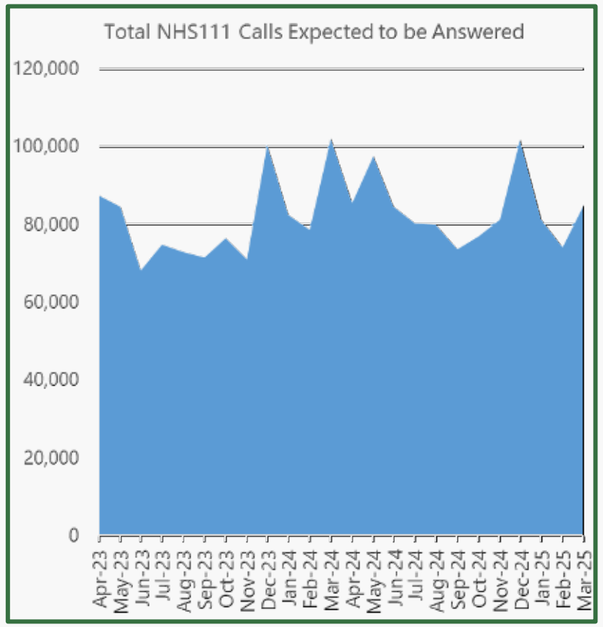
(Responsible Officer: Lee Brooks)

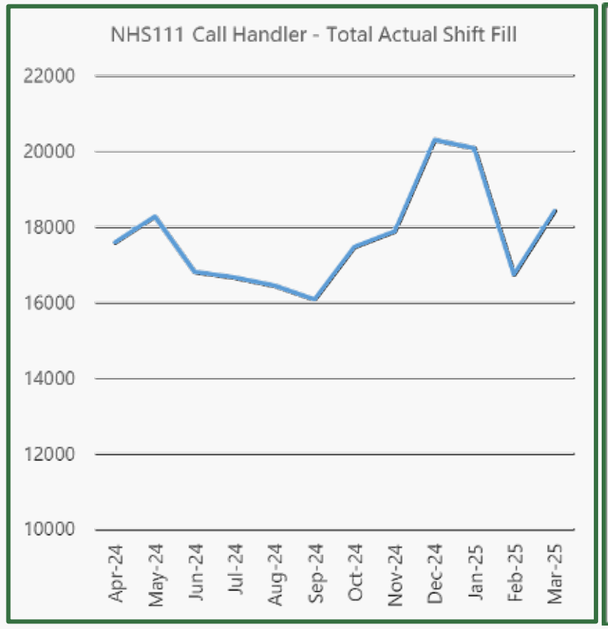
Abandonment Rate: R

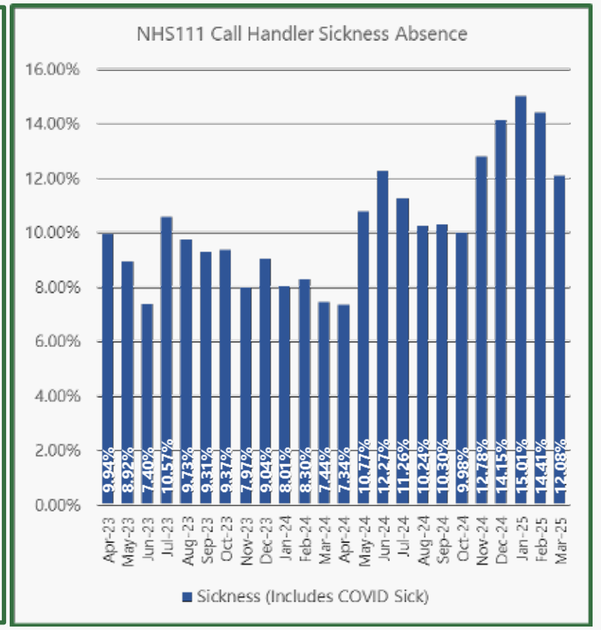
FPC

Influencing Factors – Demand and Call Handling Hours Produced









Analysis

The 111-call abandonment rate increased to 11.2% in March 2025 from 10.1% in February 2025. The percentage of 111 calls answered within 60 seconds decreased, from 30.6% in February 2025 to 28.6% in March 2025 and continues to remain significantly below the 95% target.

Following a decline in performance during the middle part of 2024, due mainly to the introduction of the new 111CAS system, which went live on 30th April 2024, performance did improve during the latter months of 2024, however February and March 2025 have seen a further dip in performance levels. This follows a similar pattern to the last few years, which has seen demand increase during March. This is at a time when UHP capacity for call handlers has reduced slightly, compared to January 2025 and March 2024, and abstraction levels have increased to over 35%.

Remedial Plans and Actions

Key actions include:

- Actions have been undertaken to try and improve the call handling position across the Winter and Spring months with record levels of resourcing seen in December 2024 as well as opportunities for further bolstering including overtime, bank and managers/supervisors also re-aligned to call handling.
- A focus on realising the benefits of the new 111CAS;
- A 111-re-roster pre-work review (underway) 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.
- The 111-re-roster project is also considered a key response to improving sickness levels i.e. more workable patterns.

Expected Performance Trajectory

We might expect to see an improvement in performance in the spring, traditionally a period with lower demand and sickness..

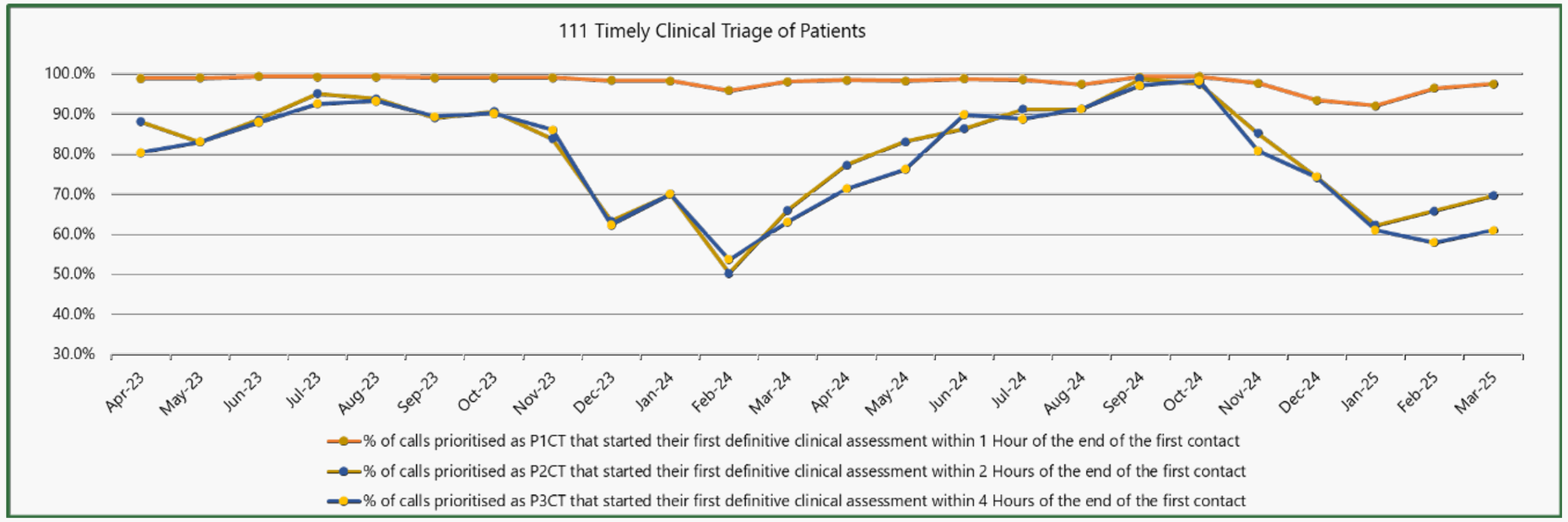
Our Patients: Quality, Safety & Patient Experience
111 Clinical Assessment Start Time Performance Indicators
Influencing Factors – Demand and Clinical Hours Produced

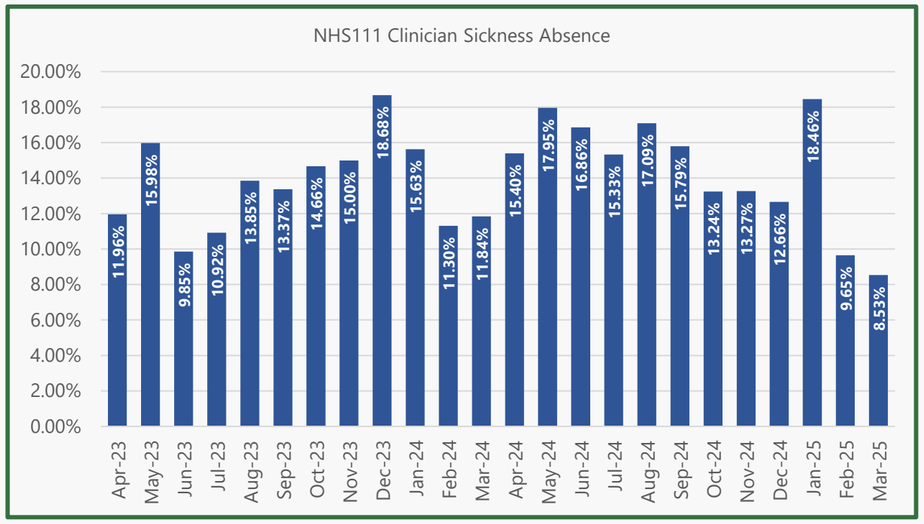
(Responsible Officer: Lee Brooks)

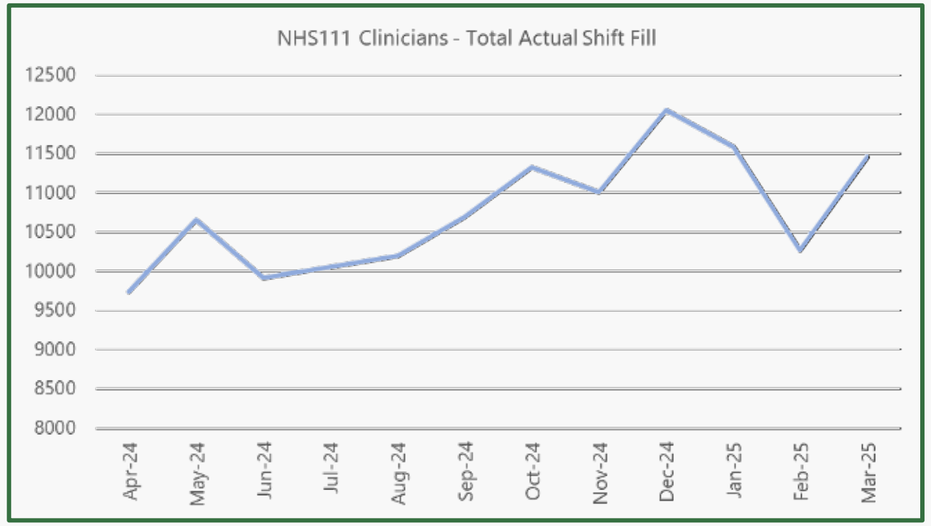
P1CT G

FPC

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 97.5% in March 2025.

Ring back times for lower category calls did decline between October 2024 and January 2025, linked to a higher-than-average level of clinician sickness absence and an increase in demand, but we have seen an improvement over the past two months. If following a similar pattern to last year it is anticipated that these times will improve further over the next few months.

Numbers of clinician hours produced increased last month, rising from 10,268 hours in February 2025 to 11460 hours in March 2025. Clinician sickness absence during March 2025 was 8.53%.

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 review to determine appropriate levels of capacity to meet increasing demand, including rostering practice (review now live).
- This review also considered key to improving clinician sickness absence along with exploring rotation, as part of the Strategic Workforce Plan.

Expected Performance Trajectory

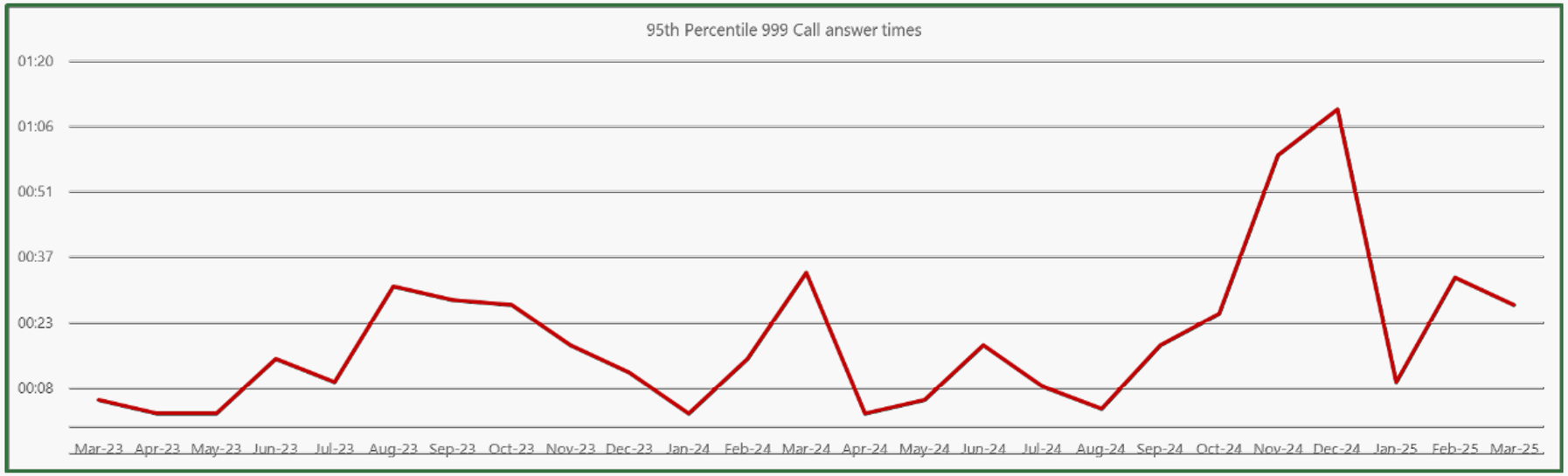
The new 111CAS will bring performance benefits. Initial approach to performance prediction developed, but further work being undertaken to refine the accuracy of the predicter.

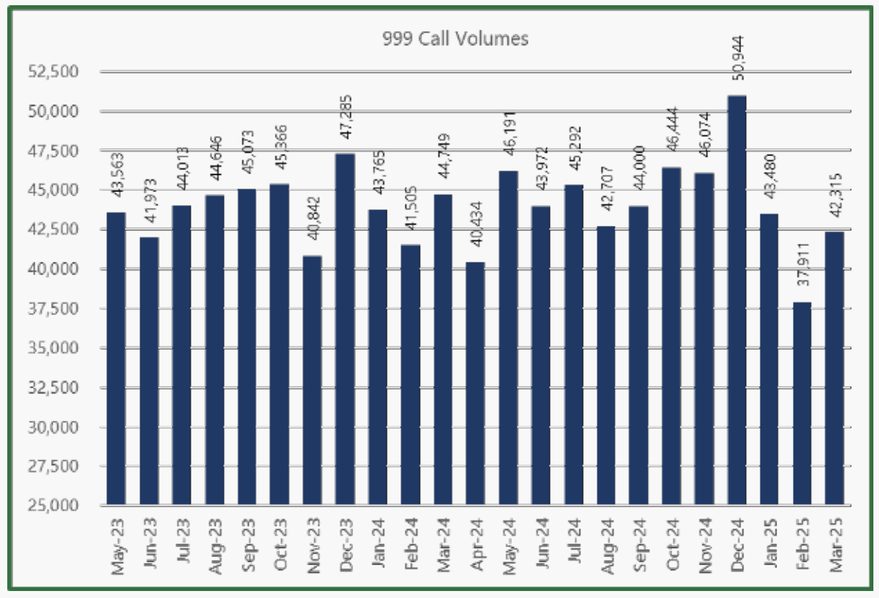
Our Patients: Quality, Safety & Patient Experience
999 Call Performance Indicators

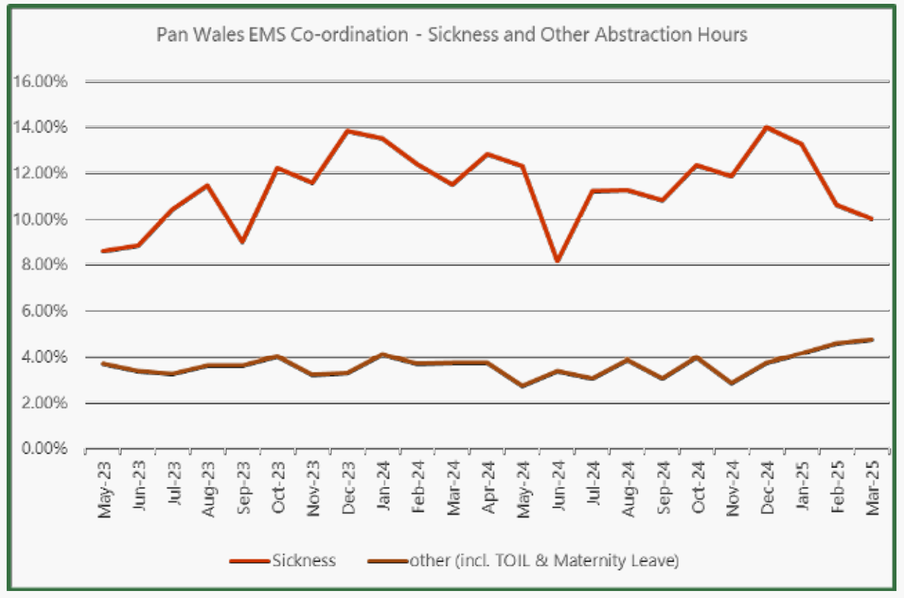
(Responsible Officer: Lee Brooks)

R FPC CI

Influencing Factors – Demand and Hours Produced







Analysis

The 95th percentile 999 call answering performance decreased to 27 seconds in March 2025 and failed to achieve the 6 second target; however, the median call answer time for the 999-service has been consistently good at 2 seconds (October 2024). However, due to the migration of the 999-telephony service, data quality checks are being undertaken for further 2024 data.

There was increase in demand in March 2025 to 42,315 calls from 37,911 in February 2025.

Sickness levels saw a slight decrease from 10.62% in February 2025 to 9.99% in March 2025.

Remedial Plans and Actions

- Will continue to overrecruit for the next few months (as approved by the ADO and the EDoOps) which will also support potential losses from the Bryn Tirion move to Ty Elwy.
- Further recruitment is underway in North, and 3 cohorts started by the end of the fiscal year.
- Work is ongoing to identify what is contributing to high sickness via the Managing attendance at work and attrition via the recruitment and selection processes.

A transformation programme concluded in November:

- **Roster Review.** A dispatch roster review for Allocators and Dispatchers. Complete.
- **Boundary changes.** Realignment of dispatch boundaries to balance workload and pressures for individual dispatch teams. Complete.
- **Broader Ways of Working**. This project is looked 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. Complete.

Expected Performance Trajectory

The median and 65th percentile are performing very well and are stable. Paper currently being drafted on future resilience of EMSC i.e. winter demand v capacity (with efficiencies).

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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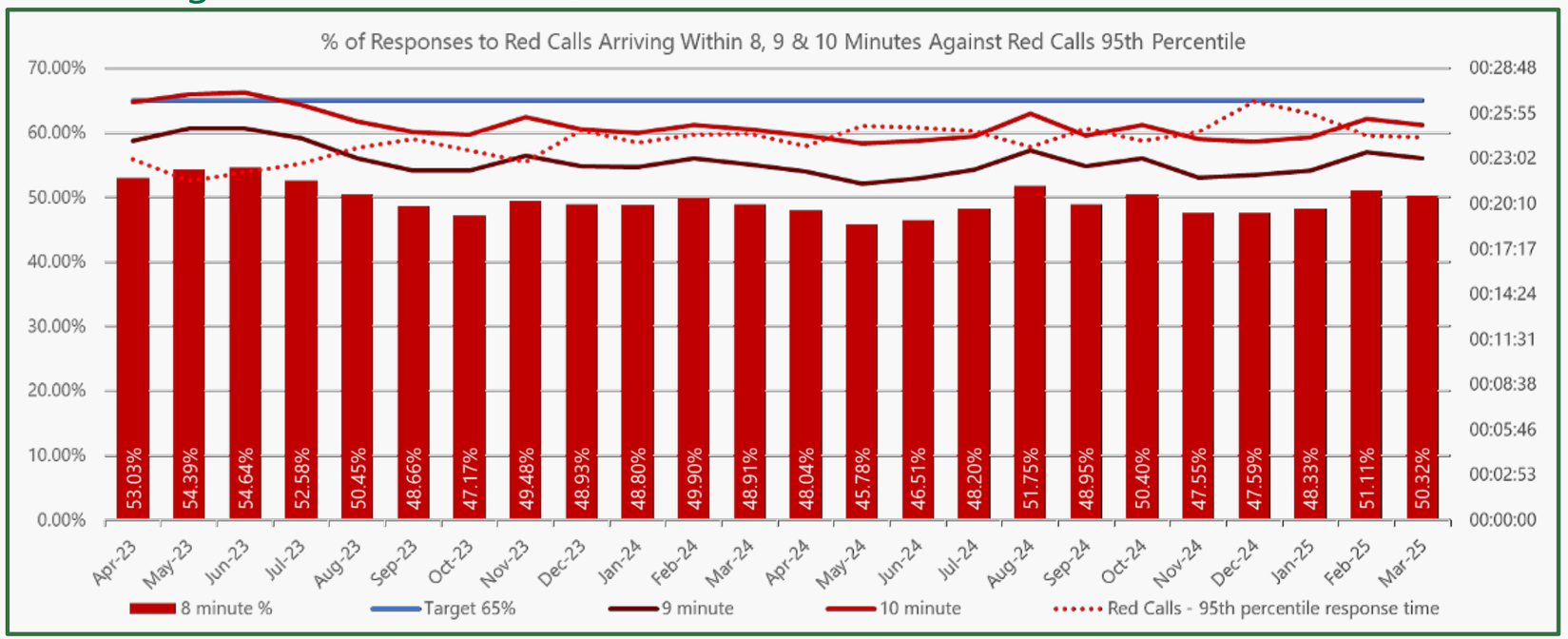

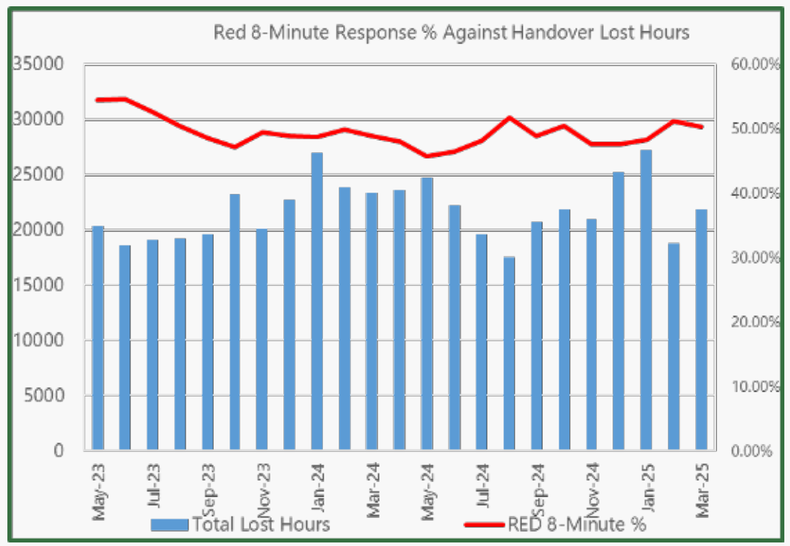

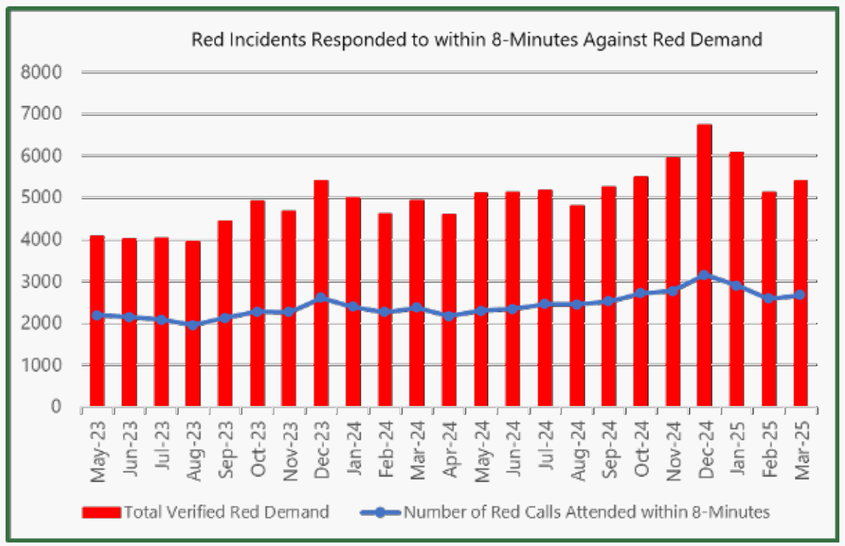

Analysis

Red 8-minute performance continues to remain below the 65% target slightly decreasing in March 2025 to 50.32% from 51.11% in February.

Red 10-minute performance for March 2025 was 61.2%, which is marginally above the 2-year average (61.2%).

One of the main determinants is **red demand**, which has **increased** over the last few years, with red demand in March 2025 being 9.32% higher than that seen in March 2024. As red demand has increased, so too has the number of red incidents responded to within 8-minutes, with the figure for March 2025 of 2677, being 12.76% higher than the figure for March 2024, 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 21852 lost hours in March 2025.

Remedial Plans and Actions

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

- To maintain commissioned establishment in post levels overall: the Trust remains close to achieving its 95% UHP benchmark in March with 91% UHP (all resources);
- Full roll out of the Cymru High Acuity Response Unit (CHARU): the Trust achieved its highest ever CHARU UHP in January;
- The deployment of rapid clinical screening, as outlined in our IMTP (the Trust achieved this); and

Expected Performance Trajectory

On the 11th March 2025 the Cabinet Secretary for Health & Social Care announced that the current Red category will be replaced with a new arrest category and emergency category from 01 July 2025, with the focus moving to measures of the chain of survival and patient outcomes i.e. saving lives, rather than a hit/miss time target.

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

(Responsible Officer: Lee Brooks)

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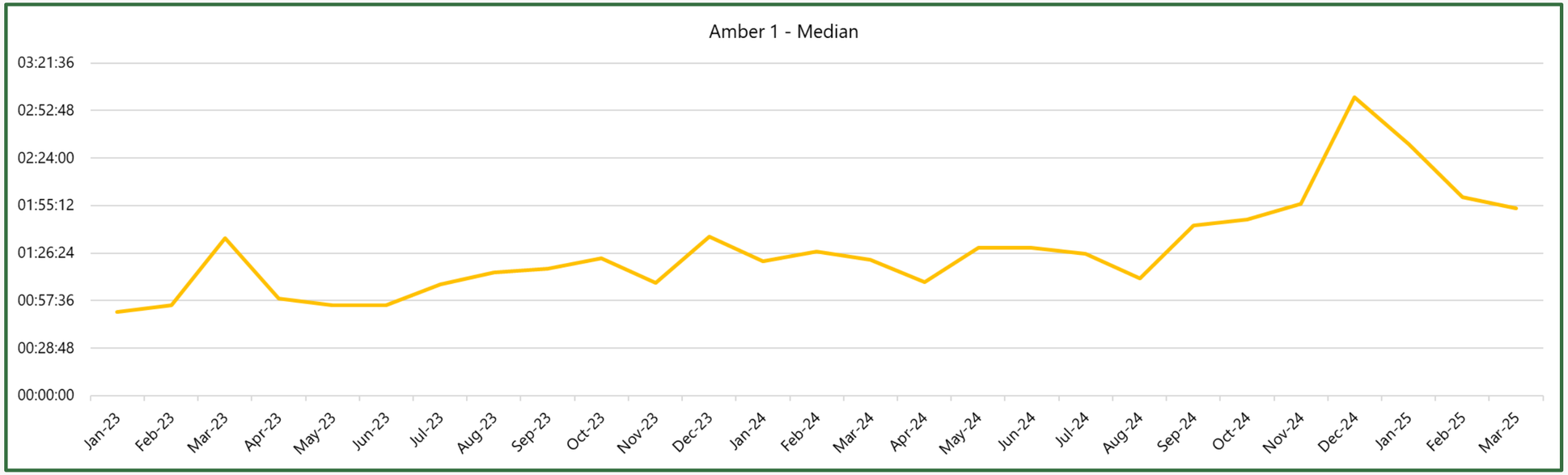
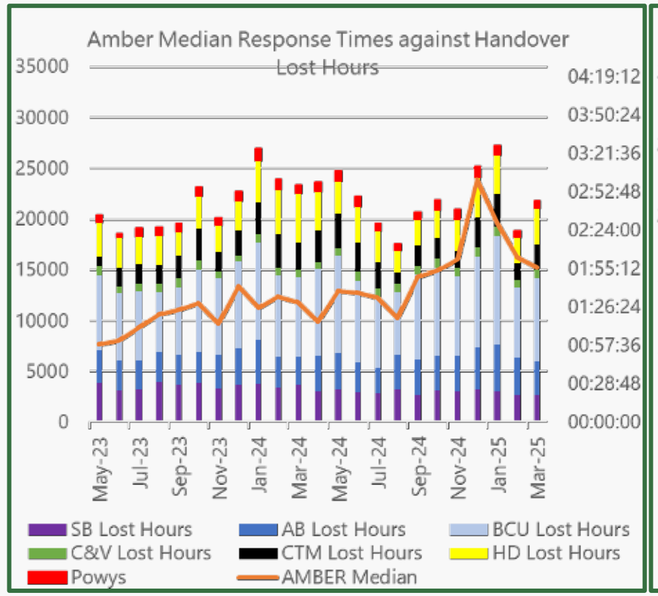
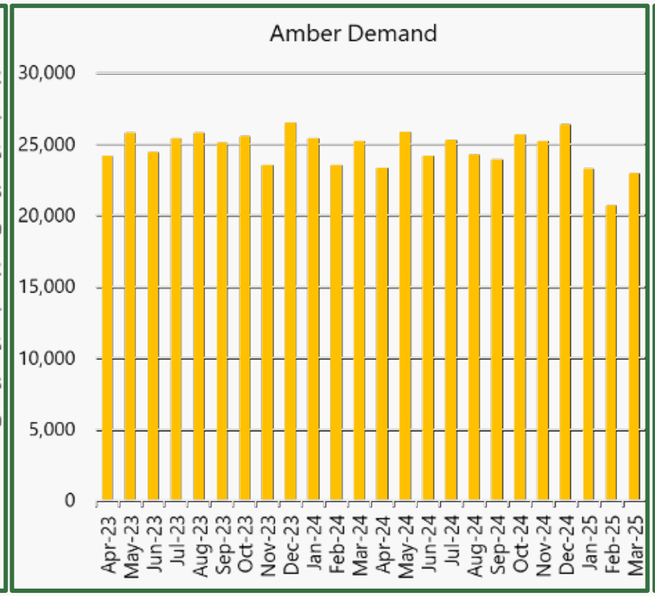
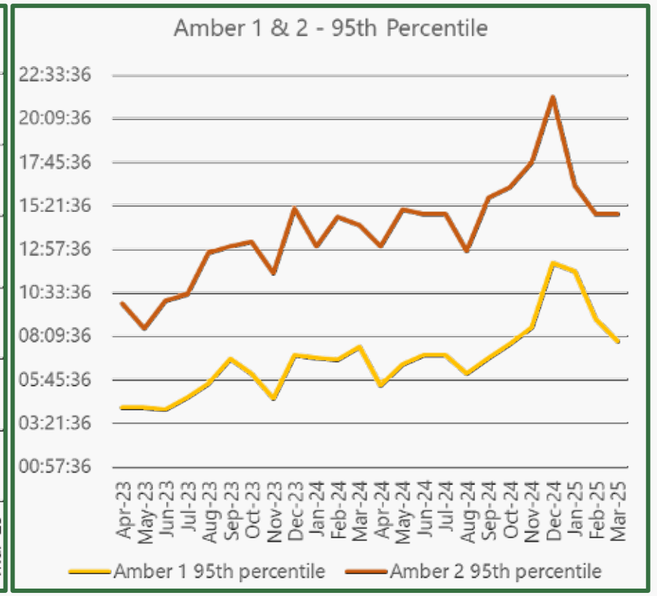
Influencing Factors – Demand, Hours Produced and Hours Lost









Analysis

The Amber 1 median performance time decreased during March 2025 to 1 hour and 53 minutes compared to 2 hours in February 2025. The ideal Amber 1 median response time remains at 18 minutes.

The Amber 1 95th percentile also decreased during March 2025 to 7 hours 53 minutes, down from 9 hours 6 minutes in February 2025. This time remains far too long and remains above the 2-year average figure of 6 hours 54 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. A Welsh Government review of Amber response times is due to start imminently.

Expected Performance Trajectory

The Trust's commissioned level of production (its rosters) is designed to cope with 6,000 hours of handover lost hours. Unless there is a material reduction in handover lost hours and a transformation of the 999 emergency ambulance pathways, the Trust will continue to see long amber waits and avoidable patient harm. Trust expecting to join a WG led meeting on how handover can be reduced to the 6,000 level.

Our Patients: Quality, Safety & Patient Experience

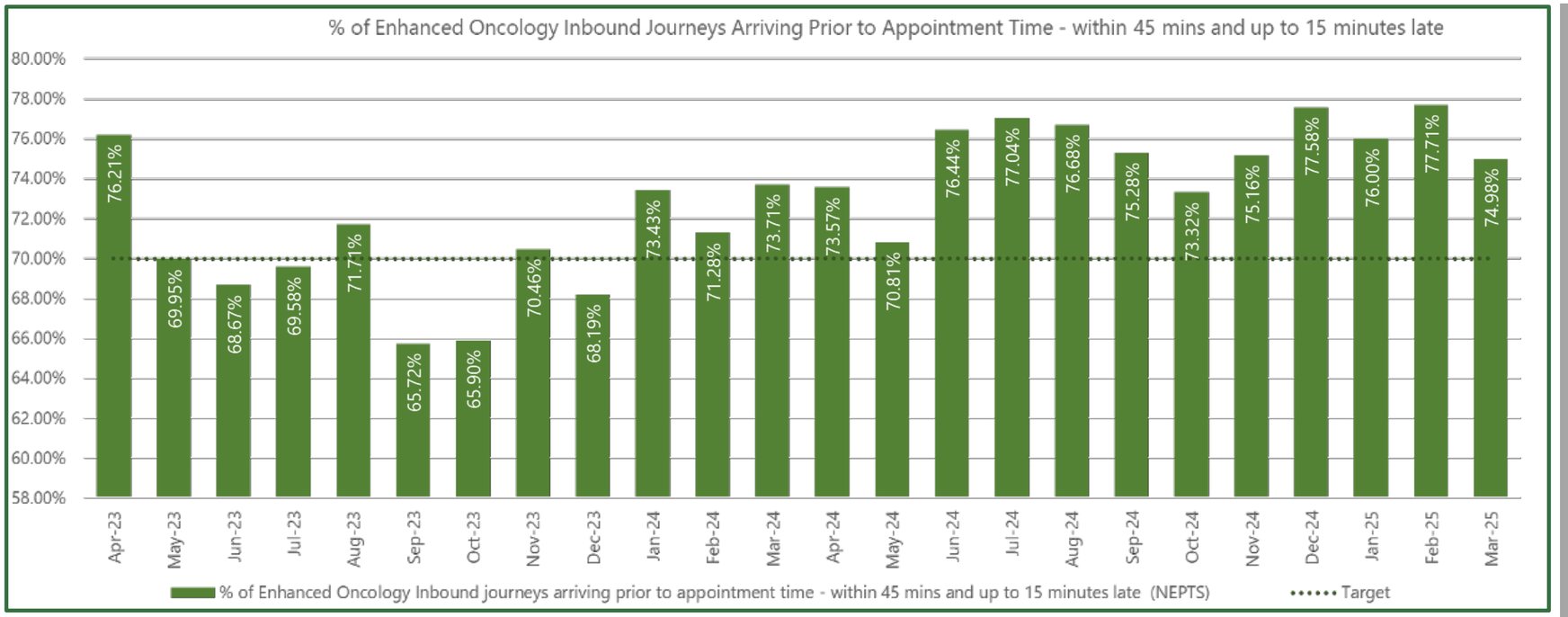
Patient Experience – Influencing Ambulance Care Indicators

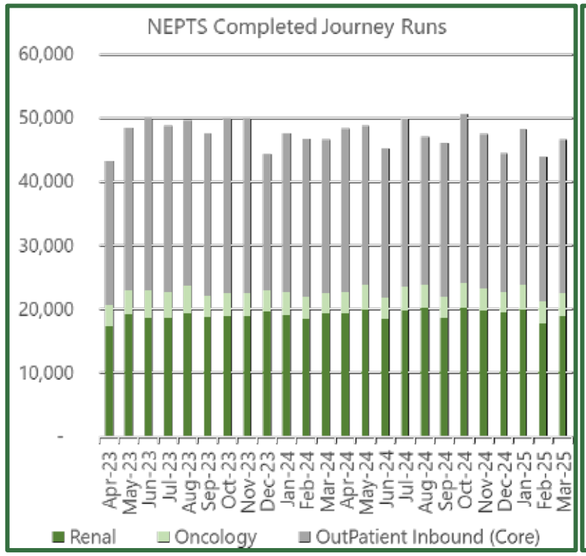
(Responsible Officer: Lee Brooks)

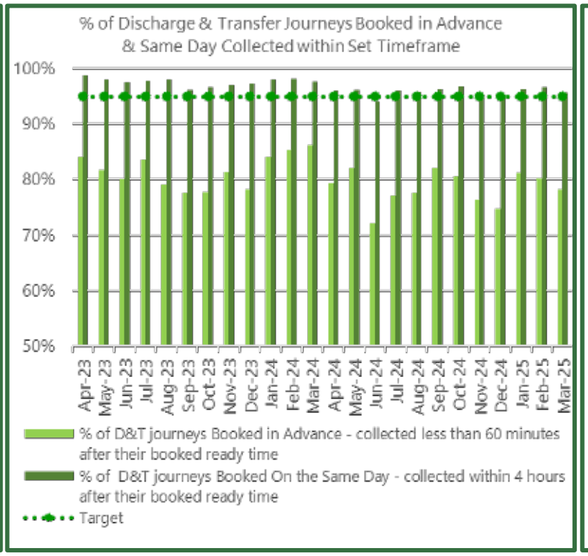
D&T	Oncology	Welsh Calls
R	G	G

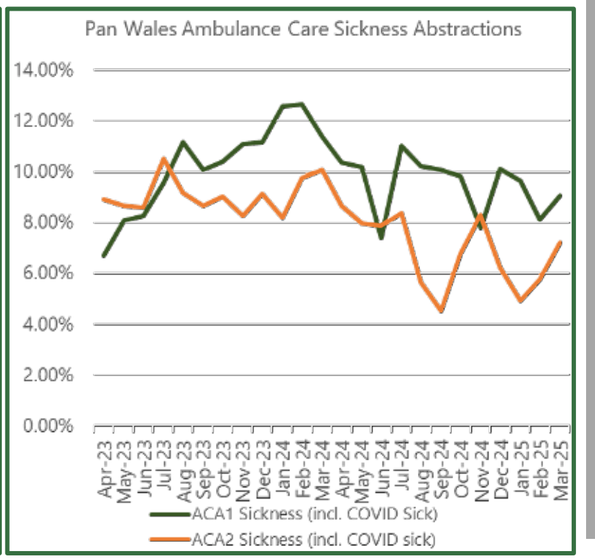
FPC

CI









Analysis

74.98% of enhanced Oncology journeys arrived within 45 minutes prior and up to 15 minutes late of their appointment time in March 2025, once again achieving the 70% target. 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 decreased marginally in March 2025 to 78% but remains below the 95% target.

Enhanced Renal journeys minimally increased for the fourth month in a row to 73.76%, which therefore achieved the agreed performance standard of 70% for only the third time since September 2024.

Call volumes answered increased to 16,389 calls during March 2025, up from 16,237 in February 2025; however, the average speed of call answering decreased from 3 minutes 22 seconds to 7 minutes 52 seconds.

ACA1 sickness remains above the 5.99% target, at 9.04% in March 2025. ACA2 sickness has risen above the target increasing to 7.22% in March 2025.

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 have been finalised based on updated demand with the roster review now commenced.

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

The re-roster, which will take six months to deliver will enable the Trust to reach more patients within the current resource envelope

Our Patients: Quality, Safety & Patient Experience
Clinical Indicators

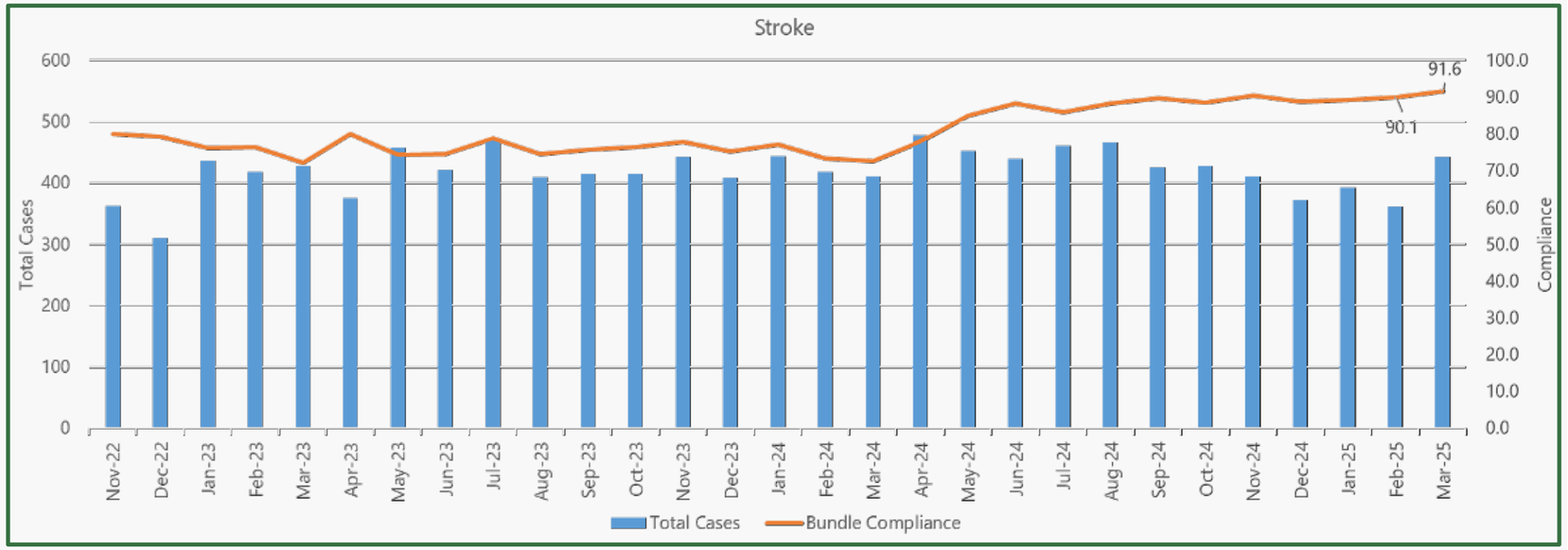
Return of Spontaneous Circulation, Suspected Stroke Patients with Appropriate Care, ST-elevation myocardial infarction (STEMI) with Appropriate Care

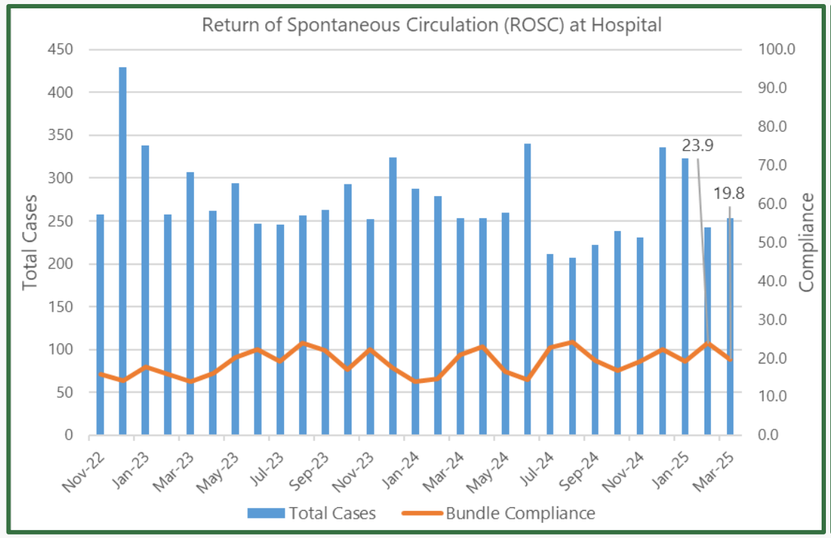
Stroke	ROSC	STEMI
A	G	R

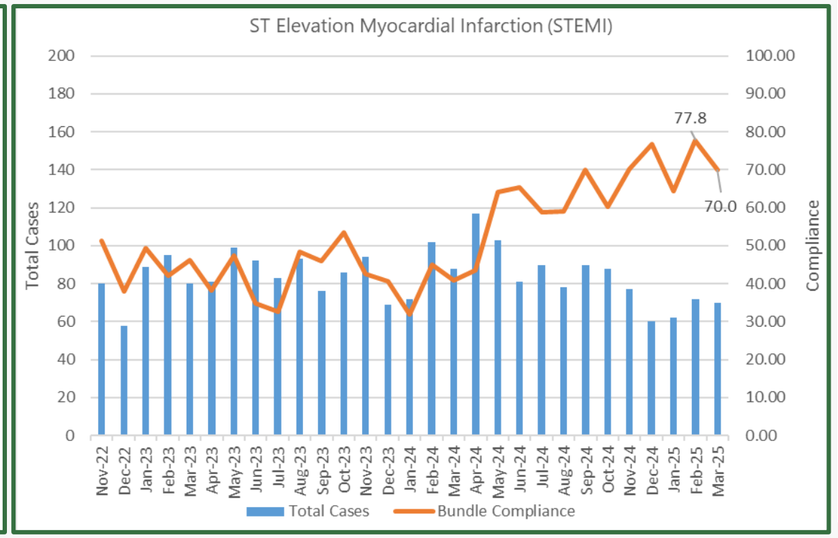
Self-Assessment: Strength of Internal Control: Moderate

QUEST

(Responsible Officer: Andy Swinburn)







Analysis

The percentage of patients documented as receiving appropriate care bundles in March 2025 was:

Stroke – 91.6%, a slight increase from 90.% in February 2025. There is a close correlation between documenting FAST (a test to detect symptoms of stroke) and care bundle compliance.

STEMI (heart attack) – 70%, a decrease from 77.8% in February 2025. There has been a decrease in documenting all criteria in Q1, particularly in the pain score and analgesia components. The number of cases remained low (70) therefore, increasing the volatility of the compliance data so this could be natural variance.

Return of Spontaneous Circulation at hospital (from cardiac arrest) – 19.76%, a decrease from 23.9% in February 2025. An update was made to the ROSC coding scripting which affected the data from July 2024. This resulted in a step change with August 2024 being the highest since ePCR was implemented. A 'nudge' to improve documentation for specific fields including outcome was implemented in October 2024. Months since have continued to see higher numbers of cases in this indicator.

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 are multifactorial and as such it is not possible to identify the specific element.

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 update scheduled for Spring 2025, the impact will be monitored by the Clinical Intelligence & Assurance Group.

Our Patients: Quality, Safety & Patient Experience
Clinical Indicators

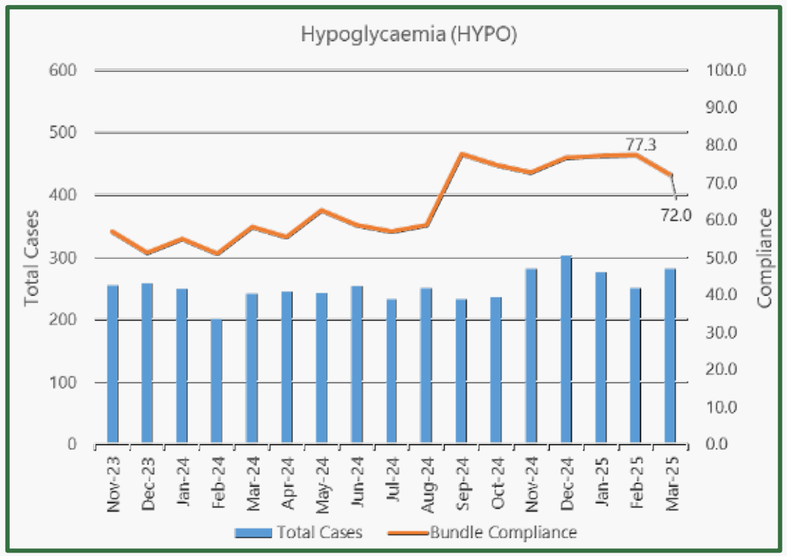
Hypoglycaemia, Fractured Neck of Femur (#NOF) and Time-Based metrics (Stroke & STEMI)

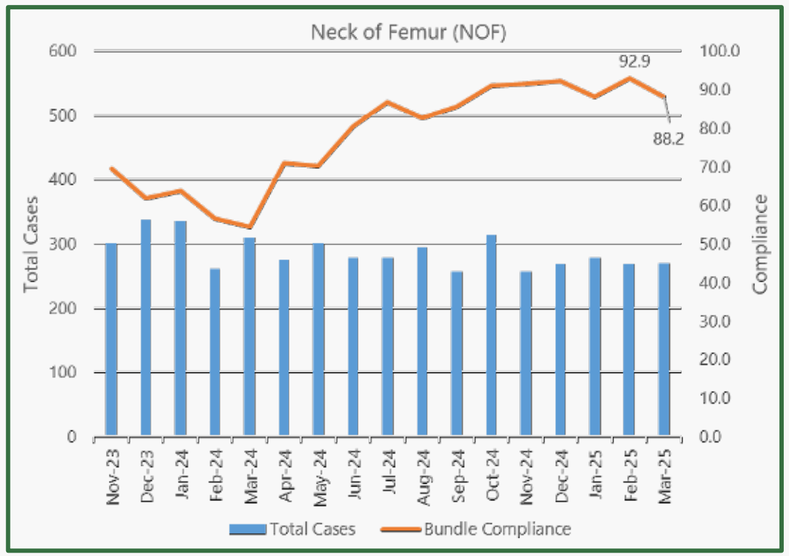
(Responsible Officer: Andy Swinburn)

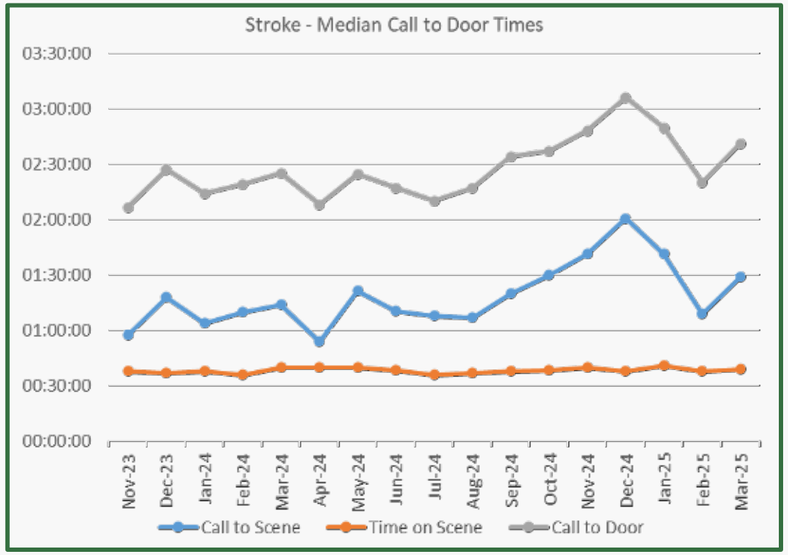
Call to Door
A

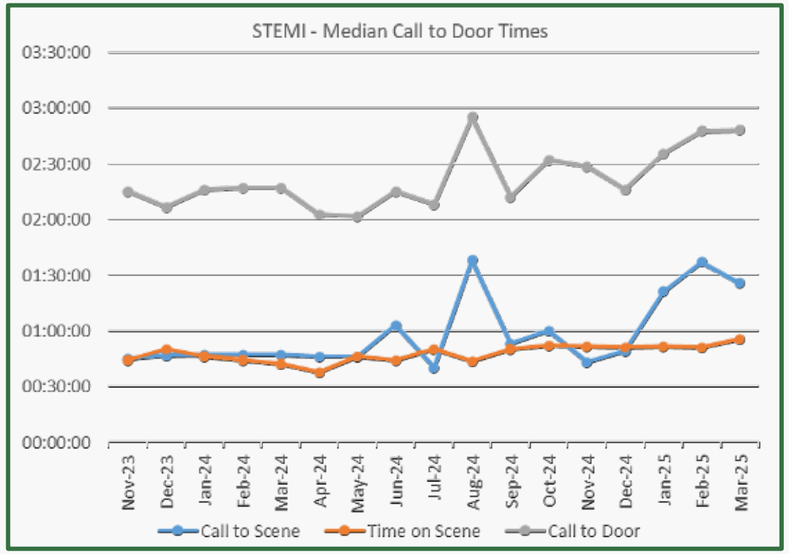
Self-Assessment: Strength of Internal Control: Moderate

QUEST









Analysis

The percentage of patients documented as receiving appropriate care bundles in March 2025 was:

Hypoglycaemia (diabetic patients with low blood glucose) – 72%, a decrease from 77.3% % in February. Compliance has remained quite static but dropping slightly in Q3, although with a slight increase in the number of cases from 251 (Feb 24) to 282 for March. This is likely to be within the natural variation.

Fractured Neck of Femur (hip fracture) – 88.2%, a slight decrease from 92.9% in February. Only a slight increase in compliance this can be attributed to a decrease in the documenting analgesia and vital signs elements.

Call to door times for Stroke and STEMI – Although call to door times extended for STEMI during Q1, the corresponding report for stroke improved with the changes both being attributed to the call to door element of the call cycle. There have been changes in the clinical model in this period and more analysis over an extended period will be required to understand the underlying trend and route cause of this.

Remedial Plans and Actions

- A recovery plan implemented from April – September 2024 and remains BAU monitored through CIAG to maintain the improvements:
- Continued focus on communication with clinicians to use the bespoke electronic Patient Clinical Record fields (in addition to the narrative).
- Provided weekly non-compliant data to support Senior Paramedics conversations with clinicians to improve compliance.
- Promoted Clinical Indicators, care bundles and electronic Patient Clinical Record completion at Health Board area focussed workshops.
- Review of the ePCR interface led by the Digital Directorate.

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
Responses Indicators

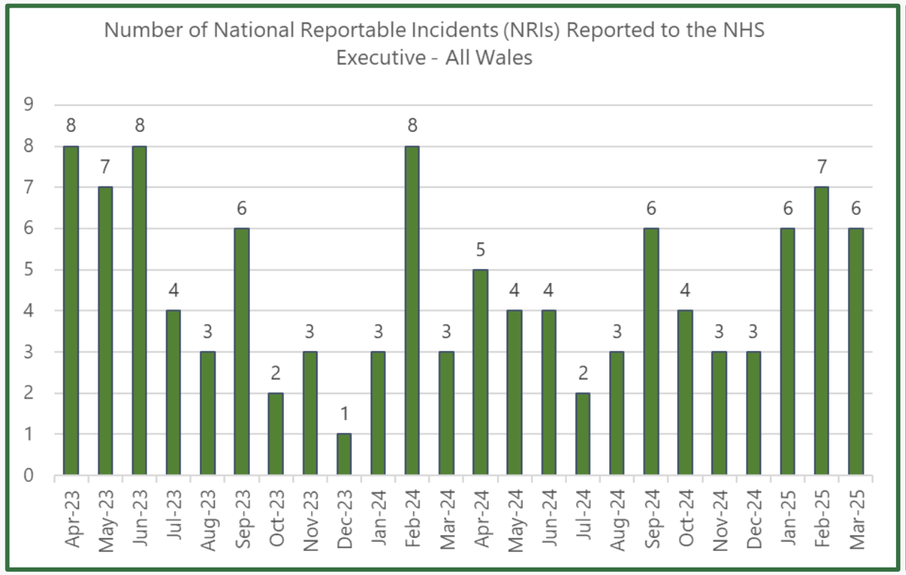
(Responsible Officer: Liam Williams)

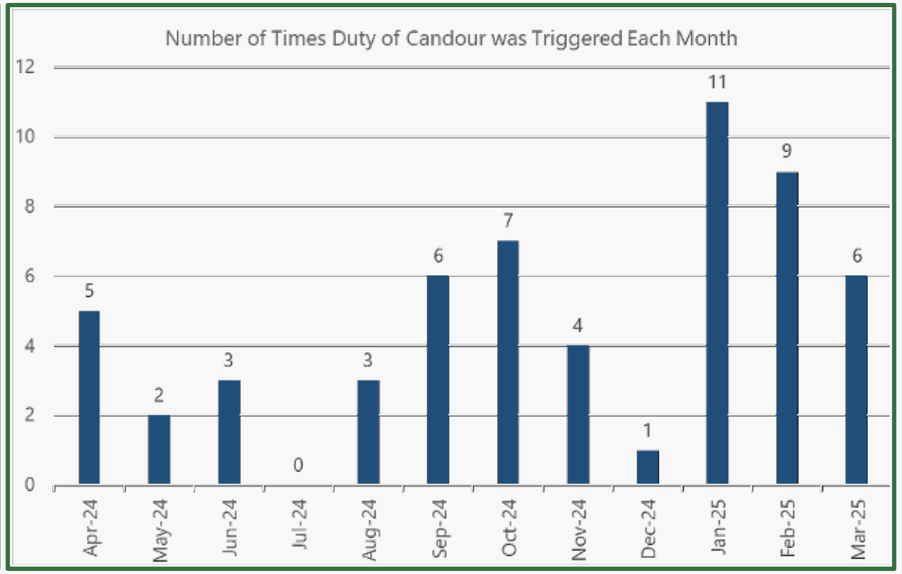
Concerns.
R

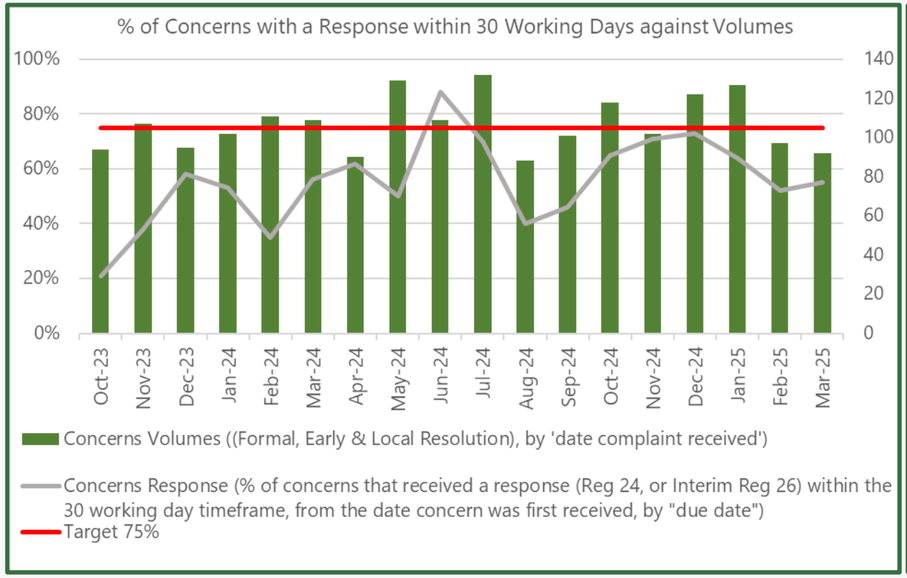
Self-Assessment: Strength of Internal Control: Moderate

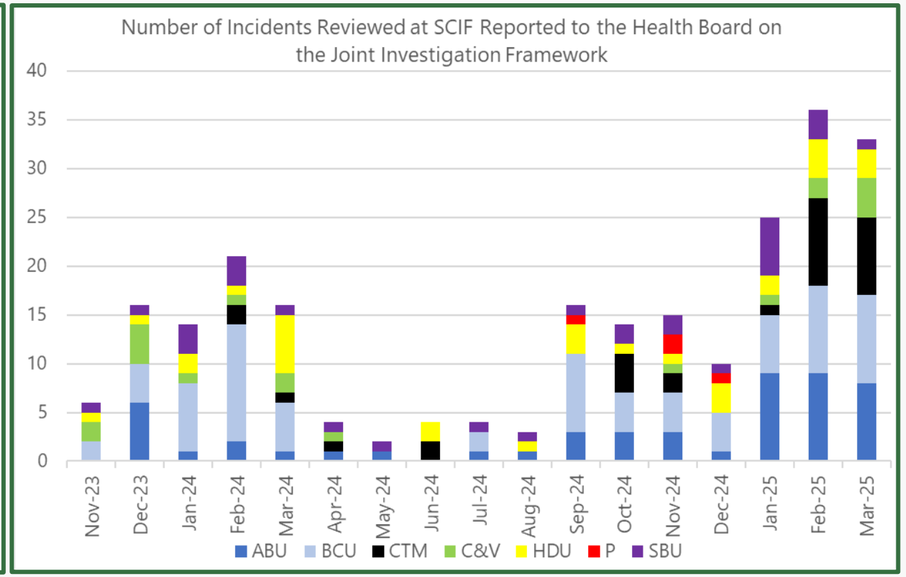
QUEST

Health & Care Standard
Health - Safe Care / Timely Care









Analysis

Compliance with the 30 working day complaints target has improved slightly on last month, however, continues to reflect the challenges associated with increased pressures across the organisation during the winter period. Open complaint volumes have also continued to grow. Challenges in obtaining critical information to complete investigations in relation to information from Clinical Support Desk (CSD) remain.

The number of NRIs reported shows a demonstrable 'winter peak' following a period of Critical Incident declaration and sustained high levels of operational activity. The Trust continues to develop maturity in identifying Moderate harm incidents that trigger the statutory Duty of Candour, in addition to those which meet the threshold for NRI reporting.

Historically high volumes of incidents are being shared with Health Boards under joint investigation arrangements.

Remedial Plans and Actions

- Ongoing monitoring of national incident reporting, enactment of the Duty of Candour and Complaints performance is monitored by team leads on a regular basis.
- All teams are working to achieve national timescales and a benchmarking position comparative to other NHS Wales organisations as visible in the national Quality and Safety dashboard, Beacon.

Expected Performance Trajectory

Operational frontline focus over the winter period is likely to continue to influence complaints performance over coming months. Cross directorate teams continue to work together to expedite the required information wherever possible to conclude investigations, and provide short-, medium- and long-term solutions.

**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

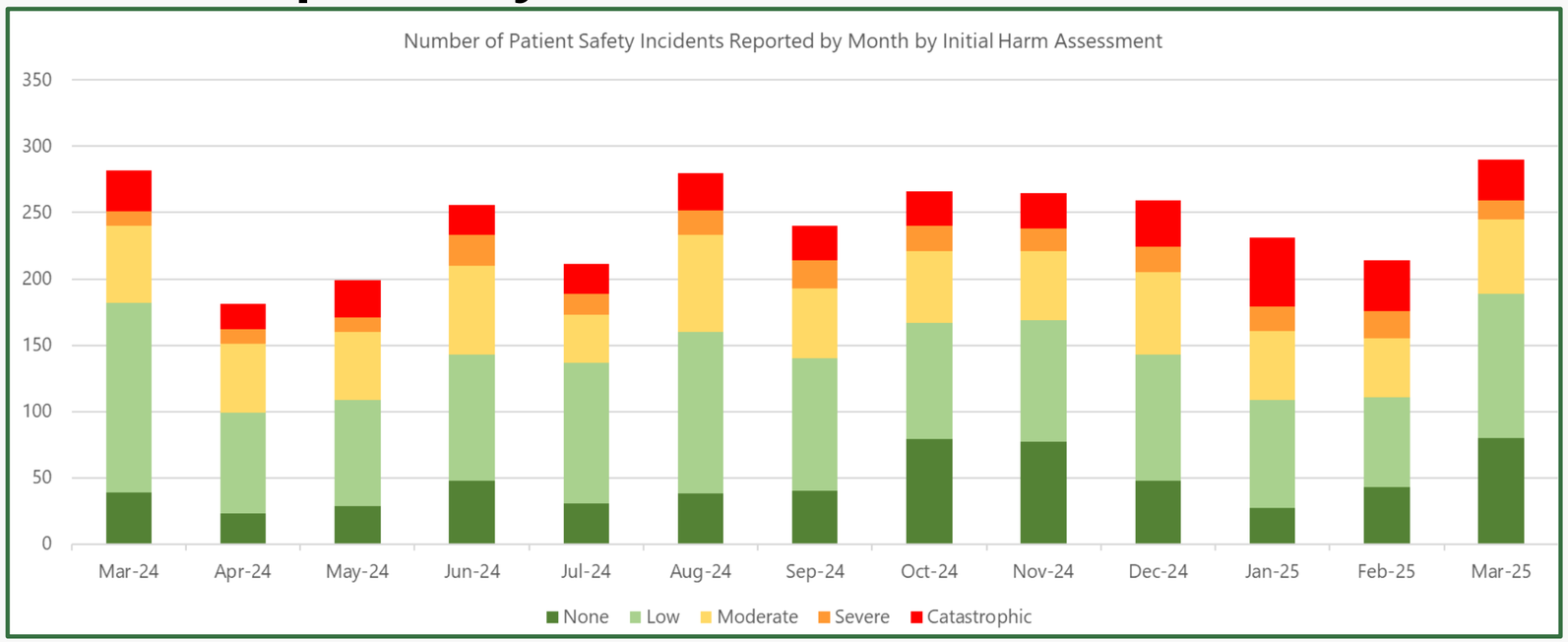
Our Patients: Quality, Safety & Patient Experience
Patient & People Safety Indicators

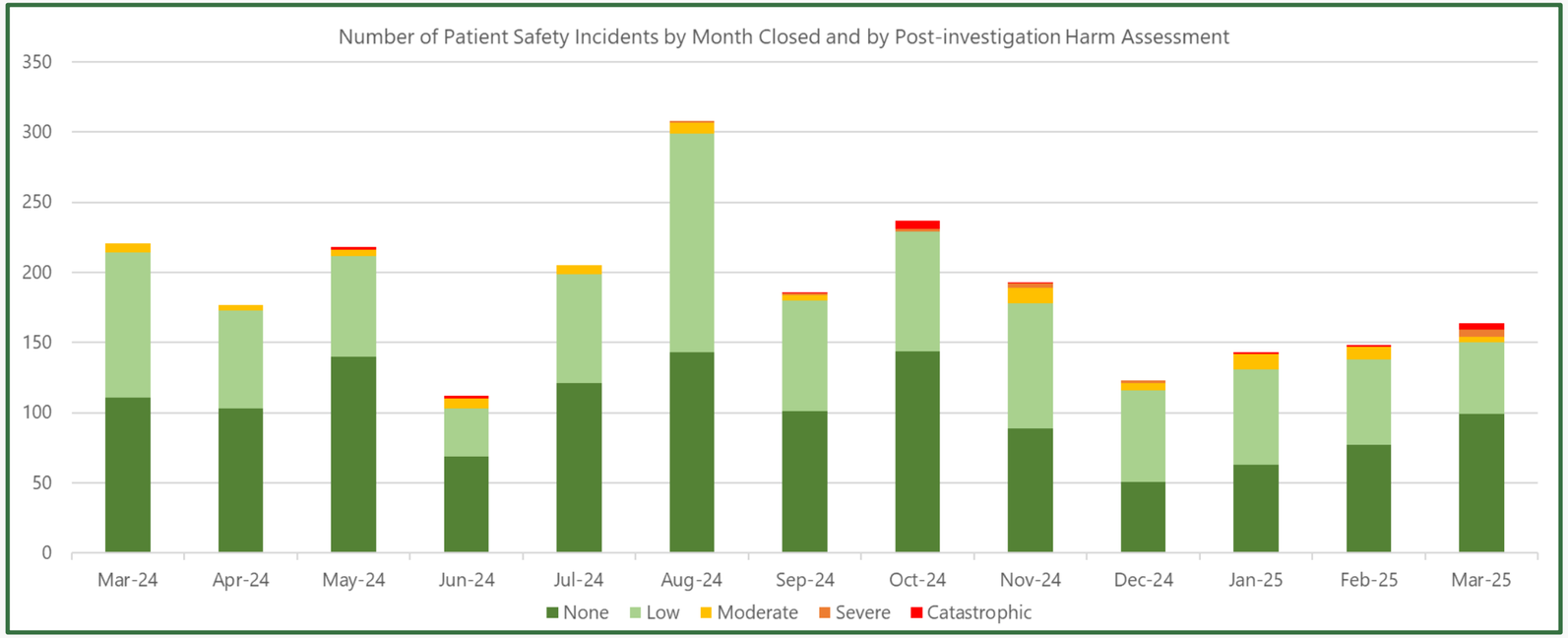
(Responsible Officer: Liam Williams)

Self-Assessment: Strength of Internal Control: Moderate

QUEST

Health & Care Standard
Health – Safe Care





Analysis

Incident reporting volumes have increased since last month to a level comparable to March 2024. Near miss reporting is being encouraged during daily operational meetings to ensure we learn from all opportunities. Closed incidents continue to demonstrate that validated levels of severe or catastrophic harm remain consistently low. NRI's that have been closed with the NHS Executive Wales have improved during the last month.

Monthly volumes should be interpreted with caution as incidents can be duplicated on the system (for example two crews submitting the same incident); however, the introduction of the Rejection SOP by the Quality Team has reduced the risk of duplication. Incident volumes include those reported internally by WAST staff, but also those reported by Health Board colleagues about WAST services or care.

Harm levels for March 2025 were: -

- No harm or hazard - 80
- Low - 109
- Moderate - 56
- Severe harm - 14
- Catastrophic/Death - 31

Remedial Plans and Actions

- Incident management culture is being supported through newly established Datix User and Datix Governance Groups (Datix Cymru is the electronic reporting software for incident reporting).

Expected Performance Trajectory

Incident volumes and harm levels are being closely monitored and triangulated with other sources of intelligence related to Clinical Model Transformation changes.

Data source: Datix

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

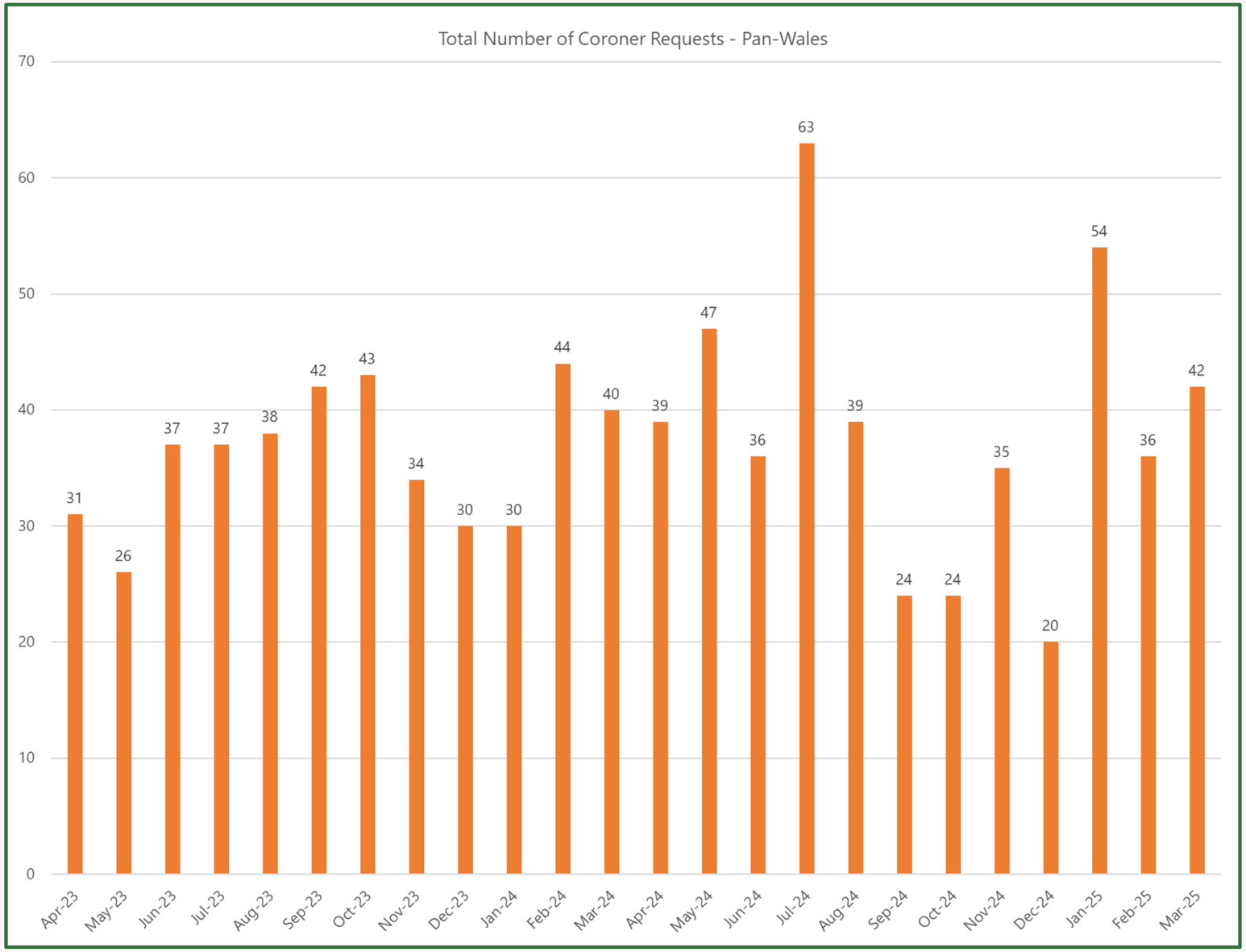
(Responsible Officer: Liam Williams)

Coroners Self-Assessment: Strength of Internal Control: Moderate

Mortality Self-Assessment: Strength of Internal Control: Moderate

QUEST

Health & Care Standard
Health – Safe Care



Mortality Reviews Data source: Internal Web Application

Analysis

The number of coroner approaches continues to bring a high level of activity to the Trust. Inquest cases continue to present with increased complexity and large numbers of statements and witnesses being called. It is noticeable that many requests are accompanied by short timescales. Challenges to meet deadlines, in particular those in relation to EMSC with Clinical Support Desk involvement, continue to require extension of deadlines.

The Trust continues to mature its Learning from Mortality approaches, through a quarterly meeting on thematic learning, weekly triage of Medical Examiner referrals and fortnightly learning panels for Medical Examiner feedback.

Mortality - Following the publication in May 2024 of the All-Wales Learning from Mortality Reviews Model Framework (Second Edition) (the Framework), the Trust has established an effective clinical governance structure to discharge all 5 levels of the Framework.

226 referrals were received from the MES between 1st October 2024 and 31st March 2025. Cases are triaged promptly at Level 1 with 26 cases have been triaged as requiring further review and investigation under the PTR guidance. Level 2 Medical Examiner Learning Panels will now run at increased frequency to address cases awaiting review.

There is a decreasing number of Medical Examiner referrals since April 2024 which is believed to be due to relational work undertaken with other health bodies to reduce the duplication of cases.

Remedial Plans and Actions

- Additional temporary resource in the Legal Services team is supporting the management of inquest coordination and activity across the Trust.
- Operations Quality have provided estimated completion dates for coronial deadlines, which will provide some assurance and expectations of completion dates to the coroner.

Expected Performance Trajectory

Coroner activity will continue to be monitored and delays in statement gathering escalated and prioritised internally as appropriate.

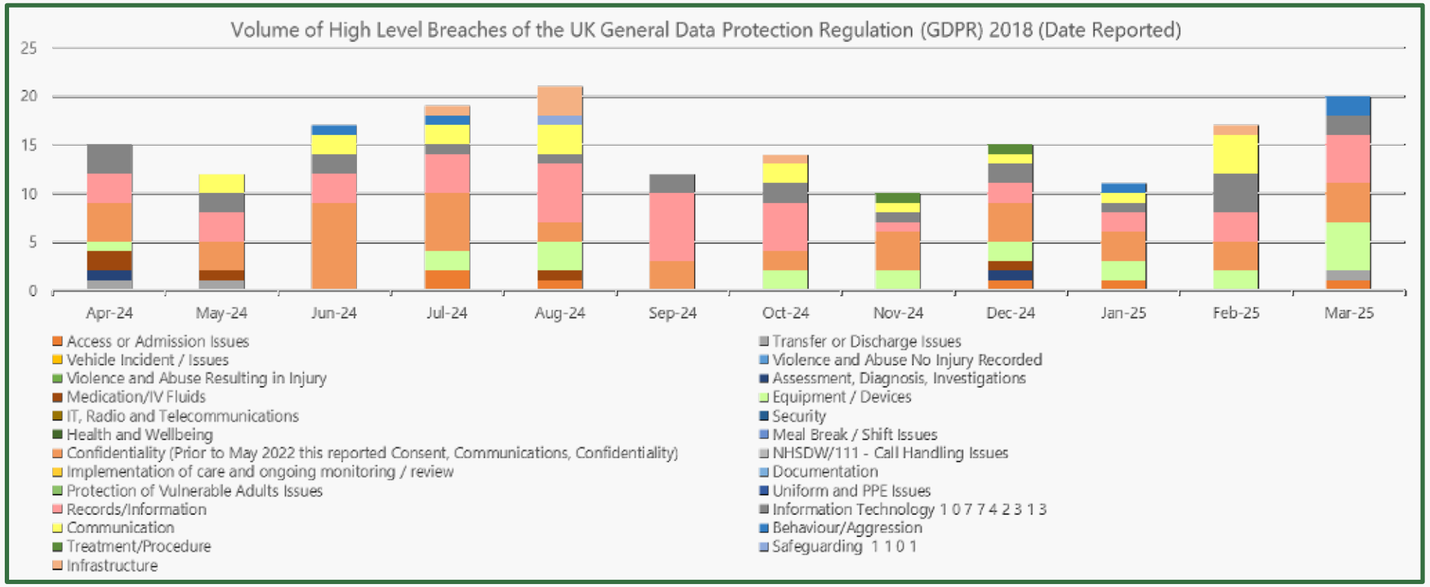
Our Patients: Quality, Safety & Patient Experience Safeguarding, Data Governance & Public Engagement Indicators

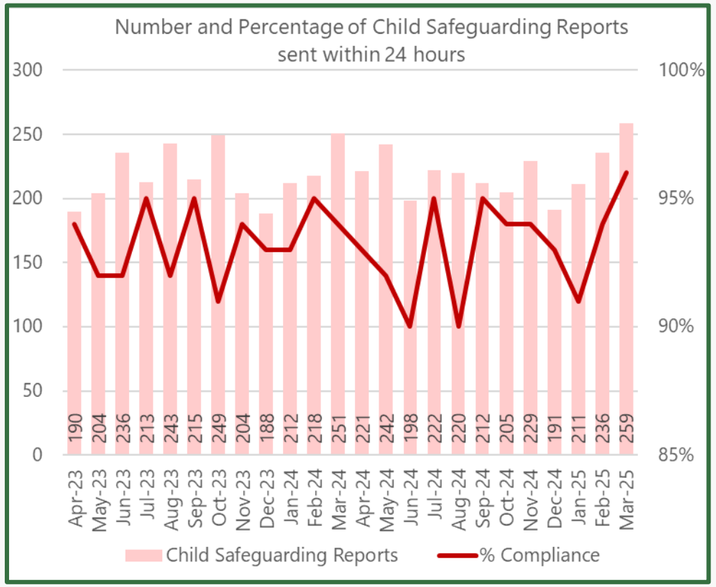
(Responsible Officers: Jonny Sammut & Liam Williams)

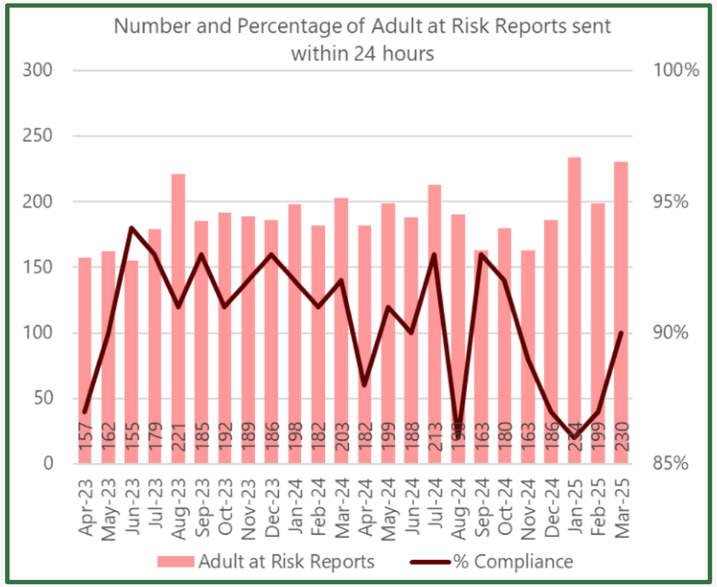
Health & Care Standard
Health – Safe Care

Self-Assessment: Strength of Internal Control: Strong

PCC







Analysis

Safeguarding: In March 2025 WAST colleagues submitted a total of 230 Adult at Risk Reports, 90% of these were processed within 24 hours. Whilst the Trust does not report on Adult Need for Care & Support reports (wellbeing); 719 reports were shared with local authorities across Wales during this reporting period. There were 259 Child Safeguarding Reports submitted in March 2025, 96% of these were processed within 24 hours.

Data Governance: In March 2025, there were 20 information governance (IG) related incidents reported on Datix Cymru categorised as an Information Governance (IG) breach. Of these 20 breaches, 5 related to Equipment / Devices, 5 Records/Information, 4 IG/Confidentiality, 2 IT, 2 Behaviour/Aggression, 1 Access/Admission, and 1 Transfer/Discharge.

Public Engagement: During March, PECI attended 34 community engagement opportunities, engaging with approx. 430 people. This included attending Newport 50+ Forum, a Women's Health event hosted by BCU Health Board, a BME Young People's Group hosted by EYST, Swansea LGBTQ+ Forum and Barry Veterans Group.

Remedial Plans and Actions

Safeguarding: The Trust manages all safeguarding reports digitally via Doc-works Scribe and regular monitoring of the system by the Safeguarding Team provides a means to identify any problems with delayed reports with appropriate action taken to support WAST colleagues. Only minimal paper safeguarding reports are now received, they are used as a back-up.

Data Governance: During the reporting period, of the 20-information governance related incidents reported on Datix, no incidents were reported to the Information Commissioner's Office (ICO). The IG Team continues to monitor, and review reported incidents where applicable.

Public Engagement: Community involvement and engagement with patients/public forms an integral part of the Trust's strategic transformation ambitions to deliver value-based healthcare evaluated against service users' experiences and health outcomes. The PECI Team will continue to engage in an ongoing dialogue with the public on what they think could be done to improve services.

Expected Performance Trajectory

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

Data Governance: The IG Toolkit submission was completed on 31st March 2025.

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

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

Safeguarding Data source: Doc Works

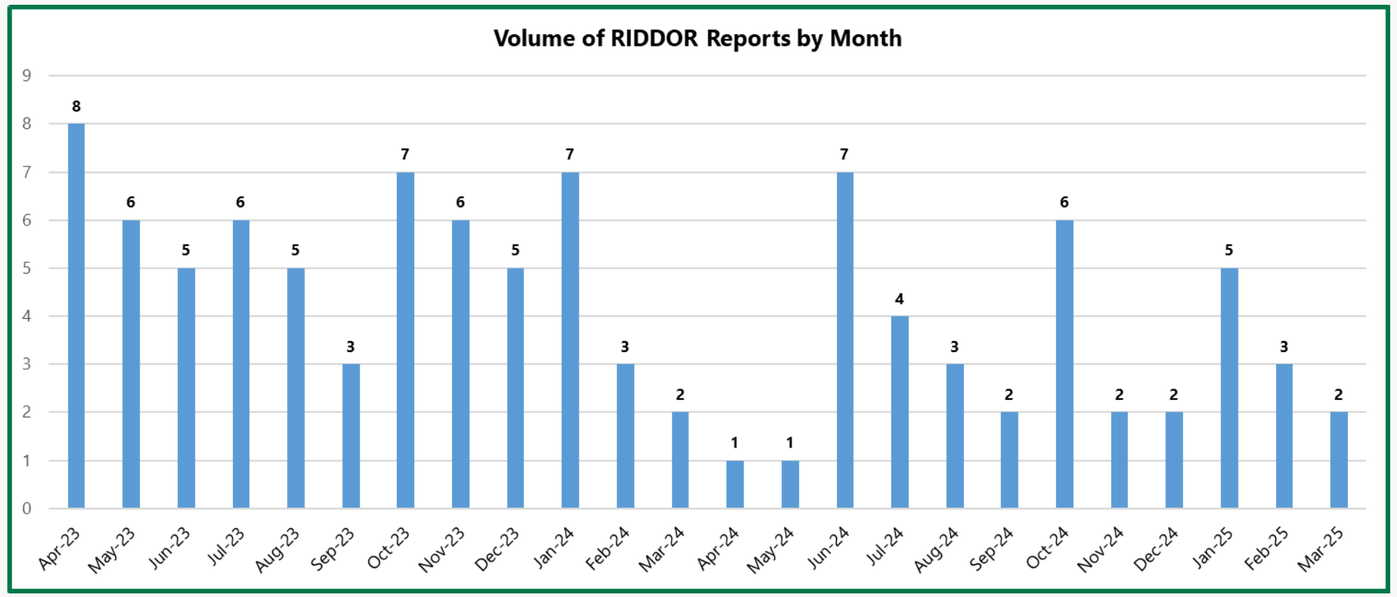
Our Patients: Quality, Safety & Patient Experience
Health & Safety (RIDDORS) Indicators

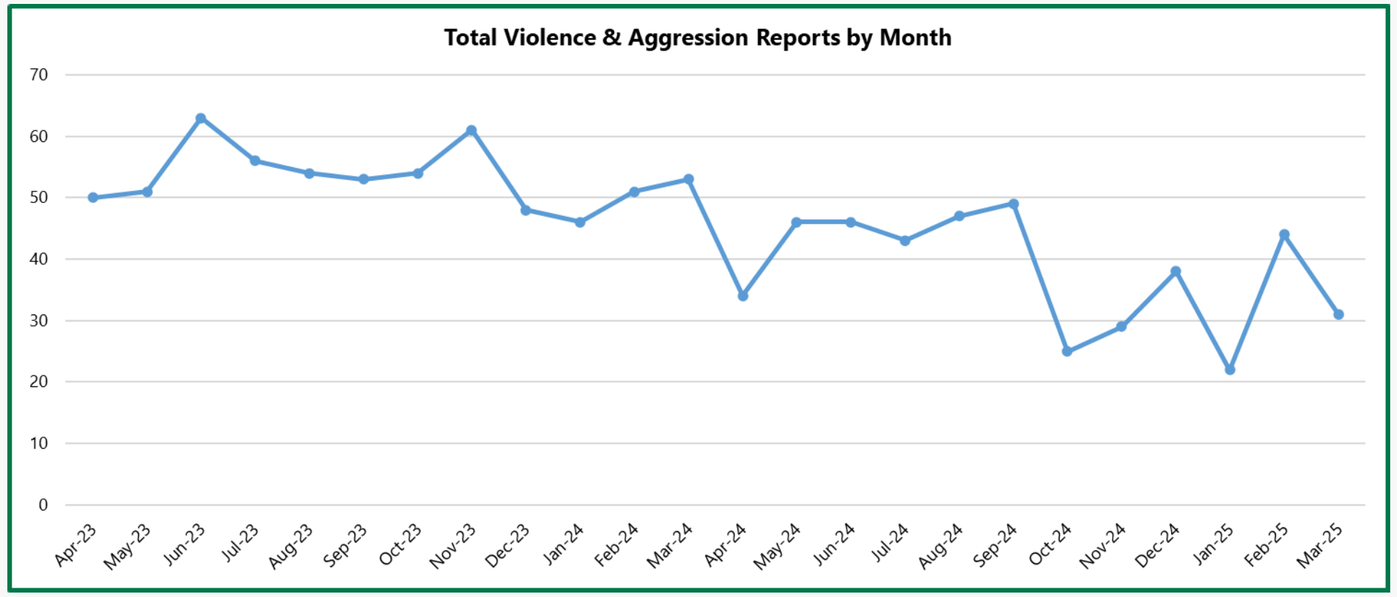
(Responsible Officer: Liam Williams)

Self-Assessment: Strength of Internal Control: Moderate

PCC

Health & Care Standard
Health – Safe Care





Analysis

RIDDOR: There were 2 incidents requiring reporting under RIDDOR during March 2025.Both were for an injuries requiring over 7 days of work

100% of the RIDDOR's were submitted within the HSE reporting timelines due to good working relationships with the H&S and Operational Teams.

1 over 7- day injury was due to fall over patients' items left at place of treatment
1 over 7-day injury was to staff members patella due to stepping on even ground.

Violence and Aggression: A total of 31 incidents have been reported of V&A in March.
6 Physical Assaults on staff were reported during the month with 25 incidents of verbal abuse
6 incidents were reported as Moderate in harm and 15 noted as low harm with 1 case being reported as causing severe harm.

The number of verbal assault incidents increased significantly during the month with aggressive and threatening behaviour accounting for 25 of the 31 incidents.

- The number of V&A incidents reported in March has decreased with 31 incidents for the month compared to 44 for the previous month.
- Toolbox talks, raising awareness of case management support are taking place across the Region by the V&A Team to support staff and raise awareness.
- Verbal abuse continues to be the major category of reporting received with aggressive and threatening behaviour toward staff still at high levels.

Remedial Plans and Actions

RIDDOR: A weekly Datix incident meeting is being used to identify RIDDOR reportable incidents and assign a Safety Advisor to assist with the investigation and reporting to the HSE.

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

Expected Performance Trajectory

RIDDOR: As the weather improves over the coming months there us expected to be a lower number of slip and trip incidents reported due to improvement in ground conditions at patient properties.

Violence and Aggression: The number of verbal assaults is expected to rise over the coming months as staff become more confident in the support provided by the V&A team.

Data source: Datix

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

(Responsible Officer: Andy Swinburn)

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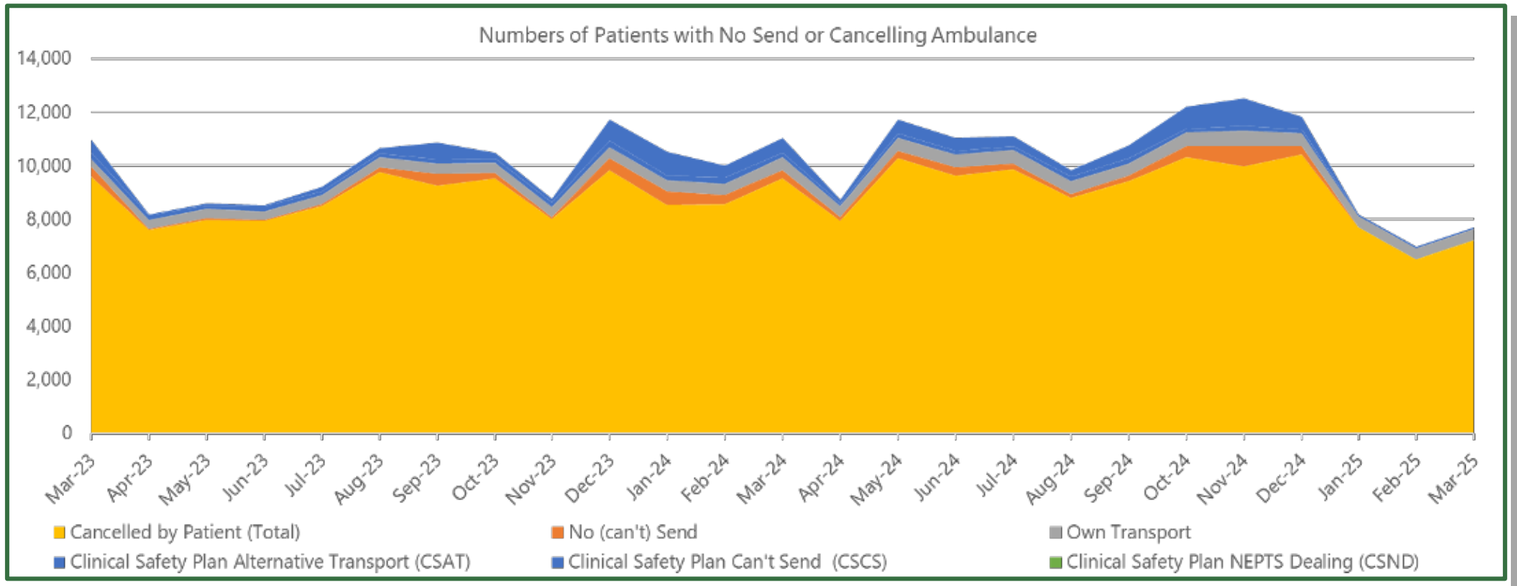

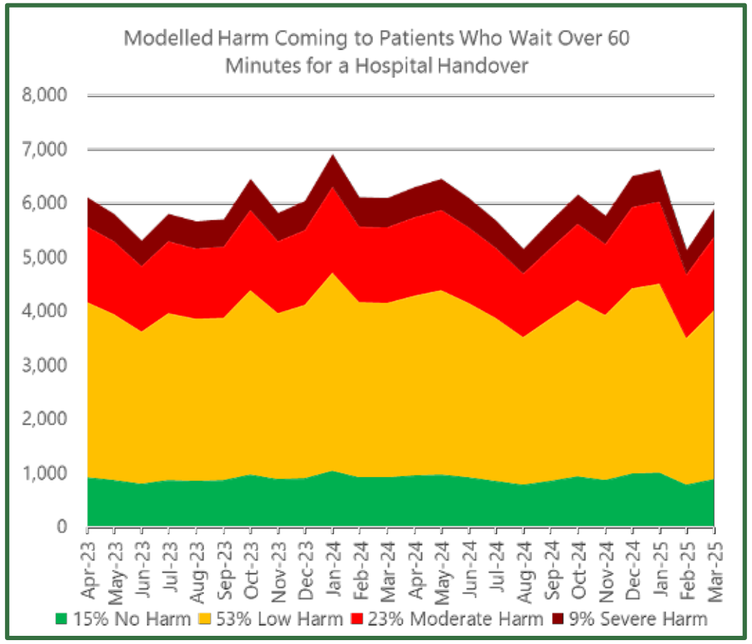

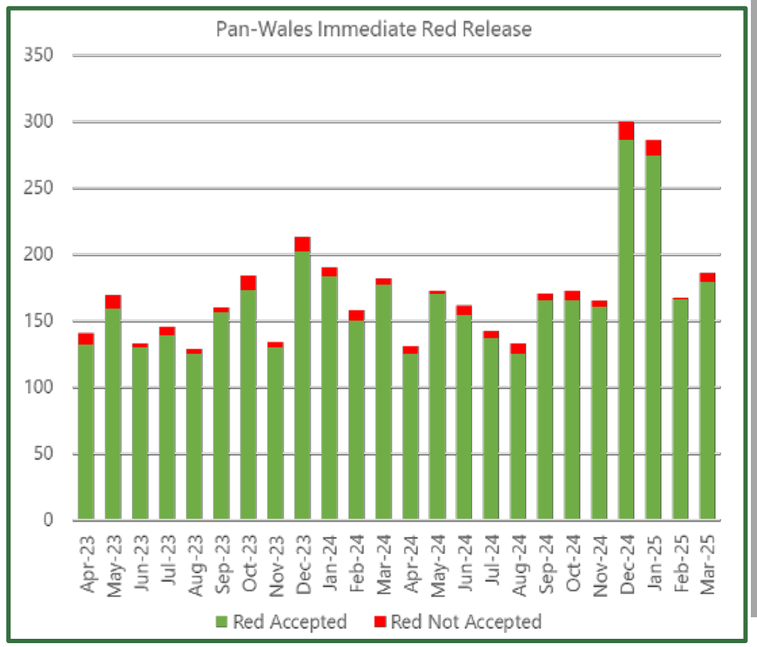

Analysis

In March 2025, 73 ambulances were stopped due to Clinical Safety Plan (CSP) alternative transport. In addition, 7,229 ambulances were cancelled by patients (including patients refusing treatment at scene) an increase from the 6,499 in February 2025. There is a downward trend in patient cancellations which the Trust thinks is connected to the implementation of Rapid Clinical Screening.

There were 769 requests made to Health Board EDs for immediate release of Red or Amber 1 calls in March 2025. Of these 179 were accepted and released in the Red category, with 7 not being accepted. Further to this, 183 ambulances were released to respond to Amber 1 calls, but 400 were not.

The graph in the bottom left shows that in March 2025 of the 5,903 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% (885 patients) would experience no harm, 53% (3,128 patients) would experience low harm, 23% (1,357 patients) would experience moderate harm and 9% (531 patients) would experience severe harm.

In March 2025 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 with new arrangements expected from Q1. 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

March 2025		
NEPTS (238 responses)	Benchmark	Score
How long did you wait for your transport to take you home after your appointment.	85	88
Were you happy with the transport you received?	85	96
999 (7 responses)	Benchmark	Score
The 999-call taker who answered your call was reassuring.	85	75
The 999-call taker who answered your call explained what was going to happen next.	85	100
You felt confident in the call taker ability to manage your call and provide appropriate advice.	85	75
The length of time I waited for an ambulance to arrive was acceptable.	85	83
111 (10 responses)	Benchmark	Score
Do you feel your call to 111 Wales was helpful?	85	35
Did you follow the advice given to you by NHS 111 Wales?	85	100
Would you consider using NHS 111 Wales again?	85	25
WAST Overall - Friends & Family Test How was your overall experience with the service today?	Ranked from very poor to very good.	
o Ambulance care	91.75% Good	5.15% Poor
o Integrated Care (NHS 111 Wales Telephone line only)	0.00% Good	75.00% Poor
o EMS (including CSD)	50.00% Good	33.33% Poor
o NHS 111 Wales Online	50.00% Good	28.57% 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=96).

In the 999 survey 'The length of time waited for an ambulance to arrive was acceptable' question failed to meets its target. Whilst within 111 survey the only question to achieve its 85-benchmark was 'Did you follow the advice given by NHS 111 Wales?'

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.

Engagement and survey outcomes remain largely consistent and tell us that people continue to be very concerned about response times in the community and frustrated at hospital handover delays. 111 callers have told us that they experienced long waits for call backs. NEPTS users told us that overall, they continue to be happy with the transport they receive but experience delays when waiting for their transport home following their appointment.

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

A DPIA to allow distribution of surveys to patients via SMS Texting is currently with the IG Team and we expect this to be submitted to the ICO for approval imminently.

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 have now been formally released by Welsh Government alongside an updated Welsh Health Circular.

Expected Performance Trajectory

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

Our People
Capacity - Ambulance Abstractions and Production Indicators

(Responsible Officer: Lee Brooks)

EA Production	Abstractions
A	R

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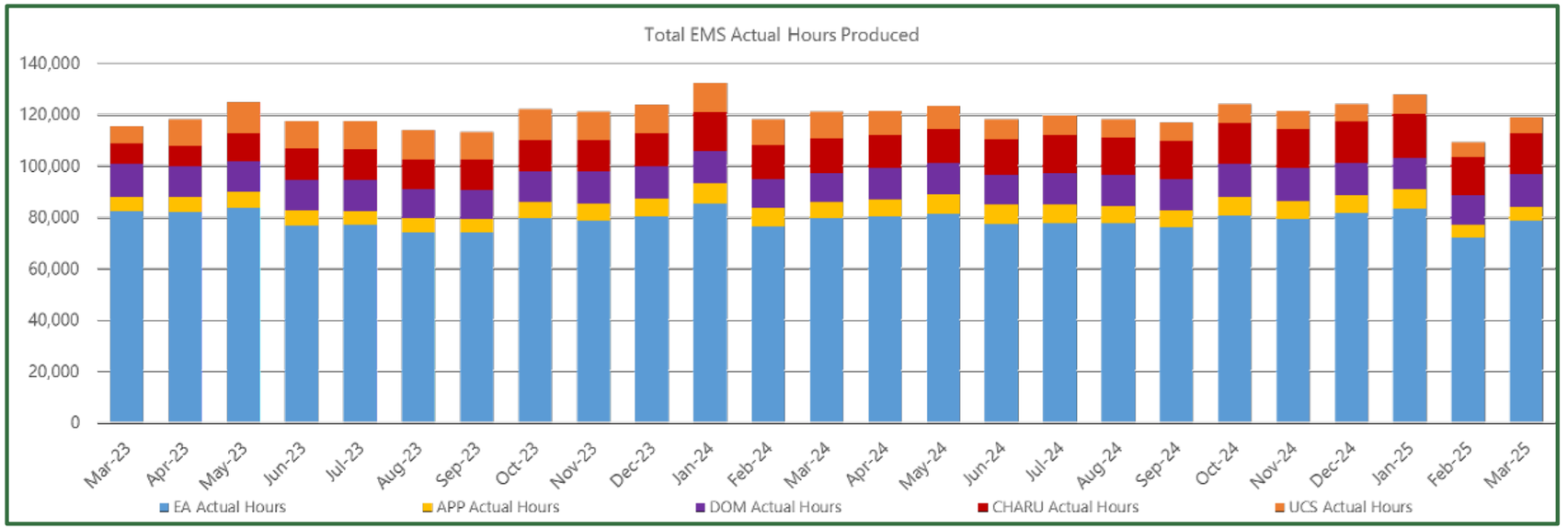

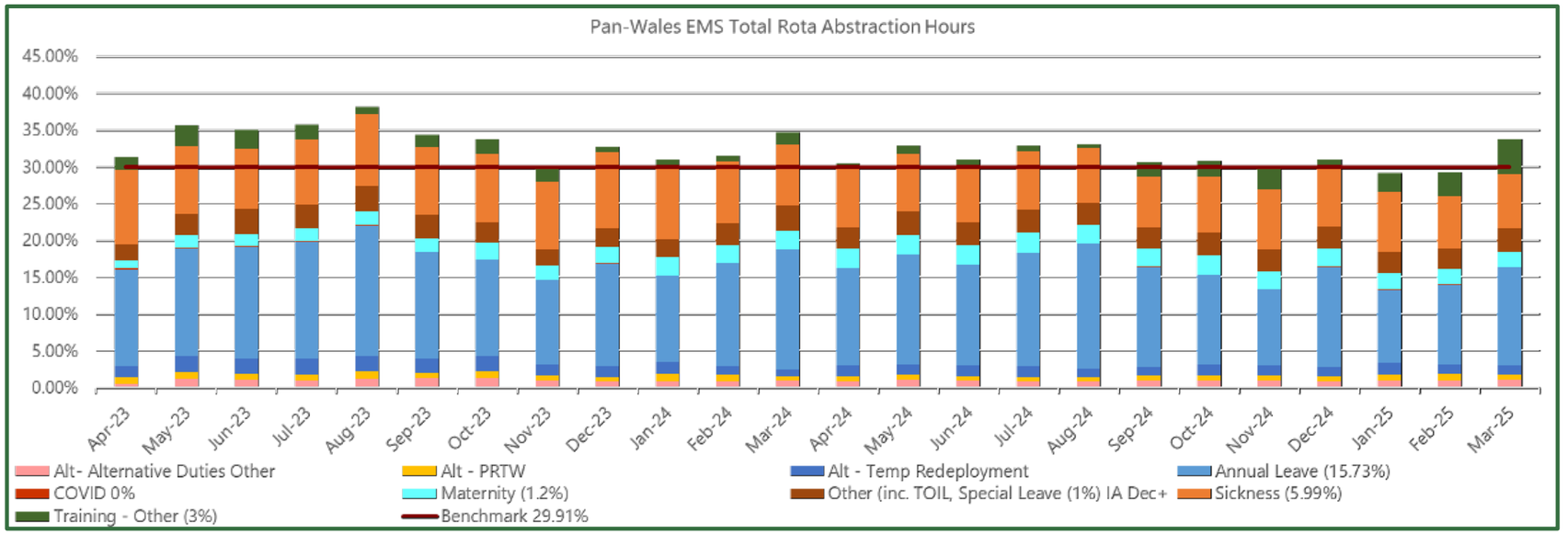

Analysis

The total EMS hours produced is a key metric for patient safety. The Trust produced 118,812 hours during March 2025, a slight decrease compared to the 121,069 hours produced during March 2024. 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. March 2025, saw a total EMS abstractions (excluding Induction Training) of 33.86%. This was an increase on the 29.36% recorded in February 2025 and does not achieve the 29.91% benchmark. The highest proportion of abstractions was due to annual leave at 13.31% followed by sickness at 7.43%.

Emergency Ambulance Unit Hours Production (UHP) achieved 91% in March 2025 which equated to 78,738 Actual Hours.

In March 2025 CHARU UHP was 87% 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 just below target..

The Trust maintains an ambition to reduce sickness to 6% and maintain 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 R

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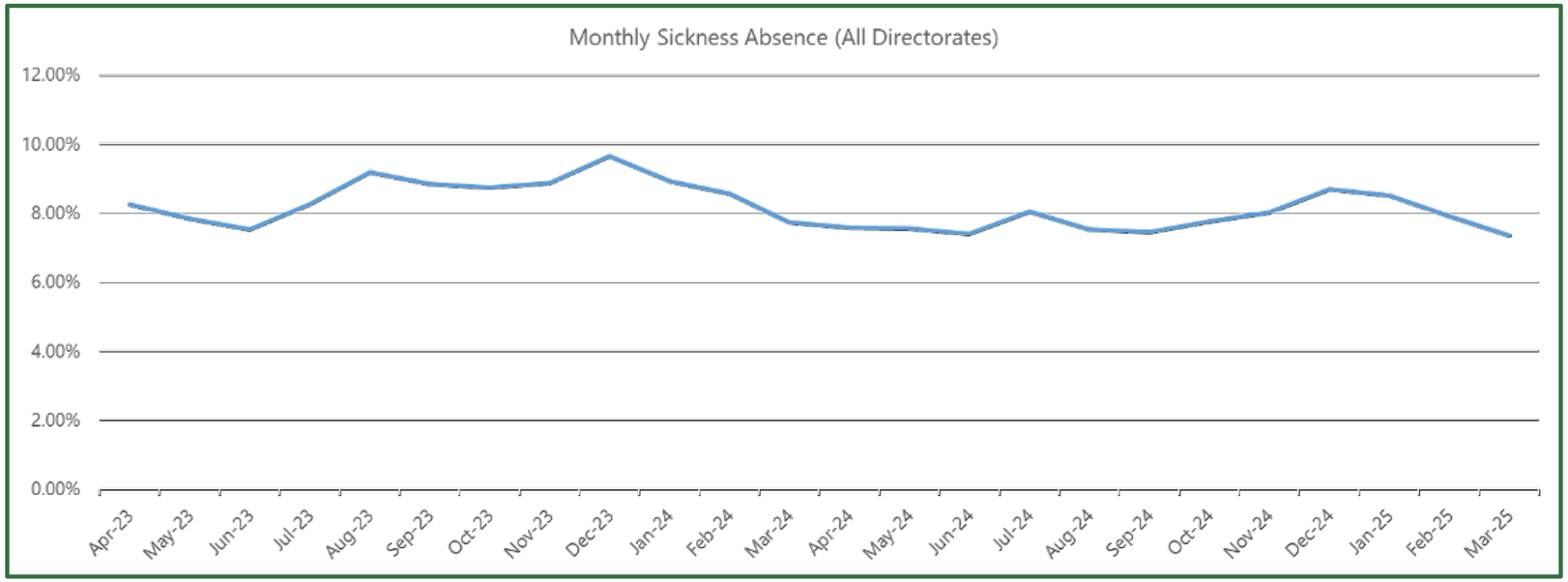
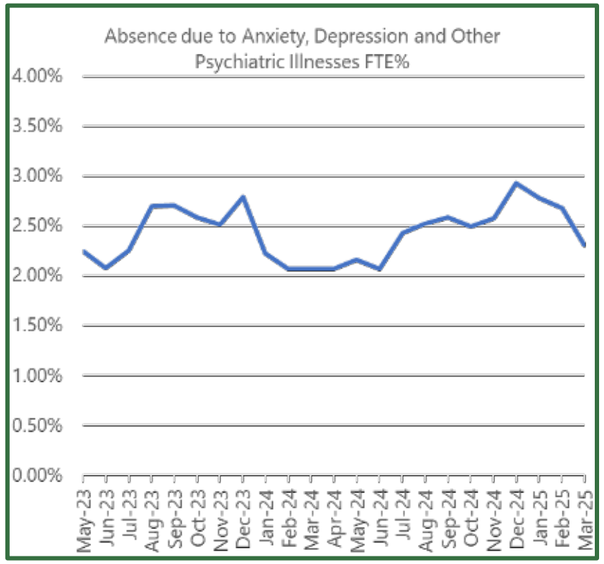
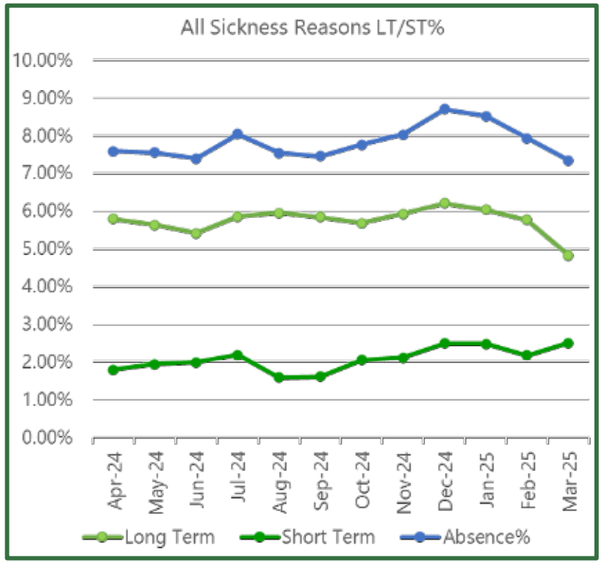




Average working days lost per FTE (Annual)	
17.84	days
Single month Absence %	
7.35%	
Long Term	**Short Term**
4.83%	2.51%
Mental Health	**Other MSK**
(S10 Stress/Anxiety)	(excluding Back)
2.31%	0.73%



Analysis

There was a slight decrease in overall sickness absence rates between February 2025 and March 2025, dropping from 7.93% to 7.35%. Long term absence decreased from 5.77% in February 2025 to 4.83 % in March 2025, while short-term absence increased slightly to 2.51% in March 2025 from February 2025 (2.17%).

The highest reasons for absence in March 2025 were Anxiety/ Stress/ Depression, other musculoskeletal problems, Gastrointestinal problems and injury fracture. Absence due to Mental Health decreased slightly for the fourth consecutive month from 2.68% in February 2025 to 2.31% in March 2025.

55 OH management referrals were received in March compared to 166 in February. The self-referral portal on Opas G2 continues to prove popular and has helped streamline the service, 12 self-referrals were received in March. In March we received a total of 72 Wellbeing referrals; 29 wellbeing management referrals, 7 self-referrals and 36 walk–in referrals.

For the 2024/25 Flu campaign, 1,423 flu vaccines were administered by our WAST OH / Peer Vaccinators. 1,035 were given to WAST employed staff with 250 WAST staff also confirming they have received the flu vaccine elsewhere i.e. GP / Pharmacy, therefore, 28.93% of the WAST workforce were vaccinated. A further 277 WAST staff have completed our Microsoft Form to state they wish to opt-out from having the flu vaccine this year.

Remedial Plans and Actions

- The Health and Wellbeing Plan for 2025-29 has been approved by the WAST Board and a delivery plan has been developed and implemented. The focus of the plan is to improve workplace relationships, increase the trauma-awareness of the organisation and address health and wellbeing challenges increasingly on a systemic level, in addition to providing support on an individual level.
- The programme plan for the pilot Health Check Programme, Health Diagnostics, (HD), has now started. The programme was promoted at the roadshows, and we will be scheduling clinics inviting staff to book screening appointments.

Expected Performance Trajectory

The Trust has indicated through its IMTP that sickness levels will fall in this financial year, but the Trust is unlikely to achieve the 6% target for the year given continuing system pressures.

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

Our People
Capacity – Staff Turnover

(Responsible Officer: Angela Lewis)

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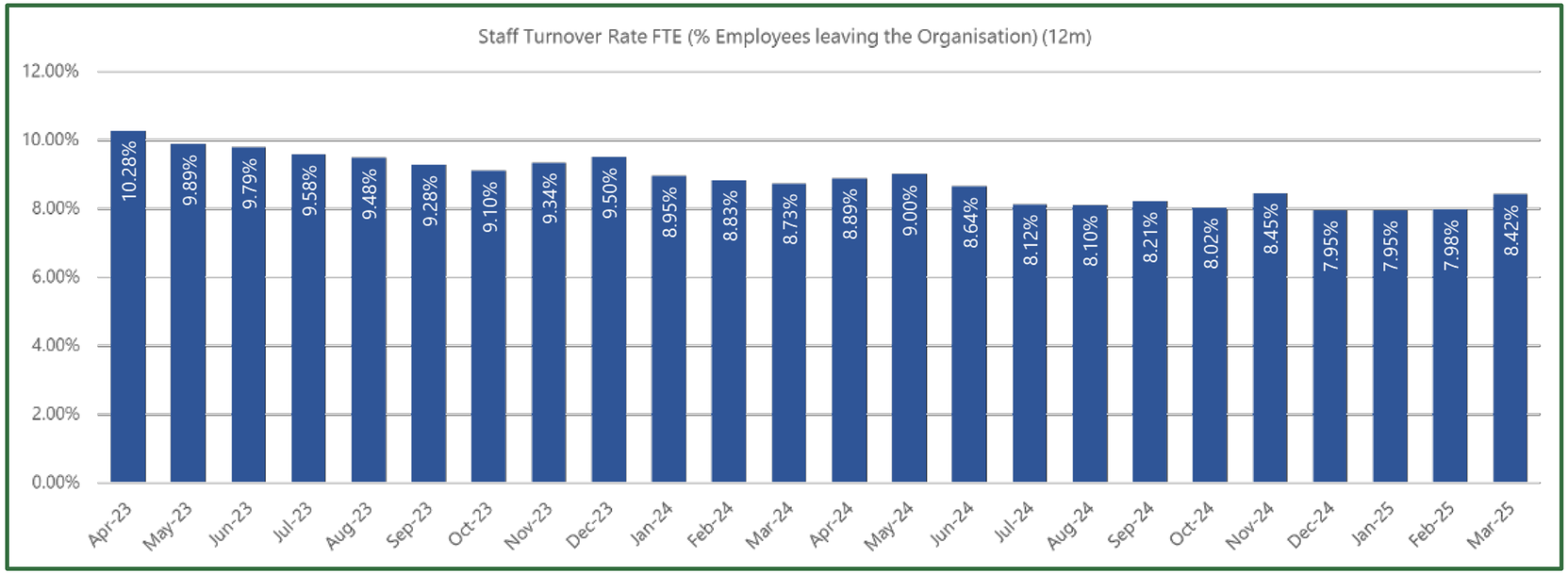

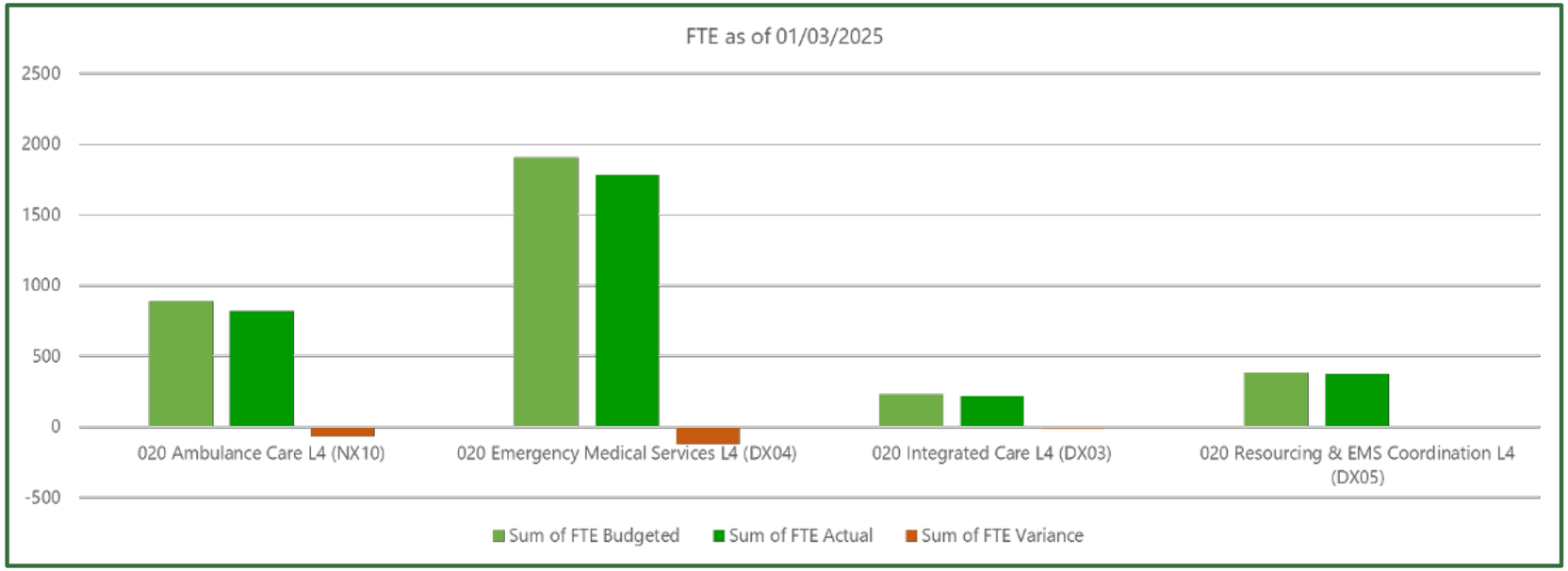

Analysis

Staff turnover rates in March 2025 were 8.42%, increasing from 7.98% in February 2025. March saw 52 leavers (43.97 FTE). Turnover trends are being monitored. Currently it has been noted that in January & February months a peak occurs predominately due to retirements. This was compensated by 42 joiners (41.35 FTE). Of those leaving, the group with the greatest number were Ambulance Care Assistants or Patient Transport Drivers (12 people),
Technicians (11 people), Staff Nurse (5 people) and Paramedic (5 people).

Occupational Health continue to meet national KPIs set by the All-Wales Occupational Health standards and scope of practice, i.e., regarding turnaround times for referrals the national KPI states: The 1st offered appointment date will be within 29 calendar days of the date referral received. KPI that this is achieved 80% of the time.
Our waiting times have fluctuated over the past months, this has been due to staff changes and staff sickness. The current waiting time for management referral is 6.41 days.
Staff are currently waiting approx. 14.85 days for pre- employment screenings from date of this has been due to submission to first offered appointment.

Remedial Plans and Actions

- The team continue to work closely with Civica to improve the system, including a text reminder service for appointments and awaiting access to visual diaries.
- The Wellbeing team continue to support colleagues and managers by attending regular meetings, providing targeted support and facilitating drop-in sessions for colleagues.
- Team members from OH/Wellbeing/TRiM continue to promote our services via Siren, outstation visits and drop-in clinics. We regularly give presentations to newly recruited staff to highlight and promote the Occupational Health & Wellbeing service.
- Our Head of Workplace Wellbeing offers psychological consultation to managers and People Services for sensitive and complex situations (e.g., suicide risk, long-term sickness regarding mental ill health).

Expected Performance Trajectory

The team continue to review the Occupational Health and Wellbeing provision, so that we ensure that services/interventions offered are relevant, appropriate, and up to date, our focus is on continuous improvement.

Our People
Capability - PADR and Training Rates Indicators

(Responsible Officer: Angela Lewis)

PADR: A

Stat & Mand: G

CI

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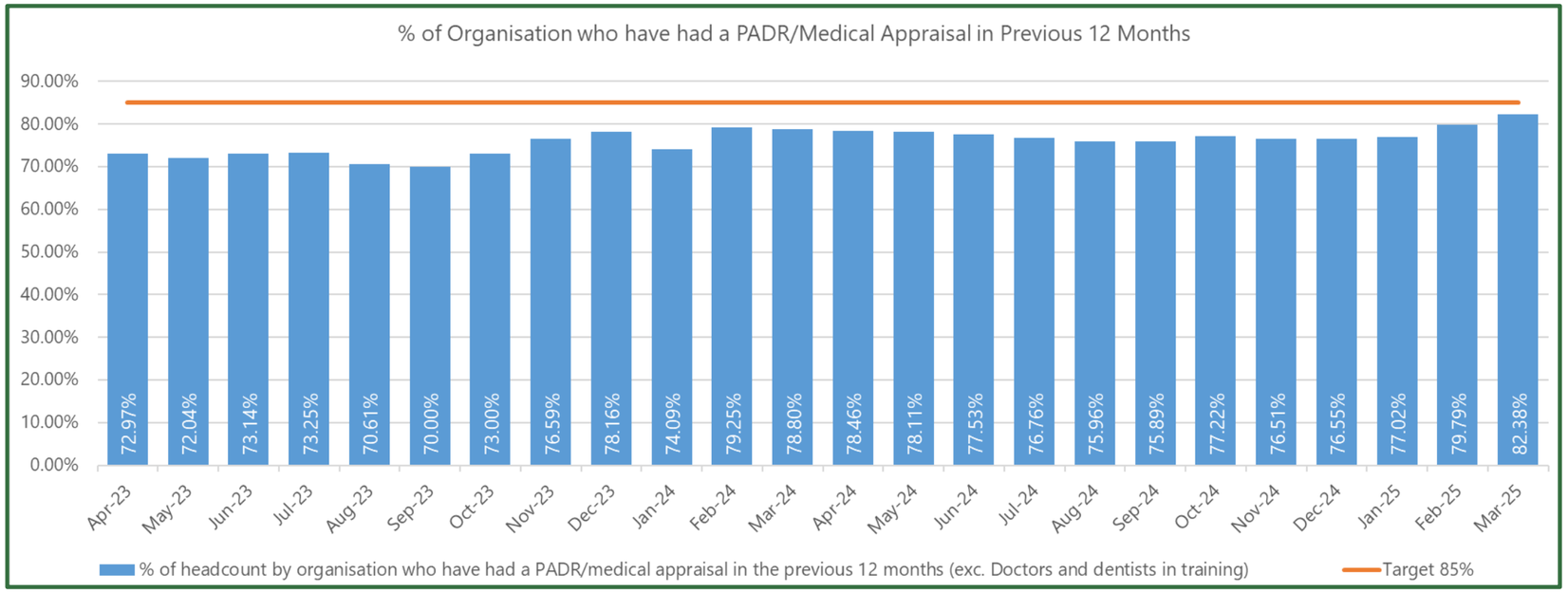
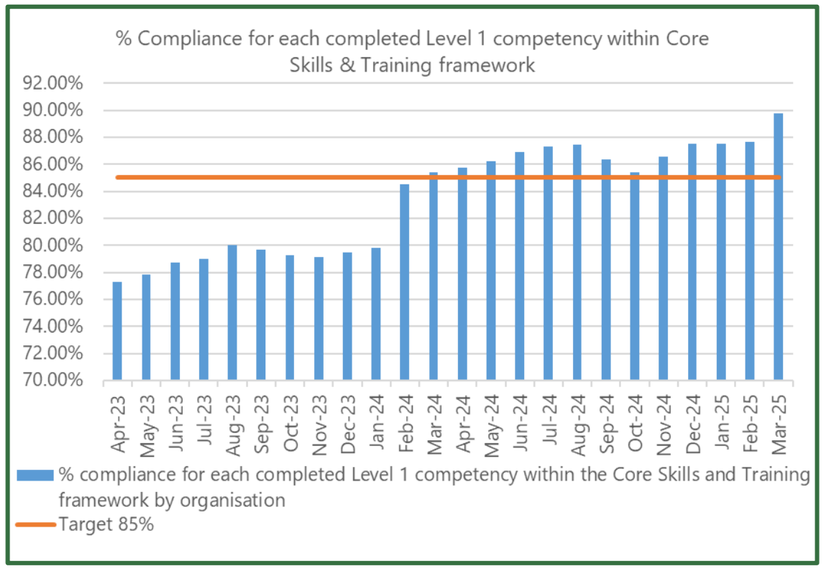
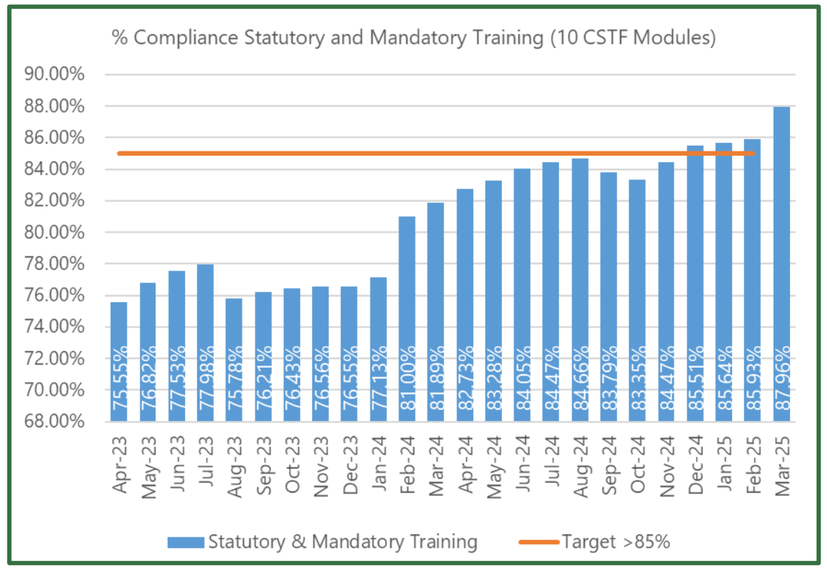
Health & Care Standard
Health – Staff & Resources

Self-Assessment: Strength of Internal Control: Strong







Analysis

PADR rates minimally increased from 79.79% in February 2025 to 82.38% in March 2025 and is close the 85% target. Over the reporting period this target has only been achieved once, in December 2022.

In March 2025 Statutory & Mandatory Training rates reported a combined compliance of 87.96% exceeding the 85% target for the fourth consecutive month. However, only Dementia Awareness (98.13%), Moving & Handling (95.67%) and Safeguarding Adults (97.94%), achieved the 85% target. Equality & Diversity (82.32%), Information Governance (79.20%), Fire Safety (77.16%), Paul Ridd (75.94%), Fraud Awareness (75.71%), Violence Against Women, Domestic Abuse & Sexual Violence (73.58%) and Welsh Language Awareness (70.79%) 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:

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

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, 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 environment enabling easier access to these reportable competencies.

Expected Performance Trajectory

Performance is improving as compliance has risen.

Data source: ESR

Our People
Health and Well-being – Shift Overruns

(Responsible Officer: Angela Lewis)

Overruns
R

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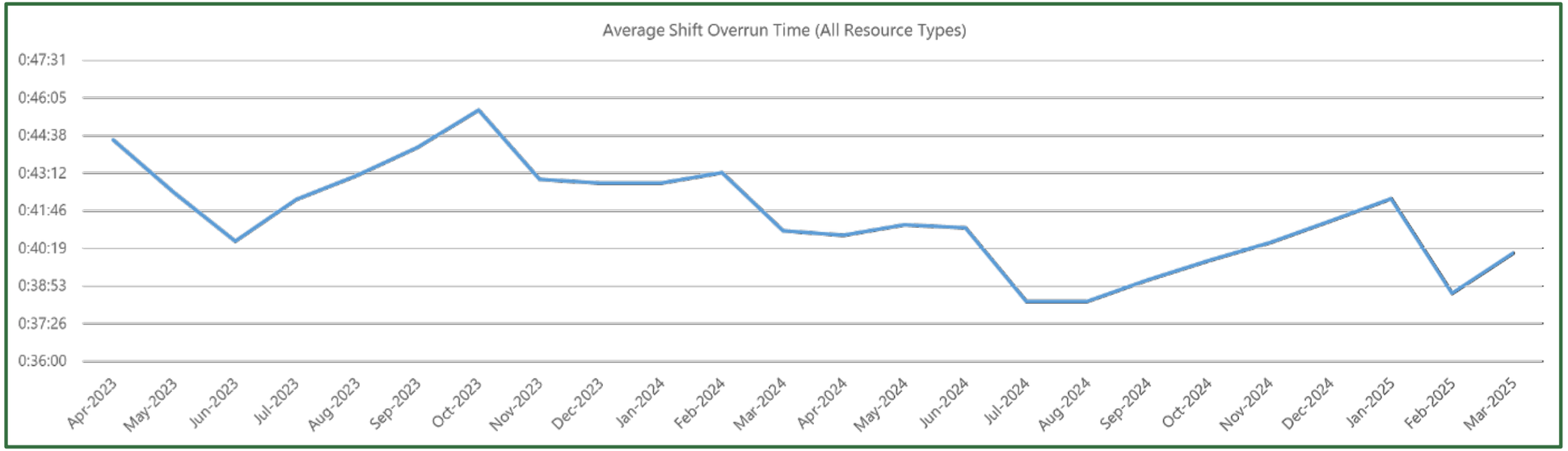
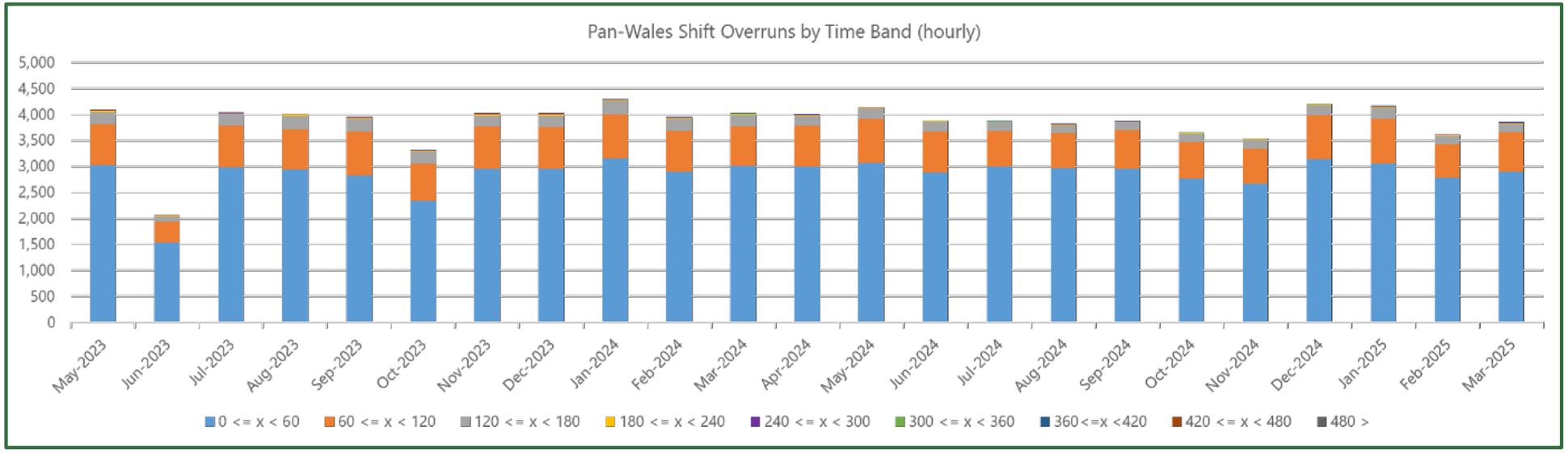




Analysis
There were 3,839 shift overruns during March 2025.

The average overrun figure for March 2025 was 40 minutes and 8 seconds, a minimal increase from February 2025 (00:38:36). 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% of the total. 19.2% fall within the 61 to 120-minute category, 4.4% in the 121 to 180-minute category, 0.3% in the 181 to 240-minute category and 0.2% 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.

Collaborative work is ongoing with our Trade Union Partners via a dedicated Task and Finish group to find ways to reduce overruns for our people.

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 2025.

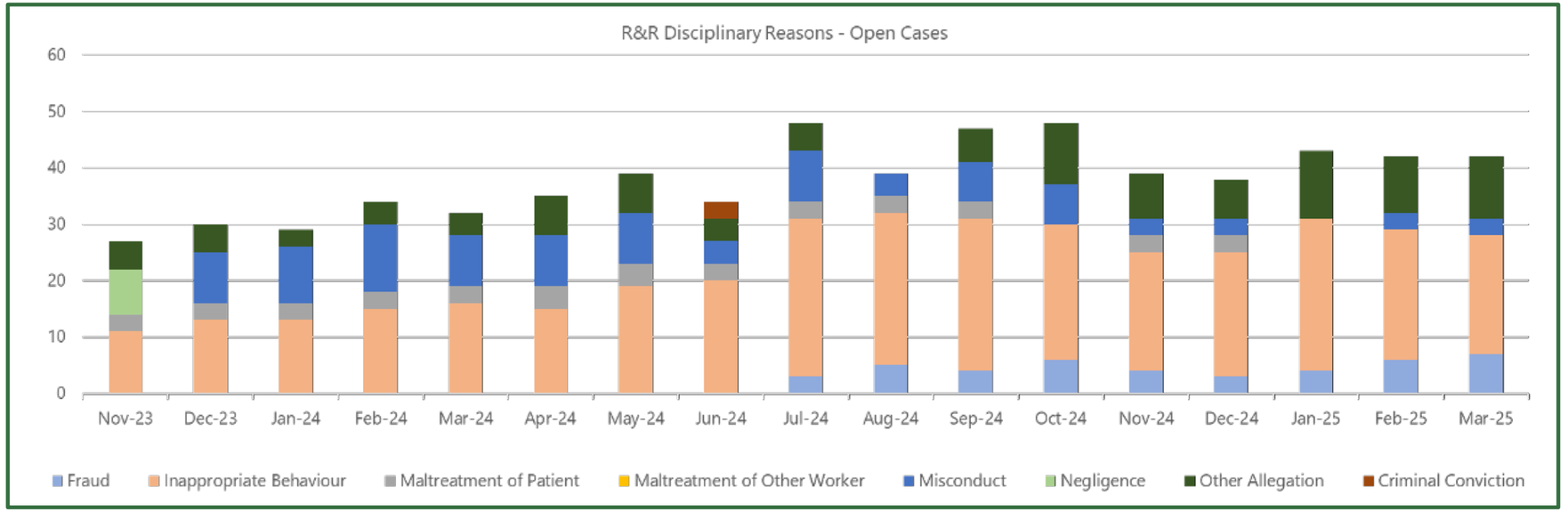
Expected Performance Trajectory
Overruns correlate with handover lost hours and may continue to increase.

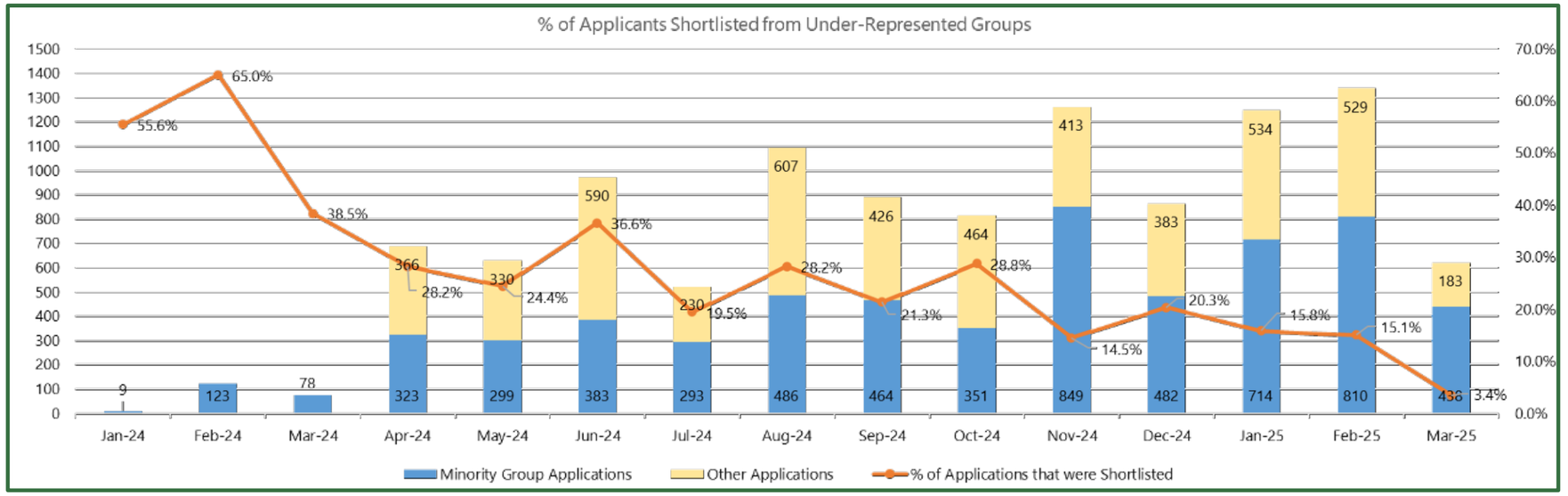
Our People
Culture – Number of R&R Disciplinary Hearings and Number of Applicants Shortlisted from Under-Represented Groups

(Responsible Officer: Angela Lewis)

Self-Assessment: Strength of Internal Control: Moderate

PCC





Analysis

There were 42 open formal disciplinary cases recorded at the end of March 2025, which remains consistent with the previous month. Of these Disciplinary cases, the majority are again due to allegations of inappropriate behaviour, followed by fraud.

There were 14 open formal Respect and Resolution cases submitted by employees in March 2025, two less than the 16 February 2025. These are a mixture of both Respect and Resolution Grievances and Dignity at work.

The bottom graph shows that in March 2025, 621 job applications were processed, and 32 interviews planned.

Of the 621applications, a total of 438 were from under-represented groups with 328 in the category of Ethnicity, 74 within Disability and 36 identifying within Sexual Orientation.

In March 2025, 3.4% (n=15) of all applications from under-represented groups made it through shortlisting and were invited for interview. This was a decrease from the 15.% in February 2025.

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. Two workshops have taken place to recruit for Black, Asian and Ethnically diverse applicants into our digital roles and work is ongoing on how to expand this to other areas such as Graduate Paramedics. Unconscious bias training for the managers that will be involved in their recruitment is underway.

Expected Performance Trajectory

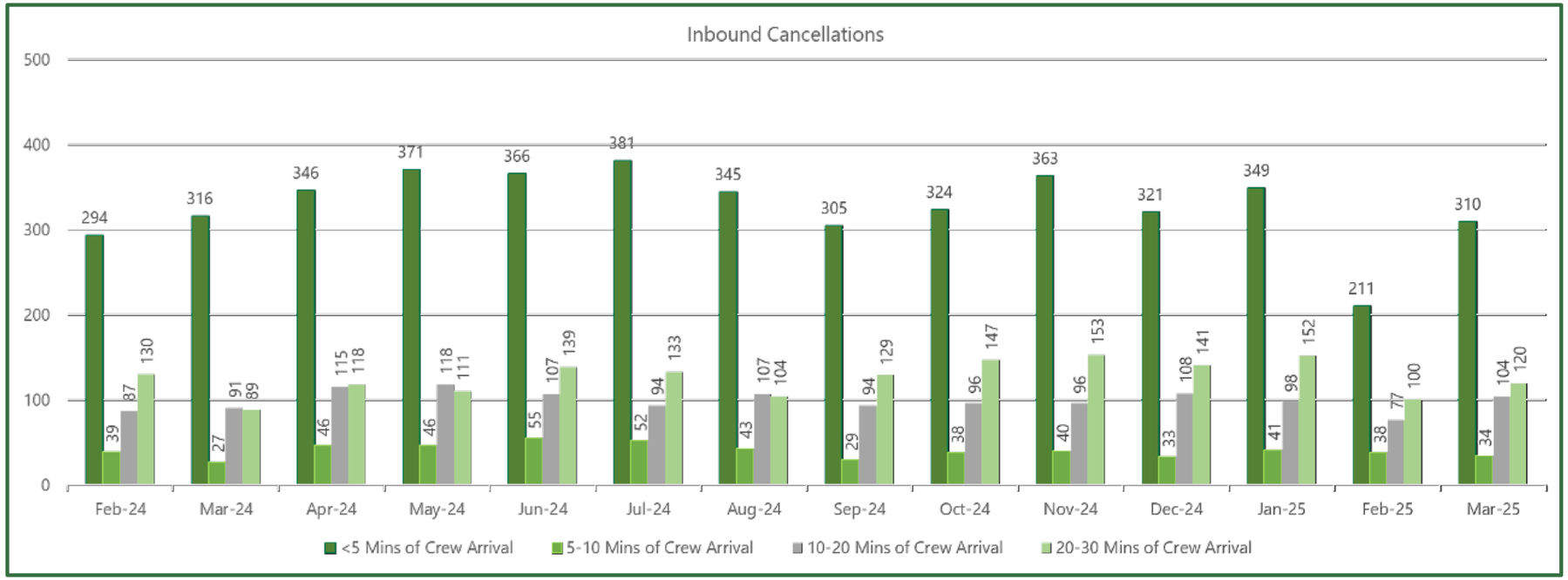
Continue to monitor levels, no trajectory for this measure.

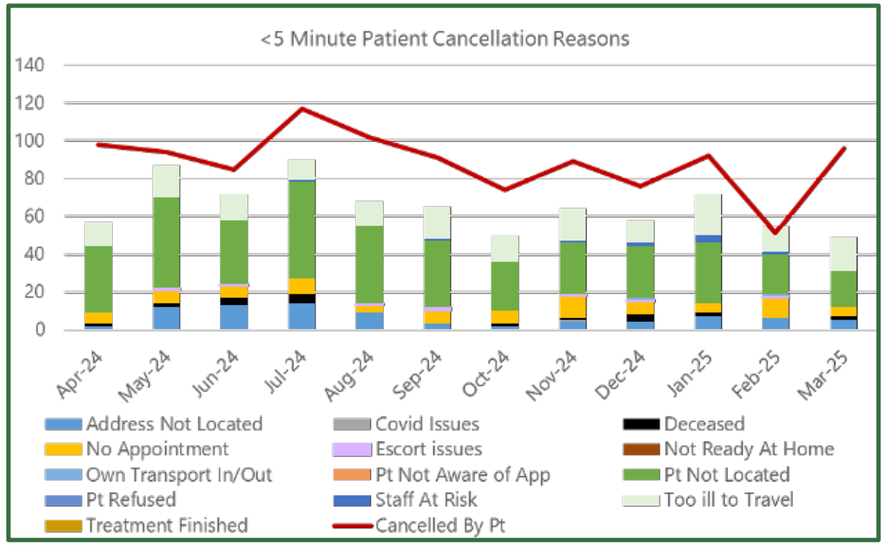
Finance, Resources and Value
Value: Ambulance Care Indicators

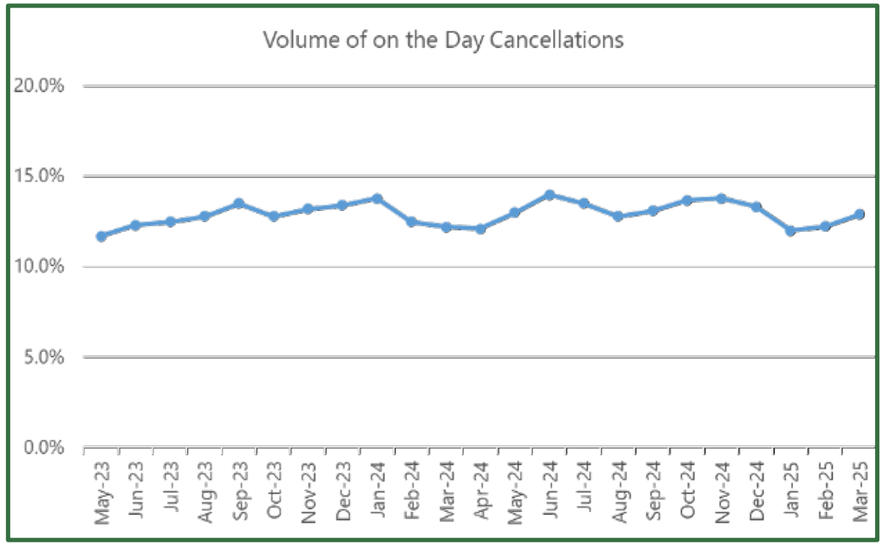
(Responsible Officer: Lee Brooks)

Cancellations
R

FPC







Analysis

Inbound cancellations of 5 minutes or less of the crew arrival time saw an increase in March 2025 to 310, compared to 211 in February 2025. The total number of cancellations within 30 minutes also increased from 426 in February 2025 to 568 in March 2025.

In March 2025 there were 96 travel bookings cancelled by patients (including via SMS), increasing from 51 in February 2025.

The other top reasons for less than 5-minute cancellations included: 19 patients not located, 18 unwell/too ill to travel, 5 no appointment and 5 address not located.

Same day cancellations increased slightly in March 2025 to 12.9%, up from 12.0% in February 2025.

Remedial Plans and Actions

Work with Hywel Dda to develop a direct link between their PAS system and our CAD, 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, that requires WAST transport.

Work is also underway to enhance the service's text messaging options to improve notification to patients.

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.

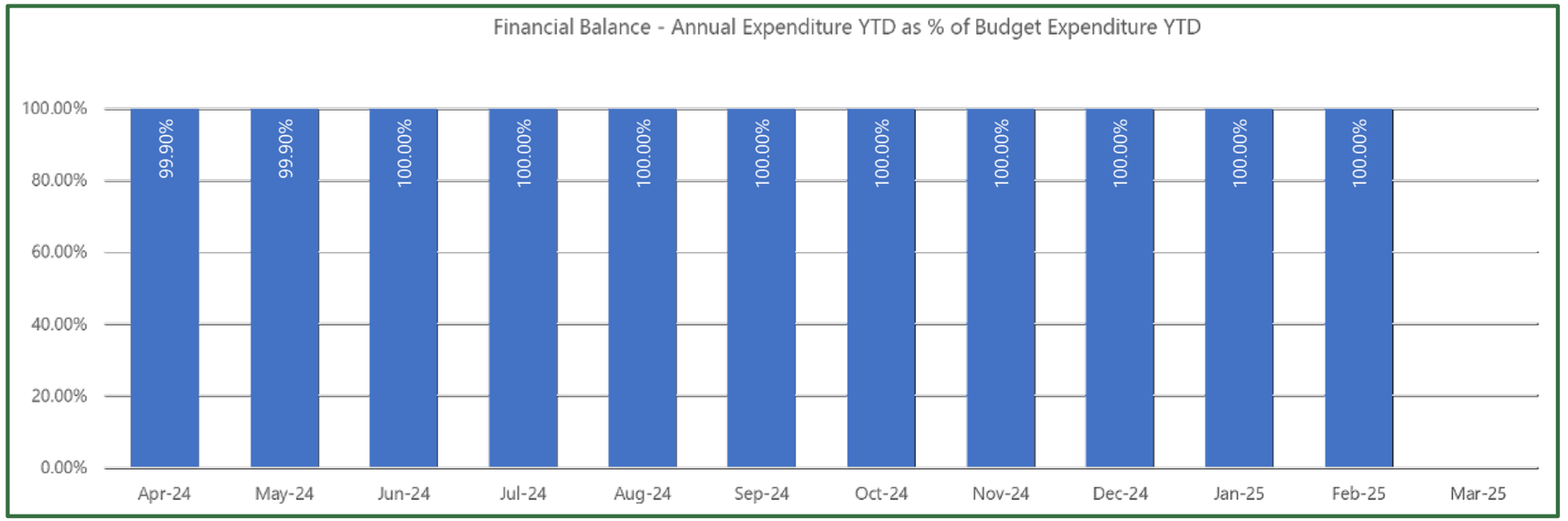
**Please note that MDTs do not appear to provide specific cancellation reasons for either inbound or outbound journeys. There are at present multiple and duplicated reasons both crews, control and the liaison desk can select.*

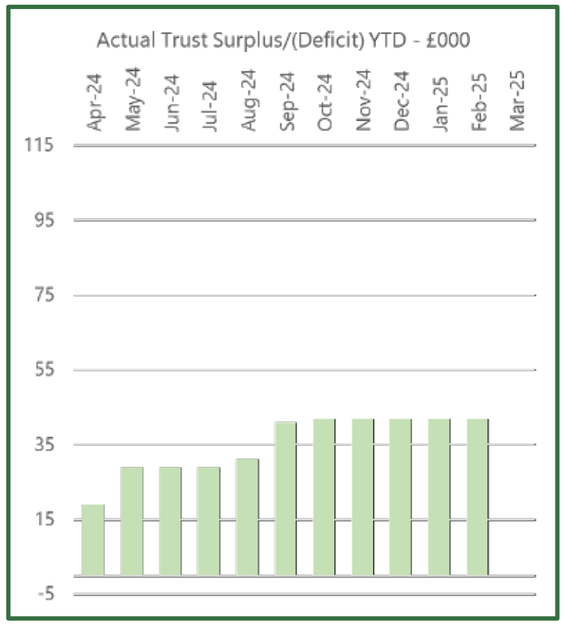
Finance, Resources and Value
Value - Finance Indicators

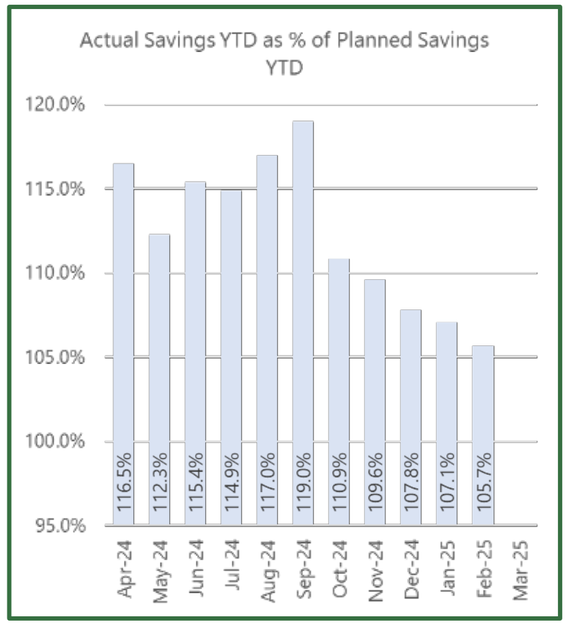
(Responsible Officer: Chris Turley)

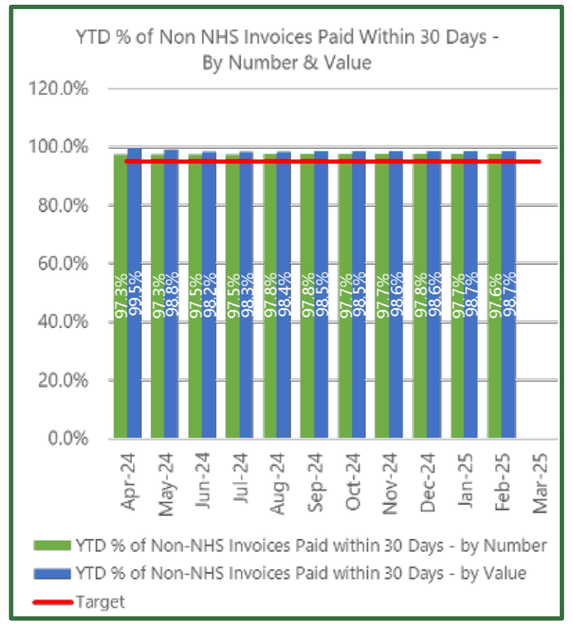
G

FPC









Analysis

The reported outturn performance at Month 11 is a surplus of £42k, with a forecast to the yearend of breakeven.

For Month 11 the Trust is reporting planned savings of £5.975m and actual savings of £6.317m (an achievement rate of 105.7%).

The Trust's cumulative performance against PSPP as at Month 11 is 97.6% against a target of 95%.

At Month 11 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, 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.

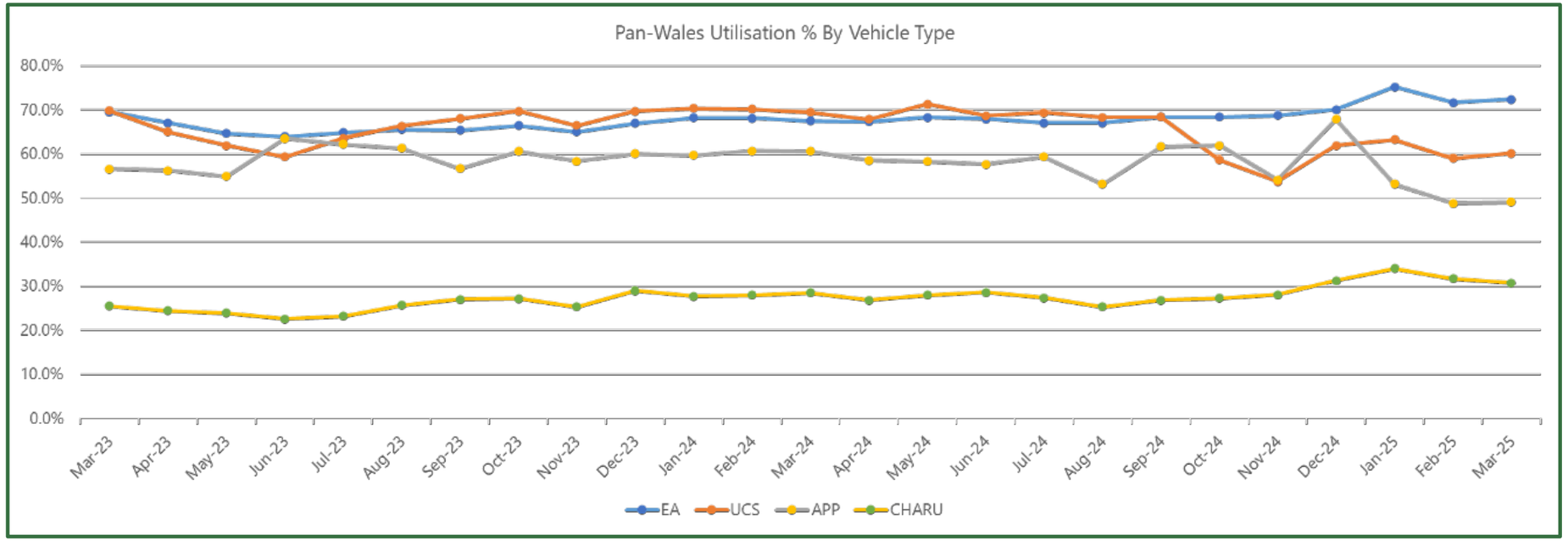
Month 12 data not yet available

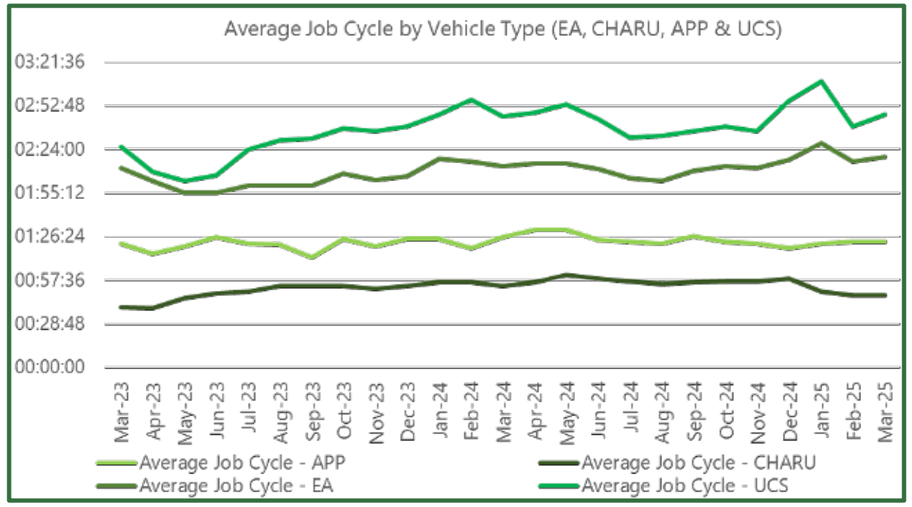
Finance, Resources and Value
EMS Utilisation & Average Job/Shift Times

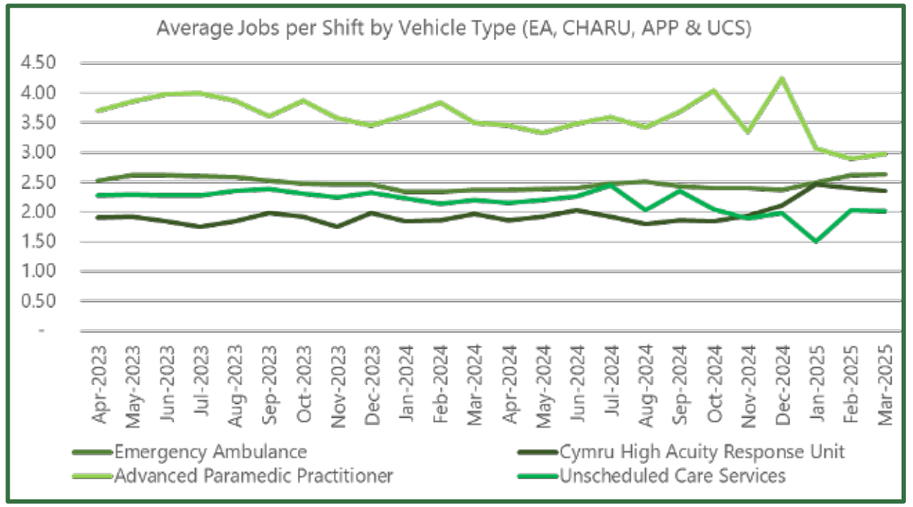
(Responsible Officer: Lee Brooks)

Jobs Per Shift	CHARU Utilisation	FPC
R	G	

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







Analysis

Pan Wales Utilisation metrics in March 2025 were 64.4% for all vehicles types, an increase from 63.8% in February 2025. EA saw the highest rate during the month at 72.4%, returning to the upwards trend over the past year. The optimal utilisation rate for EAs needs to be lower so that they are free to respond to incoming calls.

As demonstrated in the bottom left graph, the average job cycle increased in March 2025 for EAs (2 hours 19 minutes) and UCS (2 hours 47 minutes). The others remained the same as the previous month: APPs (1 hour 23 minutes)., and CHARU (48 minutes).

Overall average jobs per shift was 2.56 in March2025, indicating a minimal increase from February 2025 (2.55). EAs averaged 2.64 jobs per shift and UCS crews 2.02. This is lower than what would be ideal and a product of handover delays.

APPs attended on average 2.98 jobs per shift and CHARU's 2.36. 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.

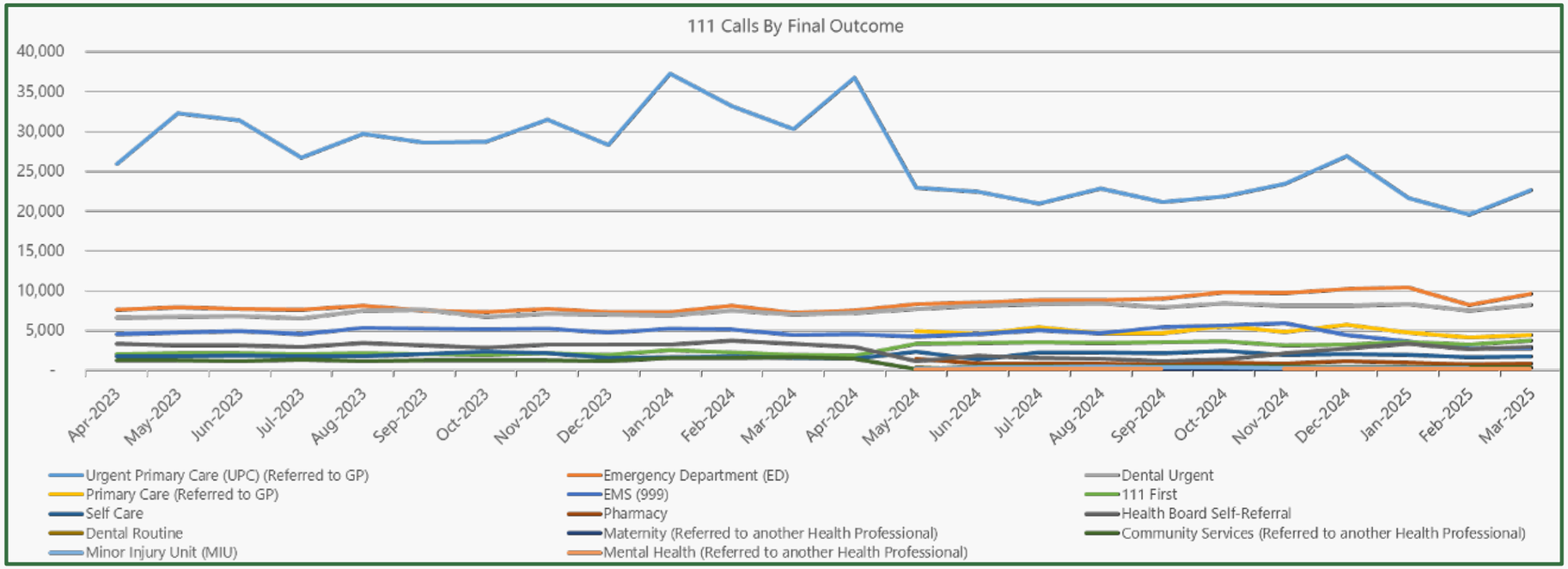
Expected Performance Trajectory

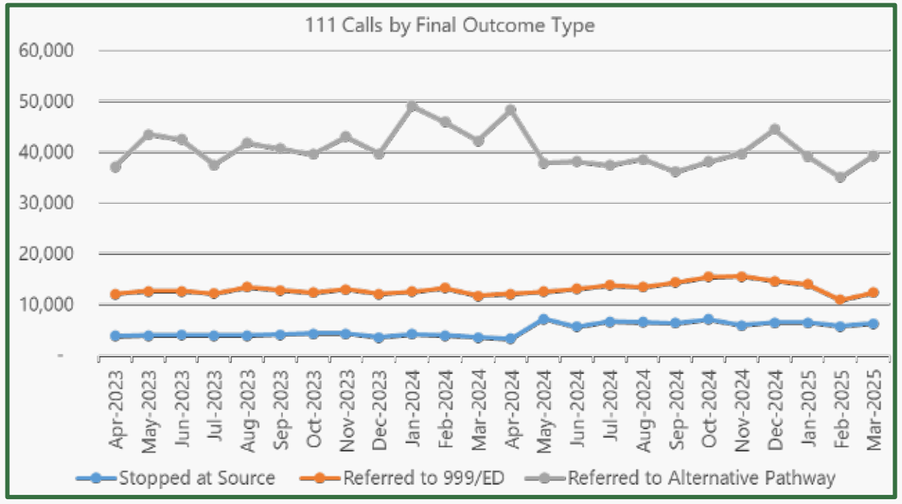
The Trust's ability to reduce the high utilisation rates for EAs and UCS is a product of handover, which it does not control. The Trust would expect an increase in CHARU utilisation and a decrease in EA utilisation during 2025/26 linked to the remedial actions identified above.

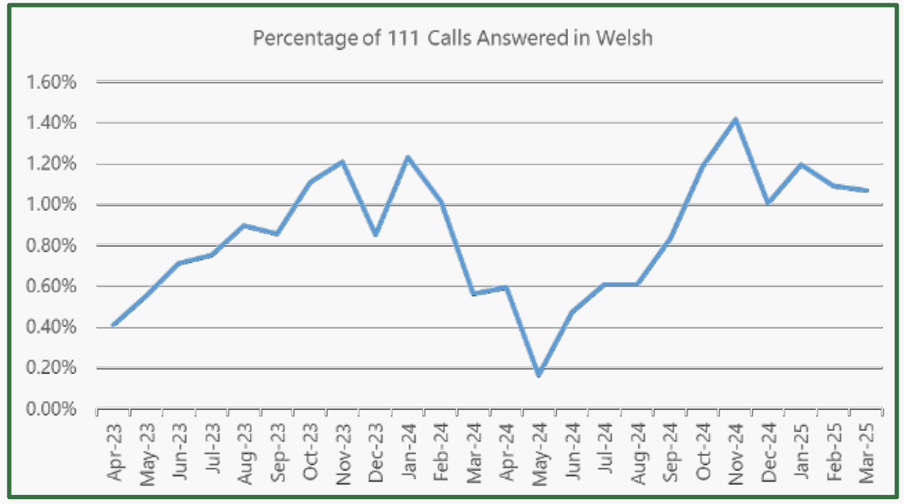
Partnerships / System Contribution
NHS111 Hand Off Metrics and NHS111 Consult & Close Indicators
Influencing Factors – Demand and Clinical Hours Produced

(Responsible Officer: Lee Brooks)

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







Analysis

During March 2025, 58,144 calls were allocated into the 14 categories displayed in the graph opposite, an increase compared to the 51,833 seen during February 2025. However, data quality issues continue within 111 reporting which are currently being addressed.

Calls Referred to a General Practitioner (handover of care) continued to be the top outcome for NHS111 accounting for 33.27% of all calls during March 2025, but there has been a material drop since the implementation of new 111CAS.

As the bottom left graph highlights, in March 2025, 6,363 calls were 'Stopped at Source', with no onward referral, a slight increase from 5,801 in February 2025. 12,369 calls were referred to 999/ED in March 2025.

The percentage of 111 calls answered in Welsh decreased slightly from 1.09% in February 2025 to 1.07% in March 2025. This equated to 57% 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, Six Goals, commissioners and DHCW. The focus is the development of a nationally reportable 111 data set. Similar to what is currently in place for Ambulance Service Indicators (ASIs). Part of this work involves looking at the reporting of disposition final outcomes.

Expected Performance Trajectory

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

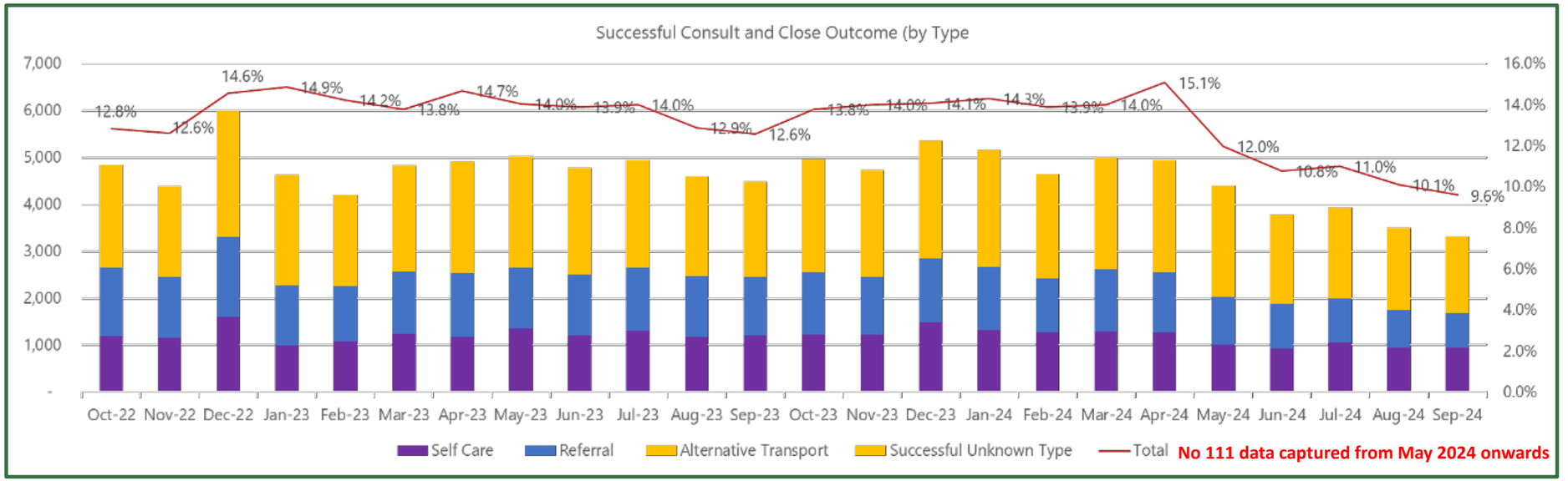
Partnerships / System Contribution
Consult & Close Indicators

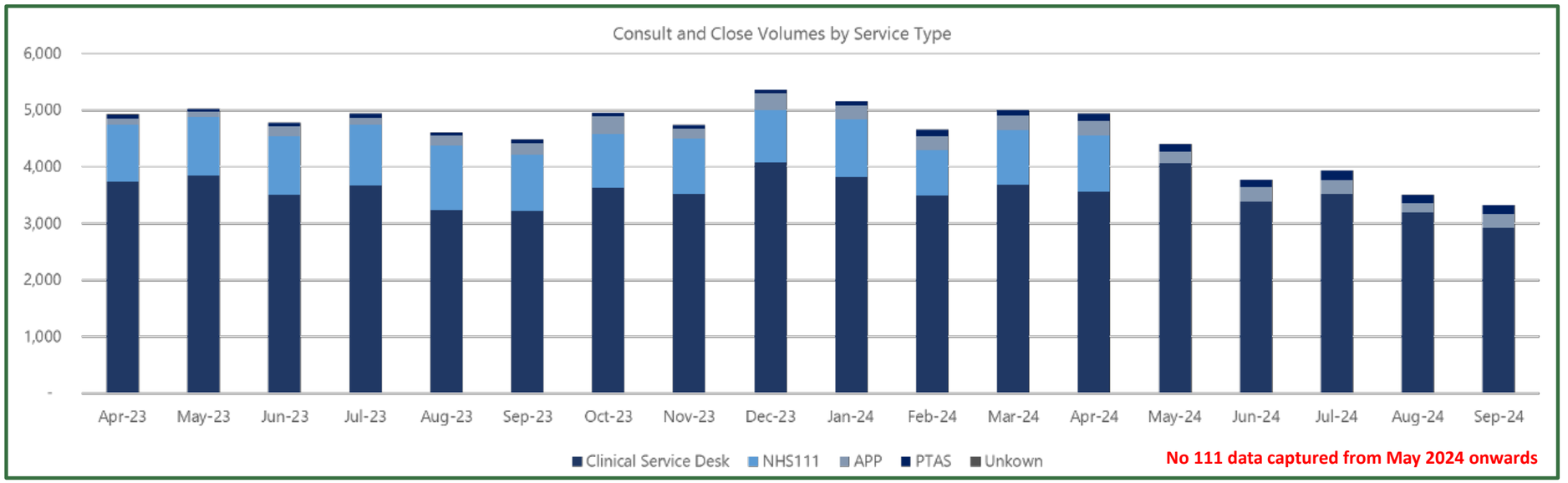
(Responsible Officer: Lee Brooks)

C&C Outcomes

FPC

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





No additional analysis possible given no 111 data is currently available on these metrics.

A revised metric is under development.

See separate patient harm mitigations report to Trust Board.

New metric definition agreed. Required Executive and Commissioner sign off before it be used.

A one-off IDS assured graph indicates that the Trust is achieving a +20% consult & close rate.

Partnerships / System Contribution
Conveyance to ED Indicators

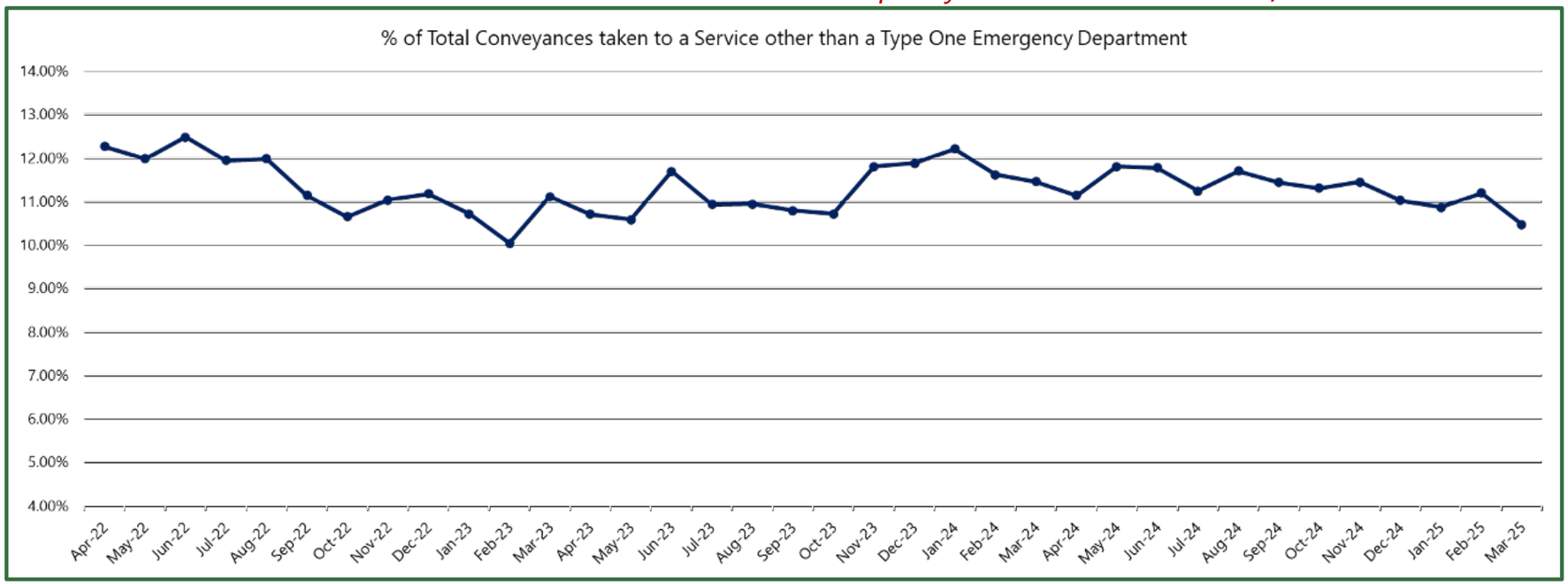
(Responsible Officer: Andy Swinburn)

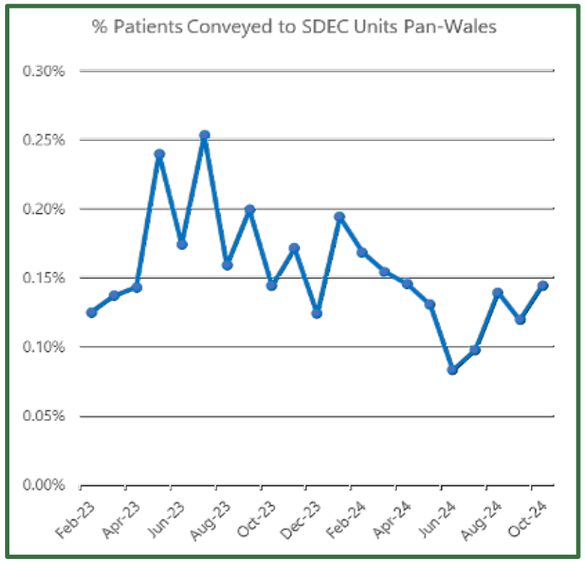
Conveyances
G

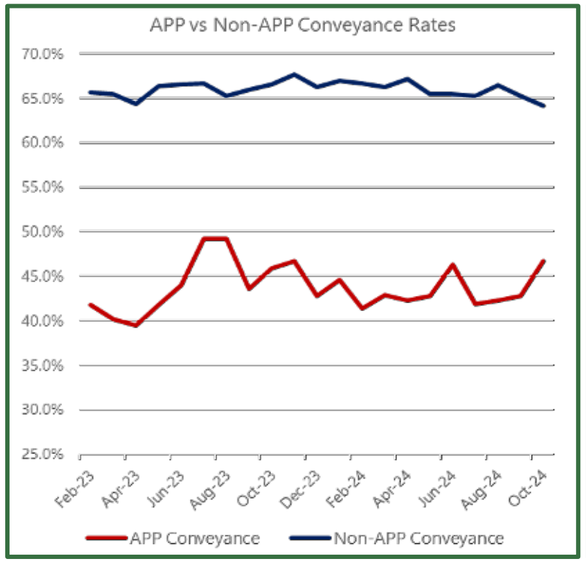
FPC

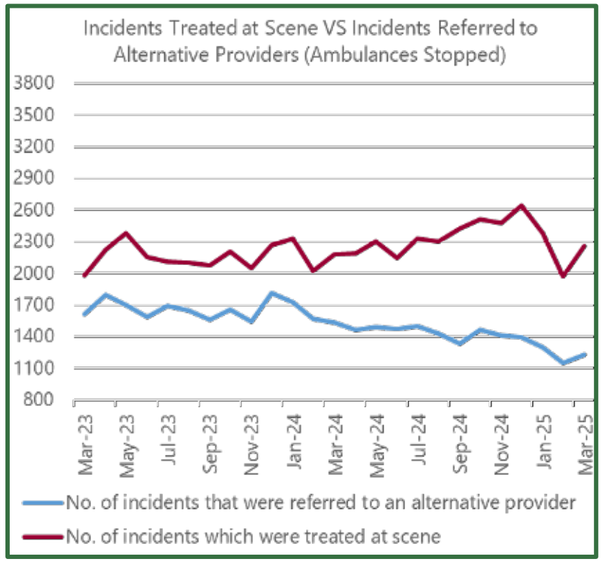
Ministerial Measure

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









Analysis

In March 2025 10.48% of patients (1,343) were conveyed to a service other than a Type One ED, while 38.18% of patients were conveyed to a major ED, as a percentage of verified incidents.

The combined number of incidents treated at scene or referred to alternate providers increased, from 3,124 in February 2025 to 3,494 in March 2025.

The APP conveyance rate was 46.6% in October 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). Patients conveyed to SDEC's in October 2024 remained low at 0.14%. No further data is available.

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.
- 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.

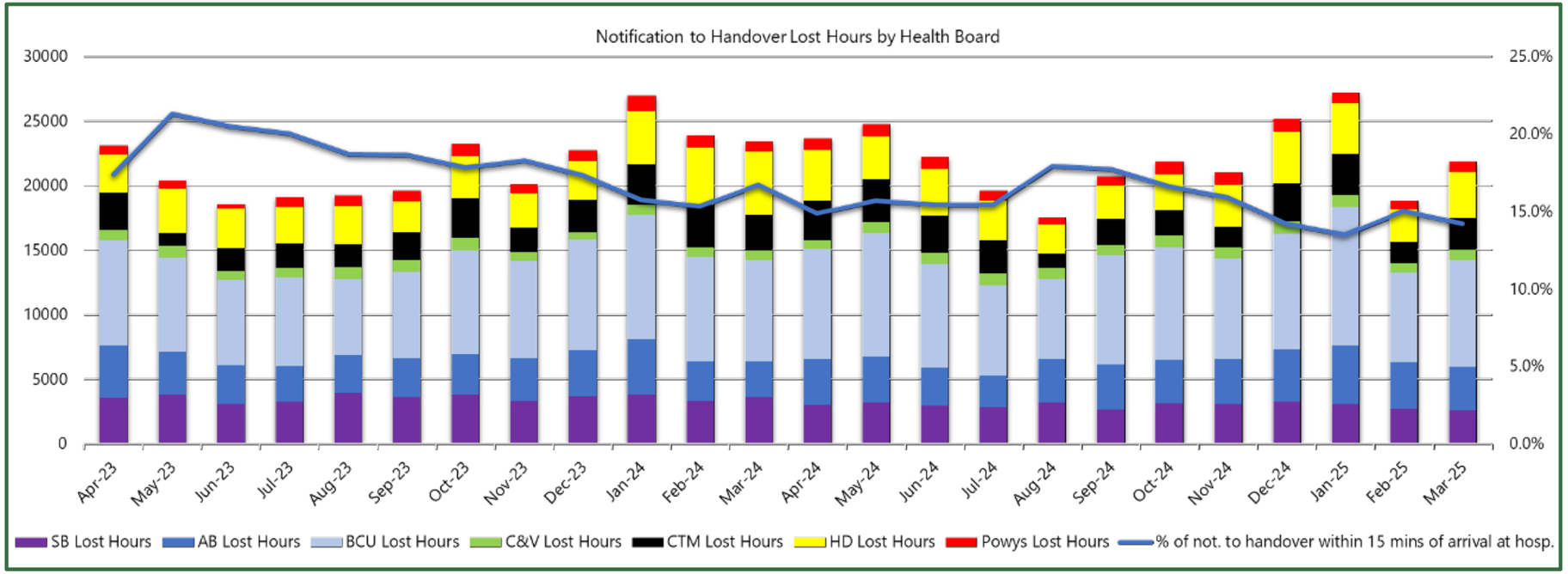
Partnerships / System Contribution
Handover Indicators

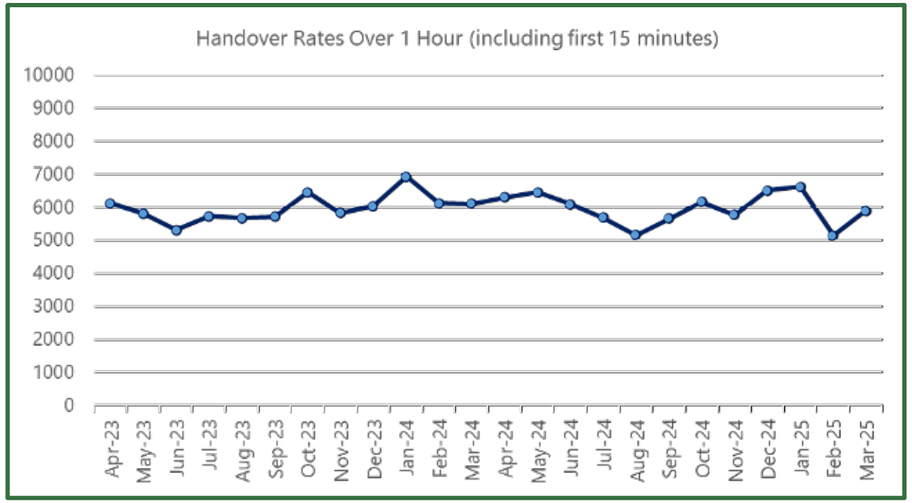
(Responsible Officer: Health Boards)

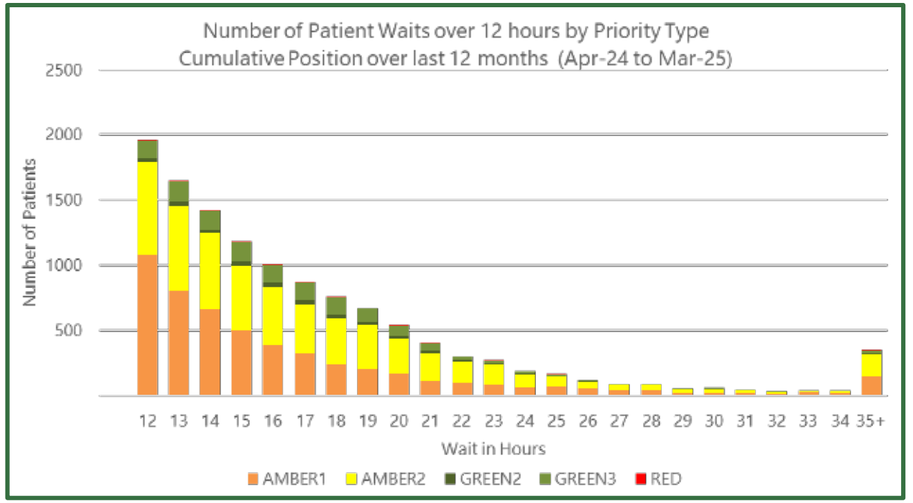
Lost Hours R

CI

QUEST







Analysis

264,393 hours were lost to Notification to Handover, i.e. hospital handover delays, over the last 12 months (Apr-24 to Mar-25), compared to 260,398 hours over the same timeframe the previous year. There were 21,852 hours lost in March 2025, which is 7.09% lower than the 23,403 hours lost during March 2024.

The hospitals with the highest levels of handover delays during March 2025 were:

- Grange University Hospital (ABUHB) at 3,282 lost hours
- Glan Clwyd Hospital (BCUHB) at 2,879 lost hours
- Ysbyty Maelor Hospital (BCUHB) at 2,717 lost hours
- Morriston Hospital (SBUHB) at 2,526 lost hours
- Ysbyty Gwynedd Hospital (BCUHB) at 2,446 lost hours

Notification to handover lost hours averaged 705 hours per day during March 2025 (31 days) compared to 672 hours per day (28 days) in February 2025.

In March 2025, the Trust could have responded to approximately 6,893 more patients if handovers were reduced, which highlights the impact these numbers are still having on the service.

In March 2025, 760 patients waited over 12 hours for an ambulance response.

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

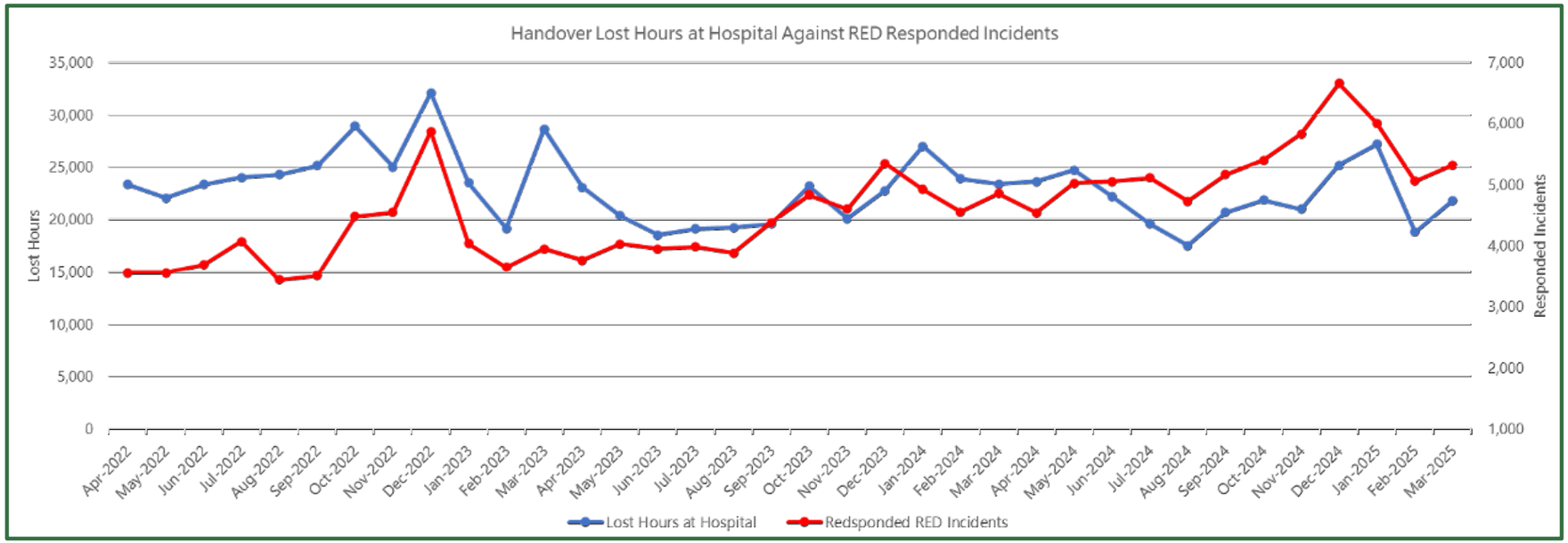
The Welsh Government handover target for 2024/25 is no waits over one hour; this equates to 7,500 hours lost to handover delays per month. There would need to be a 60% reduction in current handover levels for this to be achieved.

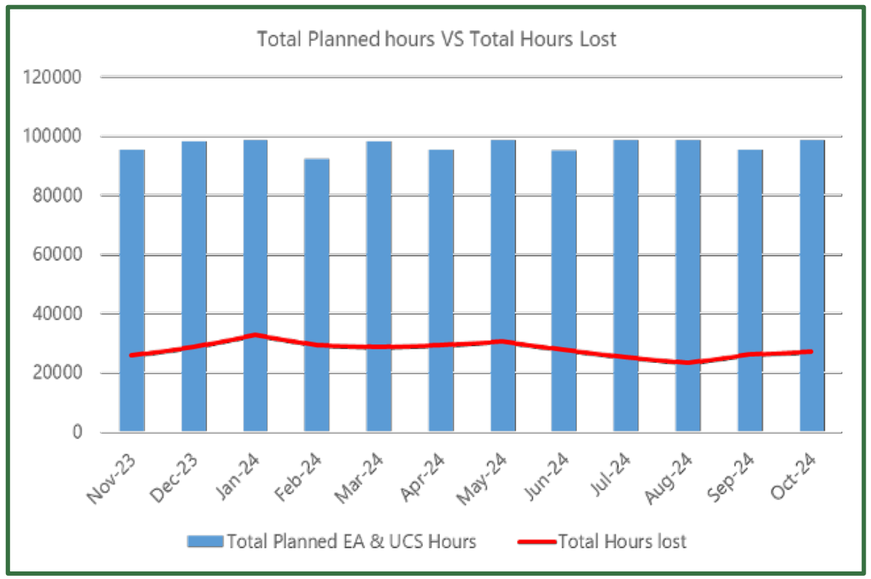
Partnerships / System Contribution

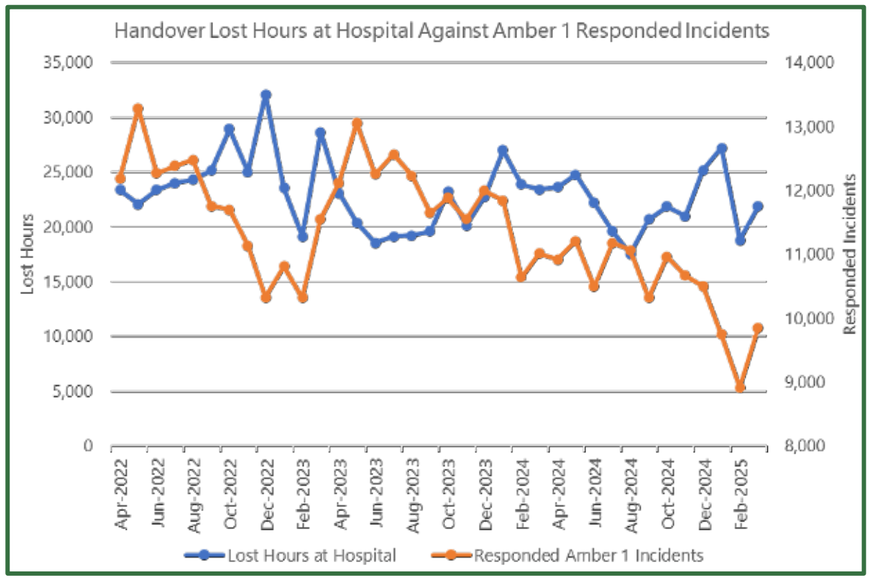
Handover Lost Hours Against Red & Amber 1 Responded Incidents

(Responsible Officer: Health Boards)

CI QUEST







Analysis

The top graph highlights that as handover lost hours have increased since February 2022, 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 right graph illustrates, there is a correlation between lost hours increasing and a decrease in the number of Amber 1 incidents being responded to, particularly at times of high demand, such as during December 2022. This is notwithstanding that some of these patients within the Amber 1 category will still be seriously ill.

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. The Welsh Government target was to see a 30% reduction in this metric by December 2024. However, this has not been achieved, with the 21,853 hours lost in March 2025.

**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	RRV	Rapid Response Vehicle
APP	Advanced Paramedic Practitioner	DAG	Delivery & Assurance Group	H&W	Health & Wellbeing	NQPs	Newly Qualified Paramedic	SB / SBUHB	Swansea Bay / Swansea Bay Health Board
AQI	Ambulance Quality Indicator	D&T	Discharge & Transfer	HR	Human resources	NRI	Nationally Reportable Incident	SCIF	Serious Concerns Incident Forum
BCU / BCUHB	Betsi Cadwaladr / Betsi Cadwaladr university Health Board	DU	Delivery Unit	HSE	Health and Safety Executive	OBC	Outline Business Case	STEMI	ST segment Evaluation Myocardial Infarction
CASC	Chief Ambulance Services Commissioner	EAP	Emergency Ambulance Practitioner	IG	Information Governance	OD	Organisational Development	TPT	Tactical Pandemic Team
CCC	Clinical Contact Centre	ED	Emergency Department	IMTP	Integrated Medium Term Plan	ODU	Operational Delivery Unit	TU	Trade Union
CCP	Complex Case Panel	ELT	Executive Leadership Team	IPR	Integrated Performance Report	OH	Occupational Health	UCA	Unscheduled Care Assistant
CEO	Chief Executive Officer	EMD	Emergency Medical Department	JCC	Joint Commissioning Committee	P / PHB	Powys / Powys Health Board	UCS	Unscheduled Care System
CFR	Community First Responder	EMS	Emergency Medical services	KPI	Key Performance Indicator	PCR / PCRs	Patient Care Record(s)	UHP	Unit Hours Production
CI	Clinical Indicator	ePCR	Electronic Patient Care Record	LTS	Long Term Strategy	JRCALC	Joint Royal Colleges Ambulances Liaison Committee	U/A RTB	Unavailable – return to Base
CHARU	Cymru High Acuity Response Unit	FTE	Full Time Equivalent	MACA	Military Aid to the Civil Authority	PECI	Patient Engagement & community Involvement	VPH	Vantage Point House (Cwmbran)
COOs	Chief Operating Officers	GDPR	General Data Protection Regulations	MIU	Minor Injury Unit	POD	Patient Offload department	WAST	Welsh Ambulance Services University NHS Trust
COPD	Chronic Obstructive Pulmonary Disease	GPOOH	General Practitioner Out of Hours	MPDS	Medical Priority Dispatch System	PPLH	Post Production Lost Hours	WG	Welsh Government
COVID-19	Corona Virus Disease (2019)	GTN	Glyceryl Trinitrate	NCCU	National Collaborative Commissioning Unit	PSPP	Public Sector Purchase Programme	WIIN	WAST Improvement & Innovation Network
CMT	Clinical Model Transformation	HB	Health Board	NEPTS	Non-Emergency Patient Transport Services	QPSE	Quality, Patient Safety & Experience		
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	**11**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**1**

Medicines Management Assurance Report for 2024/25

MEETING	Quality, Patient Experience and Safety Committee
DATE	9 May 2025
EXECUTIVE	Andy Swinburn, Executive Director of Paramedicine
AUTHOR	Jonathan Chippendale Asst Director of Clinical Development
CONTACT	Jonathan.chippendale@wales.nhs.uk

EXECUTIVE SUMMARY

1. The committee has requested a summary annual medicines management report.

2. Reporting cycles within the paper are now aligned to financial years as opposed to calendar years.

3. This paper covers the financial year 2024/25 in the absence of a 2023/24 report to QuEST, and for comparative purposes, reports were generated for the 23/24 period for inclusion.

4. A number of the measures reported, have been initiated in direct response to feedback received from Internal Audit reviews.

5. Medical management assurance reports are presented to the Ambulance Practice Steering Group monthly, and quarterly to the Senior Operations Team.

6. Close working with Operational teams ensures compliance is monitored and local audits are completed in time.

7. Areas covered in the report include:
   - Vehicle medicines Audit
   - Omnicell Monthly Cycle Count
   - Unresolved Controlled Drug Discrepancies on the Omnicell System
   - Patient Group Directions (PGD) – Evidence of Signed Authorisations
   - Expired PGDs
   - Abloy System
   - Notification Alerts
   - Controlled Drug Quarterly Occurrence Reports

- Medication Errors
- Penthrox (Ref audit report)
- Antimicrobial report

Recommended that the committee note and discuss the content of the appended report as required.

KEY ISSUES/IMPLICATIONS
As detailed in the Executive Summary

REPORT APPROVAL ROUTE
Clinical Directorate Business Meeting for approval (April 2025 CANCELLED) QUEST for discussion, (9th May 2025)

REPORT APPENDICES
MMAR Annual 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	Yes
Environmental/Sustainability	Yes	Legal Implications	Yes
Estate	Yes	Patient Safety/Safeguarding	Yes
Ethical Matters	Yes	Risks (Inc. Reputational)	Yes
Health Improvement	Yes	Socio Economic Duty	Yes
Health and Safety	Yes	TU Partner Consultation	Yes

Medicines Management Assurance Report

Annual update for 2024 - 2025

This report provides an overview of medicines related quality measures, drawn from monthly Medicines Management Assurance Reports (MMAR) for the financial period 2024 – 2025, including 2023-2024 data for comparison. A number of the measures reported have been initiated in direct response to feedback received from Internal Audit reviews. MMAR reports are presented to the Ambulance Practice Steering Group monthly, and was, until recently, presented quarterly to the Senior Operations Team.

Vehicle Medicines Audit (CD05)

Vehicle Medicines Audits (VMAs) have been established in WAST for several years. The main purpose of the audits are to check that the stock levels of vehicle controlled drug (CD) safes are consistent with the vehicle CD safe register, and those of the vehicle drug case consistent with the contents list and are in date. The quality measure for this audit, is for every Locality to complete at least one VMA (one vehicle) per month. ***Table 1*** shows a general increase in compliance across health boards but still only 4 out of the 8 health board areas achieved the 95% compliance required. It is unclear why compliance is low in HART but the area will now be added to the monthly MMAR as a means of driving up compliance.

LHB Area	% Compliance	
	2023-2024	2024-2025
Aneurin Bevan	98	100
Betsi Cadwaladr	89	94
Cardiff and Vale	100	92
Cwm Taf Morgannwg	94	97
HART	50	25
Hywel Dda	100	94
Powys Teaching	100	100
Swansea Bay	92	100

Table 1: VMA Compliance by Health Board Area for financial period 2024-2025

Omnicell Cabinet Monthly Cycle Count

Omnicell Cycle Counts are aimed at ensuring stock levels within the cabinets are accurate and remain capable of supporting operational requirements at all times. A cycle count is considered to be complete if a minimum of 36 of 41 'POM' items and all 4 'CD' items have been counted. In ***Table 2*** below, compliant counts are represented in GREEN and non-compliant RED, for the 2024-2025 period.

Table 3 shows an overall improvement in overall cycle count compliance for the period 2024-2025, compared to the previous year. However, cycle count compliance in Ysbyty Gwynedd and West Wales General hospital sites require attention. If an area has achieved the required 95% compliance, this is shown in GREEN.

The data in tables 2 and 3 does not currently include any Advanced Paramedic Practitioner medications. The feasibility of including this in further reports is being explored.

HB	Cabinet	Apr-24		May-24		Jun-24		Jul-24		Aug-24		Sep-24		Oct-24		Nov-24		Dec-24		Jan-25		Feb-25		Mar-25	
		POM	CD	POM	CD	POM	CD	POM	CD	POM	CD	POM	CD	POM	CD	POM	CD	POM	CD	POM	CD	POM	CD	POM	CD
%		90%	75%	90%	90%	85%	80%	95%	90%	95%	90%	95%	95%	90%	90%	85%	85%	90%	90%	100%	100%	100%	100%	95%	100%
AB	GUH	41	4	39	4	41	4	41	4	41	4	39	4	39	4	41	4	41	4	41	4	39	4	41	4
AB	Nev Hall	38	3	38	4	41	4	37	4	41	4	41	4	40	4	41	4	41	3	41	4	41	4	41	4
SB	Morriston	41	4	41	4	41	4	41	4	41	4	41	4	41	4	41	4	41	4	41	4	41	4	41	4
BCU	YGC	41	4	39	4	41	4	41	4	41	4	37	4	38	4	41	4	41	4	41	4	37	4	41	4
BCU	YG	10	1	10	3	10	3	41	4	41	4	14	4	15	1	15	4	41	4	41	4	41	4	18	4
BCU	Wrexham	41	3	41	4	41	4	41	4	41	4	41	4	41	4	41	4	41	4	41	4	41	4	41	4
BCU	Dobshill	41	0	41	0	41	4	41	3	41	4	41	0	41	4	41	4	41	4	41	4	41	4	41	4
C&V	UHW	41	4	41	4	41	4	41	4	41	4	41	4	41	4	38	4	41	4	41	4	41	4	41	4
C&V	UHL	41	4	41	4	39	4	41	4	40	4	41	4	41	4	41	4	35	4	41	4	41	4	41	4
CT	Prince Charles	41	4	41	4	41	4	41	4	41	4	41	4	41	4	37	4	9	2	40	4	40	4	40	4
CT	POW	37	3	41	4	41	3	41	4	41	4	41	4	41	3	41	4	41	4	41	4	41	4	41	4
CT	R Glam	41	4	41	4	41	4	40	4	41	4	41	4	41	4	8	0	41	4	41	4	41	4	41	4
HD	Bronglais	41	4	41	4	41	4	41	4	41	4	41	4	41	4	40	4	41	4	41	4	41	4	41	4
HD	Withybush	41	4	41	4	41	4	41	4	41	4	39	4	41	4	41	4	41	4	41	4	41	4	41	4
HD	WWG	9	4	12	4	3	1	7	4	4	1	38	4	8	4	8	4	38	4	37	4	41	4	41	4
HD	Prince Philip	41	4	40	4	9	1	39	3	41	2	41	4	41	4	41	3	41	4	41	4	38	4	41	4
POW	Newtown	41	4	41	4	41	4	41	4	41	4	41	4	41	4	41	4	41	4	41	4	41	4	41	4
POW	Welshpool	41	4	41	4	41	4	41	4	41	4	41	4	41	4	41	4	41	4	41	4	41	4	41	4
POW	Brecon	41	4	41	4	41	4	41	4	41	4	41	4	41	4	39	2	41	4	41	4	41	4	41	4
POW	Llandrindod	41	4	41	4	41	4	41	4	41	4	41	4	41	4	41	4	41	4	41	4	41	4	41	4

Table 2. Omnicell cycle count by HB area and cabinet site 2024 – 2025

			2023-2024 % Compliance			2024-2025 % Compliance	
HB	**Cabinet**		**POM**	**CD**		**POM**	**CD**
AB	GUH		83	92		100	100
AB	Nev Hall		92	58		100	83
SB	Morriston		100	92		100	100
BCU	YGC		67	75		100	100
BCU	YG		50	42		42	67
BCU	Wrexham		100	100		100	92
BCU	Dobshill		100	67		100	67
C&V	UHW		92	100		100	100
C&V	UHL		92	83		92	100
CT	Prince Charles		83	83		92	92
CT	POW		100	100		100	75
CT	R Glam		92	92		92	92
HD	Bronglais		100	100		100	100
HD	Withybush		100	92		100	100
HD	WWG		33	58		42	83
HD	Prince Philip		83	67		92	67
POW	Newtown		100	100		100	100

POW	Welshpool		100	100		100	100
POW	Brecon		100	100		100	92
POW	Llandrindod		100	100		100	100
	TOTAL		**88**	**85**		**93**	**90**

Table 3. Omnicell cycle count by HB area and cabinet site percentage of compliance per financial year

Unresolved CD Discrepancies on Omnicell System

Omnicell discrepancies are reported by Health Board area monthly, as part of the MMAR. ***Figure 1*** below, shows the total number of CD discrepancies created across Wales by month and those that were unresolved. ***Table 4*** provides a comparison between the number of CD discrepancies created and left unresolved between the reporting periods. During the 2024-2025 period, although the number of discrepancies created reduced, the percentage unresolved did not improve.

CD discrepancies on the Omnicell cabinet usually occur due to user error in counting the number of items in a specific area. In the CD area of the cabinet, users are required to count the number of items in a specific area (secure bin), prior to removing the required number of items. Most discrepancies occur because a user has removed an item, then counted the remaining items. If the number of items entered by the user is below that expected by the cabinet, a discrepancy alert is created and emailed directly to Duty Operations Managers (DOM)/Senior Paramedics (SP) and includes the user's details. This mechanism is designed to ensure that DOMs/SPs can contact the user within minutes of the discrepancy occurring, establish the reason for the discrepancy, and resolve it at the cabinet.

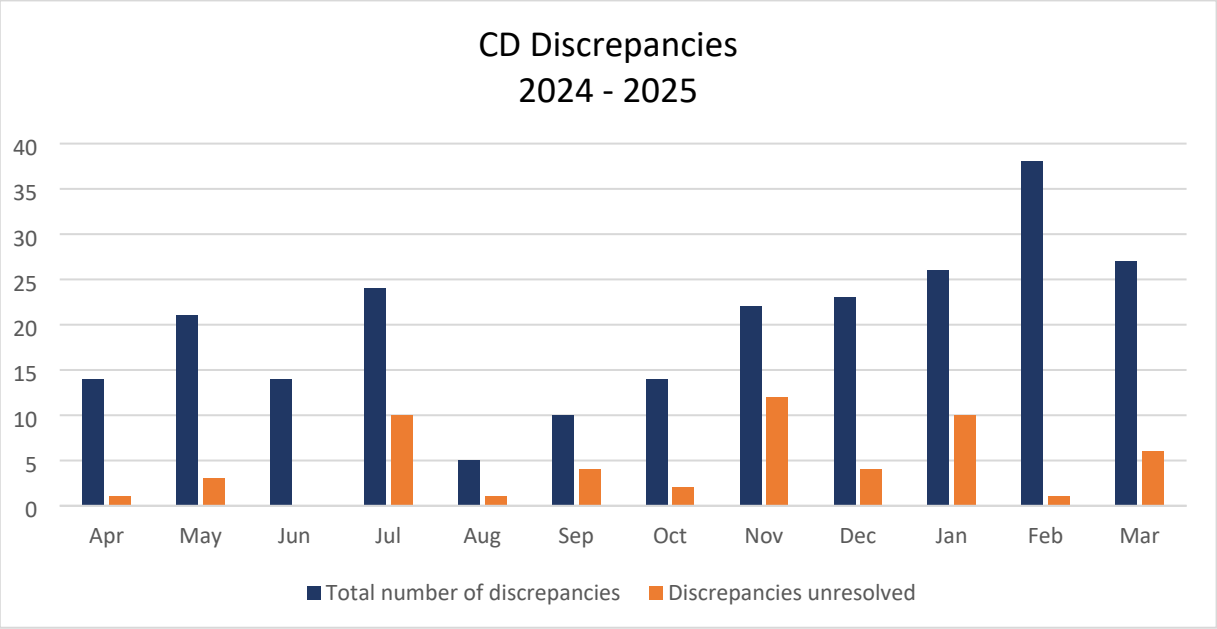


Figure 1. Omnicell CD Discrepancies 1st April 2024 to 31st March 2025

	2023-2024	2024-2025
Total Discrepancies	275	238
Percentage Unresolved	23.7	22.7

Table 4. Comparison of total number of Omnicell CD discrepancies and percentage unresolved per financial year

Patient Group Direction – evidence of signed authorisations

Patient Group Directions (PGDs) are a legal mechanism that permit groups of WAST clinicians (registrants), to administer drugs not currently included in Schedule 17 of the Human Medicines Regulations (2012). There are four EMS specific PGDs for intravenous use by WAST paramedics: Diazepam 10mg/2ml, Tranexamic Acid 100mg/ml, Co-amoxiclav 1200mg and Magnesium Sulfate 20%. Compliance is reported as the proportion of signed authorisations held on file by WAST Medicines Management, considering the number of paramedics in each Health Board area, minus abstractions (long-term sick, maternity leave, alternative duties).

Reporting of compliance against the 'Paramedic' PGD medicines began in January 2022. ***Table 5*** below, shows national compliance for the 'Paramedic' PGDs. The latest reissue date of each PGD is shown in each column. It should be noted that Magnesium Sulfate 20% was introduced in March 2025 so compliance is reported from that date and is, for the first time, captured on ESR. All other PGDs are being recorded manually on Excel. Utilising ESR appears to have improved the rate of compliance as it is a mandatory requirement and identifies those paramedics who are non-compliant in a timely manner. Considering that overall compliance has declined (see ***Table 6***) compared to the previous year the intention is to utilise ESR for all PGDs. Target compliance for all PGDs is 95%, represented as a GREEN cell.

Health Board	Diazepam (August 2023)	TXA (August 2024)	Co-amoxiclav (April 2024)	Magnesium Sulfate (March 2025)
Aneurin Bevan	66%	67%	42%	72%
Betsi	87%	88%	42%	61%
Cardiff & Vale	100%	100%	100%	77%
Cwm Taf	85%	85%	50%	71%
HART	92%	98%	96%	85%
Hywel Dda	97%	97%	63%	72%
Powys	99%	100%	100%	83%
Swansea Bay	97%	98%	80%	65%
Overall	**90%**	**92%**	**72%**	**73%**

Table 5. PGD Compliance for 'Paramedic' medicines as of 31st March 2025

Health Board	Total Annual % Compliance for all PGDs	
	2023-2024	**2024-2025**
Aneurin Bevan	94%	62%
Betsi	98%	69%
Cardiff & Vale	100%	94%
Cwm Taf	99%	73%
HART	100%	93%
Hywel Dda	98%	82%
Powys	100%	96%

Swansea Bay	100%	85%
Overall	**99%**	**82%**

Table 6. Comparison of PGD Compliance for 'Paramedic' medicines per financial year

Advanced Paramedic Practitioners (APPs) have access to an additional 19 PGDs. The regional PGD compliance for Advanced Paramedic Practitioners, as of 31st March 2025 is shown in ***Table 7***. Compliance has declined compared to the 2023-2024 financial year (see ***Table 8***). This could be attributed to the introduction of the Fosfomycin PGD and renewal of four other PGDs in March 2025.

PGD (APPs and Bank)	North	Central & West	South East	Total
	% Compliance 2024-2025			
Amoxicillin	63	43	25	**41**
Cetirizine Hydrochloride	88	81	83	**84**
Clarithromycin	94	95	96	**95**
Co-Amoxiclav	44	43	33	**39**
Codeine Phosphate	100	95	88	**93**
Diazepam	100	95	88	**93**
Doxycycline	100	95	92	**95**
Fosfomycin	63	48	46	**51**
Flucloxacillin	56	38	42	**44**
Ibuprofen	75	90	71	**79**
Loperamide Hydrochloride	94	90	75	**85**
Nitrofurantoin	100	95	92	**95**
Oral Rehydration Salts	75	90	83	**84**
Paracetamol	100	95	88	**93**
Penicillin 'V'	56	38	38	**43**
Prednisolone	88	86	83	**85**
Prochlorperazine	88	90	83	**87**
Trimethoprim	100	95	96	**97**
Salbutamol MDI	81	76	63	**72**
Regional Average	**82**	**78**	**72**	**77**

Table 7: 'Advanced Paramedic Practitioner' PGD Compliance 31st March 2025

PGD (APPs and Bank)	Total Annual % Compliance	
	2023-2024	2024-2025
Amoxicillin	86	41
Cetirizine Hydrochloride	93	84
Clarithromycin	75	95

Co-Amoxiclav	88	39
Codeine Phosphate	89	93
Diazepam	85	93
Doxycycline	89	95
Fosfomycin		51
Flucloxacillin	87	44
Ibuprofen	93	79
Loperamide Hydrochloride	93	85
Nitrofurantoin	89	95
Oral Rehydration Salts	90	84
Paracetamol	75	93
Penicillin 'V'	87	43
Prednisolone	93	85
Prochlorperazine	90	87
Trimethoprim	88	97
Salbutamol MDI	92	72
Regional Average	***88***	**77**

Table 8. Comparison PGD Compliance for 'Advanced Paramedic Practitioner' medicines per financial year

Due to an increase in Trainee Advanced Paramedic Practitioners (TAPPs) in the past year, new data has been added to advise on the current compliance rates of all TAPPs in WAST. TAPPs are segregated into different groups to represent where they are on their journey to qualifying as an APP, with the year of study added onto the title. TAPPs in the first year of training do not have access to any advanced practice PGDs. Second year (TAPP2) are permitted to use the following 6 PGDs: Amoxicillin, Clarithromycin, Doxycycline, Ibuprofen, Paracetamol and Prednisolone. TAPPs in the third and final year of study (TAPP3) can access the full range of advanced practice PGDs. Compliance for TAPP3s and TAPP2s per region is presented below (***Tables 9 and 11)***. Compared to the 2023-2024 financial year, (see ***Tables 10 and 12***) TAPP3s and TAPP2s PGD compliance has improved. This could be attributed to the introduction of TAPP induction programme where the medicines management team discuss the importance of PGDs and support staff in signing them. Knowledge checks have also been introduced for all new PGDs to encourage the reading and understating of the PGD in line with NICE guidance.

PGD (TAPP3s)	North	Central & West	South East	Total
	% Compliance 2024-2025			
Amoxicillin	50	72	27	**54**
Cetirizine Hydrochloride	100	94	73	**89**
Clarithromycin	100	100	100	**100**
Co-Amoxiclav	17	39	27	**31**
Codeine Phosphate	100	94	100	**97**
Diazepam	100	94	100	**97**
Doxycycline	100	100	100	**100**
Fosfomycin	50	50	36	**46**
Flucloxacillin	33	33	27	**31**
Ibuprofen	100	89	82	**89**
Loperamide Hydrochloride	100	89	82	**89**
Nitrofurantoin	100	94	100	**97**

Oral Rehydration Salts	100	94	73	**89**
Paracetamol	100	94	100	**97**
Penicillin 'V'	33	56	27	**97**
Prednisolone	83	78	82	**80**
Prochlorperazine	100	83	82	**86**
Trimethoprim	100	94	100	**97**
Salbutamol MDI	83	78	64	**74**
Regional Average	**82**	**80**	**73**	**81**

Table 9: 'Trainee Advanced Paramedic Practitioner 3' PGD Compliance 31st March 2025

PGD (TAPP3s)	Total Annual % Compliance	
	2023-2024	2024-2025
Amoxicillin	88	54
Cetirizine Hydrochloride	77	89
Clarithromycin	90	100
Co-Amoxiclav	75	31
Codeine Phosphate	69	97
Diazepam	74	97
Doxycycline	90	100
Fosfomycin	0	46
Flucloxacillin	77	31
Ibuprofen	84	89
Loperamide Hydrochloride	77	89
Nitrofurantoin	79	97
Oral Rehydration Salts	77	89
Paracetamol	78	97
Penicillin 'V'	77	97
Prednisolone	84	80
Prochlorperazine	77	86
Trimethoprim	79	97
Salbutamol MDI	72	74
Average	**79**	**81**

Table 10. Comparison PGD Compliance for 'Trainee Advanced Paramedic Practitioner 3' medicines per financial year

PGD (TAPP2s)	North	Central & West	South East	Total
	% Compliance 2024-2025			
Amoxicillin	50	67	57	**58**
Clarithromycin	50	100	57	**67**
Doxycycline	50	100	57	**67**
Ibuprofen	50	67	57	**58**

Paracetamol	50	100	57	**67**
Prednisolone	50	67	57	**58**
Regional Average	**50**	**83**	**57**	**63**

Table 11: 'Trainee Advanced Paramedic Practitioner 2' PGD Compliance 31st March 2025

PGD (TAPP2s)	Total Annual % Compliance	
	2023-2024	2024-2025
Amoxicillin	13	58
Clarithromycin	13	67
Doxycycline	0	67
Ibuprofen	13	58
Paracetamol	0	67
Prednisolone	0	58
Average	**6**	**63**

Table 12. Comparison PGD Compliance for 'Trainee Advanced Paramedic Practitioner 2' medicines per financial year

A further three PGD medicines to support the administration of 'Enhanced Analgesia' are available to a limited number of WAST SPs and paramedics working on the Cymru High Acuity Response Unit (CHARU) and Hazardous Area Response Team (HART). The three PGDs (***Table 13)*** are Flumazenil, Ketamine and Midazolam, they were renewed in September 2024 which may account for the decline in compliance compared to the 2023-2024 financial year.

Paramedic Grade	Ketamine %		Midazolam %		Flumazenil %	
	2023-2024	2024-2025	2023-2024	2024-2025	2023-2024	2024-2025
CHARU	99	69	99	69	98	69
Senior	100	98	100	98	100	98
HART	95	67	95	67	95	67

Table 13. 'Enhanced Analgesia' PGD compliance per financial year

Methoxyflurane (Penthrox)

A further sign off process has been added to the Medicines Management database following the introduction of Penthrox, an inhaled analgesia, in early May 2023. This applies to APPs, SPs, CHARU Paramedics, Paramedics, Emergency Medical Technicians (EMTs), Emergency Ambulance Practitioners (EAPs) and Ambulance Care Assistants 2 (ACA2s) all of which are included in the data in ***Table 14***. As of 31st March 2025 the compliance is as follows:

Penthrox				
Health Board	Total Staff	Received	Abstractions	Compliance
Aneurin Bevan	488	423	0	**87%**
Betsi	545	503	5	**93%**
Cardiff & Vale	237	215	2	**92%**
Cwm Taf	259	223	10	**90%**
HART	45	44	1	**100%**

Hywel Dda	351	330	8	**96%**
Powys	181	177	4	**100%**
Swansea Bay	265	246	3	**94%**
Overall	**2371**	**2161**	**33**	**93%**

Table 14. 'Penthrox Protocol' compliance per financial year

The introduction of Penthrox also applies to Community First Responders (CFRs) within the Trust, who due to the volunteering nature of their role, do not possess payroll numbers for identification. The CFR management team are responsible for retaining records of their responders. The medicines management MS Forms records currently show 478 CFRs having completed the Penthrox sign off authorising its use.

The introduction of Penthrox was focused on meeting three objectives. These are as follows:

a) Improve patient care and pain relief options for patients suffering traumatic injuries
b) Improve patient access to pain relief by training and equipping all emergency patient facing staff to be able to provide a standardised analgesia option which is not reliant on clinical grade
c) Improve clinical services offered by EMS, UCS and partner organisations we devolve health care provision to, in order to avoid extended periods of suffering for patients in the community

a) Improve patient care and pain relief options for patients suffering traumatic injuries

WAST now has a range of analgesic options for managing patients suffering traumatic injuries. This includes:

- Paracetamol (oral and intravenous (IV))
- Ibuprofen
- Codeine Phosphate (APP only)
- Entonox
- Penthrox
- Morphine Sulfate (IV)
- Ketamine

The addition of Penthrox to the formulary has increased the analgesic options for clinicians within WAST.

b) Improve patient access to pain relief by training and equipping all emergency patient facing staff to be able to provide a standardised analgesia option which is not reliant on clinical grade

Penthrox is authorised to be used by all clinicians in WAST that respond to 999 calls as part of their role. This includes APPs, SPs, CHARU Paramedics, Paramedics, Emergency Medical Technicians (EMTs), Emergency Ambulance Practitioners (EAPs) and Ambulance Care Assistants 2 (ACA2s). Successful completion of an e-learning package and signing the Penthrox protocol, authorises staff members to administer Penthrox in practice. As shown in ***Table 14***, overall compliance with signing the protocol is 93%, meaning that irrespective of clinical grade that attends the incident, access to a standardised analgesia option is highly likely.

c) Improve clinical services offered by EMS, UCS and partner organisations we devolve health care provision to, in order to avoid extended periods of suffering for patients in the community

For the first time in the UK, Penthrox is also authorised to be used by WAST CFRs who complete the same e-learning package and sign off process as clinicians employed by WAST.

Table 15 shows that for the 2024 calendar year there were 152 incidents where Penthrox was administered to a patient when a CFR was first on scene. In 53% of these cases, the CFR administered Penthrox prior to a WAST resource arriving. This resulted in a patient receiving

analgesia stronger than paracetamol, an average of 54 minutes before the first WAST resource arrived. This demonstrates a far better patient experience and an avoidance of extended periods of suffering for patients in our communities.

	2024
Total cases Penthrox administered where CFRs were first on scene	152
Total cases Penthrox given by CFR	81
Percentage of cases Penthrox administered by CFR	53%
Average time Penthrox given before EMS (HH:MM)	00:54

Table 15. Number of incidents where Penthrox was administered when CFRs were first on scene and length of time patient had access to Penthrox before WAST resource arrived for date range 1st January 2024-31st December 2024

Further benefits of the introduction of Penthrox have also been realised. ***Table 16*** shows that in 2022 of all drug administrations, 2.72% were attributable to Entonox. In 2024, this figure reduced to 2.58%. ***Table 17*** shows that there were 8802 administrations of Penthrox and Entonox documented on ePCR for the 2024 calendar year. 3794 of these cases received only Penthrox (as opposed to a combination of Penthrox and Entonox, or only Entonox). This accounts for 43% of cases where, in the absence of Penthrox being available, it could be argued that Entonox would have been administered. Entonox has 298 times the effect on global warming compared to Carbon Dioxide (UK Government, 2021) and some studies highlight the potential of switching from Entonox to Penthrox [in certain situations] contribution to the NHS carbon emission reduction target (Martindale et al, 2024)

	2022	2024
Total administrations (any drug)	126136	165592
Administration of Entonox	**3435**	**4268**
Percentage Entonox administered	2.72%	2.58%
Administration of Penthrox		**4534**
Percentage Penthrox administered		2.74%

Table 16. Total drug administrations with Entonox and Penthrox percentage for calendar periods shown

	2024
Total administrations of Penthrox and Entonox	**8802**
Penthrox and Entonox given together for same ePCR	740
Cases where Penthrox alone was given	3794
Percentage Entonox could have been given	**43%**

Table 17. Entonox and Penthrox administrations for 2024 calendar year

To ensure that Penthrox was being used safely by both WAST clinicians and CFR teams, an audit was commissioned to review all uses of Penthrox for the period of August 2023. ***Table 18*** shows the highlights of that audit with 460 patients receiving Penthrox and 95.7% of administrations given within the protocol. The report also highlights the need for improvements in pain score recording as well as documenting administrations in the correct section of ePCR. For the 4.3% of patients who were administered Penthrox outside of the protocol, DATIXs were submitted by the audit team which were then reviewed by the clinician and their Health Board Clinical Lead to identify any learning. There were no identified instances of patient harm.

Patients received Penthrox	460
Administration within protocol	95.7%
Administration OUTSIDE protocol	4.3%
Patients received just 1 dose	417

Patients received 2 doses	43
Pain score recorded before 1st dose	83.9%
Pain score recorded before 2nd dose	67.4%
Penthrox recorded ONLY in the narrative	30

Table 18. Summary of Penthrox audit completed for the month of August 2023

A further audit was completed by NHS Wales Audit and Assurance services for the period October 2023 to September 2024 with findings and agreed actions published March 2025.

A high-level overview of Pentrox usage in the trust for the 24/25 year can be seen in *appendix 1* with data drawn from the ePCR dashboard.

The Datix system was accessed and searched for entries relating to Penthrox (search criteria: 'Medication, IV Fluids' and 'Methoxyflurane') over the financial year 24/25 with the following findings;

8 Administration error DATIXs in total

4 given to under 18 year olds

2 given to non-trauma related pain

1 for patient with new confusion

1 for alcohol dependant patient (crew found out after administration)

All but one entry has been closed following local investigation with appropriate action plans in place.

Each incident was self-reported.

To the authors knowledge there have been no other events reported. No SCIF incidents were involved with a Penthrox administration identified as a cause.

Abloy System

The Trust Abloy system was rolled out in August 2020 and supports the safer management of CDs. It is a Web-based operating system (controlled access) which reports the following as of 31st March 2025:

- individual issue keys – **1,466** issued to paramedics
- percentage of receipts received – **97.14%**
- number of lost and deactivated keys (since introduction) – **125**
- number of broken keys (since introduction) - **137**

At the start of their shift, paramedics are required to dock their key in the station wall mounted programming device. This action will upload CD access activity for the previous shift, before activating the key for a fixed 15-hour period. Once activated, paramedics can access all vehicle CD safes. Access to station-based CD safes is restricted to specific individuals (DOM/SP/CHARU), dependent on the access profile assigned to their keys.

Notification Alerts

The Trust receives alerts and notifications (medicines, equipment, patient safety), from a range of sources. The Medicines Management team is responsible for reviewing all medicines related notifications to assess their impact on the organisation and/or its clinicians. The vast majority of notifications have no implications, therefore requiring no action. ***Table 19*** shows the number of notifications received and those that required action in WAST for the 2024-2025 financial year. Most commonly, notifications are related to medicines shortages/supply issues. At the time of writing this report one notification that required action is still ongoing and this is related to a national shortage of intravenous paracetamol. Pharmacies across Wales are receiving 80% of their usual allocation. To ensure WAST clinicians are aware of the shortage and only use the intravenous paracetamol when necessary, a clinical notice has been issued and a notification added to all WAST Omnicells.

Notifications	Public Health Alerts	Applies to WAST
Apr-24	11	1
May-24	14	1
Jun-24	11	0
Jul-24	10	0
Aug-24	16	0
Sep-24	4	0
Oct-24	14	0
Nov-24	5	0
Dec-24	14	1
Jan-25	6	1
Feb-25	6	0
Mar-25	8	0
Total	**119**	**4**

Table 19. Total number of medication alerts and number that required WAST action

Controlled Drugs Quarterly Occurrence Reports

The UK Government's response to the Shipman Inquiry's Fourth Report, Safer management of controlled drugs (2008), required all healthcare and social care organisations to be accountable for the safe management of the CDs it uses. In Wales, each Health Board is responsible for organising and chairing a Local Intelligence Network (LIN). Chaired by the Health Board Accountable Officer, LIN meetings are generally held on a quarterly basis. Each organisation that uses CDs within the boundaries of a LIN, is required to submit a quarterly occurrence report, detailing the type of incident (loss/theft/discrepancy/breakage), and describing any actions taken to minimise a recurrence. In WAST, the Head of Medicines Management is responsible for reviewing all reported CD incidents and preparing the LIN report on behalf of the Trust Accountable Officer (Executive Director of Paramedicine), which is circulated to each of the 7 LIN in Wales. ***Table 20*** provides an overview of the number and type of incidents reported over the four quarters of the 2024-2025 financial year.

	No. of incidents	Incident type
2024 Q2	9	• *Accidental breakage = 3* • *Other =1* • *Discrepancies = 5 (4 resolved, 1 HB incident)*
2024 Q3	14	• *Accidental breakage = 2* • *Other = 5 (3 x OOD Morphine, 2 x disposal errors)* • *Discrepancies = 3 (1 resolved)* • *Unexplained breakage = 4*
2024 Q4	11	• *Accidental breakage = 4* • *Unexplained breakage = 1* • *Other = 2* • *Discrepancies = 3 (2 resolved)* • *Unaccountable loss = 1*
2025 Q1	9	• *Accidental breakage = 3* • *Unexplained breakage = 1* • *Other = 3* • *Discrepancies = 2 (2 resolved)*

Table 20. Summary of CD incidents reported to LIN Jan-Dec 2023

Medication Errors

Table 21 provides an overview of closed medication errors reported on DATIX up to 31st March 2025. Limited resources within the Medicines Management team limits the ability to conduct an in-depth analysis of this data in the time available to prepare this report, but it is hoped to include this in future annual MMARs. ***Table 22*** shows a 59% decrease in reported medication errors in 2024-2025 compared to the previous year. It should be noted that the DATIX system recorded 104 medication errors for 2024-2025 but a manual review reduced this to 29 due to either incorrect categorisation by the reporter or incidents being reported that did not involve WAST staff.

Number of reported incidents by Harm (reporter)					
Financial Year	**No Harm**	**Low Harm**	**Moderate Harm**	**Severe Harm**	**Total**
2024-2025	8	17	3	1	29
Number of reported incidents by Sub-category					
Incorrect medication	**Incorrect strength/dose**	**Expired medication**	**Administration contraindicated**	**Unauthorised 1 Early administration 3 Incorrect route 2**	**Total**
2	4	8	9	6	29

Table 21. DATIXs received shown by severity and category for 2024-2025 financial year.

	2023-2024	2024-2025
Total Discrepancies	49	29

Table 22. DATIX recorded medication errors for financial year of periods shown

Antimicrobial Stewardship

The Medicines Management Policy v4.0 was renewed in August 2024 and section 16.6 states the following:

'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.'

In the first iteration the annual antimicrobial audit has been produced alongside the assurance report and included as ***Appendix 2***. It is anticipated that future iterations will be a standalone document with more specific sections reviewing compliance to antimicrobial PGDs as well as overall antimicrobial use. This audit will be added to the planner for the clinical audit team to undertake annually.

To further support antimicrobial stewardship and to ensure safe practice within our growing numbers of non-medical prescribers (NMPs), the Medicines Management

team and the APP Leadership team have been working collaboratively to produce a formulary from which our NMPs can prescribe. Having a formulary promotes safe prescribing practice for our patients and the Trust, as well as allowing prescribing audits to be conducted effectively.

Future Plans

- Add HART to the monthly MMAR reports for VMAs
- Link in with local management teams to increase compliance with Omnicell cycle counts at Ysbyty Gwynedd and West Wales General hospital sites
- Assess feasibility of including APP medications to monthly Omnicell cycle count
- Issue guidance around withdrawal of CD medications from the Omnicell to avoid discrepancies
- For all future PGD compliance to be captured on ESR
- Medicines Management team to continue supporting TAPP inductions
- Review Procedure for CFR restocking of Penthrox with reference to NWSSP audit actions due May 2025 if required.

If you require any further information following the Medicines Management Assurance Report, please contact; AMB_MedsManagement@wales.nhs.uk

This report was jointly prepared by Dr Chris Moore, Head of Medicines Management, Huw Jackson, Head of Medicines Management and Dr Sofia Fernandez, Lead Pharmacist.

References

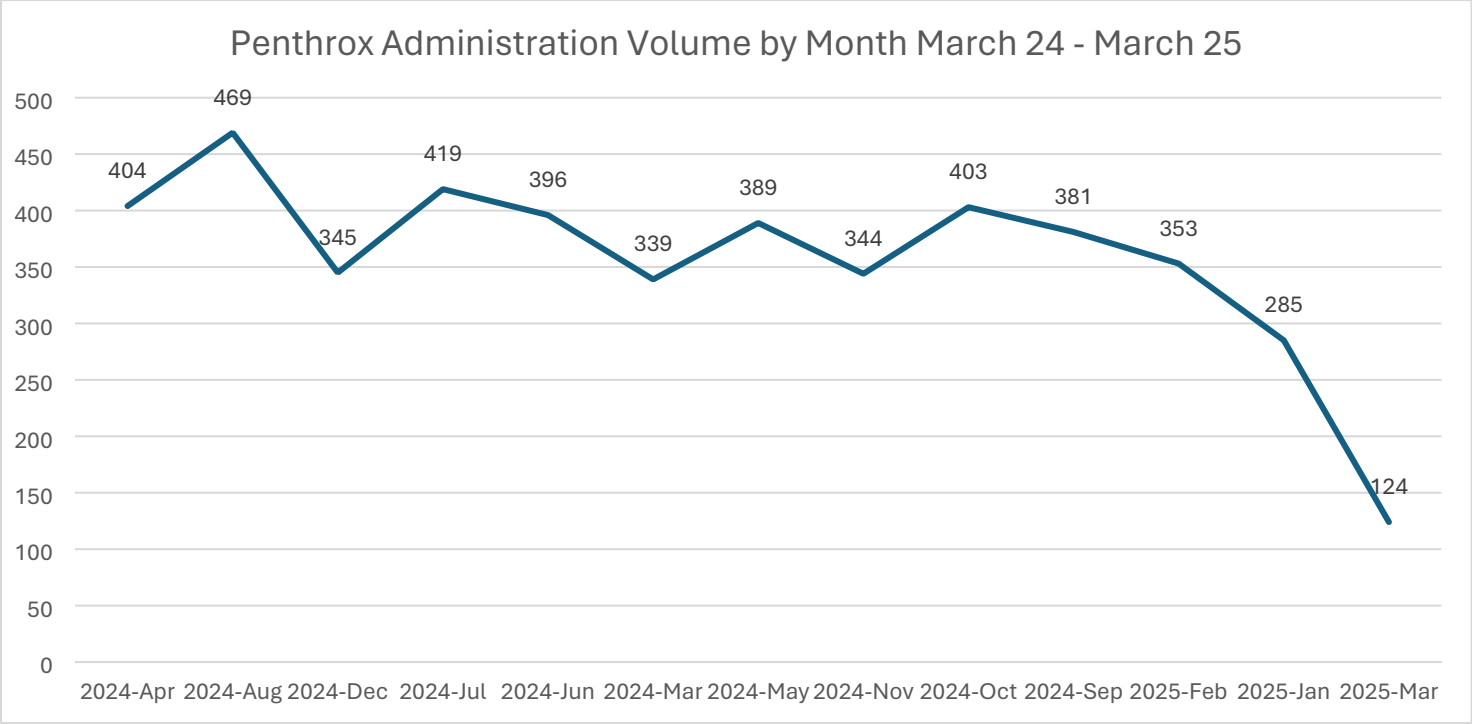
Martindale AE, Morris DS, Cromarty T, Fennell-Wells A, Duane B. Environmental impact of low-dose methoxyflurane versus nitrous oxide for analgesia: how green is the 'green whistle'? Emerg Med J. 2024 Jan 22;41(2):69-75. doi: 10.1136/emermed-2022-213042. PMID: 37770121.

UK Government Conversion Factors for Company Reporting 2021. Available from: https://www.gov.uk/government/publications/greenhouse-gas-reporting-conversion-factors-2021. Accessed 8/6/2021

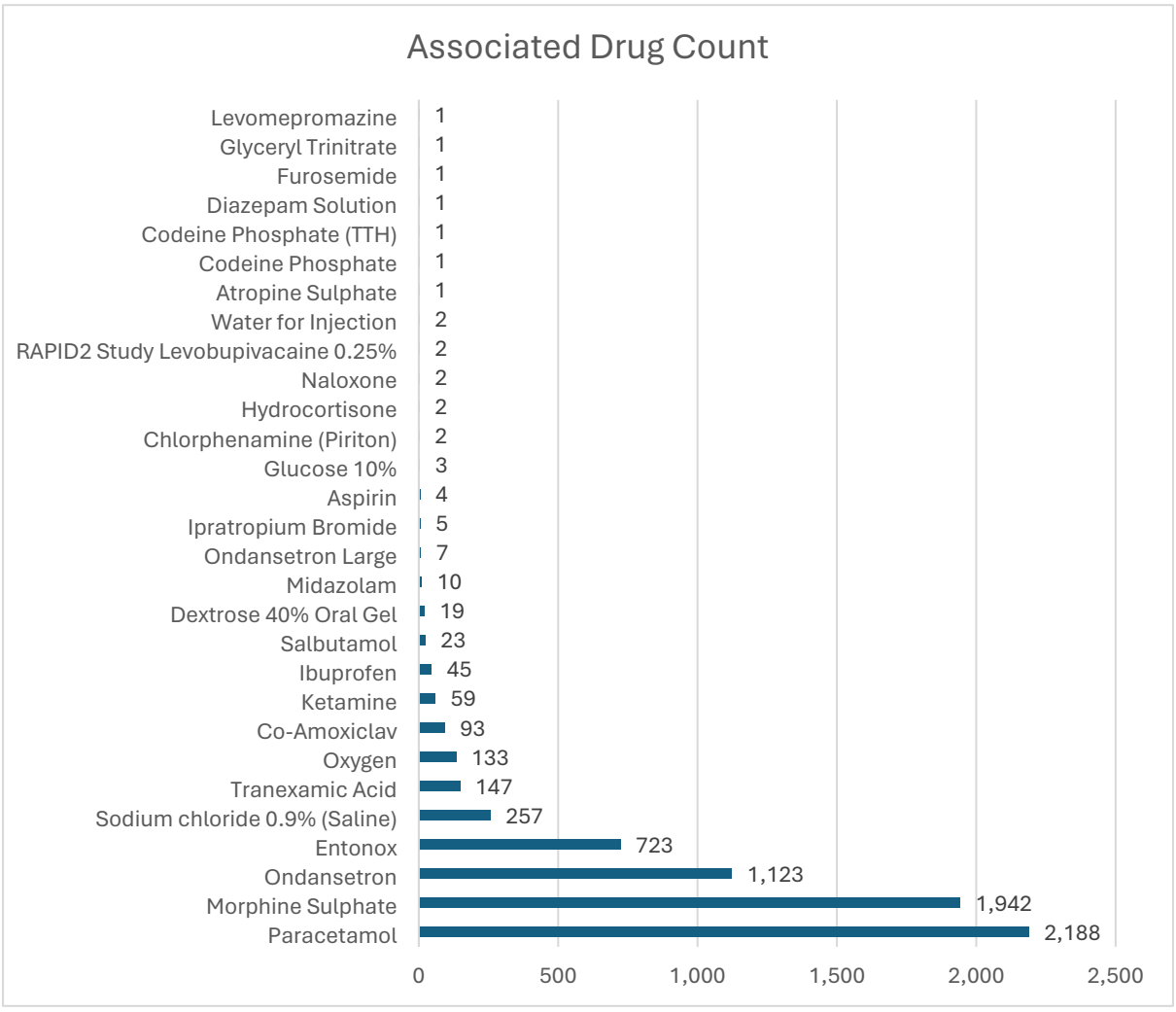
Appendix 1 - ePCR dashboard analysis of Penthrox usage April 24/March 25.

Appendix 2 – WAST Antimicrobial report.

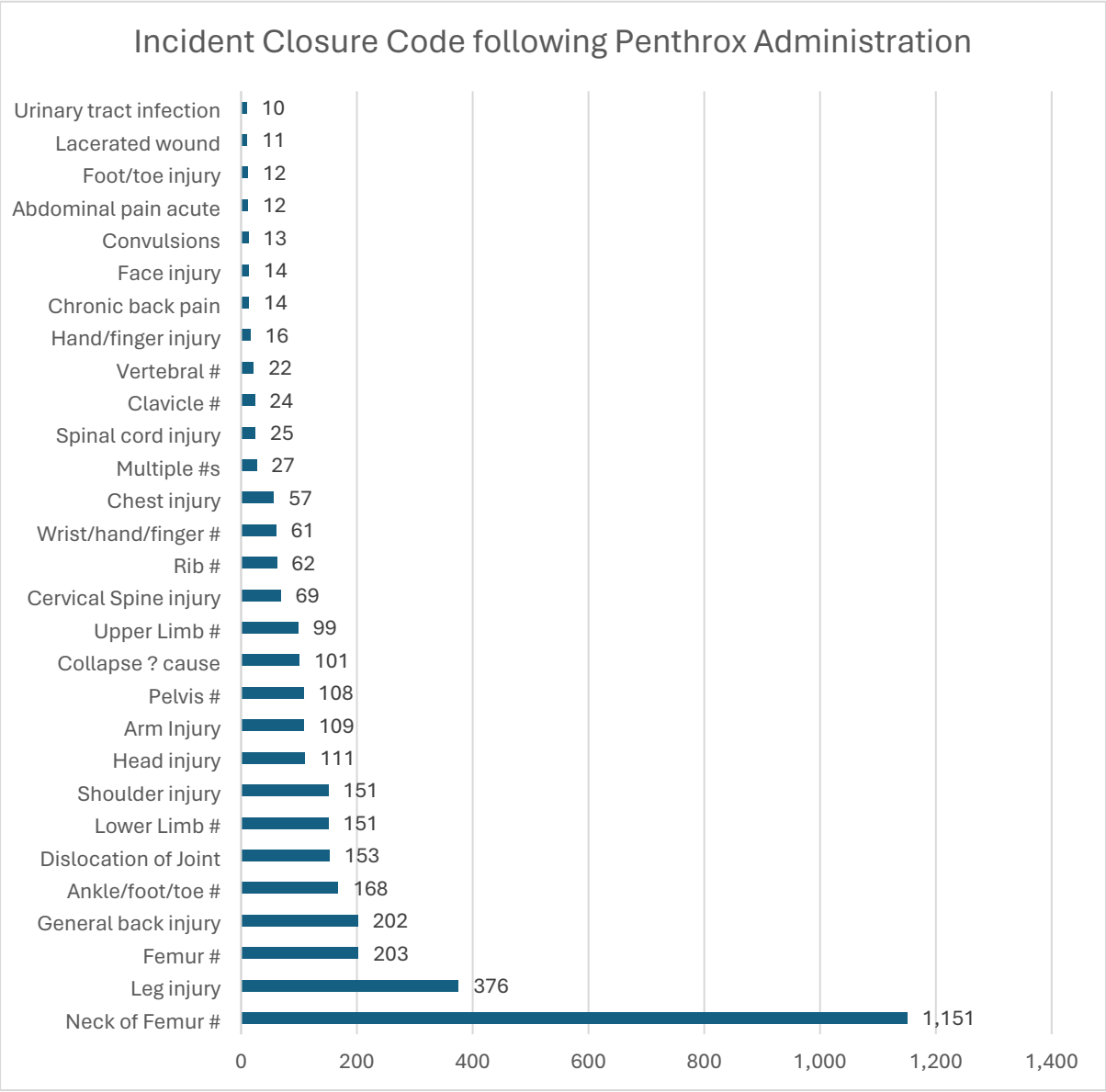
Penthrox Administration April 2024 – March 2025



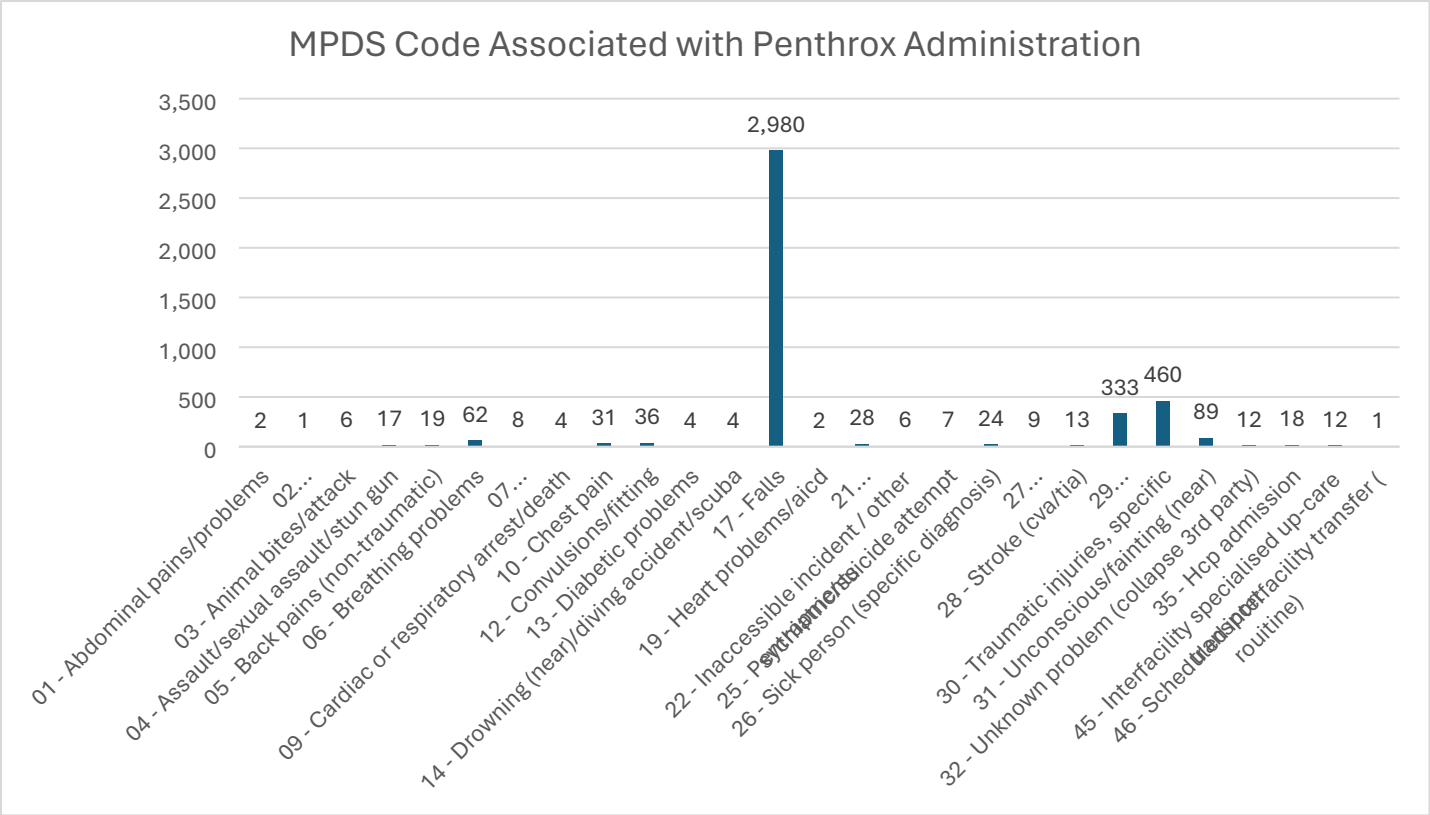
The above graph illustrates the number of penthrox administrations broken down by month, equating to a total of 4,651 total administrations for the stated period.



Where penthrox is administered, it is regularly accompanied by Paracetamol (47% of the time) and morphine (41.8% of the time).

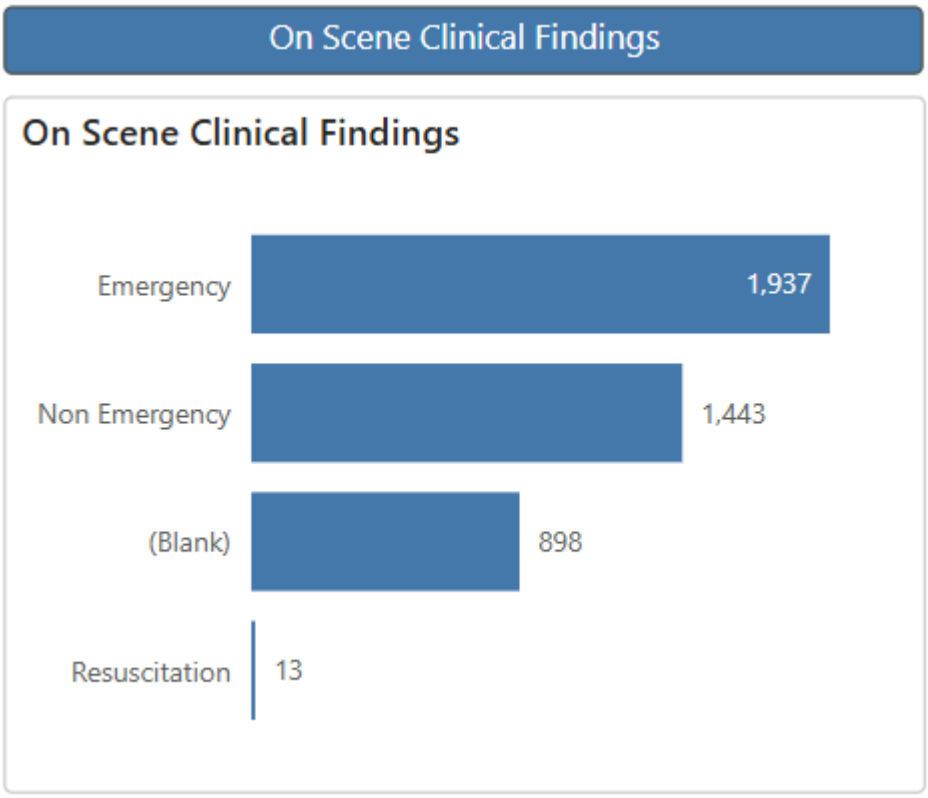


The administration of penthrox is strongly associated with lower limb injuries, particularly neck of femur fracture. All closure codes with less than 10 entries have been removed.

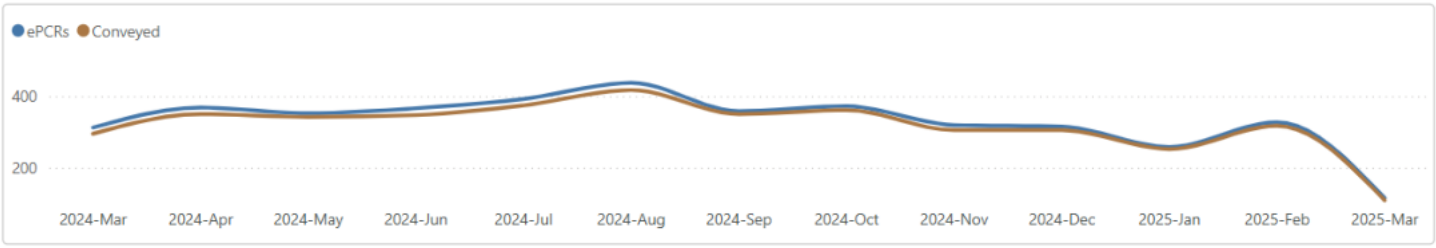


The administration of penthrox is predominantly seen within MPDS codes that suggest a traumatic presentation, namely falls, RTC and traumatic injuries.

Within ePCR, the individual completing the record will record whether they believe the on scene clinical findings to be of an emergency, non-emergency or resuscitative nature. The below illustrates most are considered to have clinical findings that suggest an emergency.

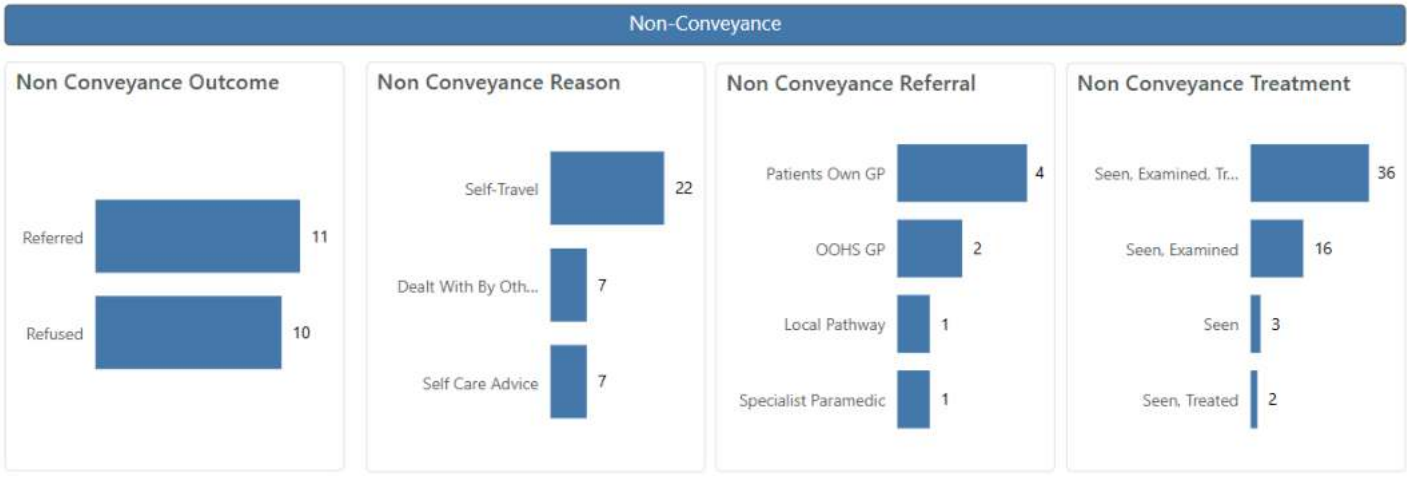


Patients who receive penthrox have a significantly high percentage of conveyance (96.1%) to a secondary care department, as shown below:

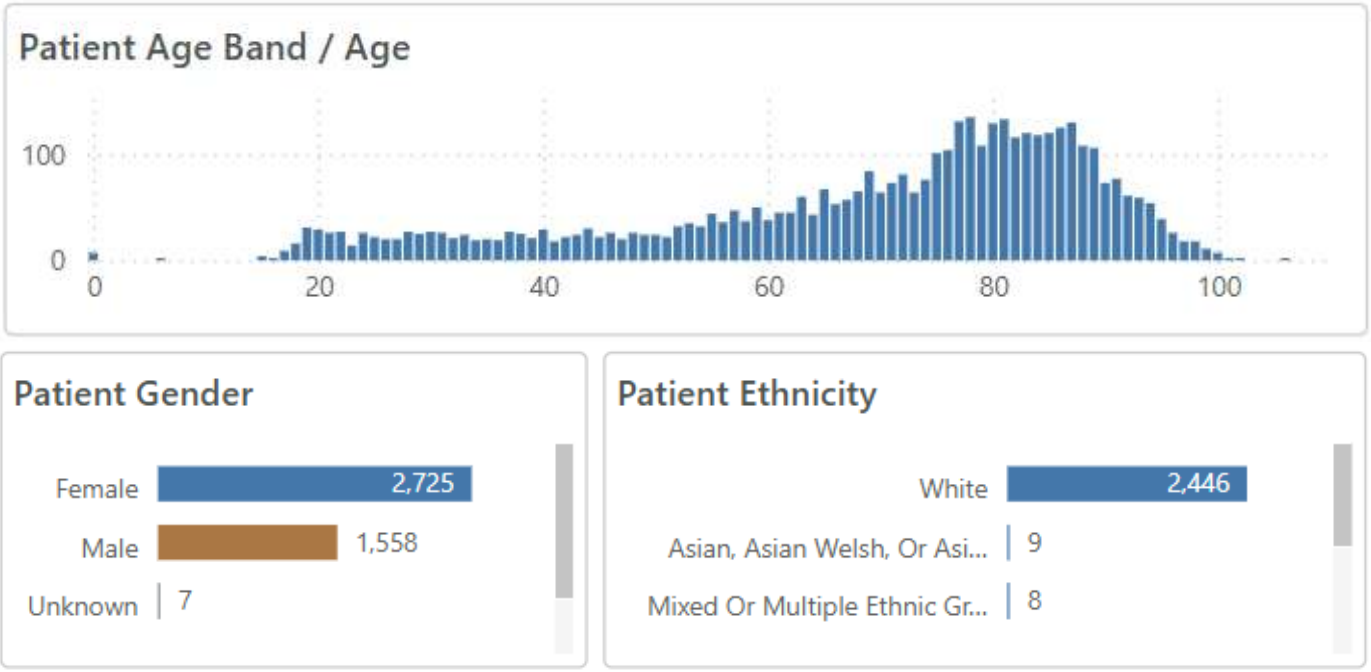


Of the 4,291 patients who receive penthrox, 954 were pre-alerted to a secondary care department, equating to 22.2%.

Where the patient was not conveyed by a WAST resource, the below illustrates the reasons:



The demographic data associated with the administration of penthrox is shown below:



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

WAST Antimicrobial Audit Report

Annual update for Year 2024

Introduction

This report is aimed at providing an overview of the antimicrobial usage within the Welsh Ambulance Services University NHS Trust (WAST). This includes:

- **Paramedic antimicrobials:**
  - **S17 antimicrobials:** medicines listed in Schedule 17, Part 3 of the Human Medicines Regulations which paramedics can administer for the immediate, necessary treatment of sick or injured persons. This list at present includes benzylpenicillin IV
  - **PGD antimicrobials**: given to a patient as defined on a WAST PGD. These PGDs only include a limited number of antimicrobials. This list for 2024 included: amoxicillin, clarithromycin, co-amoxiclav (oral), co-amoxiclav (IV), doxycycline, flucloxacillin, nitrofurantoin, phenoxymethylpenicillin (penicillin V) and trimethoprim.
- **NMP antimicrobials**: prescribed by a WAST non-medical prescriber (NMP). Paramedic NMPs are allowed to prescribe any antimicrobial according to their scope of practice and competence.

The term “antimicrobial” refers to any antibiotics, antifungals, antivirals and antiparasitic medications.

WAST is committed to contribute to the UK 20-year vision to confront and address antimicrobial resistance (AMR). This sets a goal of ensuring AMR will be controlled and contained by 2040.

Wales, alongside the other three UK nations, has developed a series of five-year national action plans towards achieving the vision for change to confronting AMR from 2024 to 2029. As a result, the Welsh Government published a new Welsh Circular setting the improvement goals from 2024 to 2025 (WHC/2024/038 2024).

The Healthcare Antimicrobial Resistance and Prescribing (HARP) team Public Health Wales, as directed by Welsh Government, has provided a final position and defined the current situation against the improvement goals (HARP 2024). WAST will aim to comply with those improvement goals defined by Public Health Wales for Primary Care:

❖ **Total antimicrobial usage**

- **A 10% reduction in total antimicrobial usage by 2029/30**
- As defined in the HARP report, the reporting of total antibacterial is in line with the UK's national action plan. Antibacterials excluded from the data set: TB drugs including rifampicin; anti-parasitic drugs including spiramycin and tinidazole; neomycin due to toxicity; drugs whose main use is not for the treatment of bacterial infection i.e. demeclocycline for SIADH, and rifaximin for prevention of hepatic encephalopathy.

❖ **Proportion of total usage from the WHO "Access" category**

- **At least 70% of total antibiotic use from the Access group of the AWaRe categories by 2029/30**
- Antimicrobials were assigned AWaRe categories based on the Word Health Organization categories (WHO AWaRe 2024).
    i. **Access group**: first or second choice antibiotics that offer the best therapeutic value while minimising the potential for AMR
    ii. **Watch group**: first and second choice antibiotics only indicated for specific limited number of infective syndromes as they are more prone to AMR
    iii. **Reserve group**: last resort antibiotics for highly selected patients to ensure their continued effectiveness

This report runs on a calendar year (1st of January to 31st of December) to include the data provided by NHS Wales Shared Services Partnership (NWSSP) which gets reported with a delay of 2 to 3 months.

Other audits may be introduced by WAST to monitor that the use of antimicrobials follow the current local and national guidelines.

Results

1. Total WAST antibiotic usage for 2024 as per WHO "Access" category

Table 1 describes the total number of antibiotics used by any WAST clinician for the year 2024. This includes any antibiotics given under S17 or any WAST PGDs. It also includes any antibiotics prescribed by paramedic NMPs.

The top 3 antibiotics used in Wales by WAST are oral doxycycline, oral amoxicillin and IV co-amoxiclav, all given as per PGDs. Prescription of antibiotics by NMPs remains low reflecting the small but growing number of NMPs in WAST.

93% of the antibiotics used by WAST are from the WHO Access group. This is above the target of 70% set out by Public Health Wales.

The majority of antibiotics are currently being given by paramedics using S17 or PGDs. The prescription of antibiotics by NMPs is lower.

	AWaRe category	TOTAL 2024	NMP antimicrobials	Paramedic antimicrobials
Doxycycline 100mg cap	Access	309	35	274
Amoxicillin ALL formulations	Access	275	37	238
CO-AMOXICLAV 1000/200MG VIAL	Access	232	0	232
Nitrofurantoin ALL formulations	Access	128	15	113
BENZYLPENICILLIN 600MG VIAL	Access	105	0	105
Clarithromycin ALL formulations	Watch	76	10	66
Trimethoprim ALL formulations	Access	40	0	40
Flucloxacillin ALL formulations	Access	22	2	20
Co-amoxiclav 500/125mg tab	Access	21	0	21
Penicillin V ALL formulations	Access	18	12	6
Fosfomycin Trometamol 3g sach	Watch	13	13	n/a
Cefalexin ALL formulations	Access	7	7	n/a
Co-Trimoxazole 160mg/800mg tabs	Access	7	7	n/a
Pivmecillinam Hydrochloride 200mg tabs	Access	6	6	n/a
Ciprofloxacin 500mg tabs	Watch	1	1	n/a
Metronidazole 400mg tabs	Access	1	1	n/a
Percentage of antimicrobials within the Access Category	**93%**			

Table 1: Antimicrobials supplied by any WAST clinician in year 2024

2. Total antibiotic usage per incident Health Board area as reported on the electronic Patient Care Record (ePCR)

Antibiotics given by paramedics under S17 or PGDs have been separated per Health Board area as reported on the ePCR (***Figure 1***).

Betsi Cadwaladr University (BCU) is the Health Board area with higher usage of antibiotics. This is not related to a higher number of Advanced Paramedic Practitioners (APPs) in the North, with South East having the highest number of APPs. However, APPs in BCU have an established rotation in primary care which may contribute to a higher confidence when supplying antibiotics using the PGDs.

Some ePCRs have not defined the area of the incident and therefore these could not be allocated to a specific Health Board.

The ePCR also records the indication for which the antibiotics have been used. To ensure that antimicrobial prescribing is safe, effective and appropriate, they should be prescribed or given as per local and national guidelines. At present there is no system in place to audit this within WAST.

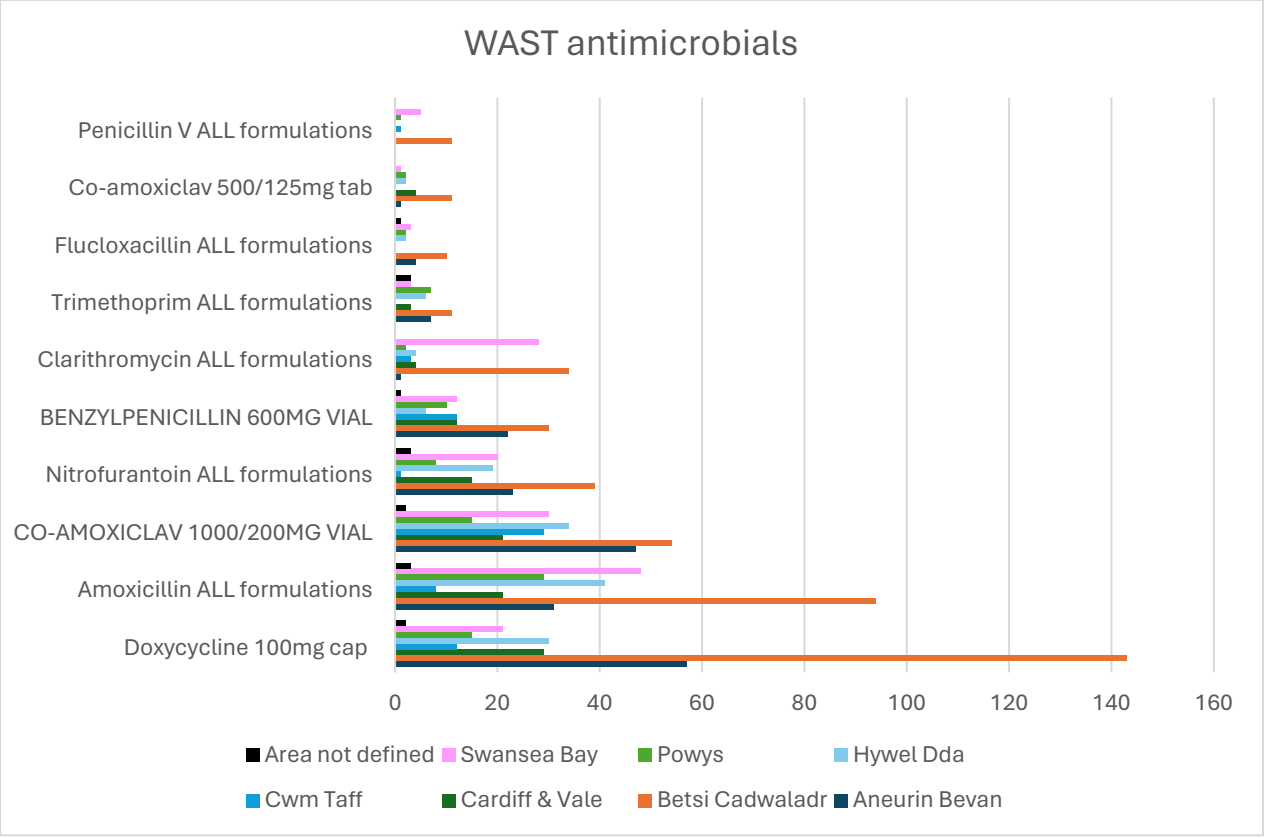


Figure 1: Antibiotics given by paramedics under S17 or PGDs separated per Health Board area as reported on ePCRs

3. Comparison of antibiotic usage by WAST paramedics

The aim of Public Health Wales is to have a 10% reduction in total antimicrobial usage by 2029/30.

WAST's usage of the top 10 antibiotics has increased by 43% from 2023 (***Table 2***). This could be a reflection of the increasing number of PGDs, APPs and NMPs within WAST and may not be representative of a trend of over-usage of antimicrobials.

	TOTAL 2023	TOTAL 2024
Amoxicillin ALL formulations	**176**	**275**
BENZYLPENICILLIN 600MG VIAL	**81**	**105**
Clarithromycin ALL formulations	**38**	**76**
CO-AMOXICLAV 1000/200MG VIAL	**226**	**232**
Co-amoxiclav 500/125mg tab	**12**	**21**
Doxycycline 100mg cap	**186**	**309**
Flucloxacillin ALL formulations	**11**	**22**
Nitrofurantoin ALL formulations	**84**	**128**
Penicillin V ALL formulations	**14**	**18**
Trimethoprim ALL formulations	**31**	**40**
TOTAL	**859**	**1226**

Table 2: Comparison of top 10 antimicrobials supplied by any WAST clinician

4. Antimicrobials prescribed by WAST NMPs

Table 3 includes all prescriptions written by WAST NMPs containing an antimicrobial medication as reported by NWSSP. The description of the item and its cost gets collated after it has been dispensed by a community pharmacy.

NMPs are allowed to prescribe antimicrobials that are not included within the list of S17 and/or WAST PGDs according to their expertise and scope of practice. They are encouraged to use antibiotics within the Access group as first choice and refer to local antimicrobial guidelines (Eolas) in practice.

The number of NMP antimicrobials is expected to increase as the NMP workforce increases within WAST.

The top 2 antibiotics prescribed by WAST NMPs have been amoxicillin and doxycycline. The highest expenditure has been on pivmecillinam and nitrofurantoin. Although the Health Boards cover the cost of prescriptions issued by paramedic NMPs, the cost of antimicrobials is shown below and it is currently quite low.

ANTIBACTERIAL DRUGS	TOTAL Price for 2024	TOTAL items for 2024
Amoxicillin ALL formulations	£54.58	37
Doxycycline Hyclate ALL formulations	£37.27	35
Nitrofurantoin ALL formulations	£90.78	15
Fosfomycin Trometamol 3g sach	£87.48	13
Phenoxymethylpenicillin (penicillin V) ALL formulations	£69.88	12
Clarithromycin ALL formulations	£62.01	10
Cefalexin ALL formulations	£44.28	7
Co-Trimoxazole 160mg/800mg tabs	£20.74	7
Pivmecillinam Hydrochloride 200mg tabs	£123.12	6
Flucloxacillin Sodium 500mg caps	£3.65	2
Ciprofloxacin 500mg tabs	£1.36	1
Metronidazole 400mg tabs	£0.74	1
TOTAL	**£595.89**	**146**

ANTIFUNGAL DRUGS	TOTAL Price for 2024	TOTAL items for 2024
Nystatin oral susp 100.000u/ml	£7.20	4

Table 3: prescriptions written by WAST NMPs containing an antimicrobial medications as reported by NSWSSP

Conclusions and action plan

	ACTION
93% of the antibiotics are within the Access group which complies with the target of above 70%	Continue encouraging the use of antibiotics within the Access group for PGDs and NMPs
Betsi Cadwaladr Health Board is the area with higher usage of antibiotics	This may be a reflection of a fully established primary care rotation providing more confidence to the paramedics. Continue monitoring.
Health Board area where incident happened not being reported on ePCR	Encourage accurate documentation
Safe and effective use of antibiotics not being monitored at present	A system needs to be put in place to audit the compliance to guidelines. See ***Appendix 1***
The total number of antibiotics has increased from 2023	Absolute numbers have been used for this report. If data available, these should be corrected to reflect the increasing number of PGDs, APPs and NMPs

REFERENCES

- Welsh Health Circular WHC/2024/038: Healthcare associated infections and antimicrobial resistance goals 2024 to 2025. Available at: https://www.gov.wales/healthcare-associated-infections-and-antimicrobial-resistance-goals-2024-2025-whc2024038 . Accessed 31st March 2025
- Healthcare Associated Infection, Antimicrobial Resistance and Prescribing (HARP) programme: Report on antimicrobial prescribing improvement goals from primary care and secondary care in Wales. Available at: https://phw.nhs.wales/services-and-teams/antibiotics-and-infections/antimicrobial-surveillance/all-wales-reports/antimicrobial-improvement-goals-trajectories-wales-2024/ . Accessed 31st March 2025
- WHO World Health Organization Antibiotic Categorization AWaRe. Available at: https://aware.essentialmeds.org/groups . Accessed 31st March 2025

APPENDIX 1

Audit of compliance to guidelines and formularies

ePCR reports the indication for which the antibiotics have been used. To ensure that antimicrobial prescribing is safe, effective and appropriate, antimicrobial choice and duration should follow local and national guidelines. In addition, clear documentation is needed.

The following will be checked within the ePCR for incidents involving an antibiotic:

- **Appropriate treatment choice:** All antimicrobials should be given in accordance with WAST PGDs or prescribed as recommended in the relevant local or national antimicrobial guidelines.
- **Documentation of indication:** All antimicrobial prescriptions should have the clinical indication clearly documented in the patient medical record or on the prescription chart
- **Course length:** All antimicrobial prescriptions should have a clearly documented duration (or review date) which is appropriate for the indication and is in accordance with recommendations in the relevant local or national guideline or microbiology advice
- **Completion of the allergy box:** 100% of antimicrobial prescriptions should also have a clearly documented allergy status for the patient on the prescription chart.

Compliance will be assessed in the following manner:

- **Red (poor compliance):** below 50% total compliance
- **Amber (good compliance, improvement needed):** total compliance between 50 and 89%
- **Green (excellent compliance):** total compliance 90% or above

This will be discussed with the Clinical Audit and Effectiveness Team. An action has already been added to the annual audit plan.

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

AGENDA ITEM No	**12**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**0**

INTERNAL AUDIT: ROLLOUT OF PENTHROX

MEETING	Quality, Patient Experience and Safety Committee
DATE	09 May 2025
EXECUTIVE	Trish Mills, Director of Corporate Governance/Board Secretary
AUTHOR	Alex Payne, Corporate Governance Manager
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. The Audit, Risk and Assurance Committee (the ARAC) received and discussed the reasonable assurance **Rollout of Penthrox internal audit report** at its meeting on the 06 March 2025. This report summarises the discussion from this meeting in reference to this report.

2. *Internal Audit comments:*
   2.1 The audit assessed the impact of the rollout of Penthrox on patients and staff. The audit highlighted the need for updated training modules for Community First Responders, improved access to Omnicell cabinets and safes, better protocol compliance, and reporting on the benefits of Penthrox. Four medium-rated recommendations were made and accepted by management.

3. *Committee comments:*
   3.1 The audit recommendations and the need to revisit training was noted. The balance between security and accessibility for Penthrox was highlighted, with plans to revisit training modules and access protocols. Additionally, the significant improvement in patient experience and outcomes due to the use of Penthrox – in the context of wider system pressures – was acknowledged.

   3.2 There was consideration of how the carbon footprint of the use of Penthrox was reported. The environmental benefits of reducing Entonox use were discussed, with Penthrox contributing to a lower carbon footprint. It was confirmed that medical gases, which includes Penthrox, is reported through the Trust's Decarbonisation Action Plan (reporting against which is to the Finance and Performance Committee).

RECOMMENDATION:
The Quality, Patient Experience and Safety Committee is asked to note the discussion at the meeting of the ARAC on the 06 March 2025, and the assurance that was received following receipt of the audit report and agreed management actions.

KEY ISSUES/IMPLICATIONS
Not applicable.

REPORT APPROVAL ROUTE
Not applicable.

REPORT APPENDICES
Not applicable.

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

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

LEARNING FROM DEATHS (MORTALITY REVIEWS) REPORT QUARTERS 3 AND 4, OCTOBER - MARCH 2024/2025

MEETING	Quality, Patient Experience & Safety Committee
DATE	9 May 2025
EXECUTIVE	Liam Williams, Executive Director of Quality and Nursing
AUTHOR	Wendy Herbert, Deputy Director of Quality & Putting Things Right Claire Appleton, Assistant Director – Putting Things Right
CONTACT	Wendy.Herbert3@wales.nhs.uk Claire.appleton2@wales.nhs.uk

EXECUTIVE SUMMARY

1. This report provides an update to the Committee on the current position and progress since the last report in November 2024 in respect of the Mortality Review process and learning from deaths.

2. An update is provided on performance and outcomes in respect of Medical Examiner Referrals, with Level 1 triage now well established but difficulties in achieving timely review at Level 2 Learning Panel that are being actively addressed following a challenging winter period.

3. The Trust's Learning from Deaths Forum continues to develop its Work Programme, encompassing mortality learning from across the organisation, coronial work, clinical audit, patient experience and concerns management. The Forum has a clear remit to drive increased access, visibility and triangulation of mortality intelligence through digital and data insights.

4. The Learning from Death Forum also oversees external learning sources from Prevention of Future Death reporting, National Clinical Audit, National Learning Reports and National Inquiries and these are also drawn through in this Report.

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

KEY ISSUES/IMPLICATIONS
(i) 226 Referrals have been received from the Medical Examiner Services (MES) in the final two quarters of 2024/25. 26 cases have been triaged as requiring further review and investigation under the PTR Guidance. (ii) Medical Examiner Learning Panels will now run at increased frequency to address cases awaiting review. (iii) Thematic learning from referrals in Quarter 3 and Quarter 4 continue to identify delays in attending in the community, alongside improvement opportunities for Advanced Care Planning and enhanced end of life care in the community to guide family expectations, avoid admission where not indicated and provide dignified and personalised care. (iv) Additional thematic analysis about the Health and Care Quality Standards has been facilitated at a national level and will become visible in future reporting in respect of its application to WAST care and service delivery. (v) The Medical Examiner Service undertakes proportionate scrutiny and there are aspects of the Trust's work that are not in scope of their Reviews. The Trust's existing assurance processes (concerns management, audit and accreditation) provide complementary assurance about quality and safety. The Trust is seeking to extend access and triangulation of mortality data to provide additional assurance. (vi) Two Prevention of Future Death Regulation 28 Reports have been received since the last Report. Both related to delays in reaching people in the community and have been responded to within the required timescales

REPORT APPROVAL ROUTE	
Clinical and Quality Governance Group	14 April 2025 (Virtual)
Quality, Patient Experience & Safety Committee	9 May 2025

REPORT APPENDICES
ANNEX 1 - SBAR Report

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

REPORT ABBREVIATIONS			
ePCR	Electronic Patient Clinical Record	OfWCMS	Once for Wales Concerns Management System (Datix Cymru)
CCP	Complex Case Panel	PFD	Prevention of Future Deaths
HQIP	Healthcare Quality Improvement Partnership	PTR	Putting Things Right
MDT	Multi-Disciplinary Team	QuESt	Quality, Patient Experience & Safety Committee
ME	Medical Examiner	SCIF	Serious Case Incident Forum
NHS	National Health Service	WAST	Welsh Ambulance Services University NHS Trust
NRI	Nationally Reportable Incident	WRP	Welsh Risk Pool

SITUATION

1. This Learning from Deaths Report covers the period from 1 October 2024 - 31 March 2025.

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. Key to current considerations are the Thirlwall Inquiry and the police investigations taking place into allegations of preventable deaths and injuries at Sussex Hospitals NHS Foundation Trust.

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.

6. Following the publication in May 2024 of the *All Wales Learning from Mortality Reviews Model Framework (Second Edition)* (the Framework), the Trust has established an effective clinical governance structure to discharge all 5 levels of the Framework.

WAST Medical Examiner Triage (Level 1 - 'Signposting and sifting referrals')

7. Referrals from the ME Service are reviewed weekly at the ME Triage Meeting undertaken by the Patient Safety Team, including at least one team member with registered clinician status in addition to their PTR and patient safety expertise. The Group review the Referrals, applying a proportionate approach to determine next steps, and ensuring that statutory and mandatory responsibilities such as safeguarding, PTR and Duty of Candour are considered.

8. The Group will triage the Referrals into the following categories (in accordance with the options available on Datix Cymru):

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, where limited opportunities for novel learning exist and where the issues can be mapped to existing Programmes of Work 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). In practice this category is almost entirely comprised of delays in community response and handover of care.

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.

WAST Medical Examiner Learning Panel (Level 2 - 'MDT Review Panel')

9. The WAST Medical Examiner Learning Panel will receive the recommendations of the Level 1 Medical Examiner triage undertaken by the Patient Safety Team and either agree & approve the triage actions taken to manage cases or decide that an alternative category is more appropriate.

10. The Panel is comprised of a range of senior staff from across the Trust: Patient Experience and Community Involvement, Clinical Directorate, PTR & Legal Services, Quality Governance.

11. 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 into Clinical Quality Governance Group prior to QuESt. Any non-clinical and wider organisational learning is shared at the Quality Management Group. Our learning includes positive feedback and good practice as well as areas of concern.

Pre-existing WAST investigation processes (Level 3 - 'Proportionate investigation')

12. The Framework encourages organisations to utilise established processes for further review where appropriate and therefore any cases requiring investigation are channelled into well-established processes using Datix Cymru and managed through usual routes, including SCIF and CCP where indicated, to ensure all statutory reporting and incident management requirements are adhered to (Duty of Candour, external reporting, management under the PTR Guidance).

WAST Learning from Deaths Forum (Level 4 and 5 – 'Thematic Review' and 'Shared Learning')

13. The Learning from Death Forum receives Medical Examiner data and intelligence pertaining to mortality at an organisational level. The Forum discusses internal mortality intelligence arising from concerns management, coronial work, patient experience feedback and clinical audit data as well as external sources such as public inquiries, national benchmarking and Clinical Audit and Adult and Child Practice Reviews. 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.

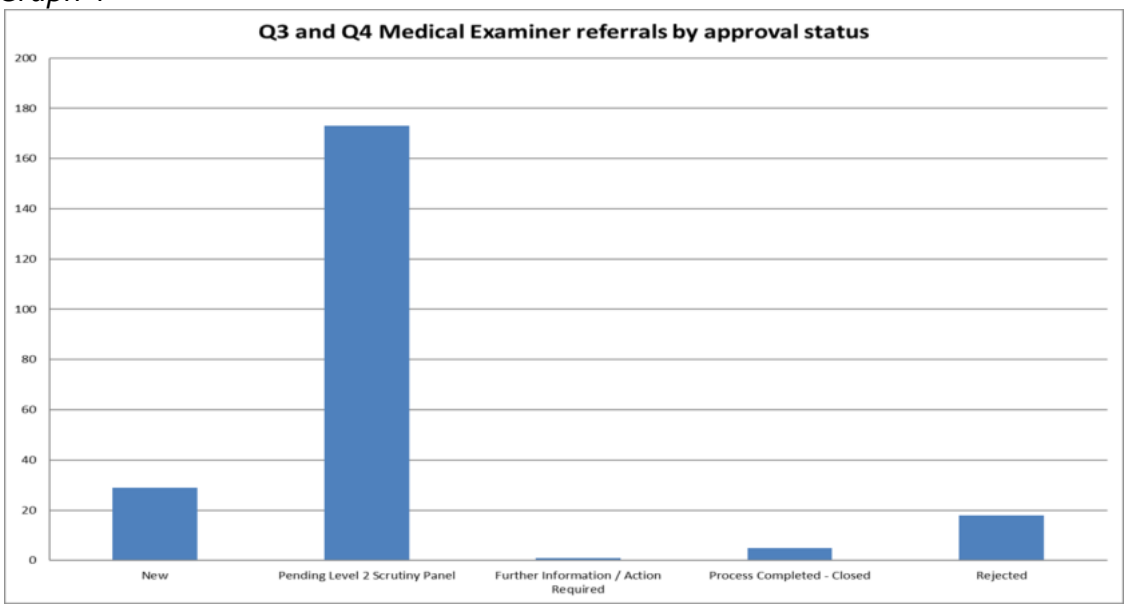
ASSESSMENT

Learning from Medical Examiner Service Referrals

14. 226 Referrals were received from the ME Service between 1 October 2024 - 31 March 2025. The current approval status of those Referrals as of 12 April 2025 is 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.

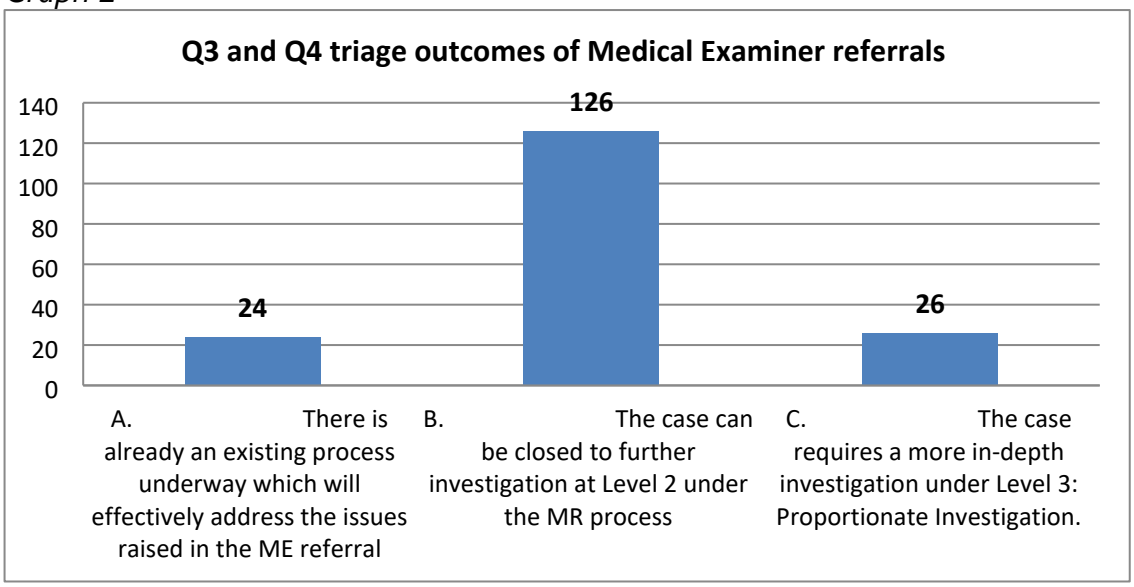
Graph 1



15. Level 2 Multi-Professional Panels have now been commenced, and progress is being monitored in the Learning from Death Forum to ensure new processes are embedded efficiently. Medical Examiner Learning Panels will now run at increased frequency to address the number of cases awaiting review.

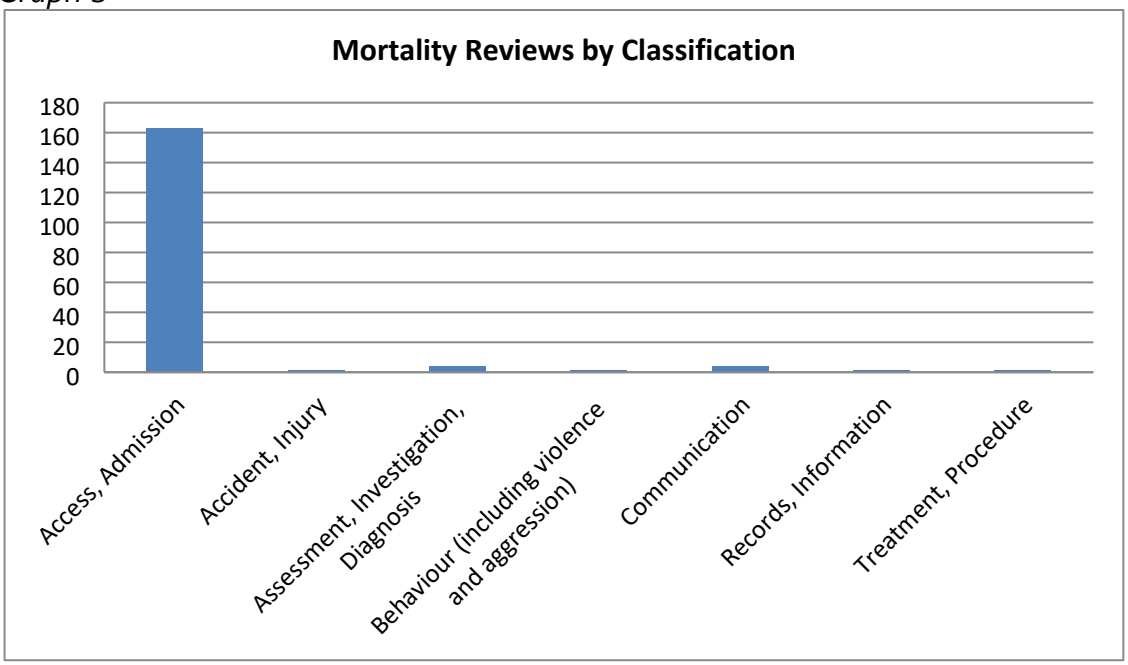
16. Graph 2 demonstrates 26 of the cases received progressing straight to Level 3 and undergoing a proportionate investigation.

Graph 2



17. Graph 3 indicates the Classification of the main referring issue for cases triaged in Quarter 3 and Quarter 4. This is a stark representation of the amount of cases concerning delays in response.

Graph 3



18. Learning themes of Medical Examiner Referrals identified and discussed at ME Learning Panel include:

- Deconditioning and long lies
- Possible opportunities for alternative Pathways and avoiding conveyance. There were cases where the escalation for emergency pre-hospital care was clearly inappropriate but being requested by other healthcare professionals, presumably as primary care options were limited or unsuitable.
- Absence of Advanced Care Planning and end of life care packages, education and preparation
- Number of patients opting to self-convey because of long Estimated Time of Arrivals (ETAs)
- Disproportionate impact on older people and concerns being raised as to whether NHS Wales is truly providing equitable services to our communities
- Very poor patient and family experiences, predominately due to delays in responding in the community as a result of system pressures. Some cases demonstrate the intensely distressing nature of the situation's families find themselves in as they are waiting.

19. Positive feedback has been received from the Medical Examiner Service regarding the quality and comprehensiveness of ePCR completion; timely provision of patient records when requested and positive comments about the robustness of the process established in the Trust following the publication last year of the revised Mortality Review Framework.

20. 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. National progress has been made in terms of trying to improve thematic data capture and learning through the introduction of categorisation against the Health and Care Quality Standards. While this provides a system level understanding of themes, it is not possible to differentiate between aspects related to WAST care as opposed to Health Board care. Data capture options have been built in to allow for this in future and this will should become gradually available in future reports.

21. The PTR & Legal Services Team continue to actively contribute to process and data improvements through the WRP Mortality Safety and Learning Network and the Once for Wales Concerns Management System (Datix Cymru) (OfWCMS) Mortality Review Workstream to ensure visibility and inclusion of ambulance care-related aspects.

22. Of the cases received during Quarter 3 and Quarter 4, only one person was known to have a learning disability and there were three people with a known diagnosed severe mental illness. However, learning disability and neurodevelopmental data is now being collected on WAST ePCRs. This is an essential step in expanding our data capture and awareness of possible interplay between potential vulnerabilities and mortality and responds to last year's report '*An overview of mortality amongst People with a Learning Disability in Wales, 2012-2022*'. Initial implementation shows a good completion rate in practice and a Dashboard is in development to enable future analysis.

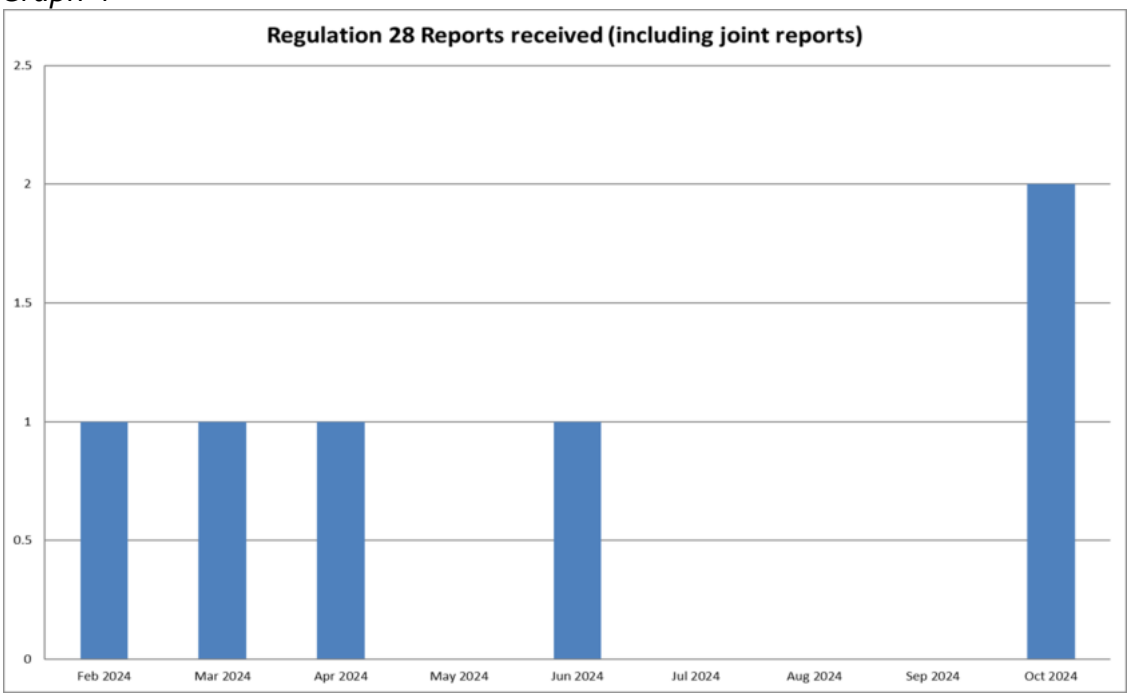
23. The Learning from Death Forum acknowledges that the approach to Medical Examiner scrutiny is a proportionate one, meaning not every aspect of every case is reviewed. This highlights the importance of the Forum receiving a wide range of mortality intelligence to provide assurance about the breadth of WAST activity. The Forum is developing its Work Programme and seeks to extend its access to and triangulation of mortality data to provide additional safeguards.

Learning from mortality in Coronial work

24. The Trust has received two Regulation 28 Reports since the last Learning from Death Report. The Trust has responded to all Reports on time with Improvement

Actions included. Our responses are published on the Courts and Tribunals Judiciary website.

Graph 4



25. 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.

26. Table 1 provides a breakdown of Regulation 28 reports addressed to the Trust in Quarter 3 and Quarter 4 of 2024/25.

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	10/2024	Response time to patient in the community as a result of hospital handover delays	Swansea Bay University Health Board, Director General for Health and Social Services
North Wales (East and Central)	10/2024	Whether the MPDS remains fit for purpose in the context of current system pressures.	

27. Table 2 provides a breakdown of Regulation 28 Reports addressed to other parties but also shared with the Trust in Quarter 3 and Quarter 4 of 2024/25. These are cases where matters of the Regulation 28 concern our organisation in some way, 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 that relate to the Trust	Sent To:
South Wales Central	01/2025	Corridor care; its impact on ambulance handover. Hospital flow.	Cwm Taf Morgannwg University Health Board
Gwent	02/2025	Limitations of MPDS categorisation.	Minister for Health and Social Services, Welsh Government

28. The Learning from Death Forum noted an increase in our attendance in recent years to prison-related deaths and therefore associated Inquests. Risks around mortality related to early release of prisoners without sufficient community preparation and provision were also noted. This intelligence has been shared with the Trust's Consultant Practitioner for Mental Health, and the Trust's Strategic Safeguarding Group for consideration and sharing into Local Safeguarding Boards.

Learning from mortality in Clinical Audit

29. HQIP commission National Clinical Audits and Outcome Review Programmes, registry data and resources to support quality improvement and improve patient outcomes. This includes the National Clinical Audit and Patient Outcomes Programme (NCAPOP), which is comprised of circa 40 projects that collect and analyse data to provide a national benchmarked picture of care standards for a wide range of conditions.

30. Learning identified from HQIP publications that have been discussed in the Learning from Death Forum include:

MBRRACE - Recommendations for Ambulance Services surrounding identification and response to ectopic pregnancy
End of Life Care - Recommendation regarding information sharing and visibility of Advance Care Plans
Child Mortality - learning regarding the role of the Ambulance Sector in identifying safeguarding concerns that may contribute to mortality, recommendations regarding increased ability within remote triage to listen to 'expert patients/parents' regarding deteriorations in their child's chronic condition.

National Inquiries

31. The Learning from Deaths Forum has previously acknowledged the Terms of Reference and the Modules being scrutinised by the Thirlwall Inquiry and the UK COVID-19 Inquiry.

32. The Thirlwall Inquiry has concluded hearing evidence, and the final Report is expected in Autumn 2025. The broad themes to date have been noted by the organisation and are informing the Work Programme of the Learning from Deaths Group; 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. The loss endured by the bereaved parents is foremost in our minds as we reflect on the early learning from the evidence to date.

33. UK COVID-19 Inquiry: Module 3 ('Impact of Covid-19 pandemic on healthcare systems in the 4 nations of the UK') remains an active Module for which findings and recommendations have yet to be issued. Whilst all Modules of the Inquiry are likely to hold relevance to the Trust, Module 3 has rich evidence and learning, particularly the impact on staff and the use and understanding of Do not attempt cardiopulmonary resuscitation (DNACPR) orders.

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

AGENDA ITEM No	**14**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**2**

PATIENT EXPERIENCE & COMMUNITY INVOLVEMENT BI-ANNUAL REPORT (OCTOBER 2024 - MARCH 2025)

MEETING	Quality, Patient Experience & Safety Committee
DATE	9 May 2025
EXECUTIVE	Liam Williams, Executive Director of Quality and Nursing
AUTHOR	Leanne Hawker, Head of Patient Experience & Community Involvement
CONTACT	Leanne.Hawler@wales.nhs.uk

EXECUTIVE SUMMARY

1. This Report presents the work undertaken over the last six months of the Patient Experience and Community Involvement Team (PECI) in preparing the Trust for the changes to the Welsh National Patient Reported Experience Measures (PREMS), Civica and Datix code adjustments as well as the continued capture, reporting and measuring of feedback using an 'experience cycle'. There is an Annual Summary of the year (April 2024 - March 2025) included at the end of the Report.

2. The work outlined in this Report is in line with 'The Peoples Experience Framework' (PEF) (WHC2024/015) and the Citizens Voice component of the Health and Social Care (Quality and Engagement) (Wales) Act 2020-21.

3. 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 PECI Team continues to engage in an ongoing dialogue with the public on how it feels to be user/patient of Trust services and what they believe to be important considerations in delivering a quality service.

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) Information governance arrangements pertaining to contacting 999 service users for Surveys are reaching their conclusion. A Data Protection Impact Assessment

(DPIA) covering contacting 999 users by SMS Text message was due to be submitted to the Information Commissioner towards the end of 2024. This was delayed due to conflicting priorities and a need to include additional detail. The DPIA identifies and addresses risks and issues including what are the reasonable expectations of callers/patients to be contacted (this would be the first time that the Trust has engaged 999 callers in this way), the lawful basis and opt-out process. A finalised DPIA with additional supporting detail has been submitted to Information Governance Team for scrutiny prior to release to the Information Commissioner's Office (ICO) for consideration.

(ii) We are also working with colleagues looking at additional ways we can increase the volume of patient experience feedback including use of QR codes on ambulance vehicles. Trust staff are also being engaged for their ideas on how we increase experience data into the Trust.

(iii) Regular Citizens Voice/PREMS data has continued to be presented weekly to the Quality Management Group (QMG). PREMS data (see **APPENDIX 1** within the attached Bi-Annual Report) continues to record small numbers of returns for the emergency 999 and 111Wales Services, with little improvement in people's ratings and reported experiences. It is expected that completion of the information governance work with the ICO will assist increasing the volume of returns.

(iv) With the recent launch of the National Peoples Experience Survey (PES) and core validated questions (Welsh Friends and Family Test (FFT)) we have commenced the process of reviewing appropriate questions to drill down into the results.

REPORT APPROVAL ROUTE
Quality, Patient Experience & Safety Committee 9 May 2025

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

REPORT CHECKLIST

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

ANNEX 1

SITUATION

1. There has been a lot of work behind the scenes in preparation for The Peoples' Experience Framework (PEF), National Peoples' Experience Survey (PES) and PREM changes, Welsh FFT, Civica and Datix compliment code changes to ensure the Trust is positioned to capture and record against the required datasets within the PEF.

2. The team have continued capturing lived experiences, and listening to public, patients and carers with themes being reported through QMG, Planning and Performance Teams to feed into the IMTP and the National Service User Experience Meetings.

3. Key themes from feedback have related to long waits and timeliness in general, across all service areas as the biggest cause of concern. People are anxious about our ability to meet their expectations of a timely response in an emergency or when they have a need of our services.

4. There has been continued positive feedback across all service areas, with people complementing our staff for being kind, caring and compassionate. We have continuously promoted and shared compliments received to staff. Some compliments were especially poignant as they were given during a very distressing time for an individual/family and demonstrated just how influential staff are in delivering a positive and memorable patient experience.

5. Patient Reported Experience Measures (PREMs) for this period are included within the PECI Bi-Annual Report (**ANNEX 1**).

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:

- The People's Experience Framework (WHC2004/015)
- 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 capturing, understanding, improving and measuring peoples' experiences, quality of services and enhancing the reputation of the Trust across communities is included within the Bi-Annual Report (**ANNEX 1**).

Patient Experience & Community Involvement (PECI)

Bi-Annual Report

October 2024 – March 2025

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

peci.team@Wales.nhs.uk

Contents

Peoples Experience within the Welsh Ambulance Service

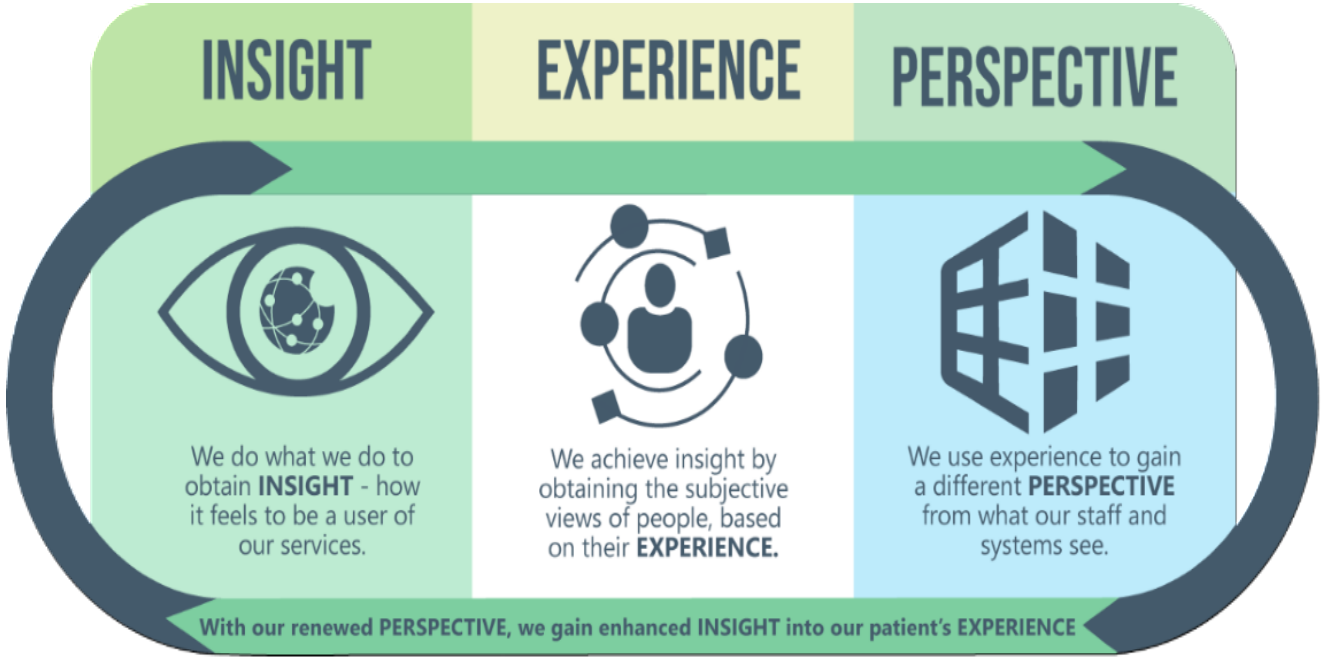
Peoples experience within the Welsh Ambulance Service University Trust (WAST) is focused on ensuring people have as positive experience as possible.

People's experience is influenced by the interactions people have with our staff, their expectations, and their first and lasting impressions. Peoples experience is defined by what it feels like to access and receive care from WAST, it is based on people's own perceptions of the care and treatment received.

Experience and feedback are essential components for monitoring and serving as quality indicators.

Information and data provided within this report has been captured using a variety of methods including face-to-face engagement to capture an individuals' experienced voice; service experience surveys, patient stories and our 'Have your say' online facility.

'The Experience Cycle'



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

Section 1
People's Experience - Insights

Peoples' 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.

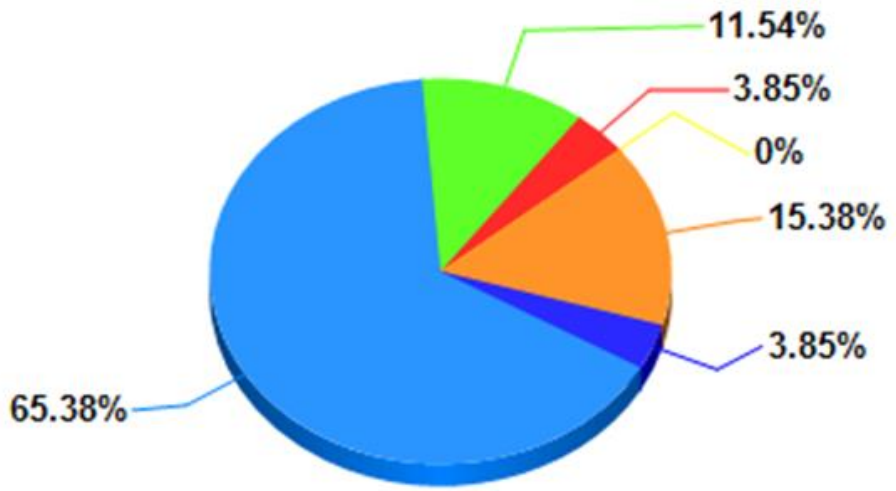
In this reporting period, we acknowledged that the low response rate to this survey does not paint a representative picture of what is feel like to be a user of our 999 service and every effort is being made to increase engagement with the survey.

Taking this into account, responses received to this survey show that people continue to tell us that our staff provide good care but wait times in the community are the largest area of concern.

In this reporting period 61 responses were received.

A full breakdown can be found under ***Section 4 Reported Experience Measures (PREMs) Data.***

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	37	65.38%
Good	7	11.54%
Neither good nor poor	3	3.85%
Poor	0	0.00%
Very poor	10	15.38%
Don't know	5	3.85%
Total	**61**	**100%**

Peoples' Experience Framework – Ambulance Care (NEPTS)

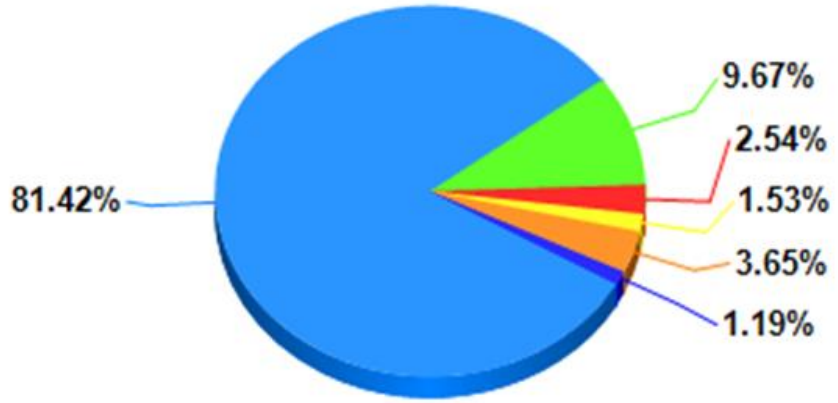
NEPTS Experience Survey

We continue to work closely with our Ambulance Care colleagues to capture the experiences of people who have received transport to planned hospital appointments. We have a well-established governance process is in place which allows us to contact people following transport to their appointment and ask for feedback.

Responses to this survey continue to provide high levels of assurance that NEPTS users are broadly satisfied with the service they receive. With survey results also being used to highlight potential areas of quality improvement. Wait time for transport home following an appointment continued to be the main area of concern, with people telling us they were uncomfortable whilst waiting, were unprepared for the wait, hadn't brought medication needed with them, couldn't access food or something to drink while waiting.

In this reporting period 1,394 responses were received. A full breakdown can be found under ***Section 4 Reported Experience Measures (PREMs) Data.***

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	960	81.42%
Good	114	9.67%
Neither Good nor Poor	30	2.54%
Poor	18	1.53%
Very poor	43	3.65%
Don't Know	14	1.19%
Total	**1179**	**100%**

Peoples' Experience Framework - NHS 111 Wales

NHS 111 Wales Experience Surveys

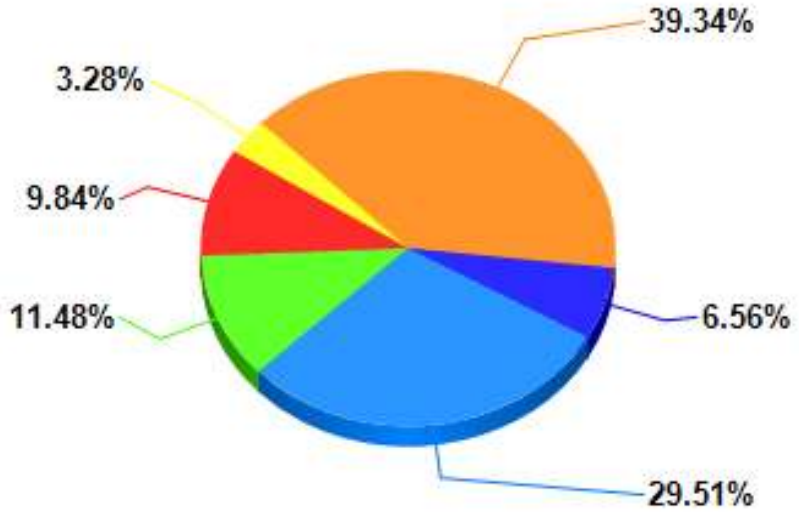
There are two surveys in place for NHS 111 Wales, separately collecting feedback about people's online experience and telephony experience.

Both surveys are promoted online, through the NHS 111 Wales website and available social media platforms. Though we largely remain reliant on people using their initiative to seek out and access the 111 Wales experience surveys themselves.

Again, every effort is being made to increase engagement with these surveys to ensure we are capturing a broader range of views and can provide a service user experience data set that more accurately represents the experiences of NHS 111 Wales users.

In this reporting period 107 responses to the telephony survey were received; and 171 to the Online survey.
A full breakdown can be found under ***Section 4 Reported Experience Measures (PREMs) Data.***

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



Available Answers	Responses	Score (%)
Very Good	30	28.03%
Good	14	13.08%
Neither Good nor Poor	12	11.21
Poor	6	5.6
Very poor	36	33.64
Don't Know	9	8.41
Total	**107**	**100%**

Peoples' Experience Framework - Other bespoke surveys

Falls Assistant Experience Survey

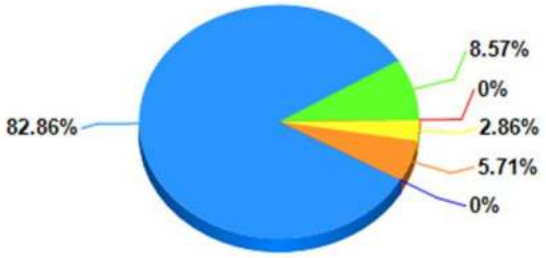
We continue to support the WAST Falls Improvement Lead with two Falls Experience surveys. One for Level 1 Falls Assistants and one for Level 2 Falls Responders.

To gain this feedback we rely on the staff attending to leave an invitation with the patient to complete a survey. 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.

There has been a reduction in feedback received to this survey since the last reporting period and we will support the Falls Improvement Lead to try and ensure all patients attended to by a Falls Assistant/Responder are being left with an invitation to provide feedback

In this reporting period 35 Falls Assistant responses were received. The number of Falls Responder responses is too low to report.

How was your overall experience with the Falls Assistant today?



Available Answers	Responses	Score (%)
Very Good	29	82.86%
Good	3	8.57%
Neither Good nor Poor	0	0.00%
Poor	1	2.86%
Very poor	2	5.71%
Don't Know	0	0.00%
Total	**35**	**100%**

Non-Conveyance Experience Survey

We have worked with colleagues in the Medical & Clinical Directorate to develop an experience survey for patients who are not conveyed to hospital or another healthcare setting.

This survey will be accessible via a QR code or email address printed onto the new Non-Conveyance Form which is left with patients. Non-conveyance could be because the patient declines treatment or because a clinician decides conveyance to hospital would not be the best course of action.

Compliments Received

October 2024	**85**	January 2025	**69**
November 2024	**60**	February 2025	**56**
December 2024	**34**	March 2025	**51**

We use compliments to share good practice, promote what we have done well and demonstrate how valued staff are by people, patients, their families and carers.

Themes from compliments have focused on the value placed on having **professional, attentive and highly skilled staff.** Feedback on the interaction with staff have shown **'dedication, compassion and showing genuine concern'** has made a positive lasting impression on people. We have heard how grateful people have been for the services and care received from staff who have **'worked above and beyond'** are **'worth their weight in gold'** and are **'a credit to the Welsh Ambulance Service'.**

We continue to share compliments with Trust staff via a dedicated page on internal communication channel Siren, station posters and directly with line managers.

Examples of Compliments Received

"I would like to pass on my gratitude to the two excellent ambulance crews that helped with my mother. The first crew arrived promptly after the call to the care home on Anglesey. Ian and Alaw, if I've remembered properly, were professional and courteous, while remaining kind to Mum and me. The circumstances were very difficult. Jason and Ella, crew from Caernarfon I think, took over outside the hospital. They were excellent - caring for a very distressed 91-year-old with dementia, while assisting the nursing staff, liaising with doctors and making sure I was ok. They all do a fantastic job, and you should be proud of your staff. I am grateful that they made the whole thing as smooth as possible. Please pass on my thanks"

"We were away on a break in Eglwysbach, last Saturday my husband who has a complex medical condition & needs antibiotics as soon as possible when his symptoms present, we as a family cannot thank Liz our 111 Call Handler enough, within no time we not only received a follow up call from a doctor , but also had received the medication, thank you just doesn't seem enough"

"Hello, both I wonder if you remember me – I was your first call three weeks ago, on Thursday 23 January. You came up a very narrow lane to my house here in Newbridge and took me to The Grange. I had been in severe pain throughout the previous night and was bent toward the floor as I opened the door to you. Even before you had fully come in, from the second you put your first foot over the threshold, cheerfully introducing yourselves, I felt huge relief. You stayed with me for several hours, well into the afternoon, and after I was seen in the ambulance by an Emergency Doctor, you took me for a scan. Then back to the ambulance and finally up to the Surgical Assessment Unit where you handed me over. I said then that I would never forget you. I am immensely grateful to you both for all your care throughout a long day. I live alone and your company itself was a great relief. I will indeed always remember you"

Section 2
PECI Activities –
Fostering a positive Patient Experience

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

People's Experience Framework (PEF)

Throughout this period numerous meetings have continued to be held at senior levels across NHS Wales and with experience leads in preparation for the launch of the:

- NHS Wales People's Experience Framework
- People's Experience Survey (PES)

It is recognised that patient-reported experience data needs to be used to assist services in meeting Health and Care Quality Standards, they are important to measuring successful healthcare provision and effective person-centre care.

There has also been a shift in the language as it is recognised that people use NHS Wales services beyond the traditional meaning associated with the term of both patient and service user.

We have been working through the 'local self-assessment tool' within the Framework to evaluate the Trusts' current position and to assist in developing an improvement experience plan. It covers all areas across the people's experience umbrella including:

- National and Local People's Experience survey
- People's Experiences Survey (PES)
- Lived experience/People's groups
- Stories
- Compliments
- Complaints
- Incidents
- Staff experiences
- Equality

The PEF introduces a requirement to build experience measures into all contractual arrangements (commissioned services) and introduces a set of core questions for People's Experience which will be a requirement within all feedback questionnaires/surveys.

NHS Wales Performance Framework
Performance Measure Learning Disabilities

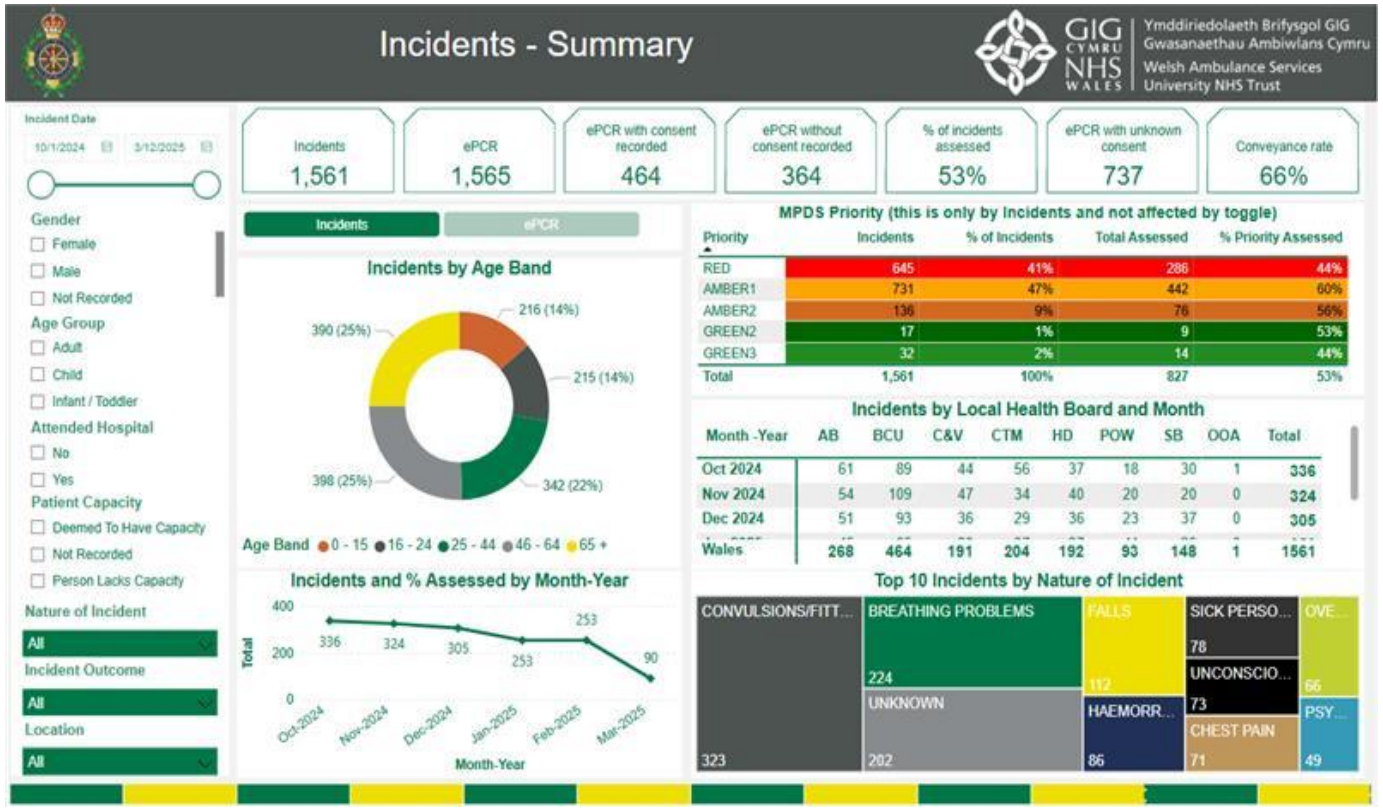
Learning disabilities dashboard

The dashboard went live on 1st October 2024, and reports on data of a patients' additional need. The dashboard sorts data according to demographics (age range, gender) and other categories i.e. incident closure type and call prioritisation.

Between 1 October '24 – 31 March '25, there have been 1,696 ePCR records where an additional need has been recorded. Convulsions/fitting and breathing problems have been the top 2 nature of incidents recorded. This data is valuable in understanding the wider national picture of health amongst the learning disability population and their impact on patient experience.

Experience data has informed agreement from Welsh Government to reshape some resourcing to appoint an ACP - Learning Disability to inform and improve our service model for people with learning disabilities and complex needs

The PECI team will continue to engage with local communities to capture experience data around people's lived experiences to support the ongoing improvements in care and patient experience and outcomes.



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

Improving awareness and skills of early CPR

Post CPR Support Resource

The online resource created by WAST and Save a Life Cymru (SaLC) to support individuals witnessing a cardiac arrest was launched on the Resuscitation Council website on 10th October 2024.

The 'Restart a Heart Live' event, organised by Save a Life Scotland set a Guiness World Record for the most CPR training sessions live-streamed, provided a platform to promote this resource and broaden our reach in educating the public on the importance of support following such an event. In collaboration with SaLC and Cardiff Met, we also produced a behind-the-scenes video showcasing an ambulance for the event, which was shared across multiple platforms to highlight that ambulances are life-saving vehicles meant for genuine emergencies.

This work was recently presented at a SaLC event held at the Senedd, where innovative approaches to improving survival rates from Out of Hospital Cardiac Arrest (OHCA) were demonstrated.

In Wales, survival rate for out of hospital cardiac arrest is less than 5%. In comparison, England is 10%, Scotland is 9% and some European countries and USA cities report survival rates of around 25%. Aligned with the Well-being goals of Healthier Wales and the NHS Wales Out of Hospital Cardiac Arrest Plan, 'Shoctober', is an annual educational campaign that aims to educate pupils in Years 4, 5 & 6 about appropriate use of 999 and become resilient members of the community. Ultimately helping more people in Wales survive an out of hospital cardiac arrest.

In October, a total of 64 volunteers delivered one-hour sessions for **3,374 pupils across 40 schools** in all Health Board regions in Wales. These figures exceeded our initial target to visiting 35 schools and engage with 2700 pupils.

Schools were a mix or urban/rural, English/Welsh medium and in some locations having a higher ratio of children with additional learning needs.

Peoples' Stories & Digital Storytelling

Peoples' Stories

NHS organisations are expected to have a process in place to capture and listen to people's stories. The stories captured are shared at Committees and Board meetings, in addition to being used as part of staff training and organisational awareness. We continued to explore different experiences by working with staff and patients across Wales, including:

- a patient in Powys described how a delayed 999 response had potentially contributed to the impact of the stroke she experienced.
- a family in Newport who lost a child to sepsis following a catalogue of errors which included some procedural inconsistencies on the part of our NHS 111 Wales service.

The experience of a patient whose first language, BSL, was achieved through collaboration with their Llais advocate. The story highlighted communication barriers which continue to affect access to NHS services by those whose first language is not English. This story was presented to the All-Wales Digital Stories Network and at QuEST Committee.

We met participants in a pilot scheme in North Wales, to match oncology patients with a dedicated Volunteer Car Service (VC) driver and heard from VCS driver and patient about how the scheme had enhanced their individual experience.

Highlighting good practice

We captured the reunion of premature twins with ambulance and control staff involved one year on from their unexpected birth.

We learned how the EMS crew successfully deployed their newly-acquired training in neonatal thermoregulation to manage the twins' temperatures until they got to hospital.

Patient Storytelling Consent Form

We have sought advice from the Trusts Information Governance team in respect of making our consent form GDPR compliant.

They have helped us revise the wording to clarify when explicit consent to share will be required, as distinct from informing users how we will use their stories as part of our public tasks function.

The new consent form has been in use since January 2025.

PATIENT STORYTELLER CONSENT FORM

If you're a patient, relative or carer, listening to your experiences of using the Welsh Ambulance Service helps us to understand what we are doing well and what we could be doing better.

When you share your Patient Story with us, we will use this to: -

- Understand what it's like to be a user of our services;
- Investigate your story to gather all the relevant information;
- Identify where we need to make improvements to our services;
- To assist with organisational learning; and
- Your story may also be shared for the management of untoward or adverse incidents with other organisations that may have been involved, such as other NHS organisations.

Optional Consent for Publication

Please also complete this section of the form if you wish to provide consent to share your story as indicated below. Please tick as appropriate: -

- ☐ Published on the internet, including the WAST website and social media channels;
- ☐ Included in publicly attended and recorded meetings and conferences such as the Trust Board meeting;
- ☐ Used in staff training (if you do not provide consent, we may still use your story but keep you anonymous).

I understand that my account may be edited in order to protect the anonymity of the patient or another third party, or to preserve the narrative integrity of the story.

I understand that I can change my mind and withdraw my consent without giving a reason. I can do this by contacting the Patient Experience and Community Involvement Team at **01792 311773** or **pecl.team@wales.nhs.uk.**

I understand that should I withdraw my consent, WAST will no longer publish the story, however if the story has already been used in publications, then it may not be possible recall all documentation or publications in which the story has appeared.

I understand that my story may also be disclosed without consent where there is a legal obligation or lawful basis to do so, for example: -

- If a serious crime has been committed;
- If there are risks to the public or our staff;
- To protect vulnerable children or adults;
- Where there is a legal duty to do so, for example to comply with a court order.

I have read and understood the consent form and I am happy for my experiences to be used as indicated above.

Signed: _____ **Date:** _____

Name: _____

Address: _____

Telephone: _____ **email:** _____

Where applicable: Signature/countersignature of next of kin, responsible carer, parent or guardian (please indicate relationship below).

Signed: _____ Date: _____

Name: _____ Relationship: _____

Section 3
Citizen Voice & Community Involvement

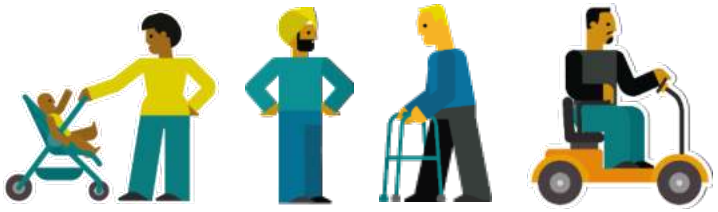
Citizen Voice - People & Community Network

103 Network members

Growing the Network

Plans have been made to grow the Network with a focus on:

- **age**
- **geographic location**
- **diversity, equity and inclusion**
- **Welsh language**



An Action Plan has been drafted to include engaging with young people in formal and informal education and using population health data to highlight key geographic areas across Wales.

People & Community Voice Group

In recent months' the group undertook an annual effectiveness review to ensure a clear vision of reflection, learning and improvement to capture the Trust's aim of meaningful engagement as set out by the Trust's strategic goals.

Feedback from one of our Network members:

> *"If the Service really wants volunteer 'advisers', it has to be a two-way relationship and not just a title."*

After an open, discussion with the group, it became clear that more needs to be done for these meetings to provide the most value for Network members and the Trust.

The Principles of Co-production

We will grow the Network and develop the People & Community Voice Group in accordance with the **five principles of co-production**, as defined by the Co-Production Network for Wales.

copronet.wales

Rhwydwaith Cydgynhyrchu Cymru
Co-production Network for Wales
Pawb gyda'i gilydd
All in this together

Citizen Voice - People & Community Network

Reader's Panel

Help and support following bereavement

Network members continue to work with the Team to draft a leaflet to provide general information and guidance to help families understand and make sense of what will happen following an unexpected loss.

Feedback so far includes:

"A flow chart might help, with colour coding for each section to make the information clearer and easier to follow."

"There seems to be too much information for someone who has just experienced a bereavement."

Network News

Network members receive regular news about the Trust and the wider health and social care community.

The latest edition included news about current and continued health board collaboration, Advanced Paramedic Practitioners treating more people in the community, the development of Rapid Clinical Screening and the progress of the Community Welfare Responder role.

Network members have had the opportunity to provide their opinions on:

- **Our Wellbeing Objectives**
- **Draft IMTP 2025-2028**
- **Bevan Commission's 'Silly Rules'**

User Experience

NHS 111 Wales Website

In December, Network members took part in a Service User Experience.

They were asked to complete four short tasks; each one a popular reason someone might use the NHS 111 Wales website.

Responses included:

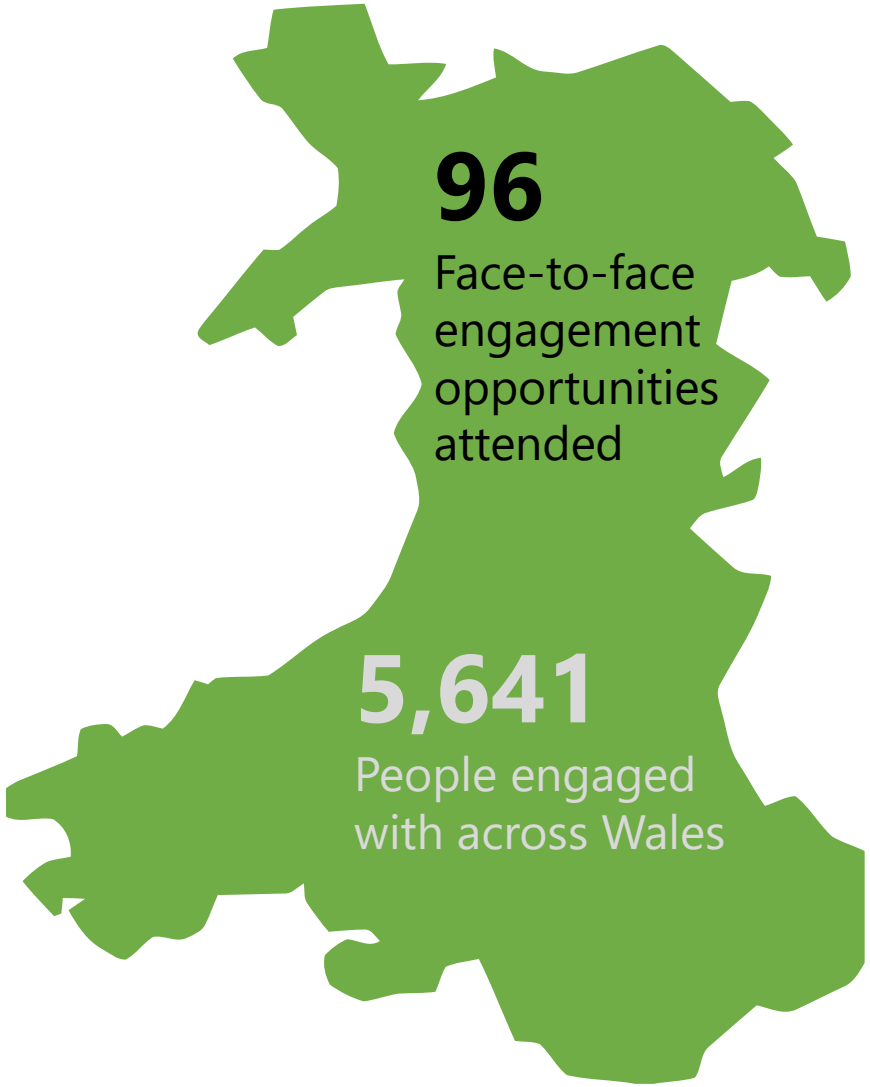
What did you like most about the website?

"The colours are clear and vivid, and the fonts used are easy to read, even for someone with poor sight."

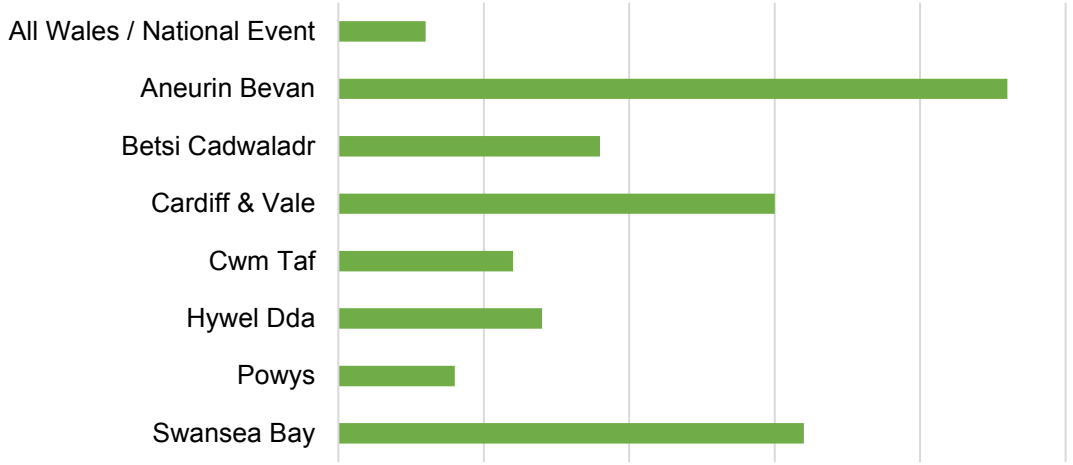
What aspects of the website do you think could be improved?

"Search engine - make better use of navigation buttons ."

Community Involvement & Co-production

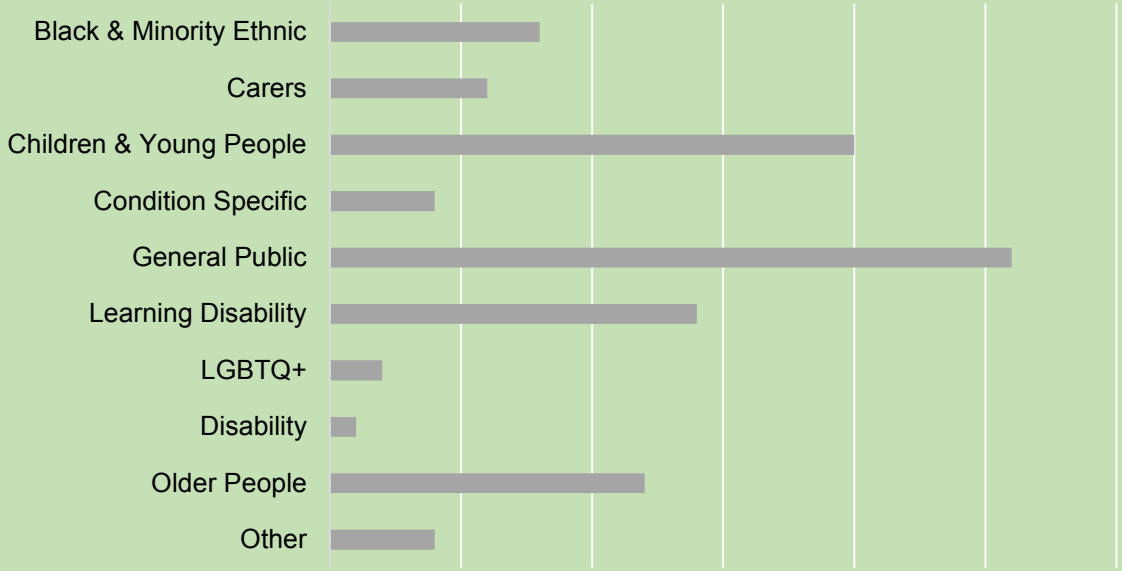


The PECI Team attended 96 face-to-face engagement opportunities across Wales, engaging with 5,641 people. We listened to people's experiences of using Trust services, captured public sentiment and asked people to tell us what matters most to them if they should ever need to use our services in the future.



We covered in all Health Board areas across Wales, with an increased number in Betsi Cadwaladr and Hywel Dda, which have been areas where we know we needed to increase our reach. This was also highlighted as an action in the recent PECI Internal audit.

Community Involvement & Co-production



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

Targeted engagement with groups known to experience health inequalities, barriers to accessing health care and those who have poorer health outcomes continued. Ensuring the voices of the most vulnerable in society had an opportunity to share their views and experiences.

Population Health and Peoples Experiences

The challenges people have reported in being able to manage their health and wellbeing have included:

- Lack of accessible services (sensory loss/disabilities/language)
- Little support in the community (friends/family/carers)
- Little understanding of other services available to help
- Poor social care/carers struggling with overload
- No involvement in decisions about healthcare needs
- Digital transformation, people feeling left behind/ a fear of digital systems
- Cost of living limiting peoples' lifestyles/options

Improving the challenges people face:

- Enable people with 'lived experiences' to be more involved in Trust development/quality improvement projects.
- Using patient experience data to learn and inform service development/ delivery.
- Incorporate lived experiences within Trust approach to Value-based Healthcare.

Section 4
Patient Reported Experience Measures (PREMs)

Peoples experience of calling 999

From October 2024 to March 2025 a total of 61 people used the 999 survey to provide feedback.

Response rates to this survey remain disappointingly low and we acknowledge that such a low response rate cannot provide a truly representative picture of what it feels like to be an EMS service user across Wales.

We are committed to increasing engagement with this survey and have spent a lot of time over the past six months collating information to help build a case to allow us retrospectively to contact 999 callers by SMS Text Message to ask for their feedback. Health Board colleagues are now doing this with great success, and we believe a similar approach is what's needed for WAST.

Of responses received in this period, responses were received from all Health Board areas across Wales. There were some positive aspects to people's experiences:

- **81% of respondents said they felt confident in the ability of the person who answered their call to manage the call and provide appropriate advice.**
- **88% of respondents said they did not receive a call back from a clinical advisor.**
- **Of those who said an ambulance was sent, 62% said the wait time for an ambulance to arrive was acceptable.**
- **Of those who said an ambulance was sent, 90% said they felt safe whilst in the care of the ambulance crew.**
- **77% of people who completed the survey rated their overall experience as 'Good' or 'Very Good'.**

Peoples' 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.

From the Heat Map below we can see that the benchmark set was met in many areas - reassuringly in the areas of feeling safe; professional & reassuring staff and being treated with dignity and respect.

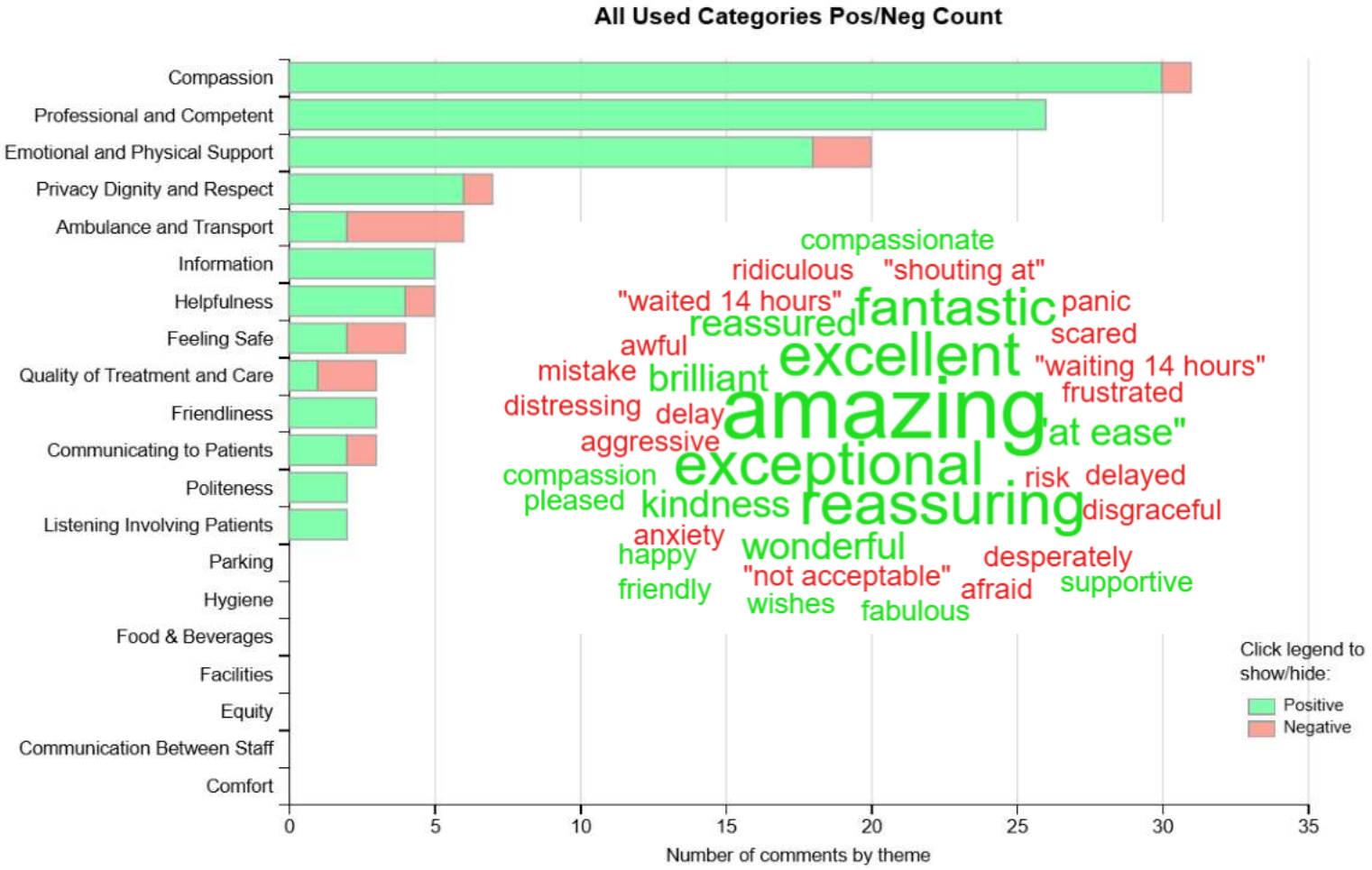
Low numbers of people saying they spoke to a clinical advisor explain why benchmarks for CSD were not met.

	Overall Experience	EMS Coordination				Clinical Support Desk				
Responses	Thinking of the last time you called 999. Overall, how would you rate your experience of the service	The 999 call taker who answered your call listened carefully	The 999 call taker who answered your call was reassuring	The 999 call taker who answered your call explained what was going to happen next	You felt confident in the 999 call takers ability to manage your call and provide appropriate advice	Was the Clinical Advisor you spoke with polite?	Did you feel that you were listened to by the Clinical Advisor?	Did the Clinical Advisor explain why an ambulance would or would not be sent to you on this occasion	Do you feel you were given enough advice on the telephone about what to do next?	Did you follow the advice given to you by the Clinical Advisor?
61	77	92	89	91	87	100	25	25	0	0
Benchmarks	85	85	85	85	85	85	85	85	85	85

EMS Response									
The length of time I waited for the ambulance to arrive was acceptable	I understood the explanation of the care and treatment provided	I felt safe whilst in the care of the ambulance staff	The ambulance staff were professional and reassuring	The ambulance journey was comfortable	Overall, I was happy with the service received from Welsh Ambulance Service	Overall, I felt that I was treated with dignity and respect	Did the Paramedic or ambulance service staff clearly explain why you were not being taken to hospita	Before leaving you at home, did the Paramedic or ambulance service staff provide you with enough inf	Overall
60	90	94	94	78	88	93	100	100	86
85	85	85	85	85	85	85	85	85	

Peoples' 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:

"Fast response time and the first responder care was excellent. Amanda & Emlyn were thorough, supportive, respectful and utterly professional. They reassured me throughout the experience, and I knew I was in safe hands."

"Understanding how busy the service and system is and knowing how far stretched the Ambulance network actually is, I was very pleased on the response time from initial call to the arrival of the crew."

"The Paramedics and telephone staff were all wonderful. The poor review is that my dying 89-year-old mother waited 14 hours for the ambulance. Then a 6 hour wait in the ambulance outside A&E. She was dying in front of us and there was nothing we could do but wait. So undignified after a lifetime of hard work. It's a broken system."

Peoples' Ambulance Care 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 October 2024 and March 2025, a total of 1,394 NEPTS patient experience surveys were completed.

We continue to take a multi-access approach, and the responses received come from people who were either sent a text message asking them to complete a survey, people who asked to receive a postal survey or users who visited the Trust's website to complete an online survey. Stickers asking patients to provide feedback are also displayed in a majority of NEPTS vehicles, the stickers show a QR code which people can use to access the survey online.

Responses were received from all Health Board areas, higher levels of engagement with the survey continue in Betsi Cadwaladr and Aneurin Bevan areas. Cwm Taf Morganwg and Powys recorded the fewest responses.

- **94% found the booking process easy. Those who answered negatively continue to say they experienced long delays waiting for their booking call to be answered.**
- **95% said they were happy with the transport they received.**
- **A majority of people (91%) said their overall NEPTS experience was either Very Good or Good.**

The NEPTS patient experience survey results continue to be positive overall, and offer reasonable 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.

Peoples' Ambulance Care experience

The NEPTS Patient Experience survey also contains four 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 fourth reporting period in a row. However, there has been a small improvement in this score, which was 81 in our last report and 80 in the one before that.

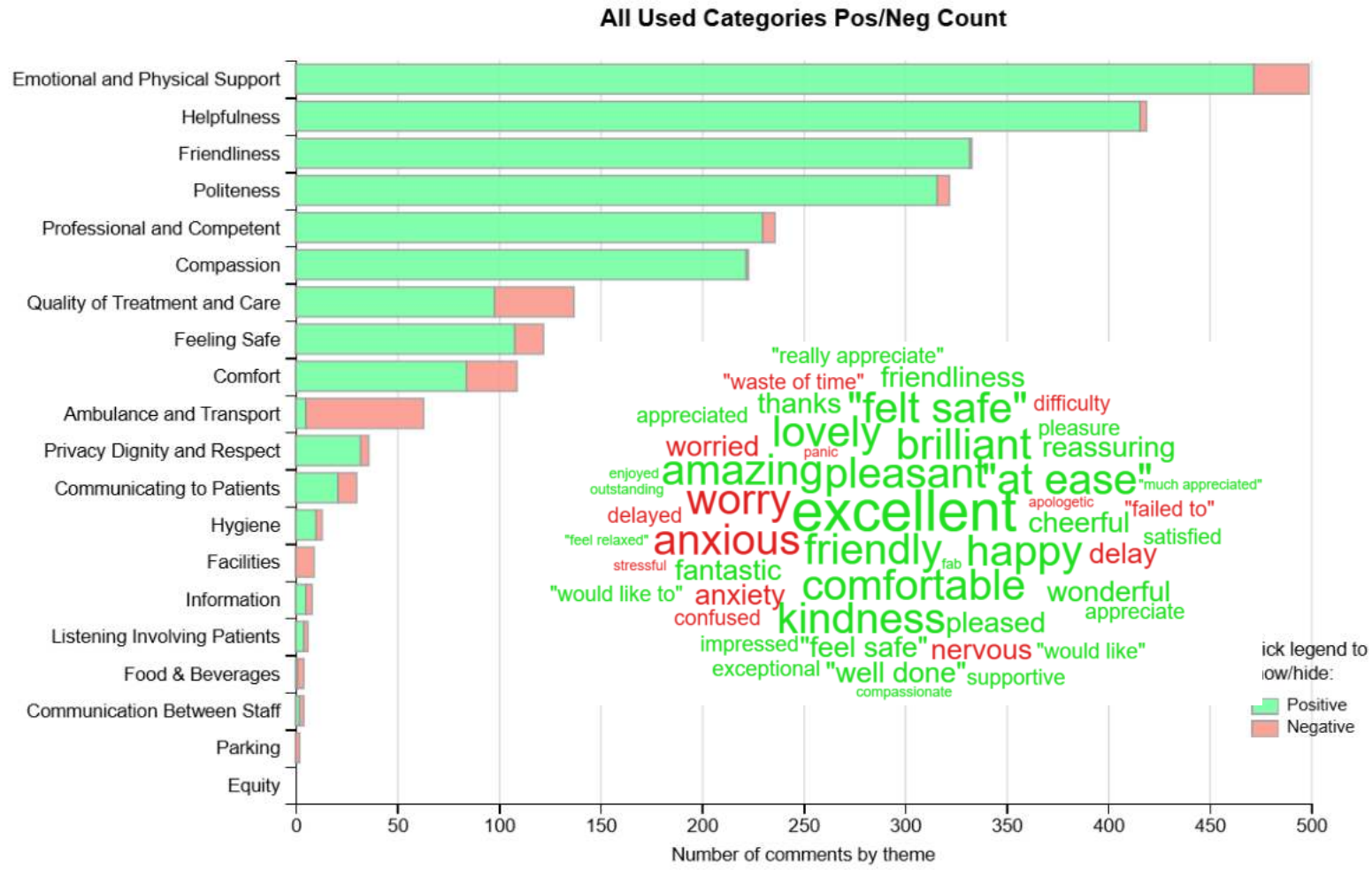
	Booking			Transport & Journey								Overall Experience	
Responses	Did you find your booking experience easy?	Was our call handler polite and courteous during the call?	Do you feel you were given all of the information you required prior to your journey?	Were you happy with the transport you received?	Did you feel that the crew were polite and helpful towards you?	Were you given support to meet any additional needs you have? For example: communication; mobility;	If you asked for assistance, did you get it when you needed it?	How clean was the vehicle you travelled on?	During your journey, were you reminded/prompted about wearing your seatbelt?	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 s	Using a scale of 0-10 (0 being bad and 10 being excellent), how would you rate your overall experien
1394	94	99	97	95	98	96	98	97	97	98	83	91	91
Benchmarks	85	85	85	85	85	85	85	85	85	0	85	85	85

Patient concern about wait times for transport home is something that has been highlighted with NEPTS Managers via Quality Management Group (QMG), and we know it is an area of focus for the Ambulance Care Team going forwards.

Looking at people's feedback about their wait time for transport home, people told us they were unhappy for a variety of reasons. Some felt the wait was just too long, with some saying they waited longer than 4 hours. Others said the wait was unacceptable as they needed access to medication which they'd left at home and would have brought with them had they known to expect a long wait. Others said they waited without access to food or anything to drink, and others said the wait was uncomfortable as the waiting area was cold, had hard seats, or there weren't toilet facilities available.

Peoples' Ambulance Care experience

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



What people said:

"The very long wait to come home. It was far too long especially as there was no catering facilities in the hospital. 3 hours wait with nowhere to get a drink is totally unacceptable"

"On all my appointments to the day centre I have always been on time for my treatments. You can rely on the service and feel safe when travelling"

"My appointment was cancelled because the transport arrived AFTER the appointment time. This is the 2nd time in a row my surgical treatment has been cancelled because transport did not turn up. I NEED to get to this appointment on time because it takes an hour, if I am not there on time they can't fit me in. This appointment is VITAL to my health and well being, I am reliant on the ambulance service because I need special assistance on the way back."

Peoples' NHS 111 Wales experience

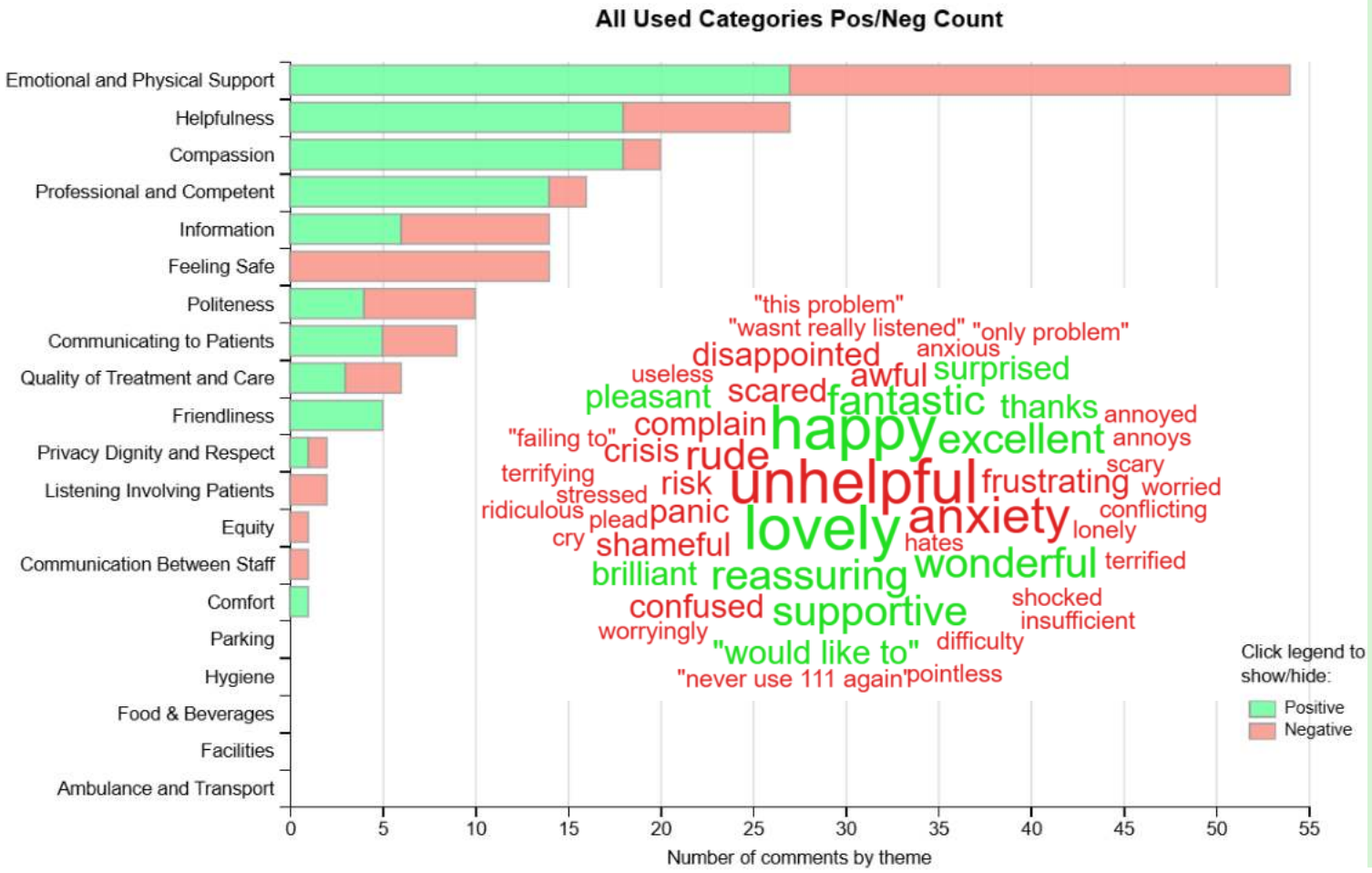
Between October 2024 and March 2025, a total of 107 NHS 111 Wales patient experience surveys were completed. Responses were received from all Health Board areas, though we acknowledge that this is a low response in comparison to overall call volumes and it is unlikely that responses received will provide a truly reflective picture of service user experience. Work continues with colleagues and the ICO to enable a greater reach of experience data.

- **73% 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.**
- **67% of people told us they called 111 looking for health information or advice for themselves.**
- **44% of people told us they found their call to NHS 111 Wales 'Extremely Helpful' or 'Helpful'.**
- **74% 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?**
	NHS 111 Wales Patient Experience Survey	NHS 111 Wales Patient Experience Survey	NHS 111 Wales Patient Experience Survey	NHS 111 Wales Patient Experience Survey	NHS 111 Wales Patient Experience Survey	NHS 111 Wales Patient Experience Survey
107	62	53	74	41	57	58
Benchmarks	**85**	**85**	**85**	**85**	**85**	**85**

Peoples' NHS 111 Wales experience

Akumen pansesic text analysis of comments left shows us that people spoke about helpfulness and compassion in positive tones. Support, information and safety were areas which had a more negative sentiment behind them.



What people said:

"I felt so supported and looked after. Every time I call 111, they are brilliant. I was directed to an OOH GP and the service has been invaluable"

"The woman on the phone has no understanding of autism whatsoever, and refused to let my carer to speak for me, she insisted I spoke"

"I tried calling this morning, msg says wait time 14 minutes, after 45 mins still on hold. Tried again this afternoon, msg says wait time 20 mins. Told press 1 for call back, then an American recorded voice says call back not available – why? Waited on hold for 50 mins. Still no answer this is awful response."

"The person who answered the phone was judgemental, short and assuming information that I hadn't given. I was so shocked and said that on the phone"

Section 5
Overview of 2024/25 & Looking ahead to 2025/26

At a Glance - Peoples' Experience 2024-25

Aspects of a quality experience based on public feedback this year

Looking back at the feedback we have received from patients, carers, communities and individuals we have spoken to over the past year, broadly speaking these are the top three positive and negative themes we have seen emerge from the experience feedback reported:

- Across all service areas, people tell us our staff are kind, caring and compassionate.
- Our EMS staff are held in high regard, people tell us they receive excellent clinical care from knowledgeable staff.
- Our Non-Emergency Transport Service provides high levels of care and is a lifeline for many people.

- Waiting and timeliness in general, across all service areas is the biggest cause of concern.
- People are anxious about our ability to meet their expectations of a timely ambulance response in an emergency.
- People are not happy with the length of time they wait for a call back from the 111 Wales service.

Recognition in 2024/25

International Forum on QUALITY & SAFETY in HEALTHCARE UTRECHT

21-23 May 2025
Royal Jaarbeurs

Institute for Healthcare Improvement

BMJ Group

Under the category of 'Populations' the title of our abstract submission '**Improving the experiences and outcomes of learning disability patients when accessing emergency care'** has been successful for a poster display at the Internal Forum on Quality & Safety in Healthcare being held in Utrecht this May.

It is hoped that the poster will showcase on an international level, the improvement to the WAST EPCR to increase the recording of Learning disability, neurodiversity and autism as well as the uptake of reasonable adjustments by responders.

This work has also drawn attention from the emerging network for Ambulance sector learning disability leads.

Blue Light Hub App

After being named runner up at The Patient Experience Network National Awards (PENNA) in Birmingham in the '*Innovative Use of Technology, Digital & Social Media*' category for the blue light gaming app (October 2024), an evaluation, created in collaboration with Cardiff University, was also published in the EMJ, following its original publication in the BMJ.

The latest update to the app includes a CPR awareness game that has attention to medical accuracy and tonality. It is anticipated that this will increase awareness across a critical topic to help improve skills and confidence in using CPR.

Peoples' Experience – Takeaways from 2024/25

There has been a strengthening of the regulatory requirements with a greater emphasis on peoples' experience metrics

We have experienced a very busy year preparing for National Peoples' Experience Framework (PEF). It has been 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),
- National Health Service (Concerns, Complaints, and Redress Arrangements) (Wales) Regulations 2011,
- Public Services Ombudsman (Wales) Act 2019,
- the Well-being of Future Generations (Wales) Act 2015, Equality Act 2010,
- Value Based Health Care Strategy and
- Socio-economic Duty

Listening and learning from people's experiences has been widely acknowledged and seen as an integral element of these regulations.

We have been preparing our surveys and hierarchy within the Civica platform as we will be expected to have a greater reporting for peoples' experiences across all our service areas throughout 2025/26. Reporting will include data from the national Peoples Experience Survey on:

- 999
- 111 Wales

This information will be pulled into the Beacon Dashboard along with data from the five core validated questions used within any local/bespoke surveys such as:

- Ambulance Care
- Falls Responder
- CFR/CWR
- Any other identified surveys

We recognised we needed to improve our ability to increase feedback. We have been liaising with the Trusts' Information Governance team throughout the year in preparing a DPIA to submit to the ICO that will enable us to survey people using our emergency 999 service and better understand peoples' experiences.

Peoples' Experience – Takeaways from 2024/25

There has been a concerted focus on the integration of peoples experience feedback to drive improvements through real-time experience insights

We have worked with colleagues to increase the visibility of outputs from peoples' feedback and its use within quality and safety management systems and always on reporting requirements in line with the Health and Social Care (Quality and Engagement) (Wales) Act 2020.

We have been regularly presenting peoples' experience through the Trusts 'Quality Management Group' (QMG) under the heading of 'Citizens Voice'. Regular discussion around data and identified improvement activities have been held along with effectiveness and sustained improvement in the quality or experience of services being reported.

We will continue to use our 'experience cycle' to gain further insights into peoples' perceptions of their care.

Some examples of discussion and improvement points this year have included:

999/EMS

Positives	**Overall, people felt confident in call takers' ability**
Negatives	People unhappy at length of time waiting, felt patients' condition was worsening

Ambulance Care

Positives	**People reported feeling safe and secure in the vehicles**
Negatives	Patients unhappy waiting too long for return journey home or experiencing a late pickup

111 Wales

Positives	**People reported receiving good care & information from staff**
Negatives	People unhappy with long waits for a call back when feeling anxious

Peoples' Experience – Takeaways from 2024/25

There has been a greater focus on the collection and use of compliments with an 'always on' system expected for the collection of compliments available for all people and communities.

Compliments in the PEF are described as: 'A positive or appreciative statement about any individual NHS Wales staff member, services, programme, or function, which includes the expression of praise, admiration, or congratulations which goes beyond common courtesy. This can be received through a variety of means including verbal and written'.

Our online 'Have your say' facility allows people to log their compliments/feedback digitally, but compliments via calls, cards/letters received at various points and stations across the Trust are not always formally recorded. Existing channels to record all compliments received will be strengthened to support learning.

Over recent months a National Compliments Workstream has been established to help bring together good practice across NHS Wales and allow opportunities for sharing and learning about how different organisations record and use compliment data.

An initial action taken by the group was to review and update the compliment codes available in Datix. This has resulted in a more comprehensive list of codes being made available that can be used to code compliments. This will allow greater ability to monitor and report on compliment themes and trends.

Having a greater focus on compliments supports our Trust's culture, providing a positive enriching employee experience, helping colleagues feel that they belong, are valued and contribute to the long-term success of the organisation.

Looking ahead 2025/26

NHS Wales First National Patient Experience Survey (NPES)

The PES which went live 1st April with 10 questions that were validated via CEDAR, is anticipated to ensure a consistent approach in reporting on peoples' experiences across the NHS in Wales. We maintain our ability to add questions as we see fit for our own service requirements to the PES.

Data pulled into the Beacon Dashboard will be from the 10 core questions, additional questions/data will remain local. The bilingual survey is available in easy read as well as the top 10 languages spoken in Wales:
Arabic Gujariti Bengali Portuguese Urdu
Polish Italian Romanian Spanish Punjabi
Indian

A BSL version is currently in development.
We will be working with colleagues across 999 and 111 to ensure we are ready to incorporate NPES in our reporting.

First National Maternity Service PES Perinatal Survey

The Maternity/Neonatal survey and NPES are very similar as they use the 10 core questions for people experience. There are technically minor differences in approach with the Maternity/Neonatal survey as there are nuances specifically for the users. Feedback is through Midwifery Board. Powys, Swansea Bay, Cwm Taf and Hywel Dda Health Boards have volunteered to be early adopters to test learning around the survey.

SMS text messaging has been one of ways experience is being captured. Early learning from the testing phase has identified the need to enable people to leave contact details, if they want so that staff can follow up.

Children & Young People (CYP) PES

It has been agreed with Clinical Networks in Wales that CYP will be the next national survey to be developed. It is expected to have a group established by the Summer to develop the survey.

Looking ahead 2025/26

The Welsh Health Circular WHC/2024/015 'Peoples' Experience Framework and People's Experience Survey' outlines a much wider impact assessment about how the NHS is situated regarding public involvement and peoples' experience in its entirety.

The Framework has identified that the Duty of Quality needs further scoping and there will be more work to do on 'always on reporting'.

Within the Duty of Quality remit, we have a statutory obligation to use quality derived measures/data as part of our core metrics for always on reporting.

In line with the development of the National Quality Outcome Framework (QOF), person centered care and people experience data will be a core area to be implemented, including agreeing definitions for benchmarking.

The NHS Executive will collaborate with Llais to facilitate public interaction and engagement to ensure public readiness and social adaptation in this new approach.

To conclude, it is recognised that Patient Experience is far more than just the PES. There is more work to do for patient experience teams, focusing on PROMS/PREMS, digital Storytelling, public involvement, and citizens' engagement with links to Llais.

We need to ensure our DPIA is approved so that we can expand our capabilities in capturing experience feedback particularly across our 999 and 111 services.

We will continue to be part of The National People's Experience Survey Task and Finish Group so that we're sighted on continuous monitoring and tracking of progress at national/local level of the national quality metrics and outcome framework, ensure we are bench-marking to inform the Quality & Outcomes Framework; participate with the wider network supporting national learning and improvement; and support the implementation of other national surveys including the maternity/neonates, Children Young People, Mental Health/Learning Disability and Primary Care.

AGENDA ITEM No	**15**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**3**

UPDATE ON HEALTH INEQUALITIES MATURITY MATRIX AND POPULATION HEALTH PLAN

MEETING	Quality, Patient Experience & Safety Committee
DATE	9 May 2025
EXECUTIVE	Liam Williams, Executive Director of Quality and Nursing
AUTHOR	Dr Penelope Cresswell-Jones, Speciality Registrar in Public Health
CONTACT	Drpenelope.cresswell-jones@wales.nhs.uk / Penelope.cresswell-jones@wales.nhs.uk

EXECUTIVE SUMMARY

1. The organisation first completed the Association of Ambulance Chief Executive (AACE) Health Inequalities Maturity Matrix in April 2024.

2. The organisation has since hosted a Specialty Registrar in Public Health from September 2024 - March 2025, with the remit of defining the population health vision for the Welsh Ambulance Services University NHS Trust (WAST) and supporting organisational progress towards reducing health inequalities.

3. An updated version of the organisations Maturity Matrix for health inequalities has been completed to reflect progress over the last twelve months. This suggests the organisation has made progress moving from 'emerging' to 'developing' in this space, but many opportunities remain particularly regarding data and insights.

4. Findings from the Maturity Matrix, and the wider work from the Specialty Registrar in Public Health (including a series of Drop-in Workshop engagement events), have led to development of a Population Health Plan for the organisation and key recommendations.

RECOMMENDED that the Quality, Patient Experience & Safety Committee note this paper and the associated presentation by Dr Cresswell-Jones.

KEY ISSUES/IMPLICATIONS
(i) Progress towards population health and reducing health inequalities needs supportive organisational cultural/mindset and engagement at all levels. This can be achieved but may require some additional resource and different ways of thinking.

REPORT APPROVAL ROUTE	
Clinical and Quality Governance Group	14 April 2025
Executive Leadership Team/Strategic Leadership Board	To be agreed
Quality, Patient Experience & Safety Committee	9 May 2025

REPORT APPENDICES

ANNEX 1 - SBAR

REFERENCE ONLY FOR QUALITY, PATIENT EXPERIENCE & SAFETY COMMITTEE MEMBERS:

To streamline meeting materials, a 'reading room' has been established in Ibabs. This digital space hosts documents for additional information, not essential for scrutiny or decision-making. The Annexes below are available there. Access to the reading room is through the documents/shared folder in Ibabs' main menu. Documents in the reading room will not be posted on the Trust's website with committee papers; however, copies can be provided upon request.

ANNEX 2 - Updated WAST Self-Assessment for the 'AACE Maturity Matrix for reducing health inequalities' March 2025

ANNEX 3 - Population Health Plan for WAST - March 2025

REPORT CHECKLIST

Confirm that the issues below have been considered and addressed		Confirm that the issues below have been considered and addressed	
EQIA (Inc. Welsh language)	Full EQIA not completed, but equalities considered throughout	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	YES	Socio Economic Duty	YES
Health and Safety	N/A	TU Partner Consultation	No, but should be involved in

			any implementation

ANNEX 1

SITUATION

1. There is opportunity for the Trust to strengthen our role in population health and reducing health inequalities. The Trust completed a Health Inequalities Maturity Matrix from the AACE in April 2024 and has since hosted a Public Health Specialty Registrar from September 2024 - March 2025.

2. This paper provides an overview of the organisational progress in terms of the Health Inequalities Maturity Matrix, a summary of the assessment, and the proposed Strategic Plan and vision for population health in the organisation developed by the Specialty Registrar in Public Health in collaboration with others.

BACKGROUND

3. Population health is important for all Health Services to consider, with the overarching aim of improving the health outcomes of the population and reducing health inequalities. This is a new/emerging area of focus for the Ambulance Sector, and the scope of practice and population needs evolve over time.

4. Public health skills and tools can be used to support the population health approach. Public health covers three broad areas which are all relevant to the Ambulance Sector, including:

    (i) Healthcare public health (optimise how we design and deliver services to maximise individual and population benefit)
    (ii) Health protection (including emergency planning and infection prevention control)
    (iii) Health Improvement (including prevention and promoting a healthy workforce)

4.1 Prevention is relevant at all levels, from primary (reducing risk of disease before it starts), to secondary (early detection and treatment), tertiary (reducing future risk of existing disease), and quaternary (reducing risk of harm from healthcare such as avoidable admissions).

4.2 Health inequalities are important to the organisation from a variety of perspectives, including understanding the needs of the population (for service design and delivery) based on existing inequalities, and understanding whether the services widen any health inequalities (for example, are women less likely to receive less pain relief than men for the same symptoms).

4.3 Specialist public health expertise can support how data can be used to provide population intelligence, using the data to understand current and future population health needs to drive change, support a sustainable healthcare system, improve health outcomes and reduce inequalities.

5. The AACE recognises the value in the Ambulance Sector in working towards population health and reducing health inequalities. They have developed an organisational self-assessment 'Maturity Matrix'. In April 2024, the Trust completed the first submission of the Matrix, where it was identified to be at an 'emerging' maturity level for health inequalities.

6. The Specialty Registrar in Public Health joined the Trust with an honorary contract in September 2024 and completed a scoping exercise to define the population health vision and strategic direction for population health in the Trust. This included engaging with staff including a series of Drop-in Population Health Workshops, contributing to different workstreams such as the fume mitigation work and the development of the Integrated Medium-Term Plan and Quality Plan, and developing a strategic Population Health Plan based on the AACE reducing health inequalities work.

7. The Maturity Matrix for reducing health inequalities has also been updated to reflect the organisational progress over the past 12 months, and recommendations have been developed for the Trust to consider.

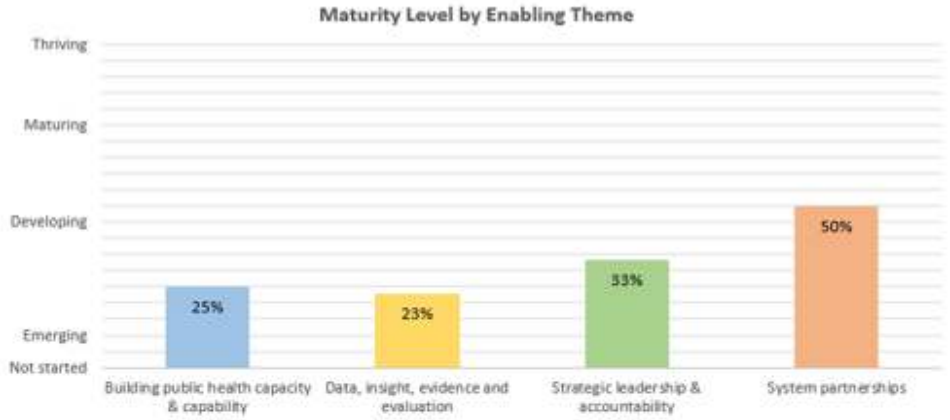
ASSESSMENT

8. Overall, there are many opportunities for population health within the Trust. There is general agreement about the values that align with a population health approach, but less certainty how it could be delivered in practice.

9. The updated Maturity Matrix for March 2025 demonstrates some overall progress has been made, with the organisation now meeting the 'Developing - building up good practice' maturity level, however there are areas for improvement including data and insights where progress was less clear.

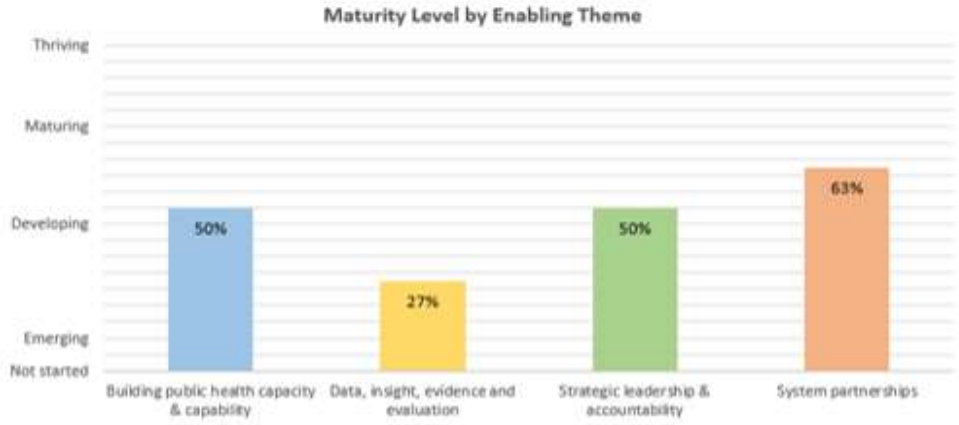
April 2024

Organisational Maturity Level: Emerging (preparatory or ad hoc work)



March 2025

Organisational Maturity Level: Developing (building up good practice)



Enabler 1: Building Public Health Capacity & Capability	1.1 - Training on health inequalities?		
	1.2 - Training and support - Making Every Contact Count (MECC)?		
	1.3 - Do you employ/host any public health specialist staff?		
	1.4 - Public Health development opportunities staff/volunteers?		
Enabler 2: Data, Insight, Evidence and evaluation	2.1 - Accurate comprehensive ethnicity data?		
	2.2 - Board routine receive data by ethnicity and deprivation?		
	2.3 - Patient level data on protected characteristics complete?		
	2.4 - Use existing population data in analysis of ambulance data?		
	2.5 - Public health analysts?		
	2.6 - Research related to health inequalities?		
	2.7 - Change programmes due to health inequalities?		
	2.8 - Data sharing agreements local systems for health inequalities?		
	2.9 - Public engagement based on health inequalities insights?		
	2.10 - Reviewed services considering equity/experience/outcomes?		
	2.11 - Reviewed how service impacts social determinants health?		
Enabler 3: Strategic leadership & accountability	3.1 - Organisational strategy commit to reducing health inequalities?		
	3.2 - Board training or development around health inequalities?		
	3.3 - Supporting delivery plan for reducing health inequalities?		
	3.4 - Executive lead identified for health inequalities?		
	3.5 - Governance for accountability for reducing health inequalities?		
	3.6 - Health Inequalities impact assessments routinely used?		
Enabler 4: System partnerships	4.1 - Represented at system-level for population health decisions?		
	4.2 - Work with system partners to embed values of anchor institutions?		
	4.3 - Accountability above and outside service for health inequalities?		
	4.4 - Engaged in system pathway redesign to reduce health inequalities?		

10. The Population Health Plan builds on the findings and recommendations from the Maturity Matrix, as well as taking a broader scope around population health. They are key areas of focus identified, to meet the following aims:

- To have a range of public health skills and tools available in the organisation
- Identification and delivery of all levels of prevention appropriate to the situation
- Intelligence from data, evidence, research, and evaluation used to inform individual patient care
- Intelligence from data, evidence, research, and evaluation used to inform service delivery and design
- Population health, including health inequalities, are in key strategic discussions and decisions
- Our services are recognised as key contributors to health of the population by system partners.

11. Barriers towards the population health approach in the organisation include: the culture of the organisation and the need to understand the relevance of the population health approach across roles in the organisation, the risk of the work becoming lost due to operational pressures and need for dedicated capability and capacity to drive forward the population health approach. Theory of change models can be used to support the organisation progress.

12. For the Trust to keep the momentum of progress with population health, there is an ongoing need for:

- Commitment in Organisational Strategy and Policy with tangible measures and accountability
- Dedicated public health expertise to lead organisational engagement and help population health become embedded
- Prioritisation of data linkage and sharing, including developments with the National Data Resource to enhance how we can use data for intelligence and insights
- Investment in time and resource to support the population health approach by increasing organisational public health capacity and capability including research and data.

Welsh Ambulance Services University NHS Trust

Clinical Indicators:

Return of Spontaneous Circulation (ROSC) at Hospital.

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

Clinical Indicators – Focus on ROSC
Version 0.1
Released: April 2025

Vince Baglole
Head of Clinical Intelligence & Assurance
vince.baglole@wales.nhs.uk

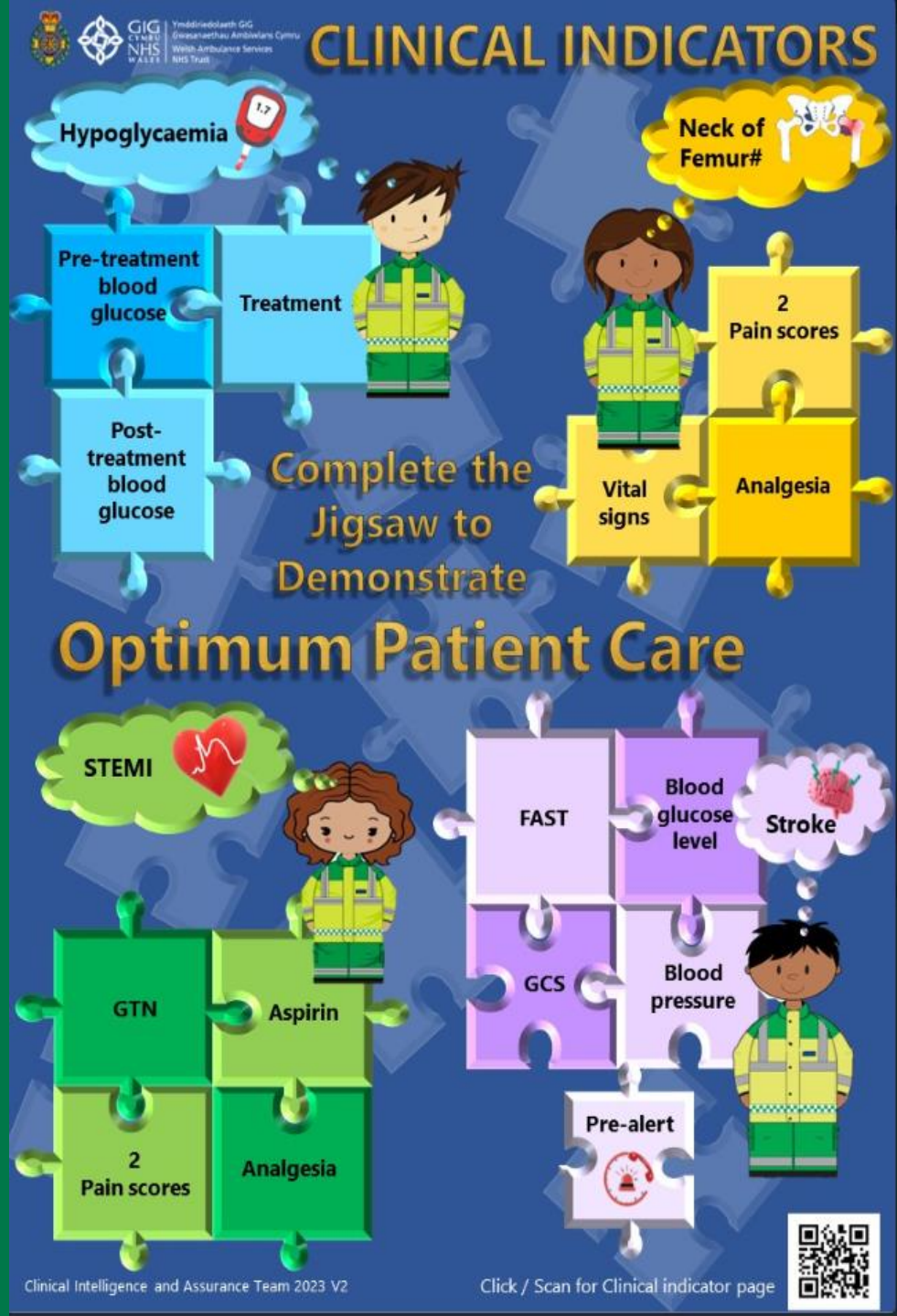
Introduction:

A Clinical Indicator (CI) is an assessment tool that is used to monitor clinical inputs or processes that affect patient outcomes. It is not a direct measure of quality but should be used to draw attention to issues that may need to be reviewed. For a CI to be effective it should be:

- **Developed in line with the best evidence, in partnership with clinicians and service users.**
- **Measurable and realistic, aiming to address issues that matter to patients and clinicians.**

If these principles are applied, then a CI is a good tool for benchmarking performance to reduce variations and to bring about improvements in care for patients.

During 2024, PowerPoint slides were produced for all Clinical Indicators in the 'Focus on CIs' series.

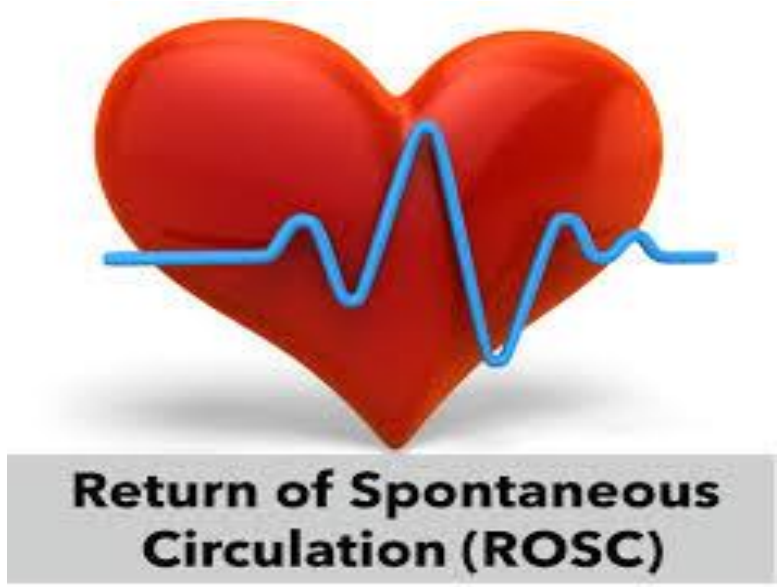


ROSC:

This is a progress report on one of the Clinical Indicators; ROSC

Within this we will highlight:

- ✓ **What we measure (criteria)**
- ✓ **Data quality and reporting**
- ✓ **Compliance / Performance**
- ✓ **Steps to improvement**



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?

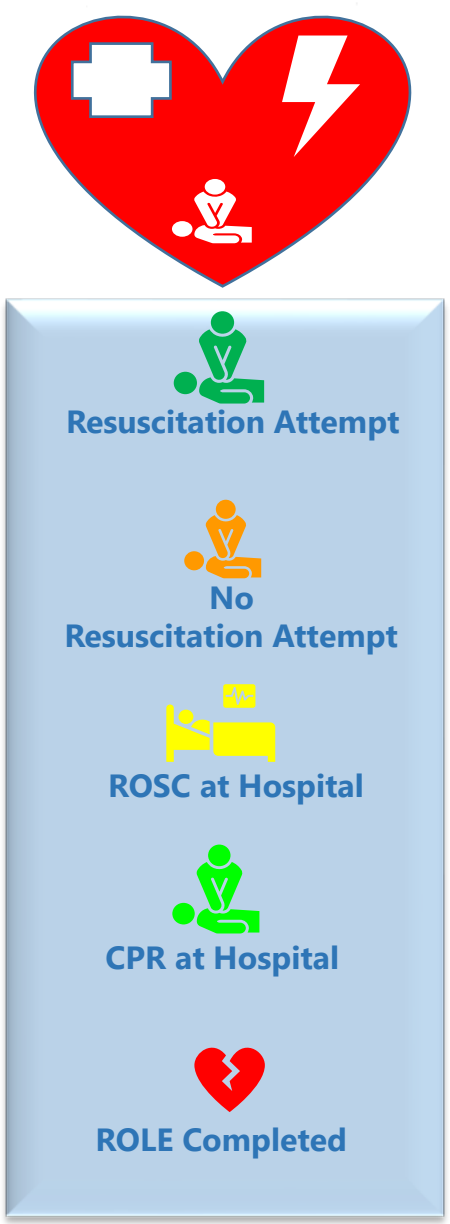
What we measure ROSC:

- **Number of EMS treated attempted resuscitations (out of hospital) *denominator***
  (excluding Inter Hospital Transfers)

  - **Compliance to the Clinical Indicator requires each of the following to be completed:**

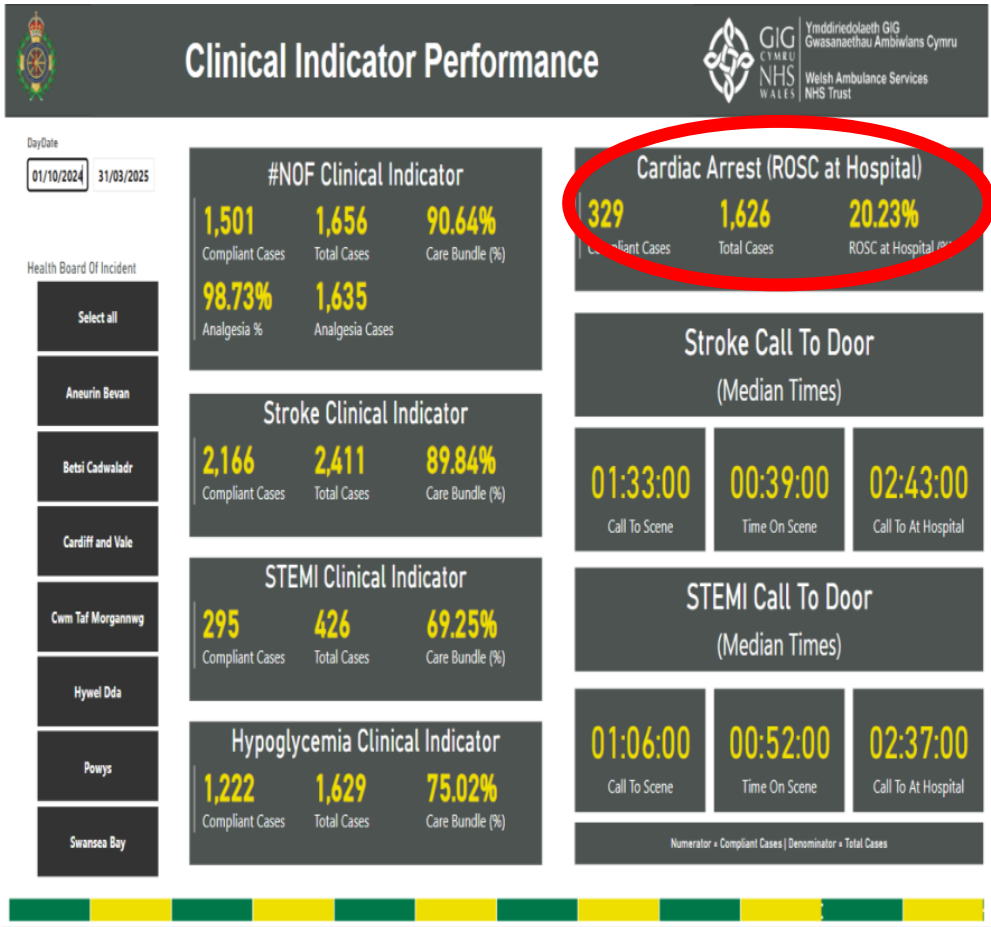
    - **Resuscitation Attempted**
    - **ROSC on arrival at Hospital**

    - **No Resuscitation Attempt (for exclusion)**
    - **CPR at Hospital (for exclusion)**



Data quality and reporting

- An ePCR technical specification was created to enable reporting
- Since the implementation of ePCR all CIs are reported on using 'raw' data inputted by clinicians (*no manual auditing prior to reporting*)
- Due to staff being unfamiliar with a new system, a reduction in CI compliance was anticipated (as in other UK Trusts), risk 535 (monitored by CIAG) was created to highlight three elements:
  - User behaviour
  - User interface
  - Scripting
- Development of a Clinical Indicator dashboard to include ROSC
- The CIAT undertook a QA (deep dive) audit to:
  - Provide a more accurate clinical picture of the care delivered
  - Highlight the variation between automated and audited data
  - Help inform future reporting and caveats
  - Help inform an improvement plan and changes to the ePCR User Interface

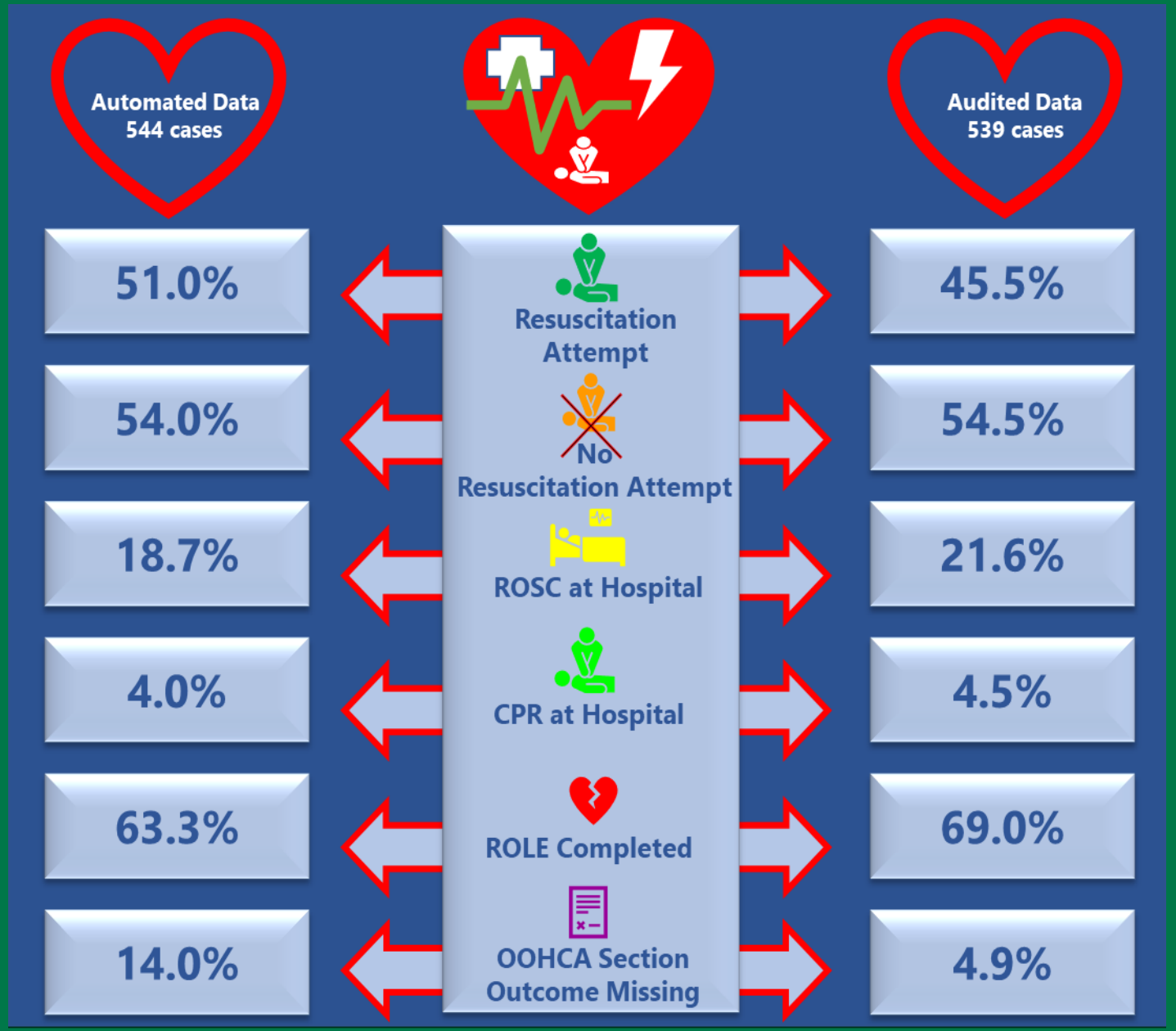


ePCR Clinical Data Assurance ROSC at Hospital:

What we did : CIAT carried out a retrospective comparative study of the ROSC individual criteria and care bundle compliance comparing:
•Automated reporting using data directly inputted into ePCR by crews at scene (Automated).
•Results following scrutiny of the Automated ePCR records by the Clinical Intelligence and Assurance team (Manual).
Why we did it : to compare the results of automated and validated data to give an accurate Clinical picture, to inform an improvement plan and future decisions on the quality of data required for reporting and to help inform ePCR completion compliance to improve automated reporting.

Recommendations include:

- Gain approval to ensure the SQL scripting is sense checked by the Clinical Data Specialist when developing future indicators.
- The trust to explore options for improving ePCR data inputting by on scene clinicians.
- The Trust to evaluate alternative (more accurate) approached for monitoring individual clinical standards of care.
- Undertake a re-audit when the TerraPACE user interface has been updated.



ROSC CI compliance April 2022 – March 2025

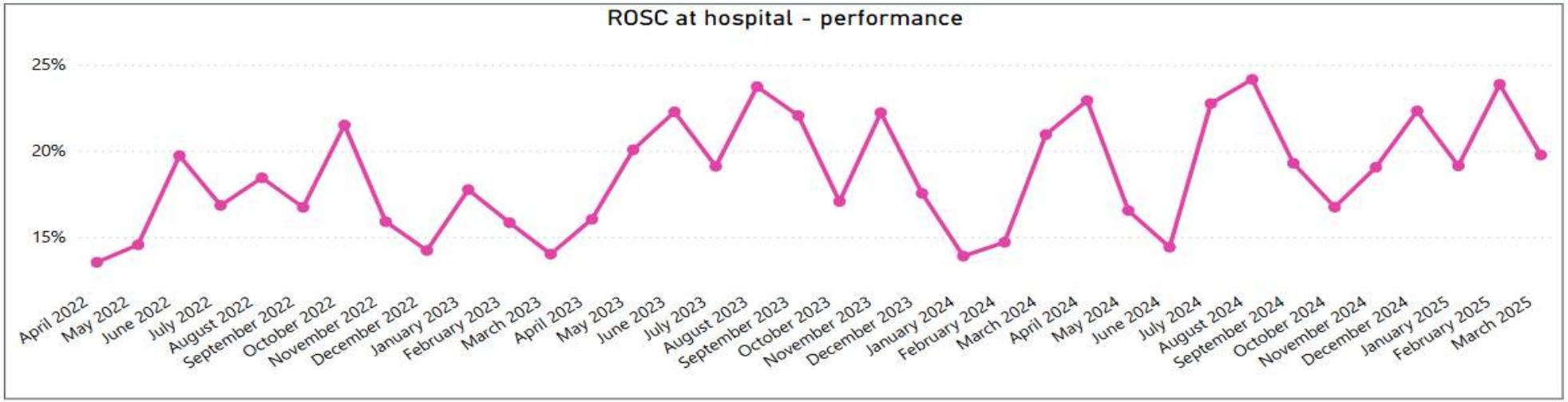
ROSC - At Hospital Indicator

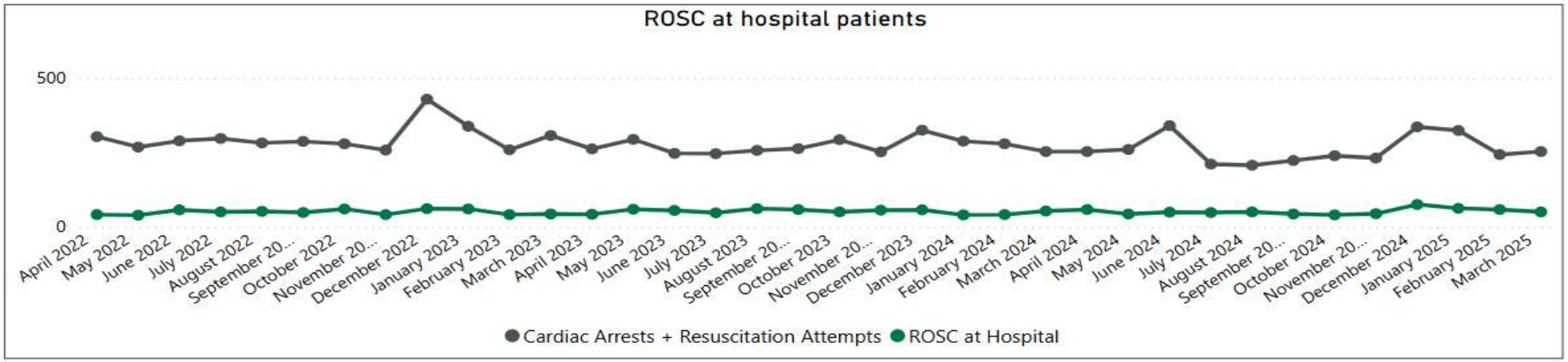
Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services NHS Trust

DayDate
01/04/2022 31/03/2025

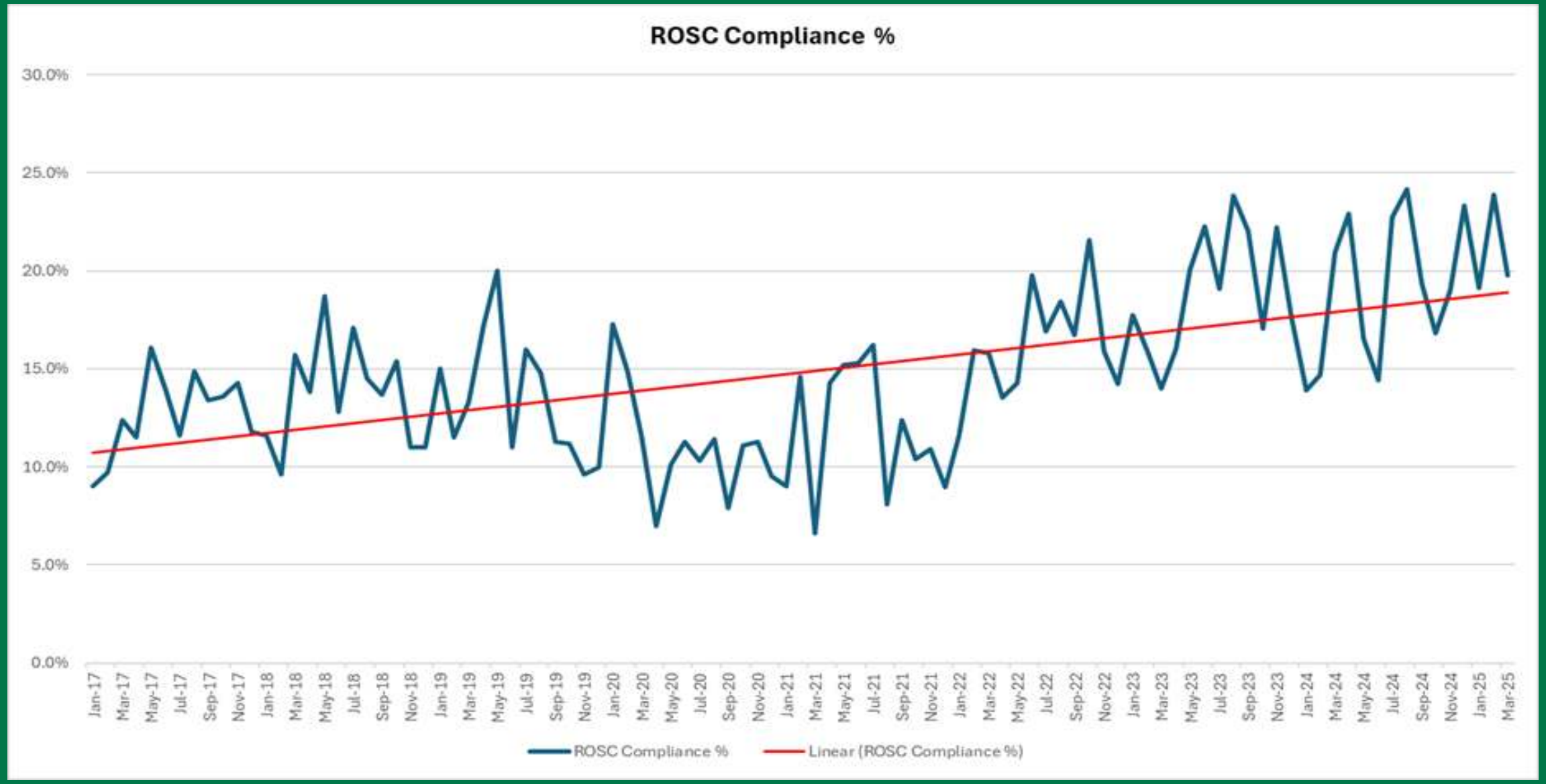
Health Board Of Incident

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





ROSC CI compliance since implementation:



OOHCA Case Selection Key Updates (2022 – 2024)

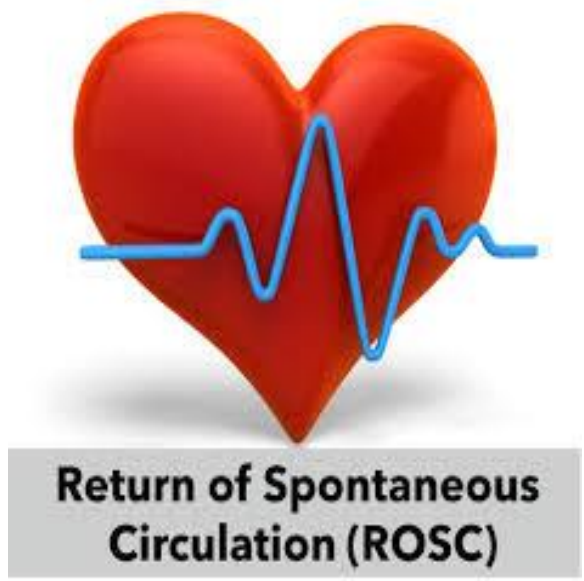
2022 – Initial Setup:
- Inclusion based an: Key fields (OOHCA / ROLE). Condition Code 133
- Adrenaline 1:10,000 / 1:100,000 use, ROLE Stop Code
- Narrative match “CPR” (excluding DNACPR)

2022 – System Updates:
- **Nov 22:** UI update for 30 min resuscitation (JRCALC Change)
- Added three Condition Code fields

2023 – Quality Assurance:
- **Findings:** Narrative matching too sensitive → false positives
- **Action:** Detailed analysis → refined matching terms (e.g. patient deceased / ALS commenced)
- **June 2023:** Tech Spec updated
- **Feb 2024:** New scripts deployed → reduced false positives

2024 – Minor Update:
- **Oct 2024:** UI wording change for “ROLE 1” (termination likelihood)
- Minor scripting tweak (no Tech Spec change)

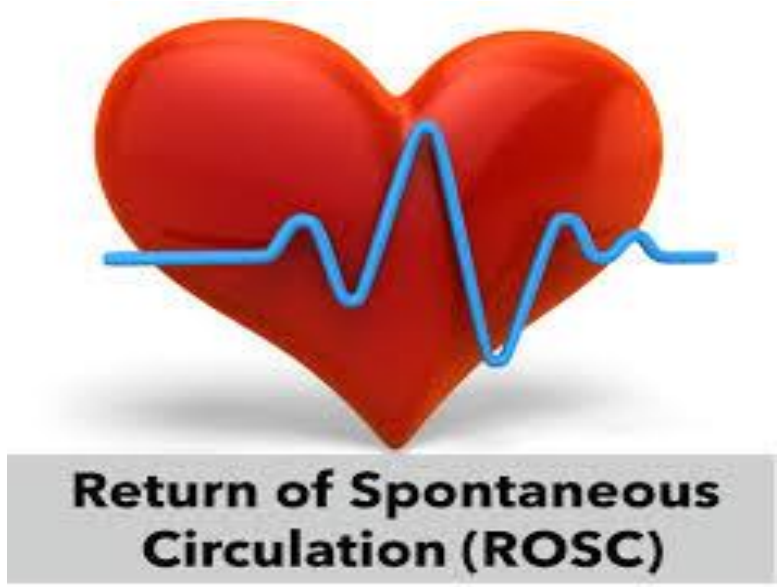
Current Status:
- No changes since Oct 2024



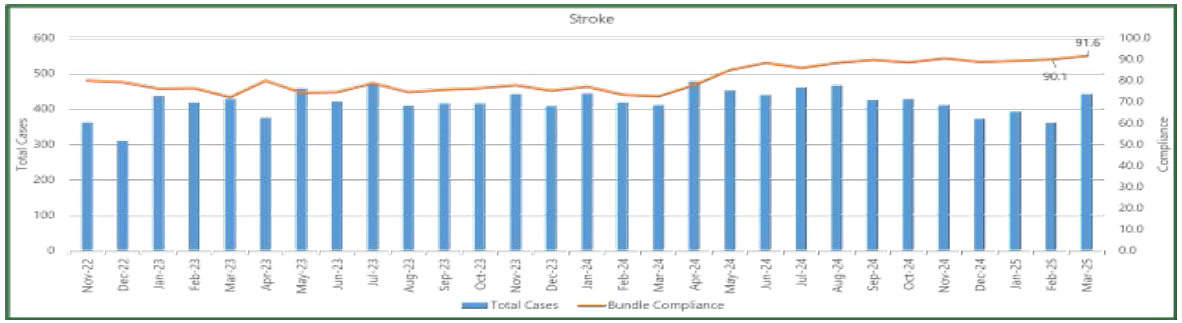
ROSC: Horizon Scanning

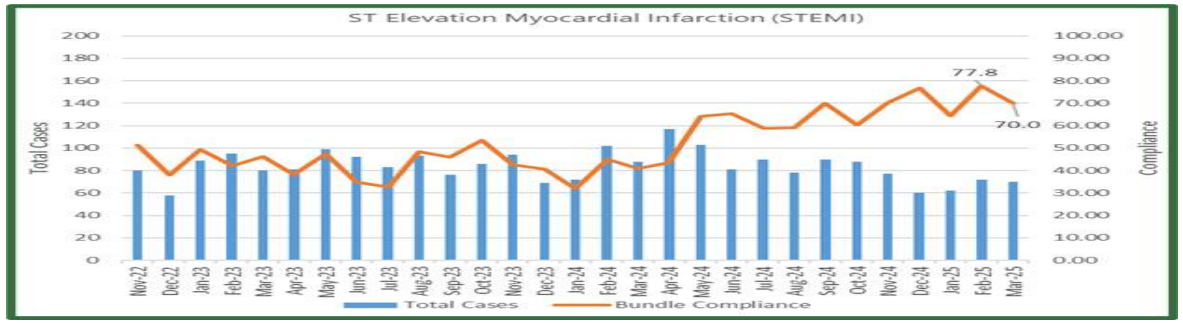
What changes will we see that will impact on ROSC?

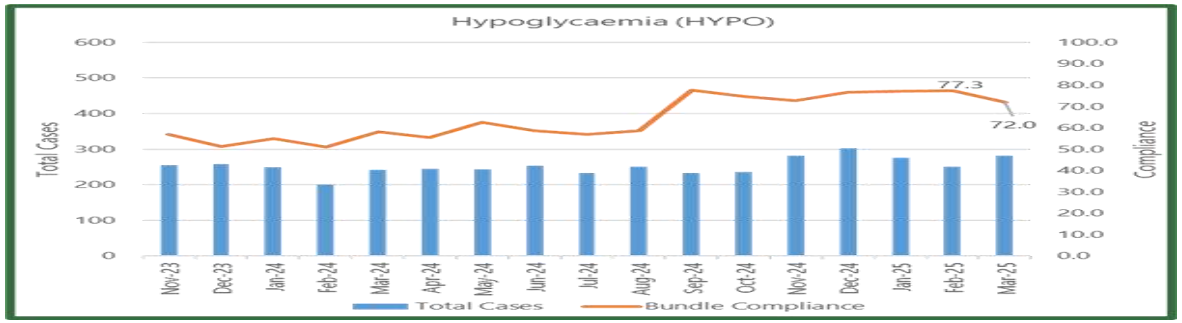
- ✓ **New clinical model categories (ARREST)**
- ✓ **ROLE guidance**
- ✓ **Continued evolution of surrounding services**
- ✓ **Linking data; ROSC or Survival to Discharge?**

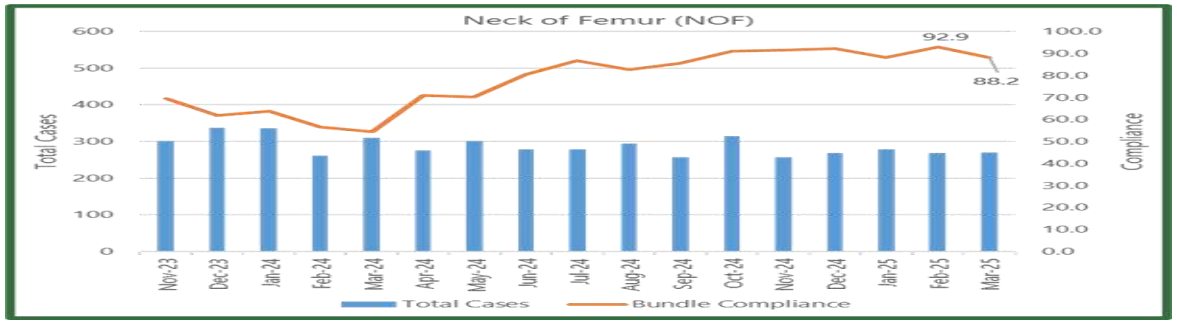


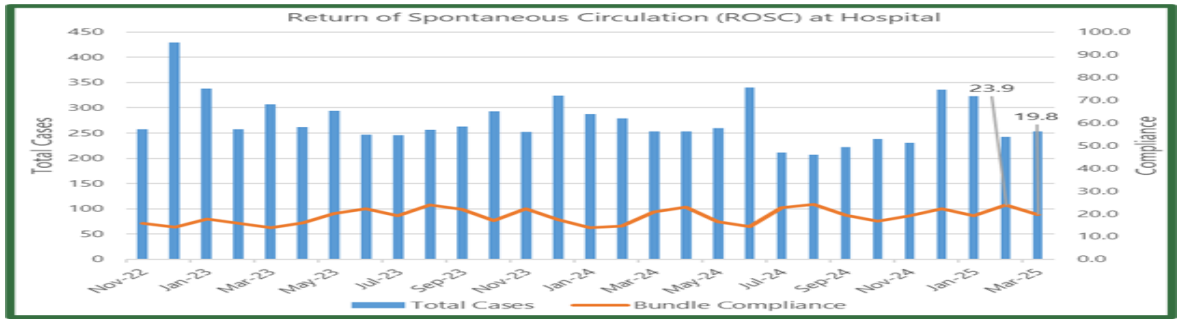
Clinical Indicator Compliance:











Thank you for listening

Any questions or comments?

AGENDA ITEM No	**17**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**1**

Clinical Audit Plan & Action Tracker
Q4 (update) 2024/25

MEETING	Quality, Patient Experience and Safety Committee
DATE	9th May 2025
EXECUTIVE	Andy Swinburn, Executive Director of Paramedicine
AUTHOR	Vince Baglole / Claire Muxworthy
CONTACT	vince.baglole@wales.nhs.uk

EXECUTIVE SUMMARY

1. Following an Audit Wales review of WAST's Quality Governance Arrangements, one of the recommendations was for the Clinical Audit Plan to be monitored on a quarterly basis at QuEST.

2. This is the Q4 2024-25 update to highlight progress with audits (the plan) and also to actions from the completed audits (action tracker).

3. The Q4 2024-25 Clinical Audit Plan contains 14 audits covering a range of topics including clinical conditions, medicines, and compliance to documentation. This is a dynamic plan which allows for additional audits to be added, however, since the Q3 update, no further audits were requested or added.

4. Of those indicated on the plan:

   - 7 have been completed, one in Q1, one in Q2 three in Q3 and two in Q4.
   - 3 of the 4 ePCR Clinical Data Assurance Re-audits will not commence as they are reliant on ePCR User Interface changes being implemented.
   - 1 of the ePCR Quality Assurance audits, STEMI***** (*heart attack*) has been undertaken and will be reported in Q1 2025 – 2026.
   - 2 are yet to start (ROSC and Recording of Failed Pathways), some are reliant on ePCR User Interface changes being implemented**,** some are not due to start until Q1.

     ****** As some changes have been possible outside of the next scheduled ePCR User Interface update (Spring 2025), CIAT has undertaken 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.

5. There are currently six completed clinical audits on the Action Tracker, with a total of 23 actions. Of those:

- 11 have been completed
- 5 are on track as planned
- 7 are delayed *(awaiting follow up information)*

RECOMMENDED: That the committee Note the Q4 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.

REPORT APPROVAL ROUTE
Quality, Patient Experience and Safety Committee - 09/05/2025

REPORT APPENDICES
Clinical Audit Plan 2024/2025 Quarter 4 – 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 Q4 2024-2025 update to highlight progress with audits (the plan) and also to actions from the completed audits (action tracker).

BACKGROUND

3. The development of this annual plan takes into consideration a number of aspects including the resources available both in terms of funding and skills. As is often the case in healthcare there are substantially more requests for clinical audits than there are resources available to manage them. For this reason, it has been necessary to tailor the plan so that it is realistic, achievable and that expectations are not overreached.

4. The plan is developed in consultation with the Clinical Intelligence & Assurance Team (CIAT), Clinical Intelligence & Assurance Group (CIAG), and senior clinical, and non-clinical managers within the Trust. Consideration is given to linking audit topics to the Integrated Medium Term Plan (IMTP), Local Directorate Plans (LDPs), and risk registers where possible.

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 for the clinical audit plan, 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, and an update noted at Clinical Directorate Business meetings.

8. Following an Internal Audit report issued in May 2024 on Clinical Audit, of the four objectives, three resulted in 'Reasonable Assurance' (Clinical Audit Strategy, Clinical Audit Planning & Clinical Audit Outcome Reporting). The fourth resulted in 'Substantial Assurance' (Benefits Realisation and Lessons Learned).

9. The Clinical Intelligence & Assurance Team are progressing with the recommendations from the Internal Audit relating to the Clinical Audit Plan.
    - Where possible clinical audits are linked to the IMTP, LDPs and risk registers. Specific fields for IMTP/LDP/Risk are now included on the audit proposal form. In addition, the decision log contains further information to justify the inclusion of audits.
    - More detailed information is now contained in the Clinical Audit Delivery Plan in relation to audits being included, and delays and issues if required. This is reported monthly to the Clinical Intelligence & Assurance Group.

ASSESSMENT

10. The Q4 2024-2025 Clinical Audit Plan contains 14 audits covering a range of topics including clinical conditions, medicines, and compliance to documentation. This is a dynamic plan and since the Q3 update, the Drug Administration Documentation' audit has been completed and presented to CIAG in March 2025. Also, the ROLE form images in ePCR re-audit was completed and presented to CIAG in April 2025.

11. Of those indicated on the plan:

    - 7 have been completed, one in Q1, one in Q2 three in Q3 and two in Q4.
    - 3 of the 4 ePCR Clinical Data Assurance Re-audits will not commence as they are reliant on ePCR User Interface changes being implemented.
    - 1 of the ePCR Quality Assurance audits, STEMI***** (*heart attack*) has been undertaken and will be reported in Q1 2025 – 2026.
    - 2 are yet to start (Return of Spontaneous Circulation (ROSC) and Recording of Failed Pathways), some are reliant on ePCR User Interface changes being implemented**,** some are not due to start until Q1.

12. 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, and at the Clinical Directorate Business meetings.

13. There are currently six completed clinical audits on the Action Tracker, with a total of 23 actions. Of those:

    - 11 have been completed
    - 5 are on track as planned
    - 7 are delayed *(awaiting follow up information)*

RECOMMENDATION: The committee Note the Q4 2024-2025 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 4

FINAL V1.0 Last Updated 1st April 2025

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 an 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.

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	Not started, decision made	**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	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	To commence after ePCR changes implemented	N/A	N/A	N/A	N/A	N/A

				Head of Clinical Intelligence & Assurance						
23_003	1	Clinical Frailty Scale (CFS) in Patients Aged ≥65 years Follow Up Audit	Richard Teulon Clinical Intelligence & Assurance Co-ordinator	Duncan Robertson Assistant Director of Clinical Development	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			
24_005	1	Drug Administration Documentation in ePCR	Clinical Intelligence & Assurance Team	Kevin Webb Head of Clinical Intelligence & Assurance	December 2024	N/A	N/A	N/A		
TBC	1	Failed Pathways Recording on ePCR Audit	TBC	Jonathan Chippendale Assistant Director of Clinical Development	Indicative Q4	N/A	N/A	N/A	N/A	N/A
TBC	1	ROLE Form Images in ePCR Re-audit	Clinical Intelligence & Assurance Team	Kevin Webb	Indicative Q4	N/A	N/A	N/A	N/A	

				Head of Clinical Intelligence & Assurance						
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	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. Update paper to CIAG November CIAG 2024, agenda item 11a remove from plan.
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

Ref	Clinical Audit Title	Rationale/Drivers	Clinical Audit Author	Clinical Audit Contact/Support	Audit Start Date	Comments
						issues. Start date of audit TBC. Awaiting full UI change to be employed. Autumn release expected. November CIAG 2024, agenda item 11a remove from plan.
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 implemented. UI changes investigated, and SBAR presented to ePCR-CRG (28/3) to confirm outstanding issues. Following Autumn 24 UI release – the CI technical specification was updated and deployed by IDS. Start date of audit Jan 25. Present findings to CIAG May 2025
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

Ref	Clinical Audit Title	Rationale/Drivers	Clinical Audit Author	Clinical Audit Contact/Support	Audit Start Date	Comments
						(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. CIAG November 2024, agenda item 11a remove from plan.
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

Ref	Clinical Audit Title	Rationale/Drivers	Clinical Audit Author	Clinical Audit Contact/Support	Audit Start Date	Comments
						adult lead and agreed in CIAG 08.03.24 Final report presented July 2024
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. Completed in preparedness for Dec CIAG. However, due to REAP4 paper rescheduled for January 2025 CIAG
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. Completed in preparedness for Dec CIAG. However, due to REAP4 paper rescheduled for January 2025 CIAG
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 Completed in preparedness for Dec CIAG. However, due to

Ref	Clinical Audit Title	Rationale/Drivers	Clinical Audit Author	Clinical Audit Contact/Support	Audit Start Date	Comments
						REAP4 paper rescheduled for January 2025 CIAG
24_005	Drug administration documentation in ePCR	To ensure that drugs administered to the patient are documented within the ePCR drugs section in line with the relevant parts of section 10.0 of the Medicines Management Policy 4.0	Clinical Intelligence & Assurance Team	Clinical Intelligence & Assurance Team	Q3	SQL developed. SBAR completed in preparedness for Dec CIAG. However, due to REAP4 paper shared for information via email. No comments received as of 02.01.25 suggesting changes required to criterion table. Approved. Approved CIAG 20 03 25
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.	TBC	Clinical Intelligence & Assurance Team	TBC	Required UI changes presented to ePCR CRG 29.05.24 CR0048, likely release Oct/Nov 2024 Revised date for UI changes Jan/Feb 2025 Now dependant on ePCR re-configurations
25_001	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	SQL developed Audit undertaken Present to CIAG April 2025
TBC	Safeguarding Adolescent Follow-up Audit	To ascertain if improvements have resulted following completion of actions from the previous audit.	Gwenan Jones-Parry Safeguarding	Claire Muxworthy Clinical Intelligence & Assurance	TBC	Initially planned to commence Q1 New Head of Safeguarding

Ref	Clinical Audit Title	Rationale/Drivers	Clinical Audit Author	Clinical Audit Contact/Support	Audit Start Date	Comments
			Specialist Paramedic	Co-ordinator		started end of May 2024 - audit delayed. Contact made with Safeguarding Specialist Paramedic 30.09.24 and 31.12.24 for update. Safeguarding audit not to be progressed at this time due to limited resources. It will however remain on the Safeguarding work plan. Potential to add to delivery plan when Safeguarding capacity allows.

AGENDA ITEM No	**18**
OPEN or CLOSED	**OPEN**
No of ANNEXES	**1**

AUDIT TRACKER – March 2025 (2024/25 Q4)

MEETING	Quality, Experience and Patient Safety Committee (QuEST)
DATE	9 May 2025
EXECUTIVE	Trish Mills, Director of Corporate Governance/Board Secretary
AUTHOR	Trish Mills, Director of Corporate Governance/Board Secretary Lisa Trounce, Head of Compliance & Assurance
CONTACT	trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. This paper provides the Committee with the 2024/25 Q4 position with respect to management actions for audits within the purview of this committee.

2. The Audit Handbook notes that it is the responsibility of this 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.

3. The Audit Tracker has been updated in Quarter 4 2024/25. In an attempt to manage volume of papers, the tracker has been added to the Ibabs reading room filtered to the actions assigned to this committee for oversight. This digital reading room hosts documents for additional information, not essential for scrutiny or decision-making. Access to the reading room is through the documents/shared folder in Ibabs' main menu. Documents in the reading room will not be posted on the Trust's website with committee papers; however, copies can be provided to those without access to Ibabs upon request.

Internal Audit

4. At the beginning of 2024/25 Quarter 4, there were 24 open internal audit recommendations relevant to the Committee. Of the 24 open audit recommendations, 15 were due for closure in quarter, and nine not due.

5. By the end of the quarter, six of the nine (67%) audit recommendations due for closure were confirmed as completed. Of those, three met their original deadlines, while the remaining three were completed after one or more deadline revisions.

6. New revised deadlines have been proposed for nine recommendations: three from 2023/24 (two on their third revision), and six from 2024/25 (all on their first revision). These new revised deadlines relate to the 2023/24 Electronic Patient Clinical Records (ePCR) internal audit, and 2024/25 Patient Experience and Community Involvement internal audit.

7. Particular attention is drawn to four open 2023/24 audit recommendations relating to the Electronic Patient Clinical Records (ePCR) internal audit. These were originally assigned to the Clinical Directorate but were transferred to the Digital Directorate in March 2025, due to their digital nature. Of these, three are on their third revised deadlines, with one deadline already lapsed.

8. To ensure progress on the ePCR audit recommendations, it is proposed that a meeting be held between the Digital Directorate and Internal Audit to review and, if necessary, reframe the outstanding recommendations and agree realistic revised deadlines. The Director of Digital will provide a further update at the ARAC meeting on 24 June 2025.

External Audit

9. All three external audit recommendations relevant to the Committee were closed during the quarter. This marks the completion of actions related to the 2022/23 Audit Wales 'Review of Quality Governance Arrangements' and the 2023/24 'National Review of Patient Flow – A Journey Through The Stroke Pathway'.

10. Recommendations 106d and 106e from the Quality Governance review will be superseded by new recommendations following the recent 'Quality Governance Follow-Up Review' by Audit Wales, to be added to the tracker in Quarter 1 of 2025/26.

11. Additionally, a Concerns Assessment by the Welsh Risk Pool (WRP) Safety and Learning Team, completed in February 2025 and reviewed in March by the Quality and Nursing Directorate, has resulted in new audit recommendations. These will also be added to the tracker in 2025/26 Quarter 1, with progress to be reported at the August 2025 ARAC meeting.

12. The current version of the tracker is now open for Directorate review for actions due in April, May and June 2025. These updates will then be reported to the Committee at its meeting in August 2025.

RECOMMENDATION

13. The Committee is requested to:

(a) Receive assurance on the monitoring of management actions to address recommendations in the Tracker, noting any revised dates for actions.

(b) Support the proposed approach to review the outstanding Electronic Patient Clinical Records (ePCR) audit recommendations.

KEY ISSUES/IMPLICATIONS
As set out above.

REPORT APPROVAL ROUTE
2024/25 Q4 Audit Tracker updates presented to the Assistant Directors Leadership Team on the 14 April 2025.

REPORT APPENDICIES
Annex 1 – Tracker 2.0 24-25 Q4 (January-March 2025) - Copy for QuEST 090525 (in reading room)

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

AGENDA ITEM No	**19**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**2**

Feedback from Effectiveness Review, Committee Cycle of Business Monitoring Report and 2025/26 Priorities

MEETING	Quality, Patient Experience and Safety Committee
DATE	09 May 2025
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. The committee discussed its effectiveness on the 04 February 2025. It was agreed at that meeting that it would be necessary to seek agreement of the final committee annual report, terms of reference and cycle of business via Chair's Action. This was completed in early April and ratification of the decision made is now sought.

2. The documents approved by Chair's Action (the final Committee Annual Report for 2024/25 and Committee Terms of Reference 2025/26) are available in the iBabs Reading Room.

3. The results from the Mentimeter survey completed in the meeting on the 04 February are included at **Annex one** for information as well. The results from the Mentimeter were summarised and included in the final committee annual report.

4. The full package of documents from the 2024/25 annual committee effectiveness reviews were presented to the ARAC at its meeting on the 01 May. A verbal update will be provided following the receipt of these documents at the ARAC on the 01 May.

5. The intended changes to operating arrangements for the committee are cited within **Annex two;** however, there are no specific arrangements for the Committee. The majority of the changes are general to all meeting arrangements and / or are components of the Integrated Governance Programme.

6. The committee is asked to discuss and approve its priorities for the 2025/26 financial year. It is suggested that the committee consider no more than two priorities for 2025/26. The committee priorities for 2024/25 and the progress update are cited below: -

   - Continue to monitor the duty of quality and duty of candour i.e. Committee will monitor implementation of the Duty of Quality and Duty of Candour following the Health and Social Care (Quality and Engagement) (Wales) Act;
   - Monitor the delivery of the Quality Strategy (Plan)
   - Monitor the organisation's compliance with the Health and Care Quality Standards 2024.

7. The cycle of business monitoring report for the committee has been presented for information for quarter one in **Annex three**. There are no issues to raise or escalate to the committee.

RECOMMENDATIONS:

8.

8.1 The committee is asked to ratify the decisions made by Chair's Action effective the 24 April 2025 in relation to the outputs of the annual committee effectiveness review;

8.2 The committee is asked to note the output of the Mentimeter survey held on the 04 February;

8.3 The committee is asked to note the proposed changes to operating arrangements for 2024/25 and the outcome of the meeting of the ARAC on the 01 May;

8.4 The committee is asked to discuss and agree its priorities for the 2025/26;

8.5 The committee is asked to note the cycle of business monitoring report for quarter one of 2025/26.

KEY ISSUES/IMPLICATIONS
Not applicable.

REPORT APPROVAL ROUTE
Not applicable.

REPORT APPENDICES
Annex 1: Mentimeter results from 04 February 2025 Annex 2: Proposed 2024/25 changes to operating arrangements Annex 3: Cycle of business monitoring report – quarter one

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

Question 1 - What would help you as report writers/reviewers/receivers of assurance?

MIQPR specific to committee

Better data flows to drive dashboard reporting

Clarity on the ask

Clarity as to what is required from a report.

standard templates

Clear work programme to make report writing predicable

Writing guidance AI tools

Possibly some more triangulation with other report writers to drive an even better flow.

Outcome-focused, aligned with strategic priorities, and include actionable recommendations to support informed decision-making

Buy-in and support from co-authors and data requirements

Having clearly defined the target or indicator or milestone and relevant data to support the narrative

Shorter more succinct reports

Standard template and guidance as to what to add as lots of repetitiveness in current reports

patient story element

Standard templates and fixed character length for reduced paper size

Clear templates to provide an outline of requirements

Shorter reports - some mandating of length perhaps?

summaries of reports to be more succinct

Clear timeline planning and support for QA

concise reports

draw attention of reader clearly to main points

Narrative update report at start of meeting from Liam/Director (high level summary / bullet points)

better succinct summaries

Better data analyses for pathways / outcomes

Concise reports

Commitment of membership

Good discussion and focus on patient experience

Professional and compassionate approach to scrutiny and gaining assurance

Question 2 - What works well in this committee?

balance of challenge and support

Patient story

The Chair!

Good discussions, although they do sometimes take us in different directions

Patient voice is heard

Chair

Amazing chair!

Good engagement from all

Lived experience

Attendance

Quality focus

Patient stories

Chairing is excellent and inclusive

variety

Avoid duplication of reporting of items which are aired in other forums/meetings/committees

Difficult to say, it's lengthy but the items are all key

Good level of engagement

Openness and transparency culture

Good chairing, inclusive

Well chaired with time given to work through issues

The focus, time for discussion, good engagement and questions

clear decisions

Excellent chairing

Patient and quality focus doesn't get lost

clear feedback to Board

Transparent and open discussion

a good amount of content but not rushed to get through

clear feedback to board

Balanced contribution / discussion

Papers give assurance

Annexures to reports to be clear if they are for information only for further context or need to be read.

Assumption that the report has been read to shorten the report

Question 3 - What improvements could we make in this committee?

It’s a very long day

More concise agenda

shorter meetings, potentially split over two days

Access to paper bundle for all

Understanding how the papers relate to the strategy and IMTP

More succinct executive summaries

right balance between data-driven discussions and patient stories to ensure a holistic understanding of patient experience and quality

papers circulated well in advance

I thought about two halves across two days but the flow may be lost

Greater focus on integrated organisational quality and safety reports rather than being channelled through service areas

not completely rehashing papers as members should have read prior so meeting should be for comment

shorter verbal introductions to papers, we often repeat what's in papers verbally and not always helpful

More triangulation across reporting

spend more time on outcomes - the "so what"; not all about the data collated; thus drive forward continuous improvement

More focused each agenda. Often feels like we need to squeeze things in.

Intros to the papers and potentially two mornings instead

We need to determine if we are committed for 4 days pa to focus on quality assurance or if we would prefer 6 shorter days

evolve how we consider our implementation of duty of quality and duty of candour

Better alignment of the papers that have data / metrics

More focus on quality and outcomes

Papers placed on website in good time prior to meeting

The papers that we write are too long and whilst the Executive Summary should be just that, our Summaries are a cut and paste from Annex 1 SBAR so all very repetitive

It was my understanding that as papers progressed through the governance route that they evolved, and some recommendations are discharged dependant on the meeting i.e., Clinical & Quality Governance Group.

I find when reading the papers that they barely change and this just doesn't feel right to me and ends up with the Committee having very long papers to read instead of the Executive Summaries which should tell them what they need to know/what they are being asked to do

CHANGES TO OPERATING ARRANGEMENTS 2025/26

Committee	Changes to operating arrangements
Board and all committees	• Further consideration to holding board meetings at venues other than Cardiff in 2025/26. • Introduce progress reports on 'what good looks like' for the strategic objective within committee remits will support the call for more of a strategic focus. • Revised approach to minutes for the board and committees. • Updated board skills mix and align to committees. • Where possible in 2025/26 the introduction of more hybrid meetings. • A reduction in the reporting against the audit tracker will be considered by ARAC in an attempt to reduce volume for committees and increase assurance. • New report front covers and SBAR templates. This includes a short form report which includes a requirement to set out purpose of report and alignment to strategic objectives, wellbeing objectives and health and care quality standards. This will support the desire to use more presentations over SBAR where appropriate • Writing guidance will set out the purpose of executive summaries in an attempt to ensure they are reflective of the comments received by members of this and other committees. • Presentation guidance and support will be provided. • Feedback following meetings on reports – both positive and where there are areas of improvement – are encouraged from committee members. This will ensure we are working towards a continuous improvement in paper length and assurance. • A 'reading room' will be established in Ibabs for documents that members may wish to review for further information, but which are not vital for scrutiny and oversight. • Members were encouraged to pose questions to report writers before meetings and allowing more time for questioning during sessions were suggested to enhance engagement. There is functionality in Ibabs to do this, or directly by email. • Continue with agenda setting meetings and encourage themes for meetings to aid in the flow and triangulation. Members are encouraged to review the agenda both when it is commissioned and closer to the meeting and alert the secretariat if insufficient time has been allocated. Likewise, presenters should ensure they are cognisant of the time allocated which includes time to present and for discussion.

CHANGES TO OPERATING ARRANGEMENTS 2025/26

Committee	Changes to operating arrangements
Quality, Patient Experience and Safety Committee	• Many of the issues raised are incorporated into the first section applicable to all committees and the board.

PAPER	PRE C'EE FORUM	FREQUENCY	Q1	Q2	Q3	Q4	LEAD	PURPOSE	COMMENT/COMPLIANCE
QUEST COMMITTEE - CYCLE OF BUSINESS 2025/26									
TERMS OF REFERENCE NOTED IN RED TEXT									
Quality Plan aligned to Delivering Excellence 2030	CQGG/TB	Initial and cyclical review					EDQN	Approval	Plan for approval in 2025/26 (including QIA and EqIA)
Clinical Plan aligned to Delivering Excellence 2030	CQGG/TB	Initial and cyclical review					EDP	Approval	Plan for approval in 2025/26 (including QIA and EqIA)
Quality Impact Assessments	CQGG	Ad Hoc					EDQN/DP	Assurance	See Notes
TBC assurance reporting on 'what good looks like' for QUEST remit	STB	TBC					EDQN/DP	Assurance	Reporting developing in 2025/26
Duty of Quality Report (to include Duty of Candour)	CQGG/TB	Annually	→				EDQN	Endorsement	Q1: Taking to extraordinary meeting in June instead.
Meds management report	CQGG	Annually					EDP	Assurance	Standalone report in Q1 on meds management (& medical devises by exception) & exception report - see Note 10
External reports	CQGG	Ad Hoc					EDQN/DP	Assurance	
Dementia Standards Report	CQGG	Annually					EDQN	Assurance	See Notes
Annual Mental Health Report	CQGG	Annually					EDQN	Assurance	See Notes re legislative compliance reporting requirement. Regular KPIs being developed 2025/26
Annual IPC report	CQGG	Annually					EDQN	Assurance	Metrics also included in MIQPR
Annual safeguarding reports	CQGG/TB	Annually					EDQN	Assurance	Annual safeguarding report (All Wales and WAST). Quarterly metric in MIQPR on risk report data and referrals
MIQPR report	ELT	Quarterly					EDSPP	Assurance	Includes balanced scorecard of all Board level metrics
Putting Things Right Report	CQGG	Quarterly					EDQN/DP	Assurance	See Notes
Policies for review and approval	Policy Group	Ad Hoc					BS	Approval	Board to approve PTR policy (SoRD). Note AW recommendations on PTR and Adverse Incident Policies in the 2024 quality governance review follow up
Clinical audit plan	CQGG/AC	Annually					EDP	Approval	QUEST report to Audit Committee that plan endorsed. See Note 9
Monitoring report on clinical audit	CQGG	Quarterly					EDP	Assurance	
Spotlight On' clinical indicators	CQGG	Quarterly					EDP	Assurance	To provide more focus on clinical care (started in Q2 23/24)
MIQPR annual review of QUEST metrics	ELT	Annually					EDSPP	Approval	To review and agree Board level metrics for coming year
PTR report annual review of metrics	CQGG	Annually					EDQN	Approval	To review and agree the Committee level metrics for the coming year (over and above MIQPR metrics - if any) currently contained in PTR report
Mortality Report	CQGG	Bi-annually					EDQN	Assurance	See Note 12
PECI report	TBC	Bi-annually					EDQN	Assurance	See note 11
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	
Board Assurance Framework	ELT	Quarterly					BS	Assurance	
Corporate Risk Register	ELT	Quarterly					BS	Assurance	
SUB-GROUPS									
Where applicable	N/A	Ad Hoc					N/A	N/A	No sub-committees - however may set up task and finish groups from time to time
GOVERNANCE									
Committee effectiveness review annual report	Audit/Board	Annually					BS	Approval	
Review of Terms of Reference	Audit/Board	Annually					BS	Approval	
Committee Cycle of Business annual refresh	N/A	Annually					BS	Approval	Q1: Dealt with via chair's action in April.
Committee Cycle of Business monthly review	N/A	Quarterly					BS	Review	Review against cycle progress at each meeting
Committee Review of Annual Priorities	N/A	Quarterly					BS	Review	
PROMPTS									
Operations Report	SLT	QUarterly					EDO	Information	

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**	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. Audit Wales Quality Governance Review 2022 made recommendations related to quality information. The 2024 Qualty Governance Follow Up Review (October 2024) re-opened previously closed recommendations as follows: - 8.1 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. This has been re-opened - 8.2 Enhance Covid-19 reporting in the integrated quality and performance report by including information about the harm caused to patients by ongoing service pressures caused by the virus. This can remain closed and is superseded given the risk posed by C19 now. - 8.3 Work with health bodies so that there are systems to determine the outcomes for patients who have received emergency ambulance services. This should particularly seek to understand the consequence and harm resulting from service failures such as long ambulance waits. This has been re-opened - 8.4 Develop patient outcome measures to support its existing quality measures. This has been re-opened. Report says: We found the Trust continues to face challenges in reporting patient outcomes due to differing patient systems in place across organisations. However, there is more the Trust can and should do to triangulate and identify themes and learning. The Putting Things Right report summarises some of the key themes from joint investigations and incidents, but not others such as concerns or mortality reviews. However, neither report [PTR and MIQPR] provides triangulation with other information to identify broader key themes and there is limited information on what is being done to address challenges and identify and implement learning. 05 November 2024 meeting: Discussion re reporting of low and no harm events (in relation to the near-miss report). Need to consider how best to receive / frequency.
2	**Duty of Quality and Duty of Care**	The 2024 Qualty Governance Follow Up Review recommendations as follow: R4 - The Trust should take steps to increase compliance rates for duty of quality and duty of candour training to ensure staff have a good understanding of their responsibilities under the requirements
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 The 2024 Qualty Governance Follow Up Review recommendations as follow: R4 - The Trust should take steps to increase compliance rates for duty of quality and duty of candour training to ensure staff have a good understanding of their responsibilities under the requirements
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. The 2024 Qualty Governance Follow Up Review recommendations as follow: R4 - The Trust should take steps to increase compliance rates for duty of quality and duty of candour training to ensure staff have a good understanding of their responsibilities under the requirements
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	**QIA**	The QIA *process* was endorsed by QUEST. Thereafter CQGG reviews all QIAs and the Chairs of CQGG will escalate those in their professional judgment should be reviewed by QUEST. QUEST paper 110523 - CQGG will: (a) Be assured that there is an appropriate QIA process undertaken for all new and existing Trust wide service redesign/transformation, projects and cost improvements; (b) Receive oversight reports on new and existing Trust wide schemes/projects that have undergone a full QIA to ensure risk planning is robust and the impact on quality and performance is being thoroughly assessed and negative impact mitigated (c) Have oversight of the framework and central repository for all QIA's; initial screening and full QIA. (d) have oversight of onward report to the Executive Management Team; Quality, Patient Experience and Safety (QuEST) Committee and; Trust Board, as appropriate. Reports to QuEST will identify QIAs completed and explicitly identify those that have required EMT review and authorisation
7	**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. QUEST to assure Audit Committee that clinical audit plan in place via AAA from Chair of QUEST. Clinical Audit Internal Audit done in 2023/24 - see recommendations Audit Wales Quality Governance Review Update 2024 made recommendations related to clinical audit: R3 - There are opportunities to further enhance reports on the Trust's Clinical Audit function, by: - 3.1 More clearly highlighting any changes made to the approved Clinical Audit Plan; and - 3.2 Capturing key findings, outcomes and learning from completed audits Report notes that whilst more recent clinical audit progress reports have provided a better summary of progress, there remains scope for reports on clinical audit to provide stronger assurance to the QuESt on its activity. The accompanying clinical audit tracker provides members with an update on recommendations arising from clinical audits, however, our review found it can be difficult to understand the key issues raised from looking only at the recommendations and progress reports do not currently highlight any findings from clinical audits. The Internal Audit review found that actions to address recommendations are monitored via relevant internal groups However, it remains difficult for QuESt members to be assured about the outcomes of clinical audit activity, and whether learning from clinical audits is becoming embedded to improve the Trust's performance without the inclusion of further narrative within progress reports
8	**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
9	**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 Service (MES) 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 2022 made recommendations related to mortality reviews. The 2024 Qualty Governance Follow Up Review (October 2024) re-opened previously closed recommendations as follows: R3 The QuESt Committee does not receive adequate assurances on mortality reviews. The Trust should ensure the QuESt Committee receives quarterly update reports to include: - 3.1 The number of reviews undertaken, and the numbers of reviews required but not yet complete. **This has been re-opened.** - 3.2 Any significant concerns, lessons learned and what changes have been made as a result. **This has been re-opened.** - 3.3 Updates on actions to address the mortality review backlog. **This has been re-opened.** - 3.4 Updates on progress implementing the all-Wales Learning from Mortality Reviews Framework. **This can remain closed.** R4 The Trust has a significant backlog of mortality reviews. The Trust should develop an action plan to reduce the backlog, reporting progress at each QuESt meeting. **This has been re-opened.** Report writers shoudl refer to the 2024 follow up report which noted that whilst the Trust has implemented the new framework for mortality reviews, there is fluctuating performance relating to delivering timely mortality reviews and there is scope for more consistent reporting of mortality review activity, outcomes and learning. See Learning From Deaths report to QUEST 13 August 2024 for background detail.
10	**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. Mental health KPIs to be developed in 2025/26
11	**Quality Plan**	Audit Wales Quality Governance Review Follow Up 2024 recommendations: Quality Strategy R1 - As the Trust develops a new Quality Plan in 2024, it should ensure that delivery is achievable within the resources available. The plan should clearly detail the funding required, the risks of under-delivery (due to capacity and resource constraints) and be underpinned with an implementation plan. Quality Strategy monitoring R2 - There is scope to strengthen quality strategy implementation plan delivery reporting. To enhance clarity, the Trust should, in its progress reports: - 2.1 Provide timescales for the expected delivery of each action; - 2.2 Differentiate between the progress of individual actions and strategic outputs; and - 2.3 Ensure that progress reports are reported regularly and are included in the QuESt cycle of business [note the report indicates quarterly from August 2024]

AGENDA ITEM No	**20**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**4**

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

MEETING	Quality, Patient Experience & Safety Committee
DATE	09 May 2025
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 27 March 2025 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*) remain static at the highest score of 25. These scores reflect individual cases of avoidable harm, highlighting ongoing challenges in the unscheduled care system due to the levels of handover delays.

7. The number of lost hours due to handover delays remained significant reported at 18,811 in February 2025.

8. 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.

9. 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.

10. There are a range of efficiencies described in the report that the Trust has undertaken in mitigation of these two risks. Three key ones being that a new Clinical Safety Plan was released in December 2024 to enable the Trust to manage risk more effectively at a system level, ensuring that patients are not unnecessarily directed to Emergency Departments (EDs) when they can be safely managed through other pathways.

11. Additionally, the Trust is on track to reach the Advanced Paramedic Practitioner (APP) recruitment target for this financial year; the evidence of utilising APPs illustrates a dramatic impact on ED avoidance with more patients being managed safely within the community.

12. A third example is the activation of the Care Planning and Winter Desk initiatives provide additional oversight and pre-emptive measures to address seasonal demand surges. These efforts are crucial to sustaining system resilience and minimising patient harm.

13. 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.

14. To support the continued, detailed review and mitigation of these risks, a second workshop took place on 13 February 2025 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 working outputs of these workshops will be presented at the next meeting for discussion.

15. Given the Avoidable Harm action plan reported at each Board and the comprehensive review of both risks at the Quality, Patient Experience and Safety Committee (QUEST) and the overarching review of all risks and the framework at the Audit, Risk and Assurance Committee, it has been decided not to continue reporting these to the Finance & Performance Committee (FPC) and the People & Culture Committee (PCC)

as has previously been the case. This will reduce volume and focus those committees on risks in their remit

RECOMMENDATION:

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

KEY ISSUES/IMPLICATIONS
17. The key issues are set out in the Executive Summary above.

REPORT APPROVAL ROUTE
• The BAF was considered by: • Assistant Directors Leadership Team (03 February 2025) • Executive Leadership Team (19 February 2025) • Audit, Risk and Assurance Committee (06 March 2025) • Finance & Performance Committee (18 March 2025) • Trust Board (27 March 2025)

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:	22/01/2025	TREND	25 (5x5)
		Date of Next Review:	22/02/2025	➡	

IF significant internal and external system pressures continue	**THEN** there is a risk of an inability and/or a delay in ambulances reaching patients in the community	**RESULTING IN** patient harm and death

	Likelihood	Consequence	Score
Inherent	4	5	20
Current	5	5	25
Target	2	5	10

IMTP Deliverable Numbers: 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 November were 20,993 and December were 25,199.**

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). V1.3 has been reviewed, updated and released (August 2024).
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.

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death		Date of Review:	22/01/2025	TREND	25 (5x5)
			Date of Next Review:	22/02/2025	➡	

IF significant internal and external system pressures continue	THEN there is a risk of an inability and/or a delay in ambulances reaching patients in the community	RESULTING IN patient harm and death

	Likelihood	Consequence	Score
Inherent	4	5	20
Current	5	5	25
Target	2	5	10

	However, it remains the case the prospective APPs are completing their education and could be deployed into the operational setting to mitigate the risk. ELT has therefore agreed to grow the APP numbers further this year, redirecting existing operational spend to bolster APP growth. This is part of the IMTP Deliverables 2024-2027.
9. Clinical Safety Plan (CSP)	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. **New CSP released 17th December 2024, released to enables the Trust to manage risk more effectively at a system level, ensuring that patients are not unnecessarily directed to EDs (can't send) when they can be safely managed through other pathways. In doing so we help to reduce demand on EDs and therefore hospital handover delays, support a better working environment for staff and ensure improved ambulance availability for those who need them most.**
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.

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	22/01/2025	TREND	25 (5x5)
		Date of Next Review:	22/02/2025	➡	

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 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.
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. Undertake the next 5-year strategic EMS Demand and Capacity review (the 2019 version will run out this year – 2024)	27. Review has been undertaken and has been reported to closed FPC committee July 2024 and Trist Board July 2024. This review details the level of resourcing required in different handover lost hour scenarios with different ways to respond to it e.g. traditional model or evolved CRN.
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 4 hour 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 Morriston 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.

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	22/01/2025	TREND	25 (5x5)
		Date of Next Review:	22/02/2025	➡	

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

10. There is currently no JCC implementation plan associated with the 2023 Demand and Capacity Review	10. The requirements for a funded implementation plan for the review i.e. resource envelope change from the JCC. The review is being reported to JCC board development session in August 2024 and is expected to go to JCC committee later this year. The expectation is that the 2025/26 commission intentions will respond to the review.

Please note that the gaps listed are not WAST's and are therefore outside of the control of WAST

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Exploring Rural model options (Paused during Pandemic Response) – subject to funding through IMTP. Now refreshed to wider rural model opportunities to include recruitment of CFRs. Additional funding has been sourced to increase posts within the volunteer function.	Assistant Director of Operations EMS / Assistant Director of Operations – National Operations & Support	Superseded	Rural model superseded by Action 9 below (Recruitment and deployment of CFRs)
2. Leading Change Together (forum to progress workforce related work streams jointly with TUPs)	ADLT Sub-Group	30.09.22 - Superseded	
3. Recruit and train more Advanced Paramedic Practitioners – Value Based Healthcare Fund bid for up to 50 WTE (I) [Source: Action Plan presented to Trust Board 28/07/22]	Director of Paramedicine / Director of People & Culture	**Superseded**	**16/01/2025 APP growth has been steady throughout the year, focussing mainly on CTM and AB Health boards which have had the lowest APP numbers. We are on track to reach our recruitment target for the year 120.7 FTE.** **A standardised training route including clinical placements in Primary Care has been supported for all trainees and the development of APP Nav models which are co-located in each Health board have been prioritised to support the UCRS Transformation work, with 49 APPs working rotationally in 6 out of 7 Health boards in an APP Nav model.** **Despite successful funding bids to support APP growth from external sources, we continue to link closely with strategic partners to showcase the impact of APPs in WAST and develop partnership working across the Health Board regions.** 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. May 24 - 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	Aug 24 – 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	Assistant Director of Integrated Care (with SRO through CMT Board)	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.

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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

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 **Commissioning** & Performance	Completed	ORH modelling underway. Initial findings January 2024, full report to Trust Board and JCC 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	Superseded with the implementation of the new model (ref: Action 5)	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 in partnership with St John Ambulance Cymru to deliver the CWR element. Initial phase due to conclude in March 2024, further extended to May 2024 due to SJAC funding accommodating extension arrangement. • NHS Charities Together (grant) funding obtained through external application, to develop internal volunteer capacity/volunteer workforce as CWRs. Piloting of the CWR model commenced in Spring 2024, with an expansion of the model in mid-October. Recruitment, onboarding and training continues with aspiration to recruit CWRs across Wales. • The SBRI innovation challenge has supported a phase 2 delivery of the digital ward model: enabling remote clinicians to care for patients in a 'virtual ward' capacity. It is envisioned this will enable patients to reach to right care at the right time, whilst being monitored remotely. The pilot has commenced for care homes in Wales, and a dedicated remote clinician is supporting the initiative generating organisational learning to expand remote care planning role the Trust can provide for the NHS Wales. The pilot initiative will conclude in March 2025. • The work will form part of the RICs workstream from September 2024.
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. Palliative Care Paramedic Unit	Assistant Director of Operations	**March 2025**	**16/01/2025 - At the end of the 3-year pilot, evaluation has been shard via an SBAR in SOT on 14th January and subsequently SLT on 21st January. This may potentially be BAU if approved.** Reducing demand via APPs – 15th January Start.

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death		Date of Review:	22/01/2025	TREND	25 (5x5)
			Date of Next Review:	22/02/2025		
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**

			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.
11. 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	**February 2025**	• 01/10/2024 - The review of the unscheduled care report part 2 (accessing urgent and emergency care) is underway and will come to the committee in November 2024. • Conducted in three phases Audit Wales will independently investigate and report on patient flow out of hospital: access to unscheduled care services and national arrangements (structure, governance, and support) • WAST will proactively support this work and offer best practice examples from other jurisdictions that can support benchmarking and improvement activities. • Expected outcomes in 2023/24.
12. 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. • May 24 – 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:	28/01/2025	TREND	25 (5x5)
		Date of Next Review:	28/02/2025	➡	

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

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 Q4 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 November were 20,993 and December were 25,199.** 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. **Increased collaboration through the Serious Case Incident Forum (SCIF), Mortality Review Group, and the Learning from Events Meeting (LFEM). These platforms emphasise joint investigations, shared learning, and actionable insights to prevent future harm and improve patient outcomes.**
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	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. Agreement was 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. An event reviewing the effectiveness of the Joint Investigation Framework is currently being scoped nationally.

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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

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.
4. WAST Clinical Notice in place - Escalating a clinical concern with a deteriorating patient outside the Emergency Department 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 JCC.
15. Escalation of patient safety concerns by Trust Board: featured in provider reports to the Joint Commissioning Committee (JCC); been the subject of Accountable Officer correspondence to the NHS Wales Chief Executive; numerous escalations to professional peer groups initiated by WAST Directors; and coverage at Joint Executive Meetings with Welsh Government. Evidence submission to Senedd Health and Social Care Committee. Written evidence submitted during Q4 21/22 to the committee to assist their inquiry into Hospital Discharge and its impact on patient flow through hospitals. Report published in June 2022 containing 25 recommendations with recommendation six specifically WAST related stating "The Welsh Government should explain how the targets outlined in the Minister for Health and Social Service's statement of 19 May 2022 on urgent and emergency care and the Six Goals Programme to eradicate ambulance patient handover delays of more than four hours and reduce the average ambulance time lost per	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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	Likelihood	Consequence	Score
Inherent	5	5	25
Current	5	5	25
Target	3	2	6

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 Joint Commissioning Committee (JCC) 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 JCC.
	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.
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

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IF	THEN	RESULTING IN
patients continue to be significantly delayed in ambulances outside Accident and Emergency Departments	there is a continued risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised	patients coming to significant harm and a poor patient experience

	Likelihood	Consequence	Score
Inherent	5	5	25
Current	5	5	25
Target	3	2	6

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.
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.

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:	28/01/2025	TREND	25 (5x5)
		Date of Next Review:	28/02/2025		

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

			Participation in the All Wales Duty of Candour implementation group by Patient Safety Team – monthly. • **Still underway**
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 **Extended**	• 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 **continuation of the LUSCII solution Continued expansion of the Connected Support Cymru initiative, leveraging digital and telehealth platforms.** **Recruitment efforts for Community Welfare Responders (CWRs) are ongoing, with engagement across Wales to bolster capacity and resilience**.
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)
13. Development of the RICS service.	**Executive Director of Quality & Nursing**	**Q4 2024/2025**	• **Winter Desk and Care Planning Initiatives:** • **The aim of Care Planning is for clinicians to provide holistic management of a patient's care journey through WAST by carrying out ongoing monitoring where appropriate to ensure patients flow to the most suitable disposition to meet their needs. The aim of Care Planning is for clinicians to provide holistic management of a patient's care journey through WAST by carrying out ongoing monitoring where appropriate to ensure patients flow to the most suitable disposition to meet their needs.** • **Activation of the Care Planning and Winter Desk initiatives, providing operational oversight and pre-emptive measures to address seasonal demand surges. These efforts are crucial to sustaining system resilience and minimising patient harm.** • **Deployment of specialists in respiratory care and pediatrics, addressing critical clinical gaps and improving care pathways.**

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:	28/01/2025	TREND	25 (5x5)
		Date of Next Review:	28/02/2025	➡	

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

- **The remote clinical care leadership is growing, with the addition of two new specialist roles to complement the existing and growing multidisciplinary expert team. The addition of specialist clinicians in remote care for pediatric and respiratory care is a significant step forward in our commitment to enhancing patient care and aligning with our organisational plans to care for more patients in more alternative ways than traditional ambulance responses.**
- **We will welcome a pediatric nurse specialist and a physiotherapist respiratory specialist in early February 2025 and look forward to understanding more about how their wealth of advanced clinical experience and expertise can contribute positively to safe person-centered outcomes for patients who often require the help and assistance of both 999 and NHS 111 Wales.**
- **Ongoing progress in appointing a Learning Disabilities Specialist to further enhance equity and inclusion in care delivery.**

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

DUTY OF QUALITY IMPLEMENTATION PLAN

MEETING	Quality, Patient Experience & Safety Committee
DATE	9 May 2025
EXECUTIVE	Liam Williams, Executive Director of Quality and Nursing
AUTHOR	Kate Blackmore, Assistant Director of Quality Governance
CONTACT	kate.blackmore@wales.nhs.uk

EXECUTIVE SUMMARY

1. The Report considers the implementation of the Duty of Quality in order to provide assurance on Welsh Ambulance Services University NHS Trust's (WASTs) compliance with the Health & Social Care (Quality and Engagement) Act 2020.

2. Key activities have been undertaken with remaining work linked to longer term plans and initiatives across the organisation.

3. Leadership structures have been established with clear governance and communication strategies including the development of the Senior Quality Leadership Team and the Quality Management Group. This activity begins our journey to a culture of Quality and aligns with 'Our WAST Way'.

4. Updated and improved governance structures help us to evidence the consideration of quality in decision making with Quality Impact Assessments become more integrated into our processes and business structures supporting the consideration and visibility of quality throughout the Trust.

5. The first Duty of Quality Report was published with work ongoing to develop 'Always On' reporting for consistent and accessible quality metrics. This includes the release of the Monthly Integrated Quality Performance Report (MIQPR) Dashboard.

6. Training and education efforts continue with a focus on increasing the uptake of e-learning packages, board development sessions and additional education products related to the Duty of Quality.

7. Full implementation of the Duty of Quality initiatives will be completed over a longer period and are linked to our Strategic Plans such as the People and Culture Plan. As such elements of the Implementation Plan are better aligned to the monitoring structures already in place.

RECOMMENDED that the Quality, Patient Experience & Safety Committee:

(1) Approves the closure of the Duty of Quality Implementation Plan.
(2) Approves the closure of the Duty of Quality Implementation Group
(3) Takes assurance on the progress made to deliver the Duty of Quality.

KEY ISSUES/IMPLICATIONS
N/A

REPORT APPROVAL ROUTE	
Senior Quality Team	28 August 2024
Senior Quality Leadership Team	September 2024
Clinical & Quality Governance Group	21 January 2025

REPORT APPENDICES
ANNEX 1 - SBAR

REPORT CHECKLIST			
Confirm that the issues below have been considered and addressed		**Confirm that the issues below have been considered and addressed**	
EQIA (Inc. Welsh language)	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	YES	Socio Economic Duty	N/A
Health and Safety	YES	TU Partner Consultation	N/A

ANNEX 1

SITUATION

1. The Report considers the implementation of the Duty of Quality in order to provide assurance on Welsh Ambulance Services University NHS Trust's (WASTs) compliance with the Health & Social Care (Quality and Engagement) Act 2020.

2. Key activities have been undertaken with remaining work linked to longer term plans and initiatives across the organisation

BACKGROUND

3. The Health and Social Care (Quality and Engagement) Act 2020 came into force on 1 April 2023. The Act comprises of four key components: Duty of Quality, Duty of Candour, Citizens Voice and Vice Chairs.

4. The revised legislation has changed the basis upon which Health Inspectorate Wales (HIW), as our regulator, assesses organisation compliance to legislation.

5. To support the implementation of the Duty of Quality and Duty of Candour, Welsh Government provided a 'Road Map' with key milestone targets. This Road Map has been translated into an Implementation Plan with additional actions identified to meet the stipulated deliverables.

ASSESSMENT

Leadership & Culture

6. Following the completion of a series of Organisational Change Processes within the Quality, Safety and Patient Experience (QSPE) Directorate, we are able to evidence appropriate leadership for the implementation of the Duties of Quality and Candour. Given the financial investment in the growth of teams in this area we are also able to evidence a willingness by the organisation to financially support and develop skills and infrastructure to support the duties implementation. Whilst recruitment processes continue this should now be considered as part of business-as-usual activity given the normal progression and retention expectations within the organisation.

7. A clear structure of quality governance is now evidenced, not only within the Directorate but also broader across the organisation. In the last 12 months the development of the Senior Quality Leadership Team structures and sub-groups, as well as the Quality Management Group, demonstrate a clear integrated governance approach with agreed Terms of Reference, meeting structures and

communication lines. In addition, work ongoing within the Corporate Governance arena supports evidence of integrated approaches to governance and reporting helping to build a culture of quality across the organisation.

8. The People and Culture Plan helps us to demonstrate the commitment to psychological readiness for change, and the continued work around behaviours, culture, psychological safety and leadership development supports the approach of continual improvement in this area. Whilst work continues on delivering the Plan including 'Our WAST Way' for developing leadership, the oversight of this activity is now better aligned to the People & Culture Directorate Business Meeting for monitoring as part of the Directorate Plan rather than the Duty of Quality Implementation Group.

9. Communication strategies have been implemented to support a compelling vision for improved quality across the organisation. Of note we should reference the continued presentations at consecutive CEO Roadshows, the integration of Senior Quality Leads into local Team Meetings and the completion of the Trust's first Quality Event (WASTQ) which was completed on 2 July 2024. In addition, the use of LMS365 to support the roll out of the E-learning Platform has proved positive with increasing numbers of staff across all Directorates now engaged with the level 1 training around duty of quality. Understanding how we best articulate the roles and responsibilities of all staff when considering the duty of quality will be a longer journey and should be considered as part of the broader People and Culture Plan including the Management Essentials Framework. The oversight of this activity is now better aligned to the People & Culture Directorate Business Meeting for monitoring as part of the Directorate Plan rather than the Duty of Quality Implementation Group.

10. The introduction of the Quality Management Group (QMG), alongside the role of Senior Quality Leads engaging with broader organisational structures, supports us as an organisation thinking and acting differently by applying the concept of quality. The integrated approach of QMG supporting all Departments across the organisation has allowed us to begin developing processes for Quality Management Systems, and to create Quality Statements, that are relevant to areas across Corporate Services as well as operational functions. This is also being monitored as part of the Quality & Performance Management Steering Group.

11. The refresh of the WAST Improvement and Innovation Network (WiiN) Programme supported by the increased quality improvement capacity continues to give staff at all levels the permission, opportunity and confidence to test new ideas. As we move forward the introduction of the Quality Hub and Quality Improvement Software LifeQI will help us develop this approach further and provide important data to demonstrate improvement activity. Local teams have

also demonstrated improvement initiatives including the 'CSD your ideas make a difference' activity.

Decision Making

12. Quality Impact Assessments (QIA) are now embedded as business-as-usual activity for strategic decision-making processes. As part of the implementation of the duty of quality, the existing documentation was updated to reflect the new Health & Care Quality Standards. These documents have clear governance processes through groups and sub-groups with oversight available at a Committee level. Work is now planned through the Local Delivery Plans of QSPE to enhance the current processes to make existing documentation more user friendly and effective.

13. Importantly Corporate Governance Teams are leading on a Task & Finish Group to develop an Impact Assessment Framework which includes the QIA. Part of the work ongoing in this Forum is to provide a clear definition of a 'Strategic Decision' to ensure that Impact Assessments are utilised appropriately, to support decision making in line with the requirements set out in legislation but do not become overtly bureaucratic to prevent improvement and delay decision making.

14. In order to evidence the development of systems and processes for informing/structuring Board decision making, the Trust Standing Orders were amended to recognise the new legislation. Additionally, the Committee Terms of Reference have all been reviewed to ensure reference to the Duty of Quality, these revised Terms of Reference were approved by Trust Board on 30 May 2024.

15. Corporate processes require Alert, Advise, Assure Highlight Reports between Groups and Committees. All Committees have minutes to document content and decision making, these minutes will include reference to Impact Assessments including Quality Impact Assessments where they have been discussed. The Integrated Governance Steering Group have agreed to the storing of approved QIA documents on Siren SharePoint, as both a Document Repository and Information Sharing Platform, which will allow the wider workforce to access examples of approved Impact Assessments to help inform the quality of submissions moving forward.

Governance & Accountability Structures

16. As previously referred to in paragraph 14, Committee Terms of Reference have been reviewed to include reference to the Duty of Quality and the Duty of Candour within their Purpose Statements. These revised Terms of Reference acknowledge the need to demonstrate the Duty of Quality through its operating

arrangements, as well as the requirement to monitor, assess and report on the implementation of Health & Care Quality Standards where relevant to their remit.

17. The monthly Integrated Quality and Performance Report is shared with Committees including Quality, Patient Experience and Safety Committee (QuESt), Finance and Performance Committee (F&P), People and Culture Committee (PCC).

18. The Integrated Governance Programme is included within the Integrated Medium-Term Plan which will be monitored through the Corporate Governance Local Delivery Plan. This Programme aims to streamline and unify the mechanics and dynamics at WAST by applying a simplified set of governance principles to the existing governance, accountability, Risk and Assurance Frameworks. The Duty of Quality will be a consideration within this Programme which aims to ensure coherence, efficiency and accountability at all levels from 'floor to Board'.

19. As part of preparations for the change in legislation a Board Development Session was completed in March 2023. In order to continue assurance to Board members in the remit of their accountability for the Duty of Quality and Duty of Candour, a further Board Development Day is scheduled for November 2024.

Reporting & Information

20. In line with the NHS Executive milestone document, a point of presence is now available on the Trust website to support our service users and stakeholders to easily access content and reporting associated with the Duty of Quality.

21. The first annual Duty of Quality Report was published via this platform (as well as the publication page of the Trust Website) following Board approval in July 2024. This Report included content to inform our service users of the nature of our services, how we monitor and govern the quality of those services and what improvements have been delivered (as well as challenges experienced) over the 2023/24 fiscal year.

22. Internally the Duty of Quality SharePoint page articulates the basis of the Duty and provides information and links to key documents including Quality Impact Assessments, e-Learning, informational videos and the Duty of Quality Annual Report for internal publication.

23. The development of 'Always On' reporting continues with the translation of the MIQPR into an accessible Power BI Dashboard. This work is ongoing with a first phase currently available for internal platforms and a second phase expected to be delivered in Quarter 3. Next steps to delivery include the development of external 'Always On' reporting which will be accessible via the Duty of Quality

page on the Trust website. The progression of the 'Always On' agenda is being monitored by the Quality & Performance Management Steering Group. The Publication Schedule has been agreed as monthly, and work is now ongoing to design what that monthly content will look like.

24. The progress of the MIQPR Power BI Dashboard will ensure consistency of reported metrics, the move to digital sources of information and a single source of truth for Committee Reports. Consideration will now be given to what information is shared with which appropriate Committee for onward assurance to Trust Board.

25. These structures provide the Board with assurance that there are clear escalation mechanisms in place for our quality related information. These infrastructures were communicated in Section 1 of our Duty of Quality Annual Report so that our staff, stakeholders and service users clearly understand these mechanisms.

Commissioning & Hosting

26. The Duty of Quality applies to all NHS bodies, Welsh Ambulance Services University Trust is a commissioned service and as such, regardless of who is delivering Health Services, the Duty is the responsibility of the commissioning body. As such the Joint Commissioning Committee must exercise its functions with a view to securing improvement in the quality of service, these are expected to be reflected in the core requirements.

27. Emergency Medical Service (EMS) Commissioning intentions for 2024/25 have been agreed with intention 5 (Harm & Outcomes) making specific reference to the Duty. Aim 1 of this intention (CI5-A2) requires the organisation to be compliant with the directions of the Duty of Quality and Duty of Candour acts and that principles span all activities undertaken by the organisation. Product 2 of this intention (CI5-P2) refers to core requirement compliance and the need for the organisation to complete a Self-Assessment against the core requirements, including a Gap Analysis for the requirements of the Duty of Quality and Candour.

28. The core requirements for Self-Assessment have not yet been stipulated following the changes to the infrastructure to commissioning and the introduction of the Joint Commissioning Committee. These core requirements are stipulated for delivery by December 2024.

29. Where WAST are identified as a commissioning organisation, the core requirements for the Duty would be expected to be stepped out through the National Procurement Frameworks held by NHS Wales Shared Services Partnership (NWSSP). However, to ensure that we are compliant as an organisation a standard paragraph for Service Level Agreements and

Memorandum of Understanding documents (such as with St Johns Ambulance) has been developed and is available for Department Leads via the Duty of Quality Siren SharePoint page.

30. A Service Level Agreement (SLA) Review Group has been implemented by the Strategy, Planning & Performance Directorate to monitor and assure appropriate SLA agreements are in place with standardised documentation and governance routes. The QSPE Team is engaged with this Review Group to ensure that the Duty of Quality requirements are considered in any future Frameworks associated with this work.

31. Several Local Health Boards and NHS Trusts host national organisation that support the delivery of Health Services. In hosting they are exercising functions in relation to the Health Service and so must do so with a view to securing improvement, in line with the Duty. This is not currently a consideration for the Trust.

Quality Standards

32. Initial processes and documentation were updated to align with the new Health & Care Quality Standards which came into effect from 1 April 2023. A focussed period of communication and engagement has continued since September 2024 to culturalise the Health & Care Quality Standards within the Trust.

33. Recent examples of Quality Impact Assessments, Joint Executive Team (JET) slide decks and Clinical Audit show reference to the Health and Care Quality Standards. In addition, the Duty of Quality Annual Report was aligned to the Standards and provided a first step towards self-assessment. Work is now ongoing nationally, supported by NHS Executive, to develop an internal Self-Assessment Tool, which WAST is engaged with. In the meantime, an interim assessment document has been developed based on a maturity matrix style approach.

34. Work is ongoing with Department Leads to develop local Quality Statements across the organisation which articulate what good looks like for the broad range of services undertaken by the Trust. This activity is monitored by QSPE through Senior Quality Team Meeting as part of Local Delivery Plan objectives and at a local level through forums such as the Senior Operations Team.

35. The Quality Management Group infrastructure supports organisational Departments to develop their internal Quality Management Systems and provides an integrated Forum with Quality Improvement and Clinical Improvement Leaders. The work undertaken by this Group, which reports to the Clinical and Quality Governance Group (CQGG), supports monitoring and improvement activity as part of business-as-usual infrastructure.

Quality Management System

36. The Trust's Quality and Performance Management Framework (QPMF) provides a Quality Policy for the organisation, consisting of five building blocks the Framework provides the core principles for the development of local Frameworks. This document was updated to align with the Duty of Quality and is now expected to be reviewed in spring 2025.

37. Pathfinder Departments have begun assessing against the Framework with a suite of Self-Assessment Tools developed by the Commissioning & Performance Team. These Tools are now available on the Siren SharePoint alongside the Framework and associated appendices.

38. Work is ongoing to support Directorates to develop 'Directorate Score Cards' as part of 'Always On' internal performance monitoring to support the Quality Management System and identify gaps for improvement activity.

39. The Quality Management Group agenda is designed around the four quadrants of the Quality Management system and encourages teams to reflect on the information available to them and possible improvement/assurance activities.

40. The QPMF is monitored through a Steering Group which reports to the Executive Leadership Team. In addition, the QMG reports through CQGG to Executive Leadership Team (ELT) providing robust governance infrastructure for the development and monitoring of Quality Management Systems across the organisation.

Communication & Engagement

41. The Road Map to implementation identified communication and engagement as an enabling activity rather than a statutory requirement.

42. Ongoing communication and focus on the Duty of Quality has included a dedicated web presence and Siren SharePoint page, engagement and attendance at recurrent CEO Roadshow events and WASTs first Quality Event held in July 2024. Importantly the Duty of Quality Annual Report was published on time and in line with the Annual Filings. The internal feedback from this document has been consistently positive.

43. The Partnership and Engagement Team remain a key stakeholder for the Quality Management Group and formed part of the core participants for the first twelve months, helping to develop communication activity and posting updates for the organisation.

44. Next steps in the communication journey include updating the existing Duty of Quality Siren SharePoint presence and implementing 'Always On' external reporting via the Trust website.

Training & Education

45. The Road Map to implementation identified training and education as an enabling activity rather than a statutory requirement.

46. As part of the preparatory work for the Duty of Quality, the Board received a Development Day Session on the new Health & Social Care (Quality & Engagement) (Wales) Act 2020 including the Duty of Quality and Duty of Candour.

47. An e-Learning package for both duties are being rolled out by NHS Executive Teams across the ESR eLearning Platform. Engagement in the Duty of Quality package was limited and so the Education and Development Teams translated the package into an LMS365 accessible document with notification reminders set within the Electronic Staff Record (ESR). As a result, there has been increased activity across the organisation with monthly updates being provided by the ESR Team and monitored through QMG.

48. As part of the Local Delivery Plan for the Quality Directorate work is now ongoing to develop, in collaboration with education and development colleagues, a suite of educational products associated with the Duty of Quality. The NHS Executive developed product is seen as a level1 requirement for all staff across the organisation. Enhanced level education will focus on the specific requirements and focus areas for levels of leadership. Consideration is also given to what, if any, local packages would be required. This activity is monitored through the Senior Quality Team.

Summary

49. The work articulated above and the ongoing Forums monitoring longer term objectives provide assurance to the Board that we have delivered on the milestone requirements for the implementation of the Duty of Quality.

50. The successful publication of the Duty of Quality Annual Report also supports this position. Whilst we acknowledge the Quality Management System is a continually improving journey there is sufficient evidence to support the closure of the Implementation Plan and instead move forwards on this journey of continuous improvement.

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

Emergency Department, The Grange University Hospital, Aneurin Bevan University Health Board

Inspection date: 02 to 04 October 2024
Publication date: 15 January 2025

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

We place people at the heart of what we do. We are:

- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

Our goal

To be a trusted voice which influences and drives improvement in healthcare

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.

Contents

1. What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection at The Emergency Department at the Grange Hospital, Aneurin Bevan University Health Board on 02 and 04 October 2024. The following hospital wards were reviewed during this inspection:

- Emergency Department (ED)- providing emergency medicine services to adults and paediatrics
- Majors – 16 beds
- Resuscitation – 8 beds
- Paediatric ED – 16 beds
- Medical Assessment Unit – 7 beds for respiratory isolation

Our team, for the inspection comprised of two HIW senior healthcare inspectors, three clinical peer reviewers and one patient experience reviewers.

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of 11 questionnaires were completed by patients or their carers and 61 were completed by staff. Feedback and some of the comments we received appear throughout the report.

Where present, quotes in this publication may have been translated from their original language.

Note the inspection findings relate to the point in time that the inspection was undertaken.

2. Summary of inspection

Quality of Patient Experience

Overall summary:

Staff were working hard under highly challenging conditions. We saw staff treating patients in a polite, professional and dignified manner. However, their efforts were often hindered by the number and high acuity of patients attending the department, and issues with the flow of patients into wards throughout the hospital.

There was overcrowding within the waiting room and reception desk area, resulting in lack of privacy and dignity for patients sharing and discussing confidential information. In addition, staff did not have good oversight of this area and risk assessments had not always been completed. We found that not all patients in the waiting area received timely analgesia where required.

Patients we spoke to, and survey respondents expressed significant dissatisfaction with waiting times. Only half felt they were assessed within 30 minutes of arrival. The department was experiencing high escalation status, and extended waiting times due to volume patients. Capacity was being managed by site managers and the nurse in charge, but patient flow was challenging due to limited ward bed availability. This system-wide issue affected the discharge process, with 350 to 400 patients awaiting discharge across the health board.

Whilst the issues highlighted above remain an issue impacting on patient safety, experience and dignity, there has been some improvement since our previous inspection in 2022. This includes initiatives implemented to improve patient triage times. Building work was also underway for an extended waiting area, which is due for completion in spring 2025. This will provide more seating for ambulant patients, and staff are confident this will help improve the patient experience and will enable better visibility of those waiting to be reviewed.

Delivery of Safe and Effective Care

Overall summary:
There were significant challenges with patient flow through the department. On the whole, this was attributed to delays with discharging patients from other areas of the hospital. This meant the department was overcrowded, thus impacting on patient care. This should be regarded in the context of national pressures on emergency departments and is not unique to the Grange University Hospital.

Overall, compliance with risk management was not always adequate. We found several examples to determine this, and some areas were replicated to that found during our inspection in 2022. Consequently, we addressed some of these issues through our immediate assurance process.

Our patient record review found that risk assessments had not always been completed for patients where applicable, particularly for people at risk of falling. In addition, we found prolonged sitting on hard chairs in the waiting room posed a risk of skin pressure damage to some patients, yet there was no mitigation in place to help prevent this. Whilst patients waiting on ambulances appeared to have timely assessments for skin pressure points, within the department, risk assessments were not routinely undertaken or completed in a timely manner.

The process for checking resuscitation equipment was not robust in all areas of the department, and we found that records to indicate whether safety checks of the equipment were undertaken, were incomplete. This finding however is not unique to the Grange University Hospital.

It was positive to find appropriate processes in place to manage infection prevention and control, however we saw staff on several occasions, not removing PPE when they left an area of infection. This posed a risk for cross infection to other areas of the department.

The process in place for safeguarding was supported by the Wales Safeguarding Procedures, and staff demonstrated an appropriate knowledge of safeguarding children and adults, the deprivation of liberty safeguards, and mental capacity.

We found that processes for medicines management were not robust including the timely review of the health board's medicine management policy. In addition, staff had not always completed daily controlled drug stock checks in line with policy.

Since our last inspection, initiatives were implemented to help improve the patient triage process, which included a new patient use eTriage system, with four digital stations based within the waiting area. Additionally, the level of communication between staff within the ED was appropriate and this was an improvement on the findings during the previous inspection.

Overall, staff were generally making the best use of available resources, such as medical equipment, supplies, and staff time, to maximize the benefit to patients, however the demands on the unit and overcrowding in the department, made this difficult to sustain.

Immediate assurances:

- Risk assessments for falls and Visual Infusion Phlebitis (VIP) were not completed in a timely manner
- Medicine management and administration of medicines was not robust to maintain patient safety
- Resuscitation equipment checks were not consistently completed
- We were not assured that all aspects of care were being delivered in a safe and effective manner and found that staff had failed to act on results of investigations
- Expired single use medical equipment was found.

Quality of Management and Leadership

Overall summary:

We found that maintaining nurse staffing levels was less challenging than that found during the previous inspection, and there was significantly less reliance on agency staff to fill vacancies or absences. We were told staff retention had improved and there was a focus on ensuring new staff were supported appropriately. Despite the department being very busy throughout our inspection, staff appeared to be coping well with the pressures and were mostly attentive and responsive to patient needs.

There was a training and development program in place for all staff, and this was supported by a practice development nurse. Processes were in place to identify staff training needs and help identify areas needing improvement. In addition, a staff induction pathway and Journey of Excellence process was in place, which new staff follow to ensure they gain all necessary competencies to work in the ED. Furthermore, compliance with the completion of mandatory training was good, over 85%.

There was a formal process in place for managing complaints, and this aligned to the NHS Wales Putting Things Right (PTR) process. We were provided with information about current complaints and actions taken to resolve them.

The service is currently in Level 3 of the NHS Wales escalation and intervention arrangements, and staff explained their focus on improving the 12 hour waiting times in the department, and lost ambulance hours as they are held outside the ED. In addition, staff described the weekly meetings held by the executive team to discuss data on patient waiting times and meeting Welsh Government targets relating to addressing patient flow through the department and wider hospital.

We found good examples of partnership working between various staff disciplines, and professions from other departments, including pharmacy, occupational therapy and physiotherapy.

Details of the concerns for patient's safety and the immediate improvements and remedial action required are provided in Appendix B.

3. What we found

Quality of Patient Experience

Patient Feedback

Throughout our inspection we engaged with patients, and also received 11 responses to our patient survey. Responses were mixed and waiting times, and the waiting areas were noted as the most negative responses. Most respondents rated the service as 'very good' or 'good'.

We received some positive comments about the service, and others on how it could be improved. These included:

> *"Amazing service and care by the team."*
>
> *"I was very impressed by service provided since my time spent here as I've heard a few stories, but I cannot fault staff here today."*
>
> *"It was evident that the waiting area was inadequate for the numbers there. At one stage I was sure that the numbers present exceeded the safe capacity from a fire regulation viewpoint plus there was only one exit accessible which also served as an entrance. As a retired clinician I understand the ranking of patients need to be seen in turn has to be governed by the extent and or seriousness of their presenting conditions. There was no clock in the waiting room and there was no system to work out when I might be seen. This was somewhat frustrating for me and for others waiting. Healthcare is and always will be complex and it was clear that many of those there were desirous of some tangible system to know when they might be seen. I know that is asking a lot as the clinical ranking to be seen can change depending on what arrives at A&E during any waiting period but it would have been better to have some idea than none. Apart from that I can only state that the clinical handling, from triage, to diagnosis and treatment and to discharge was first class and all the staff are a credit to NHS Wales. The staff were wonderful despite working under very overwhelming patient numbers."*

Person-centred

Health promotion

Health related information was available in various parts of the department, many of which were bilingual. Information on sepsis was also displayed throughout the department.

We saw good interactions between staff and patients with staff attending to patients' needs in a discreet and professional manner. We saw staff spending time with patients and offering patients advice on how to improve and maintain their health and encouraging and supporting them to do things for themselves to maintain their independence.

Dignified and respectful care

We saw staff treating patients with dignity and respect, and confidentiality was maintained, as much as a crowded environment allowed. Most patients we spoke with reported positive interactions with staff and were generally happy with their care.

Whilst staff were striving to maintain the privacy and dignity of patients who were awaiting further assessment or treatment, this was clearly more difficult to achieve for patients who were waiting on chairs in the corridor area. However, staff were mindful of the need to maintain patient privacy and dignity and endeavoured to move them into more appropriate areas of the department when personal care was required.

There was overcrowding within the waiting room and reception desk area, resulting in lack of privacy and dignity for patients sharing and discussing confidential information. In the majors' section, fit to sit chairs have been introduced, and consequently, patients are sitting closer together, which impacts on their privacy and dignity. This was due to limited space as a result of overcrowding and lack of patient flow. We did not witness any overcrowding in the paediatric department.

Building work was underway for an extended waiting area, and we were told the expected completion date was spring 2025. This will provide more seating for ambulant patients, therefore helping to improve their experience, and will also enable staff to have better visibility of those waiting to be reviewed. We were told that the existing waiting room will be used for a rapid assessment and treatment zone (RATZ), with the aim to increase flow through the department.

We found areas of the department that were well decorated and appropriate for their intended use, for example the artwork within the paediatric area and the décor of the relatives' room.

We were told that staff in the paediatric ED have worked closely with the charity 'make a wish', and charitable funds have been used to build a shared bereavement room with Adult ED, which also has a viewing room, where families can see their loved one following their passing in a more appropriate environment.

The paediatric ED staff have also liaised with the charity '4Louis', which has donated bereavement packs for parents and siblings, for use when a child has passed away. They have also developed miscarriage packs for women and their families, including a specific one for those of Muslim faith. This was implemented following patient feedback and demonstrates learning and improvement from patients.

Individualised care

We reviewed a sample of patient records and found clinician entries were recorded on a multidisciplinary basis. Within the records we found examples where improvements were needed in the planning and delivery of care. This is discussed further later in the report.

Timely

Timely care

During our inspection, patients and survey respondents expressed significant dissatisfaction with waiting times. Only half felt they were assessed within 30 minutes of arrival, while many received treatment within four hours. However, some reported waiting over 12 hours, which negatively impacted their experience and safety.

Several comments highlighted the frustration with waiting times, which includes:

> "My mother spent 12 hours sat on a chair, with no observations during that time and was a suspected heart attack. She had no food or drink offered during that time. She never saw a member of staff. When she was finally seen she was admitted to another chair, where she spent another 12 hours. It was like a zoo in the Grange. I am embarrassed to work for the NHS."

> "Bad points were the amount of time waiting for a bed."

> "There was no sitting or standing room, and ambulances outside all had patients in - so although I had suspected heart attack, I decided after 12 hours to leave and drive to a different hospital. It was my decision as if I was going to keel over, I wasn't doing it there. Wales [is] going backwards."

Upon our evening arrival, the department was experiencing high escalation status, meaning it was experiencing a significant level of crowding and operational pressure. This resulted in overcrowded waiting areas and extended waiting times due to a high number of patients. Capacity was managed by site managers and the nurse in charge, but patient flow was challenging due to limited ward bed availability. This system-wide issue affected the discharge process, with 350 to 400 patients awaiting discharge across the health board.

Patients in the majors and ambulatory areas had experienced extensive waiting times. Patients we spoke with had been sat in chairs for approximately 18 hours whilst awaiting admission to a ward bed. It was disappointing to see that some of these were frail elderly patients who required assistance for personal care. When required, they were transferred to a dedicated cubicle to receive personal care.

The waiting area was cluttered, untidy, and unclean, further impacting patient experience. A screen intended to display waiting times was not always operational, leaving patients uncertain about their waiting time to be reviewed. Overcrowding was evident, with patients standing and some waiting outside. One patient reported waiting since eight o'clock that morning.

Significant challenges in patient flow persisted, often beyond the control of ED staff, primarily due to delays in discharging patients from other hospital areas. These delays were caused by patients awaiting further support, such as rehabilitation, care packages, or placements in other facilities. Some patients spent over 48 hours in the department, which is not equipped to accommodate them for such extended periods.

Whilst the issues highlighted above remain an issue impacting on patient safety, experience and dignity, there has been some improvement since our previous inspection in 2022. The health board remains aware of these challenges and continues to explore different initiatives to improve flow within the hospital.

Not all patients in the waiting area received timely analgesia, and those with long waits were not routinely followed up with pain scores and repeat analgesia. We were therefore not assured that all patients receive timely pain assessment and analgesia, and efforts to improve patient flow must continue.

The health board must maintain the efforts to improve patient flow through the department and across the wider hospital.

The health board must develop a process where patients within the waiting room receive a pain assessment and analgesia if required.

An initiative to improve triage target times was implemented. Patients with time critical and high-risk conditions were being escalated promptly and moved to more appropriate areas within the ED for treatment. We were also told that there were good working relationships between the ED and ambulance staff in managing patient care. To manage timely triage of new patients and to address the backlog of patients waiting, more staff resource is deployed to reduce waiting times to meet the 15-minute target. This initiative has at times seen a reduction in triage time from 30 to 17 minutes. Staff endeavour to reducing triage times further to meet the 15-minute target.

Patients waiting in ambulances were well cared for, with ED staff providing care in the ambulance when needed. Patients were also taken off ambulances into the department to start treatment then returned to the ambulance. However, ambulance crew told us that diesel exhaust fumes and keeping patients warm during long waits were an issue.

Ambulance unloading times and the ability of ambulance crews to respond to patients in the community was negatively affecting the ED front door presentations. This meant that many clinically unwell patients were making their own way to the department.

When constructing the Grange Hospital, the ED was not designed for walk in patients, consequently leading to inadequate waiting areas and patient monitoring issues. There was a CCTV camera in place and the monitor screen was in the ambulatory area, however, it was difficult to determine the condition of the patient from a monitor, posing a risk that a deterioration in someone's condition may be unseen by clinical staff.

The health board should develop a robust process where patients in the waiting area are regularly monitored, in addition, that patients perceived to be more at risk of falls or developing pressure areas should be appropriately risk assessed.

We were told that patients referred by GPs were directly admitted to a specialty service, such as the Medical Assessment Unit or Surgical Assessment Unit. This reduces the burden on ED staff and assists with the issues of overcrowding and patient flow through the department.

The ED is piloting e-triage, with self-triage screens located in reception, though privacy concerns were noted with the risk others nearby able to see the screen. Staff explained that a privacy screen was in place preventing others from reading the screen.

Equitable

Communication and language
We did not observe staff communicating in Welsh; however, we saw that Welsh speaking staff were identified by the 'Iaith Gwaith' symbol on their uniform. We were told that a language line was also used to provide translation services in other languages when required. Staff in the ED could also provide patient information in easy read format, large text and Welsh language.

Within our staff survey, most felt they always explain to patients what they were doing and listened to patients and answered their questions.

To support patient navigation through the department, a flow diagram was in place in the waiting area.

Rights and Equality
We saw that staff were striving to provide care in a way that promoted and protected people's rights regardless of their gender or background. This is aligned to Welsh Governments approach to deliver good quality patient-focused care in EDs.

Welsh Government's quality statement for EDs emphasises providing the right care, in the right place, at the right time, and staff endeavoured to do this to the best of their ability, in a high-pressure environment.

Delivery of Safe and Effective Care

Safe

Risk management

Overall, compliance with risk management was inadequate. We found several examples to determine this, which are highlighted throughout this section of the report.

Prolonged sitting on hard chairs in the waiting room posed a risk of skin pressure damage to frail or elderly patients, yet there was no mitigation in place to help prevent this.

Our patient record review found that risk assessments had not always been completed for patients at risk of falling, and for those with an intravenous cannula. This was dealt with through our immediate assurance process.

In addition, risk assessments had not been completed in the rooms used to assess mental health patients, to identify potential risks to both patient and staff safety.

The health board must ensure staff are adequately supported to identify potential risks to patient and staff safety and complete a risk assessment where applicable.

As highlighted earlier, the layout of the department resulted in inadequate oversight of the waiting area. Staff relied on reception personnel to alert them to any issues or unwell patients, with clinical staff's visibility limited to a CCTV screen in the ambulatory area.

Throughout our inspection there was insufficient oversight for patients in the waiting room and discussed this with clinical staff, recommending the presence of staff to maintain patient safety. We were informed that staff had not been assigned to the waiting room to assess patients to maintain staff wellbeing. Whilst we acknowledge the importance of staff wellbeing, we suggested that staff work in pairs, if necessary, to help minimise their anxieties. It is important to ensure that patient monitoring and safety is maintained.

The health board must consider how clinical oversight of the waiting area can be improved to maintain patient safety.

We identified safety risks within the paediatric department. Notably, we found that staff had left a flask of hot water in the patient kitchen, within reach of patients, posing a risk to young children. This issue was escalated to the

management team, and the flask was subsequently relocated to a safer area during our inspection. We also found baby formula in unlocked cupboards, which were at risk of cross contamination or being tampered with by the public.

We accessed a dirty utility room (sluice room), which was unlocked and was therefore accessible to the public. Within this room there was an unknown substance in an unlabelled bottle, possibly a cleaning product, and tubs of bleach tablets. This was escalated to senior management and both items were removed and locked away.

The health board must ensure that all COSHH equipment is stored safely in a locked cabinet as stated in the COSHH regulations.

We noted there was no ligature free assessment space, toilet or wash facility within the paediatric ED and no risk assessment had been completed for this.

The health board must ensure staff are aware of the health and safety risk assessments and audits that are carried out for patient safety purposes.

We reviewed the process for checking resuscitation equipment within the resuscitation area, paediatric department and major's department. We found that the records to indicate whether the emergency equipment and defibrillator had been checked, had not been completed on multiple occasions. This was dealt with through our immediate assurance process.

The department operated a 'red release' protocol, which means a space is maintained to offload a patient from an ambulance in the event of a community emergency, negating a need to release an ambulance immediately. Due to overcrowding within the department, we found that this was not always available.

Infection, prevention and control and decontamination
The hospital had a dedicated infection prevention and control (IPC) team, and the ED had an IPC link nurse.

We saw evidence that regular hand washing audits were completed and the high scores indicated good compliance with hand hygiene. Staff are provided with updates relating to IPC by leaders and feedback from audits are provided during handovers.

We saw staff adhering to unform policy, and clinical areas were visibly clean and generally free from clutter. The department had its own domestic cleaning team, who were present during our visit.

Individual cubicles were available for isolating infected patients where required, including a negative pressure room. There are also seven beds staffed by ED nurses within the Respiratory Assessment Zone (RAZ) within the Medical Assessment Unit for those requiring respiratory isolation. This is to minimise the risk of airborne transmission of infection, such as for those with COVID 19, Flu or other respiratory infections.

Personal Protective Equipment (PPE) was available in all areas however, we saw staff on several occasions, not removing PPE when they left an area of infection. This posed a risk for cross infection to other areas of the department.

The health board must ensure staff use and remove PPE appropriately to prevent the spread of infection.

Safeguarding of children and adults

The staff we spoke with demonstrated a satisfactory knowledge of safeguarding children and adults, and for the deprivation of liberty safeguards and mental capacity.

We found robust safeguarding procedures in place for referral, escalation and follow up of safeguarding concerns. This was supported by the Wales Safeguarding Procedures. We were shown staff training compliance records for safeguarding and found these to be appropriate.

Blood management
Staff described the process of safe blood product transfusion, which in the health board is a two registered nurse process, and a clear protocol was in place to support this. We were told that staff complete blood transfusion competency training before they are permitted to administer blood products, and the department held a register of competent staff.

Management of medical devices and equipment
Staff had access to a range of medical devices and equipment, to manage the needs of patients. The equipment appeared clean and was in good condition.

There were robust systems in place to ensure that medical devices and equipment were being regularly serviced and maintained to ensure they were safe to use.

Medicines management
We reviewed the health board medicines management policy and found its review date had expired.

The health board must ensure the medicines management policy is reviewed and approved in a timely manner.

We reviewed records for Controlled Drugs and saw that records were not routinely completed in all areas of the ED. This related to drug stock balance checks in line with the health board's policy. These checks had been missed in the majors and RAZ areas.

The health board must ensure that controlled drug stock checks are completed in all areas of the emergency department.

We found expired medication in the paediatric and majors departments. We escalated this to the nurse in charge and the medications were disposed of immediately. We were also not assured that regular stock checks are undertaken to identify medicines with near expiry dates. This may pose a risk to safety if administered to patients. This was dealt with through our Immediate Assurance process.

There were four designated pharmacists that covered the department, and support was available out of hours if required. This included suitable arrangements for accessing medicines that were not in stock.

We witnessed two occasions when medication was administered and not signed for on the prescription chart. This highlighted the risk that medication could be administered twice and potentially overdose the patient.

The health board must ensure staff sign the medication record promptly after administering medication, to avoid overdose or drug errors.

We found the process for medication fridge temperature checks was not robust to ensure messages regarding out-of-range temperatures was acted on promptly. We were told an email was sent to the nurse in charge if the temperature is out of range. However, staff said that messages are not always checked due to the nurse in charge providing clinical support. Therefore, we were not assured that the system was robust and efficient to ensure temperature-controlled medication was being stored appropriately.

The health board must ensure a robust process is in place to report issues with medication fridge temperatures to ensure these can be addressed promptly.

For those we checked, we found all patients had an identification band in place. However, allergy bands were not always worn by patients with known allergies, neither were falls risk bands worn where applicable.

The health board must ensure that allergy bands and falls risk bands are placed on patients where applicable.

Preventing pressure and tissue damage
We found that skin pressure area risk assessments were not undertaken routinely or in a timely manner. On review of patient records, we found that initial completion of a risk assessment was not always done and rechecks were not recorded. When rechecks were recorded, this was usually longer than advised by the risk identifiers. We also found that where a patient's risk assessment score was high, pressure relieving mattresses or cushions were not used in a timely manner. This exposed patients to risk of skin pressure damage.

Patients arriving by ambulance received a skin inspection on triage and the triage nurse had the responsibility to reassess the patient as indicated by the Waterlow. Regular skin inspections were performed, and Datix incident reports were made if a patient had an existing pressure area, or developed one during their care in ED. However, for older adult patients sitting on hard chairs in the waiting room, we were not assured they were receiving regular pressure relief or skin inspections. We were told that often, triage nurses are too busy managing triage wait times, to enable them to regularly check patients in the waiting room. We identified at least one elderly patient who had been in the waiting room overnight and had not received a skin inspection.

The health board must ensure that patients in the waiting room are assessed for their risk of pressure damage and re-evaluated as indicated by the risk assessment.

Falls prevention
Falls risks assessments were not routinely undertaken for patients where appropriate to do so. We found an example where a patient had been admitted following a fall at home, but staff had not completed a falls risk assessment. This patient subsequently suffered a fall in the department. This was addressed through our immediate assurance process.

Staff we spoke to lacked understanding and knowledge regarding the correct way to complete falls documentation. We found that risks assessments that had been completed were not always acted upon. We were later told that the documentation was new and training on these had not been carried out by all staff at the time of our inspection.
We were told the frailty team, physiotherapists and occupational therapists supported ED staff in caring for patients identified as being at risk of falls.

Effective

Effective care

Senior staff described the department's initiatives to develop and improve the service provided to patients. This included a new eTriage system in place, as highlighted earlier, where patients can self-triage using one of four digital stations based within the waiting area.

We found clinical pathways in place for stroke, ST Elevation Myocardial Infarction (STEMI) and neck of femur fracture, additionally, the hospital had ring fenced beds to support patients with these emergencies. Paramedics also had pre-hospital pathways in use, for vascular, trauma and cardiac issues, and can divert patients to regional centres if required.

Nutrition and hydration

Patients could access food and drink when needed, and in general, the nutrition and hydration needs of patients were being met within the department, however, our inspection found this was not consistent in the waiting area. This included meeting the needs of patients who were waiting on board ambulances. Patients who required assistance with eating and drinking were seen to be supported by staff and the Red Cross volunteers.

Patient records

We reviewed a sample of nine patient care records and generally found these to be organised and easy to navigate. Handwritten records were found to be legible. However, as highlighted earlier in the report, risk assessments were not routinely completed or reviewed.

Efficient

Efficient

Hospital meetings were held throughout the day to discuss patient flow, where an overview of the department was discussed, including ambulance delays, patients awaiting ward beds and concerns regarding acuity. Whole site meetings were held every two hours during the day. These were usually attended by the nurse in charge of the ED, however, staff felt that it was difficult at times to implement the patient flow actions set at the meetings, due to the frequency of meetings.

We found an appropriate level of communication between staff within the ED, which included the sharing of patient information during shift handover, and details of the actions to help achieve patient flow. This was an improvement on the previous inspection. However, as highlighted earlier, staff were not always ensuring that patients were receiving timely care or treatment based on test

results or presenting condition, which was impacted by the volume of patients throughout the department.

Staff were generally making the best use of available resources, such as medical equipment, supplies, and staff time, to maximize the benefit to patients, however the demands on the unit and overcrowding in the department, made this difficult to maintain.

Quality of Management and Leadership

Staff feedback

HIW issued a staff questionnaire to obtain their views and their experiences of working in the ED. In total, we received 61 responses; all but one respondent said they are permanently based in the department.

Staff responses were generally negative, with most comments relating to staffing issues throughout the department, and patient flow impacting on the ability to care for patients in a timely manner. Less than half the respondents felt satisfied with the quality of care and support they give to patients, and even less felt they would be happy with the standard of care provided by the hospital for themselves, or their friends and family. Just over half said they would recommend their organisation as a place to work (32/58).

Staff comments highlighted several key issues within the emergency department. This included overcrowding, long wait times, and the lack of appropriate clinical spaces, collaboratively compromising patient safety and care quality. Staff also sited poor communication and support from senior management, which was leading to low staff morale and burnout.

Despite the issues highlighted by staff, they generally described themselves as hardworking and dedicated, and were striving to provide the best care possible under difficult circumstances.

Staff suggestions for improvement included better management of patient flow, increased staffing, and more support from senior leadership staff.

Some comments we received were concerning, and include the following:

> *"Whilst I believe that teams on the ground are working very hard and keep patient safety paramount, the overall department is frequently unsafe due to capacity issues. The department itself is well equipped and fit for purpose but every trolley is filled with patients waiting for beds which means the ED area is not used correctly and we cannot assess our emergency patients in a suitable environment. This means that we cannot move patients out of Resus and so critically unwell patients are managed in inappropriate clinical areas eg triage and ambulances. Patients who should be being assessed on the trolleys are having to sit in the waiting room. This means that they are uncomfortable, their care is delayed as they are having to move in and out of spaces for assessments, investigations and treatments. And so whilst I am confident in the skills of staff and the*

overall level of care being provided, the environment in which we are having to deliver this care is not acceptable. If the emergency department could operate as an emergency department and every trolley was available for emergency assessment and care the facility would be incredible..."

"The Department itself is very new, spacious and generally well designed. The ongoing issue is that we are always massively over-capacity and forced to treat patients in inappropriate and unsafe areas (e.g. decontamination room, back of an ambulance, corridors). We often have elderly patients sitting >12 hours in the waiting room or on chairs within the Dept..."

"It is too small to cope with the amount of people that attend. This encumbers effective patient flow through the department. Minor injury departments should be on-site which will help with timely referrals of patients requiring alternative treatments, instead of them then having to travel miles to be treated more appropriately and /or quickly than in the ED setting, and vice versa when they attend a minor injury unit only to be told they have to travel further to attend ED. This would also rotate clinical staff more effectively, keeping skills maintained instead of them being lost because of insular treatment areas."

The health board must consider the staff comments and seek feedback more widely form ED staff and consider how improvements can be made in the interest of both patients and staff.

Leadership

Governance and leadership

Despite the staff feedback relating to senior leaders and managers highlighted above, in general, we found the leadership and oversight within the ED was appropriate. It was evident that the ED leadership team was striving to improve the service, but the key issue relating to overcrowding was beyond their control, given the wider patient flow issues across the hospital.

Dring the inspection, staff responded positively when presented with areas requiring immediate action. However, several issues require ongoing work and time to implement improvements to fully reduce the risk to patients' safety and wellbeing.

As highlighted earlier, we issued an immediate assurance letter to the health board regarding several areas where immediate improvement was required. It is concerning that some of these issues were replicated from our previous inspection

in 2022, therefore highlighting a weakness in the health board's governance processes and the ability of the department to sustain improvement.

More work is required from the health board to assure itself that staff understand what is required of them when implementing improvements. In addition, strengthening the governance processes in place is required to monitor action progress and to ensure improvements are sustained. Furthermore, robust executive oversight is needed regarding progress on improvement actions, and for the accountability of sustaining the implemented improvements. This was addressed through our immediate assurance process.

Workforce

Skilled and enabled workforce

We found that maintaining nurse staffing levels was less challenging than that found during the previous inspection, and there was significantly less reliance on agency staff to fill vacancies or absences. We were told staff retention had improved and there was a focus on ensuring new staff were supported appropriately. We were provided with the staff induction pathway and Journey of Excellence (JOE), which new staff follow to ensure they gain all necessary competencies to work in the ED.

Despite the department being very busy throughout our inspection, staff appeared to be coping well with the pressures and were mostly attentive and responsive to patient needs.

We saw regular meetings taking place and were provided with minutes from previous meetings. Processes were in place to share this information with ED staff and wider staff teams throughout the hospital. We were provided with copies of staff newsletters and Educating and Recommendations After Significant Events (ERASE) bulletins and saw these displayed in staff areas.

There was a training and development program in place for all staff, and this was supported by a practice development nurse, who was based in the ED. The practice development nurse was proactive and worked effectively to identify staff training needs and help identify areas needing improvement.

Compliance with the completion of mandatory training was good, over 85%.

We were provided with records of staff appraisals and saw that 67% of staff had received an up-to-date appraisal, processes need strengthening to improve this figure.

The health board must continue with its efforts to ensure all staff receive an annual appraisal in a timely manner.

Culture

People engagement, feedback and learning

Patients and their representatives had opportunities to provide feedback on their experience of the services provided. We saw QR codes displayed in staff and patient areas to encourage feedback.

There was a formal process in place for managing complaints, and this aligned to the NHS Wales Putting Things Right (PTR) process. We were provided with information about current complaints and actions taken to resolve them.

Information

Information governance and digital technology

An electronic patient management and records system was in use within the ED to access patients GP records, order investigations such as blood tests and radiology and access investigation results. Staff, in general, commented positively on the system.

Learning, improvement and research

Quality improvement activities

The service is currently in Level 3 of the NHS Wales escalation and intervention arrangements, and staff explained their focus on improving the 12 hour waiting times in the department, and lost ambulance hours as they are held outside the ED. In addition, staff described the weekly meetings held by the executive team to discuss data on patient waiting times and meeting Welsh Government targets relating to addressing patient flow through the department and wider hospital.

We found formal processes in place for audit, and the reporting and escalation of issues within the ED, which were collectively driving forward quality improvement.

We were told that funding had been agreed for six ED consultant posts and a new model of rapid assessment and treatment is being planned. This aims to increase patient flow through the department, with more senior doctors reviewing patients and discharging patients as appropriate.

We were told the renovation work will be completed in the spring of 2025 with waiting room and triage room and existing waiting room becoming clinical treatment and assessment areas, bays and sitting area.

We saw evidence of staff wellbeing initiatives and leaders explained that since the service had received the status of Level 3 monitoring as highlighted above, there has been a focus on improving provisions for staff wellbeing.

Whole-systems approach

Partnership working and development

There were examples of good partnership working between various staff disciplines and professions from other departments, including pharmacy, occupational therapy and physiotherapy.

4. Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

The improvement plans should:

- Clearly state how the findings identified will be addressed
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

Appendix A – Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
Hot water flask in paediatric area within reach of children.	Risk of scalds or burns.	Escalated to the nurse in charge.	Flask removed to a safe place not accessible to children.

Appendix B – Immediate improvement plan

Service: The Grange University Hospital Emergency Department (ED)

Date of inspection: 02 to 04 October 2024

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Findings 1.
We looked at a sample of patient records and found that the risk assessments for patient falls and Visible Infusion Phlebitis (VIP) had not been undertaken in a timely manner.

- We found that some patients had been in the department for over 24 hours and were at risk of falling however a falls risk assessment had not been completed.
- We found examples where VIP risk assessment had not been completed.

Incomplete risk assessments pose a risk to patient safety.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
1.	The health board must ensure that measures are in place to ensure risk assessments for both Falls and Visible Infusion Phlebitis (VIP) are completed promptly, to maintain patient safety.	Safe Care and Timely Care	1. All staff have been reminded of their responsibility and the importance of timely completion of risk assessments via ED and paediatrics What's app groups	Senior Nurse	Actioned Immediately & Ongoing
			2. HIW Immediate Assurance Nursing News shared with staff	Senior Nurse	Completed

			3.	ED Staff induction and educational days reinforce the importance of accurate nursing documentation. Also covered in corporate induction	Practice Educators & Senior Nurse	Actioned Immediately & Ongoing Next corporate induction November 2024
			4.	1-patient 1-day audits ensuring all risk assessments and cannula bundles are completed daily by person on ED management. All learning to be shared with nursing staff at the time. Concerns regarding individual nursing practice to be managed in line with Health Board policies and escalated to senior nursing team	ED Management Team Daily / Senior Nurse	Actioned Immediately & Ongoing
			5.	Dignity and Essential Care Inspections (DECI) in place. All learning to be shared with nursing staff at the time. Concerns regarding individual nursing practice to be managed in line with Health Board policies and escalated to senior nursing team	ED Management Team Daily / Senior Nurse	Actioned Immediately & Ongoing
			6.	All learning to be shared with nursing staff at the time. Any concerns regarding individual	ED Management Team Daily / Senior Nurse / Head of Nursing	Actioned Immediately & Ongoing

				nursing practice to be managed in line with Health Board policies and escalated to senior nursing team		
			7.	Monitor MFRA compliance via 1-patient 1-day audits and DECIs. Improvements and learning to be shared with nursing staff at the time. Concerns regarding individual nursing practice to be managed in line with Health Board policies and escalated to senior nursing team	Senior Nurse / ED Management Team / QPS Leads	Actioned Immediately & Ongoing
			8.	Senior Nurse and Head of Nursing to undertake weekly spot checks of patients records and also undertake monthly DECI's	Senior Nurse / Head of Nursing	Weekly / Monthly
			9.	ED falls poster shared across Division and is displayed within ED, to raise awareness of risk assessment interventions	QPS Lead / ED Sister Responsible for Falls Improvement work	Actioned Immediately & Ongoing
			10.	ERASE bulletin on Cannula bundles developed and shared via email with ED team	Senior Nurse / QPS Team / ED Admin support	Actioned Immediately
			11.	All ERASE bulletins printed and displayed in the ED	Senior Nurse / Head of Nursing	Completed

			12. Improvement plan along with updates on actions will be presented to the ED Senior Management Team (SMT) meeting and Divisional Management Team (DMT)	Senior Nurse / Head of Nursing / Divisional Nurse	SMT Monthly / DMT Quarterly
			13. Updates / Assurance on Improvement plan to form part of QPS agenda in Divisional Assurance with Chief Operating Officer	Head of Nursing / Divisional Nurse	Quarterly
			14. Updates / Assurance on Improvement plan to form part of QPS agenda in Mid-Year/ End of Year presentation with executives	Head of Nursing / Divisional Nurse	Mid-Year (November 2024/ End of Year (March 2025)
			15. Updates to be provided at Health Board Patient Quality and Safety Learning Improvement Forum	Executive Director of Nursing	January 2025
			16. ED to work towards unit accreditation as part of the Health Board ward/ team accreditation process	Executive Director of Nursing	March 2025
			17. Regular monitoring of improvement plan via Patient Quality Safety Outcome Committee	Executive Director of Nursing	Quarterly

Findings 2.
HIW is not assured that the management and administration of medicines is robust to maintain patient safety.

- We found examples of expired medication within the paediatric emergency department and in the resuscitation department
- We checked the medication fridges in all areas of the department and found that daily temperature checks were not recorded on multiple occasions
- We found examples on the controlled drugs register where the stock and medication checks had not been completed on a daily basis, in line with the health boards policy.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
2.	The health board must ensure that medication stock is checked, and any items where 'use by' dates have expired are disposed of appropriately. The health board ensure medication fridge temperature checks are completed regularly. The health board ensure controlled drugs stocks are checked and recorded daily.	Safe and Effective Care	18. All Staff have been reminded of their responsibility and importance of undertaking daily checks and that these checks include reviewing expiry dates of all products via ED and paediatrics What's app groups	Senior Nurse / Head of Nursing	Actioned Immediately & Ongoing
			19. HIW Immediate Assurance Nursing News shared with staff	Senior Nurse	Completed
			20. Daily Omnicell fridge temperature report already in place for Majors and Resuscitation - emailed daily to ED Senior Nurse and Band 7 team. This is now in place in paediatrics and monitored	ED Band 7 Team / Senior Nurse	Actioned Immediately & Ongoing

			21.	Reinforcement of 'ED safety checklist' which ensures safety checks are completed daily by Nurse in Charge. This includes the requirement for appropriate CD checks as per ABUHB policy. This will be checked daily by person on ED management	ED Band 7 Team / Senior Nurse	Actioned Immediately & Ongoing
			22.	The paediatric department has implemented a new allocation checklist to monitor completion of resuscitation trolley checklist and checking all drugs are in date	ED Band 7 Paediatric Lead	October 2024
			23.	ERASE bulletin to raise awareness of CD checks, storage and disposal in development with wider Divisional and Pharmacy colleagues	QPS Lead	December 2024
			24.	Senior Nurse and Head of Nursing will undertake monthly audits of all checklists to ensure compliance	Senior Nurse / Head of Nursing	Monthly
			25.	All ERASE bulletins printed and displayed in the ED	Senior Nurse / Head of Nursing	Completed
			26.	Improvement plan along with updates on actions will be presented to the ED Senior	Senior Nurse / Head of Nursing / Divisional Nurse	SMT Monthly / DMT Quarterly

			Management Team (SMT) meeting and Divisional Management Team (DMT)		
			27. Updates / Assurance on Improvement plan to form part of QPS agenda in Divisional Assurance with Chief Operating Officer	Head of Nursing / Divisional Nurse	Quarterly
			28. Updates / Assurance on Improvement plan to form part of QPS agenda in Mid-Year/ End of Year presentation with executives	Head of Nursing / Divisional Nurse	Mid-Year (November 2024/ End of Year (March 2025)
			29. Updates to be provided at Health Board Patient Quality and Safety Learning Improvement Forum	Executive Director of Nursing	January 2025
			30. ED to work towards unit accreditation as part of the Health Board ward/ team accreditation process	Executive Director of Nursing	March 2025
			31. Regular monitoring of improvement plan via Patient Quality Safety Outcome Committee	Executive Director of Nursing	Quarterly

Findings 3.
HIW was not assured that all risks to health and safety were managed appropriately.

- We reviewed the resuscitation equipment checking process and records for the resuscitation department, paediatric emergency department and major's department and found that the emergency equipment trolley and defibrillator checks had not been recorded on multiple occasions.

- This meant that we could not be assured that the resuscitation equipment was being regularly checked to ensure that all required items were available and that they were safe to use in an emergency.

  These pose a risk to patient safety.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
3.	The health board must ensure that checks of resuscitation equipment are undertaken and recorded on a regular basis in line with health board policy.	Safe and Effective care	32. All staff have been reminded of their responsibility and the importance of daily checks of the resuscitation trolleys. The person on ED management will check each morning that all checks have been completed. Any concerns regarding consistent checking need to be escalated to senior nurse and appropriate actions put in place	Senior Nurse / Head of Nursing / ED Band 7 Team	Actioned Immediately & Ongoing
			33. Monthly resuscitation trolley checks, as per ABUHB protocol, to be undertaken to include breaking of seal, and drug expiry check. The person on ED management will check the first day of each month that all checks have been completed. Any concerns regarding consistent checking need to be escalated to senior nurse and appropriate actions put in place	Senior Nurse / ED Band 7 Team	Actioned Immediately & Ongoing

			34. Reinforcement of 'ED safety checklist' which ensures safety checks are completed daily by Nurse in Charge. This also includes the requirement for appropriate CD checks as per ABUHB policy. This will be checked daily by person on ED management	Senior Nurse / ED Band 7 Team	Actioned Immediately & Ongoing
			35. Internal Alert regarding the importance of resuscitation trolley checks to be added to the Health Board's intranet carousel	Senior Nurse for Resuscitation Services	Completed
			36. HIW Immediate Assurance Nursing News shared with staff	Senior Nurse	Completed
			37. Improvement plan along with updates on actions will be presented to the ED Senior Management Team (SMT) meeting and Divisional Management Team (DMT)	Senior Nurse / Head of Nursing / Divisional Nurse	SMT Monthly / DMT Quarterly
			38. Updates / Assurance on Improvement plan to form part of QPS agenda in Divisional Assurance with Chief Operating Officer	Head of Nursing / Divisional Nurse	Quarterly
			39. Updates / Assurance on Improvement plan to form part of QPS agenda in Mid-Year/ End of Year presentation with executives	Head of Nursing / Divisional Nurse	Mid-Year (November 2024/ End of Year (March 2025)
			40. Updates to be provided at Health Board Patient Quality and Safety Learning Improvement Forum	Executive Director of Nursing	January 2025

			41.	ED to work towards unit accreditation as part of the Health Board ward/ team accreditation process	Executive Director of Nursing	March 2025

Findings 4.

HIW was not assured that all aspects of care were being delivered in a safe and effective manner.

- We looked at one patient's care notes and found that results of investigations were not acted on in a timely manner.
- We found an example of deterioration in a patient's condition due to the delay in commencing appropriate treatment.
- We were not assured that staff were appropriately monitoring the patient in a timely manner.

These can increase risk to patient safety.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
4.	The health board must ensure results of blood tests and investigations are reviewed and action is taken promptly to avoid delays in necessary treatment.	Safe and Effective care	42. There is continued work across the Health Board to improve the flow of patients through the ED to ensure patients are cared for in the appropriate environments	Head of Operations	Actioned Immediately & Ongoing
			43. Any delays to treatment due to system flow to be escalated to the Emergency Physician in Charge (EPIC) and Operations team to support flow	Emergency Physician in Charge (EPIC) / ED Nurse in Charge	Actioned Immediately & Ongoing
			44. Any concerns regarding patient care and treatment to be escalated at the time to the speciality and the most senior clinician responsible and if required a Datix to be completed and appropriate actions undertaken	Emergency Physician in Charge (EPIC) / ED Nurse in Charge	Actioned Immediately & Ongoing
			45. All referred patients in ED to be reviewed daily with a clear medical plan and appropriate reviews undertaken	Clinical Director's for Specialties	Actioned Immediately & Ongoing
			46. If at handover medical plans or nursing care/assessments have not been implemented then reasons for this need to be identified and if required a Datix completed with appropriate investigation and outcomes	Senior Nurse / Clinical Director	Actioned Immediately & Ongoing
			47. Staff induction and educational days reinforce the importance of ensuring	Senior Nurse / Practice Educators	Actioned Immediately & Ongoing

	clinical concerns are escalated timely as part of various clinical sessions and scenarios		
48.	ERASE bulletin on the importance of checking bloods tests developed and will be shared across ED and wider Divisional teams	QPS Lead	December 2024 for ED
49.	All ERASE bulletins printed and displayed in the ED	Senior Nurse / Head of Nursing	Completed
50.	HIW Immediate Assurance Nursing News shared with staff	Senior Nurse	Completed
51.	Improvement plan along with updates on actions will be presented to the ED Senior Management Team (SMT) meeting and Divisional Management Team (DMT)	Senior Nurse / Head of Nursing / Divisional Nurse	SMT Monthly / DMT Quarterly
52.	Updates / Assurance on Improvement plan to form part of QPS agenda in Divisional Assurance with Chief Operating Officer	Head of Nursing / Divisional Nurse	Quarterly
53.	Updates / Assurance on Improvement plan to form part of QPS agenda in Mid-Year/ End of Year presentation with executives	Head of Nursing / Divisional Nurse	Mid-Year (November 2024/ End of Year (March 2025)
54.	Updates to be provided at Health Board Patient Quality and Safety Learning Improvement Forum	Head of Nursing / Divisional Nurse	January 2025
55.	ED to work towards unit accreditation as part of the Health Board ward/ team accreditation process	Executive Director of Nursing	March 2025

			56. Regular monitoring of improvement plan via Patient Quality Safety Outcome Committee	Executive Director of Nursing	Quarterly

Findings 5.

HIW was not assured that the stock of single use medical equipment was being checked. This posed a risk to patient safety.

- We found examples of expired single use medical equipment within the paediatric emergency department and in the resuscitation department, such as male external urinary sheaths and some equipment from a 'Can't Intubate Can't Oxygenate (CICO)' pack which included a Cuffed Oral Endotracheal Tube (COETT), 5ml syringe and Rapi-fit Connector.

  These issues pose a risk to patient safety.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
5.	The health board must ensure that the stock of single use medical equipment is monitored and any items where 'use by' dates have expired, are disposed of appropriately.	Safe and Effective care	57. The grab bag was immediately removed from use during the HIW inspection	Senior Nurse / Head of Nursing	Actioned Immediately & Ongoing
			58. All staff will check expiry dates of equipment prior to use. This will be included in November's Nursing News	Senior Nurse	November 2024
			59. Several reviews of the department have been undertaken to ensure all products are in date / any excess equipment removed from use immediately	Senior Nurse / ED Band 7 Team	Actioned Immediately & Ongoing

60.	All staff have been reminded of their responsibility and the importance of daily checks of the resuscitation trolleys. The person on ED management will check each morning that all checks have been completed. Any concerns regarding consistent checking need to be escalated to senior nurse and appropriate actions put in place	ED Band 7 Team / Senior Nurse	Actioned Immediately & Ongoing
61.	Monthly resuscitation trolley checks, as per ABUHB protocol, to be undertaken to include breaking of seal, and drug expiry check. The person on ED management will check the first day of each month that all checks have been completed. Any concerns regarding consistent checking need to be escalated to senior nurse and appropriate actions put in place	ED Band 7 Team / Senior Nurse	Actioned Immediately & Ongoing
62.	Reinforcement of 'ED safety checklist' which ensures safety checks are completed daily by Nurse in Charge. This also includes the requirement for appropriate CD checks as per ABUHB policy. This will be checked daily by person on ED management	ED Band 7 Team / Senior Nurse	Actioned Immediately & Ongoing
63.	Senior Nurse and Head of Nursing will undertake monthly audits of all checklists to ensure compliance	Senior Nurse / Head of Nursing	Monthly
64.	HIW Immediate Assurance Nursing News shared with staff	Senior Nurse	Completed

			65. Improvement plan along with updates on actions will be presented to the ED Senior Management Team (SMT) meeting and Divisional Management Team (DMT)	Senior Nurse / Head of Nursing / Divisional Nurse	SMT Monthly / DMT Quarterly
			66. Updates / Assurance on Improvement plan to form part of QPS agenda in Divisional Assurance with Chief Operating Officer	Head of Nursing / Divisional Nurse	Quarterly
			67. Updates / Assurance on Improvement plan to form part of QPS agenda in Mid-Year/ End of Year presentation with executives	Head of Nursing / Divisional Nurse	Mid-Year (November 2024/ End of Year (March 2025)
			68. Updates to be provided at Health Board Patient Quality and Safety Learning Improvement Forum	Executive Director of Nursing	January 2025
			69. ED to work towards unit accreditation as part of the Health Board ward/ team accreditation process	Executive Director of Nursing	March 2025
			70. Regular monitoring of improvement plan via Patient Quality Safety Outcome Committee	Executive Director of Nursing	Quarterly

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative:

Name (print): **Chris Morgan**

Job role: **Divisional Nurse – Urgent Care**

Date: **20 November 2024**

Appendix C - Improvement plan

Service: The Grange University Hospital Emergency Department (ED)

Date of inspection: 2 to 4 October 2024

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

	Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1	There remains to be significant challenges in the flow of patients through the department.	The health board must maintain the efforts to improve patient flow through the department and across the wider hospital.	Timely care	1) Ongoing - 24/4 to reduce congestion in ED and minimise crew delays (0 Patients >24hrs in ED & 0 Crews > 4hrs)	General Manager Urgent Care / Director of Operations	Completed /Ongoing
				2) Continued monitoring of ED performance as part of Welsh Government Enhanced Monitoring	General Manager Urgent Care / Director of Operations	Completed/ Ongoing
				3) Weekly meetings in place with members of the executive board to review patient flow across the Health Board & Implement improvement plans	Director of Operations	Completed/ Ongoing

Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
			4) The ED medical staff rotas are matched to attendances to ensure the staffing is maximised at the busier times of the day to improve wait times	Clinical Director for Emergency Medicine	Completed / Ongoing
			5) X6 Consultants appointed to improve Wait to be Seen Time and look to implement early Rapid Assessment / Stream to Alternative pathways	Clinical Director for Emergency Medicine	Completed / Ongoing
			6) Review of Flow Centre Pathways to ensure patients go to the right place first time	Divisional Director Urgent Care / Medical Director	March 2025
			7) Development of further pathways for Same Day Emergency Care (SDEC)	Divisional Directors for Urgent Care / Medicine & Surgery	Completed / Ongoing
			8) Continued work with WAST to reduce conveyance rates and	Associate Director for Patient	Completed / Ongoing

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action		Responsible officer	Timescale
					utilise alternative pathways to ED	Transportation Services	
				9)	Regular monitoring of improvement plan via Patient Quality Safety Outcome Committee	Executive Director of Nursing	Quarterly
2	We found that patients in the waiting area had not had a pain score assessment and had not been given analgesia.	The health board must develop a process where patients within the waiting room receive a pain score assessment and analgesia if required.	Timely care	10)	All staff have been reminded of their responsibility and importance of timely pain assessments and provision of analgesia (via PGD or prescription)	Senior Nurse / Clinical Director	Completed / Ongoing
				11)	All patients are assessed at triage and where required analgesia provided	Band 7 Team / Senior Nurse	Completed / Ongoing
				12)	Rapid Assessment Nursing team to ensure all patients receive ongoing pain assessments and analgesia. Escalate to medical staff where required	Band 7 Team / Senior Nurse	Completed / Ongoing
				13)	1-patient 1-day audits ensuring all risk assessments are completed daily by person on	ED Management	Completed / Ongoing

Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
			ED management/ Majors Lead. All learning to be shared with nursing staff at the time. Concerns regarding individual nursing practice to be managed in line with Health Board policies and escalated to senior nursing team	Team Daily / Senior Nurse	
			14) Dignity and Essential Care Inspections (DECI) in place. All learning to be shared with nursing staff at the time. Concerns regarding individual nursing practice to be managed in line with Health Board policies and escalated to senior nursing team	ED Management Team Daily / Senior Nurse	Completed / Ongoing
			15) CIVICA data shared with wider teams	Senior Nurse / Head of Nursing	Completed and Monthly
			16) All referred patients to be moved to the respective assessment areas at the point of referral	Operations Team	Completed / Ongoing

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action		Responsible officer	Timescale
				17)	Improvement plan along with updates on actions will be presented to the ED Senior Management Team (SMT) meeting and Divisional Management Team (DMT)	Senior Nurse / Head of Nursing / Divisional Nurse	SMT Monthly / DMT Quarterly
				18)	Updates / Assurance on Improvement plan to form part of QPS agenda in Mid-Year/ End of Year presentation with executives	Head of Nursing / Divisional Nurse	Completed / Ongoing
				19)	ED to work towards unit accreditation as part of the Health Board ward/ team accreditation process	Executive Director of Nursing	March 2025
				20)	Regular monitoring of improvement plan via Patient Quality Safety Outcome Committee	Executive Director of Nursing	Quarterly
3	There was poor oversight of the waiting area and unwell patients	The health board should develop a process where patients in the	Timely care	21)	All staff have been reminded of their responsibility and importance of timely risk assessments	Senior Nurse	Immediately & Ongoing

	Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
	were not regularly monitored or risk assessed.	waiting area are regularly monitored, and patients perceived to be more at risk of falls or developing pressure areas should be appropriately risk assessed.		22) All patients will be assessed at triage for falls risk and developing pressure areas and will be escalated to the NIC to try and find an appropriate clinical area within the main ED	Band 7 Team / Senior Nurse	Ongoing
				23) Rapid Assessment Nursing team to ensure all patients receive ongoing falls monitoring / Pressure Area Management	Band 7 Team / Senior Nurse	Completed / Ongoing
				24) Patients identified at triage to be a falls risk or potential deterioration in pressure areas to be prioritised for a space in the ED whilst balancing other clinical risks	Nurse in Charge / EPIC / Operations team	Completed / Ongoing
				25) Nurse in Charge (NIC) to escalate all clinical concerns to the operations team and the Emergency Physician in Charge (EPIC) of ED	Nurse in Charge / EPIC	Completed / Ongoing

Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
			26) All referred patients to be moved to the respective assessment areas at the point of referral	Operations Team	Completed / Ongoing
			27) ED Staff induction and educational days will reinforce the importance of accurate nursing documentation including risk assessments. Also covered in corporate induction	Practice Educators & Senior Nurse	Immediately & Ongoing
			28) 1-patient 1-day audits ensuring all risk assessments are completed daily by person on ED management or major's lead. All learning to be shared with nursing staff at the time. Concerns regarding individual nursing practice to be managed in line with Health Board policies and escalated to senior nursing team	ED Management Team Daily / Senior Nurse	Completed / Ongoing
			29) Dignity and Essential Care Inspections (DECI) in place. All	ED Management	Completed / Ongoing

Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
			learning to be shared with nursing staff at the time. Concerns regarding individual nursing practice to be managed in line with Health Board policies and escalated to senior nursing team	Team Daily / Senior Nurse	
			30) All learning to be shared with nursing staff at the time. Any concerns regarding individual nursing practice to be managed in line with Health Board policies and escalated to senior nursing team	ED Management Team Daily / Senior Nurse / Head of Nursing	Immediately & Ongoing
			31) Monitor MFRA compliance via 1-patient 1-day audits and DECIs. Improvements and learning to be shared with nursing staff at the time. Concerns regarding individual nursing practice to be managed in line with Health Board policies and escalated to senior nursing team	Senior Nurse / ED Management Team / QPS Leads	Completed / Ongoing

Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
			32) Senior Nurse and Head of Nursing to undertake weekly spot checks of patients records and undertake monthly DECI's	Senior Nurse / Head of Nursing	Completed Weekly / Monthly
			33) Continue to monitor Datix for potential learning opportunities	Senior Nurse / Head of Nursing	Completed / Ongoing
			34) New waiting room currently being built will provide improved patient visibility and availability of clinical space	Urgent Care Triumvirate	May 2025
			35) Improvement plan along with updates on actions will be presented to the ED Senior Management Team (SMT) meeting and Divisional Management Team (DMT)	Senior Nurse / Head of Nursing / Divisional Nurse	SMT Monthly / DMT Quarterly
			36) Updates / Assurance on Improvement plan to form part of QPS agenda in Mid-Year/ End of Year presentation with executives	Head of Nursing / Divisional Nurse	Completed / Ongoing

	Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
				37) ED to work towards unit accreditation as part of the Health Board ward/ team accreditation process	Executive Director of Nursing	March 2025
				38) Regular monitoring of improvement plan via Patient Quality Safety Outcome Committee	Executive Director of Nursing	Quarterly
4	Risk assessments had not been completed in the rooms used to assess mental health patients, to identify potential risks to both patient and staff safety.	The health board must ensure staff are adequately supported to identify potential risks to patient and staff safety and complete a risk assessment where applicable.	Risk Management	39) Management of CAMHS and adult Mental Health patients is on departmental risk register	Divisional Management Team	Completed / Ongoing
				40) Patients will be assessed at the point of triage for any potential mental health concerns and then supported in an assessment room with direct vision of nursing staff and all risks removed	Band 7 Team / Senior Nurse	Completed / Ongoing
				41) If required enhanced staffing put in place based on clinical need and risk	Band 7 Team / NIC / Senior Nurse for ED or Paediatrics	Completed / Ongoing
				42) Crisis liaison service available 24/7 with CAMHS support	Crisis Liaison service	Completed / Ongoing

	Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
				43) Mental Health & Deliberate Self harm Triage Assessment tool in development	Divisional Director / Senior Nurse	Feb 2025
5	We found that staff did not have an appropriate view of patients in the waiting area which meant patient safety was at risk.	The health board must consider how clinical oversight of the waiting area can be improved to maintain patient safety.	Risk management	44) Waiting room is currently monitored via a series of video cameras with a team of nurses overseeing this area	Nurse in Charge / EPIC	Completed / Ongoing
				45) X3 RN's & 2 HCSW's are assigned to oversee the waiting room along with an ECG technician. 46) X4 RN's & 1 HCSW also work in triage and these staff also support the waiting room	Nurse in Charge / Senior Nurse	Completed / Ongoing
				47) Catering staff provide a trolley service x3 times a day - tea/coffee/toast/ lunch / dinner and sandwiches also available on request	Facilities	Completed / Ongoing
				48) Red Cross provide support to the waiting room along with hospital volunteers	Nurse in Charge / Senior Nurse	Completed / Ongoing

Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
			49) Wellbeing assistant role to support waiting room	Executive Director of Nursing	March 2025
			50) All patients at clinical risk to be highlighted to the NIC or EPIC and moved to another area of the ED	Emergency Physician in Charge (EPIC) / ED Nurse in Charge	Completed / Ongoing
			51) New waiting room currently under construction will provide improved patient visibility	Urgent Care Triumvirate	May 2025
			52) Updates / Assurance on Improvement plan to form part of QPS agenda in Mid-Year/ End of Year presentation with executives	Head of Nursing / Divisional Nurse	Mid-Year (November 2024/ End of Year (March 2025)
			53) ED to work towards unit accreditation as part of the Health Board ward/ team accreditation process	Executive Director of Nursing	March 2025
			54) Regular monitoring of improvement plan via Patient Quality Safety Outcome Committee	Executive Director of Nursing	Quarterly

	Risk/finding/issue	Improvement needed	Standard / Regulation		Service action	Responsible officer	Timescale
6	We found COSHH equipment in areas that were accessible to patients and visitors which posed a threat to their safety.	The health board must ensure that all COSHH equipment is stored safely in a locked cabinet as stated in the COSHH regulations.	Risk management	55)	All COSHH equipment to be stored in cabinets within appropriate clinical areas	Senior Nurse / ED Band 7 Team	Completed / Ongoing
				56)	Sluices to be reviewed by Infection Prevention and Control (IP&C) & Works & Estates (W&E) to see if Locks or swipe card access is appropriate	IP&C & W&E	Dec 2024
7	We noted there was no ligature free assessment space, toilet or wash facility within the paediatric ED and no risk assessment had been completed for this.	The health board must ensure staff are aware of the health and safety risk assessments and audits that are carried out for patient safety purposes.	Risk management	57)	Management of CAMHS and adult Mental Health patients is on departmental risk register	Divisional Management Team	Completed / Ongoing
				58)	Patients will be assessed at the point of triage for any potential mental health concerns and then supported in an assessment room with direct vision of the nurse's station and all risks removed	Paeds team / Band 7 Team / Senior Nurse	Completed / Ongoing
				59)	If required enhanced staffing put in place based on clinical need and risk	Band 7 Team / NIC / Senior Nurse for ED or Paediatrics	Completed / Ongoing

	Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
				60) Crisis liaison service available 24/7 with CAMHS support	Crisis Liaison service	Completed / Ongoing
				61) Mental Health & Deliberate Self harm Triage Assessment tool in development	Divisional Director / Senior Nurse	Feb 2025
				62) Review of area to assess ability to make an assessment area ligature free	Estates Manager / Senior Nurse	Dec 2024
				63) This action will be reported through the Patient Quality Safety and Oversight Committee	Executive Director of Nursing	Quarterly
8	We witnessed staff failing to remove PPE when they left an area of infection which can cause infection to spread.	The health board must ensure staff use and remove PPE appropriately to prevent the spread of infection.	Infection, prevention and control and decontamination	63) All staff have been reminded of the correct process for using PPE	ED Band 7 Team / Senior Nurse	Completed / Ongoing
				64) IP&C spot check of Respiratory Assessment Area	IP&C Nurses	Completed / Ongoing
				65) Senior Nurse and Head of Nursing to undertake daily spot checks	Senior Nurse / Head of Nursing	Completed / Ongoing
9	We reviewed the health boards medicines management policy	The health board must ensure the medicines management policy is	Medicines management	66) Medicines management policy is being reviewed	Lead Pharmacist	Review date extended to Feb 2025 while under

	Risk/finding/issue	Improvement needed	Standard / Regulation		Service action	Responsible officer	Timescale
	and found this had not been recently reviewed.	reviewed and approved in a timely manner.					review, as agreed with Chair of CSPG Medicines Management Policy Code of Practice
10	We inspected records for Controlled Drugs and saw that records were not routinely completed in all areas of the ED. We saw controlled drug checks had been missed in the majors and Respiratory Assessment Zone (RAZ) areas.	The health board must ensure that controlled drug checks are completed in all areas of the emergency department.	Medicines management	67)	All Staff have been reminded of their responsibility and importance of undertaking daily checks	ED Band 7 Team / Senior Nurse / Head of Nursing	Immediately & Ongoing
				68)	Reinforcement of 'ED safety checklist' which ensures safety checks are completed daily by Nurse in Charge or ED area leads. This includes the requirement for appropriate CD checks as per ABUHB policy. This will be checked daily by person on ED management	ED Band 7 Team / Senior Nurse	Immediately & Ongoing
				69)	Improvement plan along with updates on actions will be presented to the ED Senior	Senior Nurse / Head of Nursing /	SMT Monthly / DMT Quarterly

Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
			Management Team (SMT) meeting and Divisional Management Team (DMT)	Divisional Nurse	
			70) Updates / Assurance on Improvement plan to form part of QPS agenda in Divisional Assurance with Chief Operating Officer	Head of Nursing / Divisional Nurse	Quarterly
			71) Updates / Assurance on Improvement plan to form part of QPS agenda in Mid-Year/ End of Year presentation with executives	Head of Nursing / Divisional Nurse	Mid-Year (November 2024/ End of Year (March 2025)
			72) ED to work towards unit accreditation as part of the Health Board ward/ team accreditation process	Executive Director of Nursing	March 2025
			73) Regular monitoring of improvement plan via Patient Quality Safety Outcome Committee	Executive Director of Nursing	Quarterly
			74) Regular monitoring of improvement plan via Patient,	Head of Nursing /	Quarterly

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action		Responsible officer	Timescale
					Quality, Safety, Learning & Improvement Forum (PQSLI)	Divisional Nurse	
11	We witnessed two occasions when medication was administered and not signed for on the prescription chart. This means there was a risk that medication could be administered twice and potentially overdose the patient.	The health board must ensure staff sign the medication record promptly after administering medication, to avoid overdose or drug errors.	Medicines management	75)	All staff will administer medication in line with Health Board policy. Any staff who do not will be managed in accordance with the Health Board's Policy for Managing and Supporting Staff Following a Medication Error	Senior Nurse / Practice Educators / Head of Nursing	Completed & Ongoing
				76)	Staff induction and educational days reinforce the importance of medication management	Senior Nurse / Practice Educators	Immediately & Ongoing
				77)	Datix to be completed for all medication errors	ED team	Completed / Ongoing
				78)	Datix is reviewed daily and appropriate actions taken	Senior Nurse / Head of Nursing / Divisional Nurse	Completed / Ongoing
				79)	1-patient 1-day audits which will check medication charts. All learning to be shared with	ED Management	Completed / Ongoing

Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
			nursing staff at the time. Concerns regarding individual nursing practice to be managed in line with Health Board policies and escalated to senior nursing team	Team Daily / Senior Nurse	
			80) Dignity and Essential Care Inspections (DECI) in place. All learning to be shared with nursing staff at the time. Concerns regarding individual nursing practice to be managed in line with Health Board policies and escalated to senior nursing team	ED Management Team Daily / Senior Nurse	Completed / Ongoing
			81) QPS slides presented monthly at Divisional Assurance to the COO	Head of Nursing / Divisional Nurse	Completed / Ongoing
			82) ED to work towards unit accreditation as part of the Health Board ward/ team accreditation process	Executive Director of Nursing	March 2025

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action		Responsible officer	Timescale
12	We found the process for medication fridge temperature checks was not robust to ensure messages regarding out-of-range temperatures was acted on promptly. We were told an email was sent to the nurse in charge if the temperature is out of range. However, we were told that messages are not always checked due to the nurse in charge providing clinical support. Therefore, we	The health board must ensure a robust process is in place to report issues with medication fridge temperatures to ensure these can be addressed promptly.	Medicines management	83)	Daily Omnicell fridge temperature report in place for Majors and Resuscitation - emailed daily to ED Senior Nurse and Band 7 team. This is now in place in paediatrics and monitored	ED Band 7 Team / Senior Nurse	Completed / Ongoing
				84)	All temperature faults reported to pharmacy/works & estates immediately so appropriate action can be taken	NIC / Senior Nurse / Divisional Pharmacist	Completed / Ongoing
				85)	Improvement plan along with updates on actions will be presented to the ED Senior Management Team (SMT) meeting and Divisional Management Team (DMT)	Senior Nurse / Head of Nursing / Divisional Nurse	SMT Monthly / DMT Quarterly
				86)	Updates / Assurance on Improvement plan to form part of QPS agenda in Mid-Year/ End of Year presentation with executives	Head of Nursing / Divisional Nurse	Completed / Ongoing

	Risk/finding/issue	Improvement needed	Standard / Regulation		Service action	Responsible officer	Timescale
	were not assured that the system was robust and efficient to ensure temperature-controlled medication was being stored appropriately.			87)	ED to work towards unit accreditation as part of the Health Board ward/ team accreditation process	Executive Director of Nursing	March 2025
				88)	Regular monitoring of improvement plan via Patient Quality Safety Outcome Committee	Executive Director of Nursing	Quarterly
13	For those we checked, we found all patients had an identification band in place. However, allergy bands were not always worn by patients with known allergies, neither were falls risk bands worn where applicable.	The health board must ensure that allergy bands and falls risk bands are placed on patients where applicable.	Medicines management	89)	Allergy bands are to be placed on all patients with a known allergy and documented on their medication chart	ED Band 7 Team / Senior Nurse / Head of Nursing	Completed / Ongoing
				90)	All patients identified with an allergy or a falls risk to have the required identification band	ED Band 7 Team / Senior Nurse / Head of Nursing	Completed / Ongoing
				91)	1-patient 1-day audits which will check medication charts and falls risk assessments. All learning to be shared with nursing staff at the time. Concerns regarding individual nursing practice to be	ED Management Team Daily / Senior Nurse	Completed / Ongoing

Risk/finding/issue	Improvement needed	Standard / Regulation		Service action	Responsible officer	Timescale
				managed in line with Health Board policies and escalated to senior nursing team		
			92)	Dignity and Essential Care Inspections (DECI) in place. All learning to be shared with nursing staff at the time. Concerns regarding individual nursing practice to be managed in line with Health Board policies and escalated to senior nursing team	ED Management Team Daily / Senior Nurse	Completed / Ongoing
			93)	Improvement plan along with updates on actions will be presented to the ED Senior Management Team (SMT) meeting and Divisional Management Team (DMT)	Senior Nurse / Head of Nursing / Divisional Nurse	SMT Monthly / DMT Quarterly
			94)	Updates / Assurance on Improvement plan to form part of QPS agenda in Mid-Year/ End of Year presentation with executives	Head of Nursing / Divisional Nurse	Completed / Ongoing

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
				95) ED to work towards unit accreditation as part of the Health Board ward/ team accreditation process	Executive Director of Nursing	March 2025
				96) Regular monitoring of improvement plan via Patient Quality Safety Outcome Committee	Executive Director of Nursing	Quarterly
14	There was no assurance that elderly patients sitting in the waiting room had regular skin inspections.	The health board must ensure that patients in the waiting room are assessed for their risk of pressure damage and re-evaluated as indicated by the risk assessment.	Preventing pressure and tissue damage	97) Please refer to actions in Point 3	Please refer to Point 3	Please refer to Point 3
15	Staff responses to the online survey were mixed with some staff critical of staffing levels and patient flow.	The health board must consider the staff comments and seek feedback more widely from ED staff and consider how improvements can be	Staff feedback	98) Bi-annual review of ED staffing in place	Senior Nurse / Head of Nursing / Divisional Nurse	Completed / Ongoing
				99) Regular staff wellbeing sessions provided	Clinical Director /	Completed / Ongoing

Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
	made in the interest of both patients and staff.			Senior Nursing / Divisional Management Team	
			100) Senior nursing, medical and Divisional management staff are visible daily in department so staff can raise concerns	Divisional Triumvirate Senior Nurse / Clinical Director / Head of Nursing / Divisional Management team	Completed / Ongoing
			101) Staff QR code in place for staff to raise concerns or ideas (this can be done anonymously). Weekly meeting in place to review submissions and provide staff with a response	Divisional Triumvirate Senior Nurse / Clinical Director / Head of Nursing / Divisional Management team	Completed / Ongoing

Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
			102) Improvement plan along with updates on actions will be presented to the ED Senior Management Team (SMT) meeting and Divisional Management Team (DMT)	Senior Nurse / Head of Nursing / Divisional Nurse	SMT Monthly / DMT Quarterly
			103) Updates / Assurance on Improvement plan to form part of QPS agenda in Mid-Year/ End of Year presentation with executives	Head of Nursing / Divisional Nurse	Ongoing
			104) ED to work towards unit accreditation as part of the Health Board ward/ team accreditation process	Executive Director of Nursing	March 2025
			105) Regular monitoring of improvement plan via Patient Quality Safety Outcome Committee	Executive Director of Nursing	Quarterly
			106) Formal Nurse Staffing Levels Assessment to be completed annually in line with the NSWLA	Executive Director of Nursing	Annually

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
				107) EDoN and Deputy EDoN visits with the Divisional Nurse	Executive Director of Nursing (EDoN)	Quarterly
16	Appraisal compliance rates were 67% meaning a significant number of staff had not received an appraisal within the last year.	The health board must continue with efforts to ensure all staff receive an appraisal.	Workforce	108) Monthly reports provided by workforce and reviewed at Senior Management Team (SMT) and Divisional Management Team (DMT) - 109) Improvement plan developed and in place	Band 7 team / Senior Nurse / Head of Nursing / Divisional Nurse / SMT / DMT	Completed / Ongoing
				110) PADR data presented monthly at Divisional Assurance with COO	Triumvirate team	Completed / Ongoing
				111) Updates / Assurance on Improvement plan to form part of QPS agenda in Mid-Year/ End of Year presentation with executives	Divisional Nurse/ Triumvirate Team	Completed / Ongoing

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print): Chris Morgan

Job role: Divisional Nurse

Date: 12 December 2024

LLAIS

Eich llais chi mewn iechyd a gofal | Your voice in health and social care

GETTING URGENT AND EMERGENCY HEALTHCARE IN WELSH HOSPITALS

FEBRUARY 2025


Emergency

About Llais

We believe in a healthier Wales where people get the health and social care services they need in a way that works best for them. We are here to understand your views and experiences of health and social care, and to make sure your feedback is used by decision-makers to shape your services.

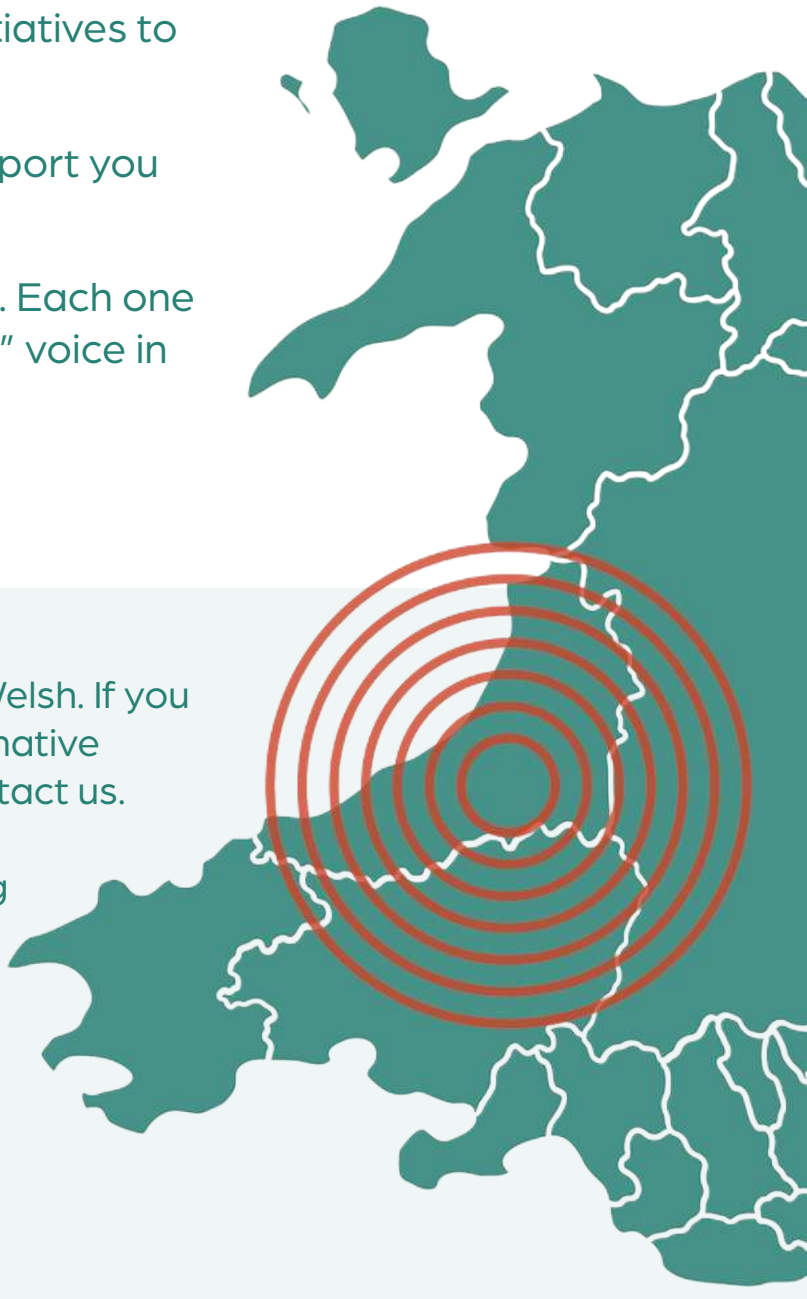
We seek out both good and bad stories so we understand what works well and how services may need to get better. And we look to particularly talk to those whose voices are not often heard.

We also talk to people about their views and experiences by holding events in your local communities or visiting you wherever you're receiving your health or social care service.

We also work with community and interested groups and in line with national initiatives to gather people's views.

And when things go wrong we support you to make complaints.

There are 7 Llais Regions in Wales. Each one represents the "patient and public" voice in different parts of Wales.



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This publication is also available in Welsh. If you would like this publication in an alternative format and/or language, please contact us.

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Getting urgent and emergency healthcare in Welsh hospitals

Over the past year Llais has been hearing a lot about the challenges facing people needing emergency healthcare in Wales.

Starting in late September 2024, over the course of 5 weeks, Llais' teams across Wales visited the Emergency Departments, Minor Injury Units and Medical Assessment Units in their local areas. We undertook 42 visits.

We also ran an online survey and held focus groups to capture people's experiences. During this 5-week period we heard directly from over 700 people about their experience of emergency healthcare.

We know that 'winter pressures' make it harder to deliver emergency care. What we saw and heard in the run up to winter clearly showed just how the big problems with the way emergency healthcare works with other health and care services is affecting the quality of the healthcare people receive – in almost every way that matters to people.

This is simply unacceptable. It must not be allowed to be seen as our "new normal".

While many people were grateful for the dedication and hard work of healthcare staff, challenges like understaffing, long, uncomfortable undignified waits, and poor communication too often overshadowed positive experiences.

Although not everyone's experience we heard about was a poor one, it is clear that emergency care in Wales is failing to meet people's needs, and the expectations we all have for our NHS.

People's experience of emergency healthcare falls far short of the commitments set out in A Healthier Wales, the 'Six goals for urgent and emergency care' and the legal duties the NHS and Welsh Government have to "continually improve the quality of the services they provide".

Since we carried out our visits, 'business critical incidents' have been declared by the Welsh Ambulance Service NHS Trust[1] and Aneurin Bevan University Health Board[2] about emergency care.

Other Health Boards, including Swansea Bay University Health Board[3] and Cwm Taf Morgannwg University Health Board[4] , released statements highlighting the extra pressures they were facing in their emergency departments. Hywel Dda University Health Board opened a pop-up minor injuries unit to try and cope with demand[5].

Earlier this month the Royal College of Nursing released its report *On the frontline of the UK's corridor care crisis*[6]. This report included shocking accounts of undignified and unsafe practices.

We set out below the key things we heard from people about their experiences of urgent and emergency care in hospitals across Wales.

These voices demand urgent action by decision makers locally and nationally to make things better for everyone.

1. Welsh Ambulance Service declares Critical Incident – Welsh Ambulance Services University NHS Trust
2. NHS Pressures: Critical Incident Declared – Updated 15/01/2025 – Aneurin Bevan University Health Board
3. Exceptional pressure on Morriston Hospital – Swansea Bay University Health Board
4. Health Board asks public to help it manage exceptionally high demand – Cwm Taf Morgannwg University Health Board
5. Health board opens pop-up weekend minor injuries unit to deal with overloaded hospital A&E – Wales Online
6. https://www.rcn.org.uk/Professional-Development/publications/

What we learned – All Wales

Getting to hospital

People's experiences of getting to the hospital were quite varied. We heard a mix of good and bad things about transportation, parking, and checking-in.

Transport issues

Often people had to wait a long time – up to 12 hours – for an ambulance to come and help them.

"Adverts tell us to act urgently with stroke patients which we did but took so long for ambulance to arrive even though we explained symptoms. Our mother died 1 week later."

Morriston Hospital Acute Medical Unit

"I got a lift here. I phoned for an ambulance but was told I'd be waiting over 12 hours."

University Hospital for Wales A&E

"I drove because the ambulance eta was 7/8 hours, but I had severe chest pain and couldn't wait that long."

Morriston Hospital Emergency Dept

Most people had to ask someone they knew to drive them, or some risked driving themselves, despite being unwell.

People who didn't have access to a car had to use public transport or pay for a taxi, which took longer and made them feel more stressed.

"Horrific. The first time I phoned 111 they took me to Glangwili which was 45minutes away with no spinal or T (trauma) and O (orthopaedics) doctors there, despite me saying I have a complicated spinal history and need to go to Swansea and that's where my residential address is, plus it's only 15 mins drive. Unable to walk, I had to get a taxi back at 3.30am at the cost of £130. The taxi driver recounted numerous stories of elderly and clearly disabled people being made to get taxis home, one even to Haverfordwest at over £250. I am shocked to my core."

Morriston Hospital Emergency Department

Some had to travel for an hour or more, and some chose certain hospitals over others because they were worried about the reputation of some places, even if it required longer travel.

"Came to PCH because of negative reputations of Grange hospital which would have been nearer."

Prince Charles Hospital A&E

Parking problems

Car parks were often full, so it was hard to find a spot. This was especially tough for older or disabled people if there weren't accessible spaces close to the hospital.

"No car parking spaces, had to park significant way away from the hospital and leave patient alone so I could get a wheelchair for patient I was with. No wheelchairs available, had to wait while security guard was sent to find one."

The Grange University Hospital A&E

"Parking – especially for those in wheelchairs – used to be right by the main entrance at UHW, that has now been taken away, so if there are no spaces in the 2 story car park opposite A&E, then it means a trek from the other multi story car park, which is not easy whilst pushing a wheelchair. It all makes for a very stressful situation for patients and their carers/families to deal with on top of the worry of someone you love, being very unwell."

University Hospital of Wales A&E

Some parking spaces were far from the hospital doors, and signage wasn't always available or clear, which made it harder for people who weren't feeling well.

"Parking was difficult at it was a busy period of the day, finding the hospital was of no issue, but no clear signage for the minor injuries department."

Cwm Cynon Hospital Minor Injuries Unit

"Came by car ... arrived at 14:45. Now 17:14. Waiting time on Display stated 3 1/2 hours. Parking is awful. Have had to park in public car park. Hope I don't get a Ticket."

Withybush General Hospital A&E

Short stay parking limits didn't give enough time for people who had to wait to be seen at the hospital.

Checking in

Some people liked using self-check-in screens because they were quick. Others found them hard to use, especially if they were sick or in pain.

The way to check-in wasn't always clear, which made people feel more worried.

"The iPads were absolute chaos to use. The questions they ask are ridiculous and intrusive. You don't get asked all those at the desk. You can't even choose to skip them, it won't let you go any further unless you've answered them. Last thing you want to do is battle with something like that when you're ill."

University Hospital of Wales A&E

"A warm welcome by the reception made my day."

Ysbyty Gwynedd A&E

"Reception members of staff were lovely, pleasant and polite. Waiting area was clean and tidy seating was spacious and comfortable for the duration of my waiting period."

Neath Port Talbot Minor Injuries Unit

Friendly staff made a big difference. When the staff were kind and helpful, it made people feel less stressed and more cared for.

Waiting to be seen

Quick triage

A lot of people were checked out by a nurse or doctor soon after they arrived, sometimes in just a few minutes. If someone was really sick, they got help faster, which people really appreciated.

"Some people came in with obviously extremely urgent problems that had made their own way in and were seen as priority which was very comforting."

University Hospital of Wales A&E

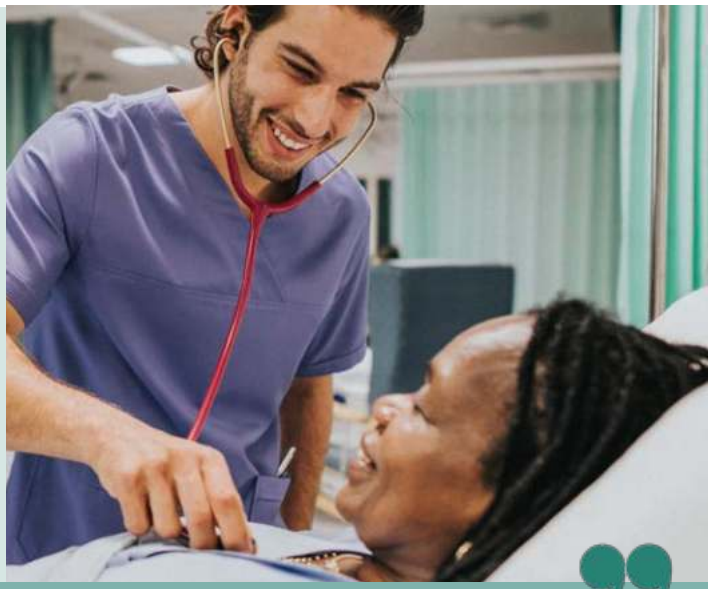
People value being able to be seen locally in smaller hospitals for things that don't need to be dealt with by bigger emergency departments.

"Being seen in MIU Llandrindod has saved a trip to Hereford which has long, long waiting times. Seen here in about 30 minutes without making a pre-appointment. Used facilities here several times over the years and all brilliant."

Llandrindod Wells County War Memorial Hospital Minot Injuries Unit

Kind and caring staff

The doctors and nurses were kind, even though they were really busy. They worked hard to take care of everyone, which made people feel less worried and frustrated.



"Kind and Caring. Easy to talk to."

Nevill Hall Hospital Minor Injuries Unit

Long waits

Some people had to wait a very long time to be seen – many waited 8–12 hours, some as long as 24 hours.

"Waiting times are terrible, but the staff have been phenomenal and trying their best to get patients into beds."

Prince Charles Hospital A&E

"I've been waiting 12 hours and only had triage and a water sample. Sadly we are expected to wait and haven't been offered food or drink. Second obs taken after 12 hours. I'm waiting in a corridor, which is paediatric waiting area and it is very uncomfortable"

Royal Glamorgan Hospital A&E

It was really hard for people who were in pain, feeling really sick, or taking care of children or others who needed extra help. Neurodivergent people often found the waiting area overwhelming due to the noise, bright lights and number of people around them.

"My son is autistic and very rarely leaves the house. Had a perianal abscess that had ruptured so struggled to sit or stand. [He has] social anxiety so can't cope with people, noise light etc. We were told I could wait in the car with him and he would be called straight through to triage. When his name was called, and he wasn't there immediately they moved on to next patient and he had to wait standing and in pain."

Ysbyty Gwynedd A&E

Lots of people said they felt unsafe or like no one was paying attention to them.

People didn't always know how long they'd have to wait or what would happen next. After seeing a healthcare professional at the start, they sometimes felt forgotten and didn't get any updates.

"I was given false information by a doctor who said I would be seen and given the ok to go home as results were clear – 3 hours later I was informed I was going up to a ward to stay overnight – I considered that I was safer at home and discharged myself."

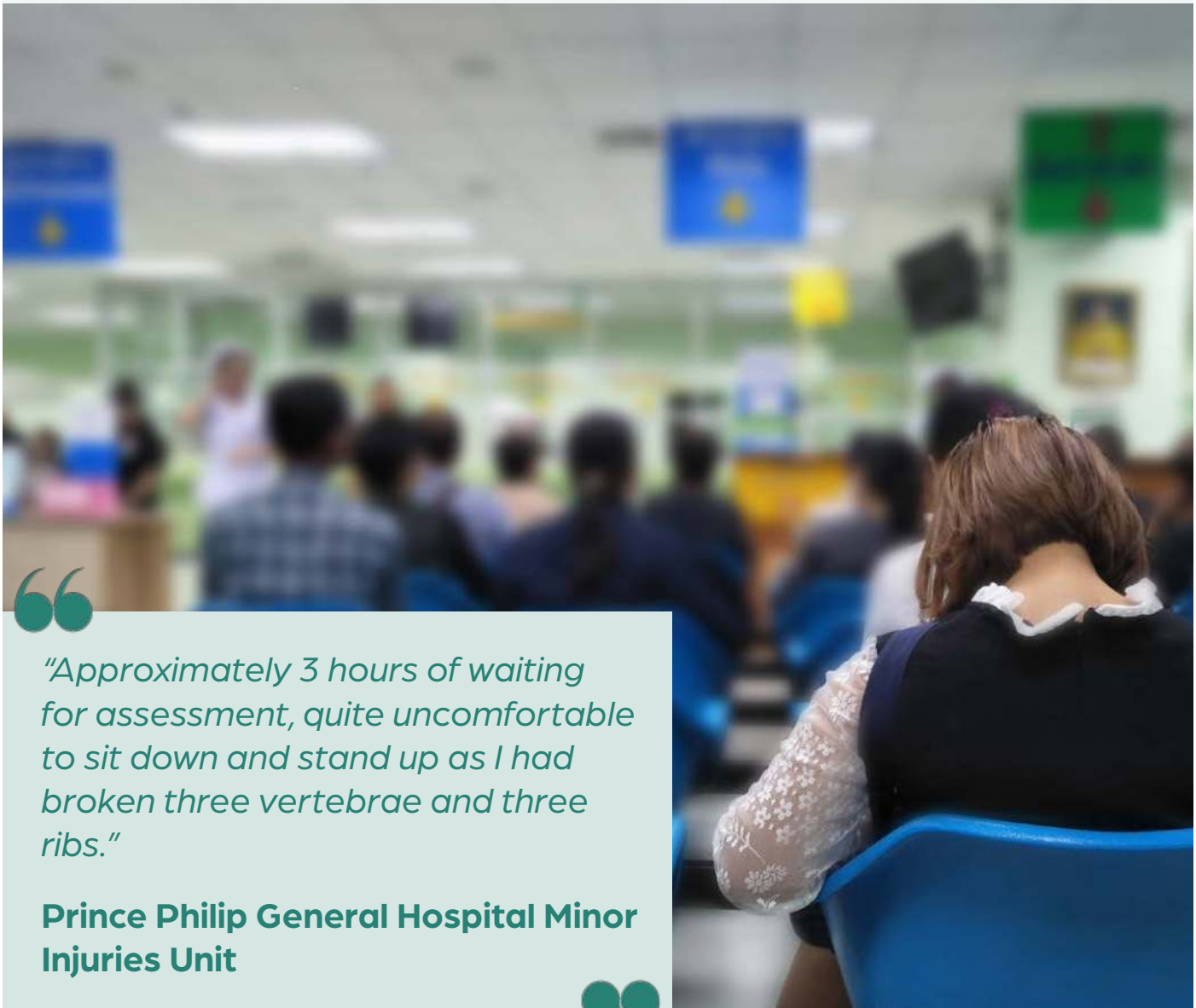
University Hospital for Wales A&E

"We are not too sure what is going on. We spoke to a nurse just over an hour ago. We are still waiting. We've been given no explanation of what the treatment is to be. Last night we phoned for an update, but wasn't given one as my husband was still in the ambulance. We think he had an x-ray, but not sure if this is the case, or if he has had anything else."

Bronglais General Hospital A&E

Crowded and uncomfortable

Waiting rooms were often really full, with not enough chairs. Some people had to stand or sit on the floor. Many people said that chairs were hard and uncomfortable, and there weren't any places to lie down if someone had to wait a long time.



"Approximately 3 hours of waiting for assessment, quite uncomfortable to sit down and stand up as I had broken three vertebrae and three ribs."

Prince Philip General Hospital Minor Injuries Unit

"I waited 24 hours on one occasion and 26 hours on another, I am disabled and was in a lot of pain but had to sleep in an uncomfortable chair. On one occasion, I was on an office chair as it wasn't anticipated that people would be waiting for a bed so, there were no comfortable/recliner chairs."

The Grange University Hospital A&E

"So upsetting. People in fear, despair, pain. Fellow patients helping fellow patients as there was no one to help. I imagined that if you were in pain, distress, fear...once you made it through those A&E doors, you could throw yourself at the mercy of the hospital. You made it. Not the case. People waiting for triage, holding wounds in tea towels, committing, crying out in pain. Absolutely awful. Felt like a triage in a war zone. I went with severe shortness of breath. I waited approximately 2 hours to see the initial triage nurse. I honestly think that people will die in the waiting room. Absolutely horrific."

University Hospital of Wales A&E

Being near others who were upset or making a lot of noise made the situation even worse for many.

"Extremely sick people were left in the waiting room and I saw a mother with a teenage son ask for help as he was really ill and in pain and being told he will have to wait it was only when he started projectile vomiting that 4 nurses suddenly appeared and took him into a cubicle. It was clear to everyone this lad needed help as he was screaming!"

University Hospital of Wales A&E

Some waiting areas were nice and clean, with comfy chairs for sitting. Often vending machines were broken, and there wasn't always water or food available.

"At one point after being in A+E for 14 hours I asked the receptionist if I could have a cup of hot water she was so indignant and said we do not give out cups of hot water someone will be out with a tea trolley between 8 and 9 pm. Unfortunately the staff were so busy this did not happen all the while the receptionist just sat there chatting. 3 hours later I asked the receptionist if I could give them my phone and go to the canteen and get some hot food as I was hungry to be told abruptly I could not as I could be called which I understand."

The Grange University Hospital A&E

"12 hours after having been sent by the GP my husband was finally admitted. During all this time, my husband was not offered anything more than one paracetamol. Every time he was called up, he lost his seat and had to stand in the waiting room, until another chair became available. The coffee machine didn't work, and the snacks machine only offered sugary junk."

Ysbyty Gwynedd A&E

Having things like clean bathrooms and drinks while waiting made the experience a bit better.

"It's nice here, clean, tidy. It's relaxing."

Cardigan Integrated Care Centre Minor Injuries Unit

Receiving care and treatment

Quality of care

Lots of people said "thank you" to NHS staff for working so hard, even when things were really tough. The staff often did more than expected to make sure patients felt comfortable and respected, going "above and beyond".

"All of the staff, from the cleaners to the consultants were amazing. I could see how busy everyone was so I don't think that I was demanding but if I wanted or needed support or care, they were available. They also cared about my wellbeing and as I was struggling to eat so night staff knew this and every night I would get my milk and biscuits!!"

The Grange University Hospital A&E

"The system is broken but the staff are fantastic."

Prince Charles Hospital A&E

NHS staff were often described as kind, patient, and caring, even when they were really busy.

"Positive, pleasant, caring, gentle and accommodating"

Ysbyty Aneurin Bevan Minor Injuries Unit

"All staff extremely kind, very busy but despite this all staff were attentive..."

Ysbyty Gwynedd Acute Medical Unit

Little but important things, like listening carefully, giving reassurance, and explaining what was happening, made people feel better.

"Very positive about staff, very helpful and kind. I have felt looked after. Good communication and clear about the process."

Royal Glamorgan Hospital A&E

We heard from some people that children, neurodivergent people, or those with particular needs were supported well, with staff showed patience, understanding, changing things where needed to help them feel more comfortable or make things easier for them.

"Excellent! My daughter is autistic, and everyone was very patient and understanding."

The Grange University Hospital A&E

"Explained that my daughter (who I had taken to be seen by medical staff) suffers from anxiety and we were seen by the triage nurse almost straightaway. Did not then have to wait too long to be seen. Overall experience was excellent – seen quickly and felt staff were understanding of my daughter's needs."

Llandudno Hospital Minor Inuries Unit

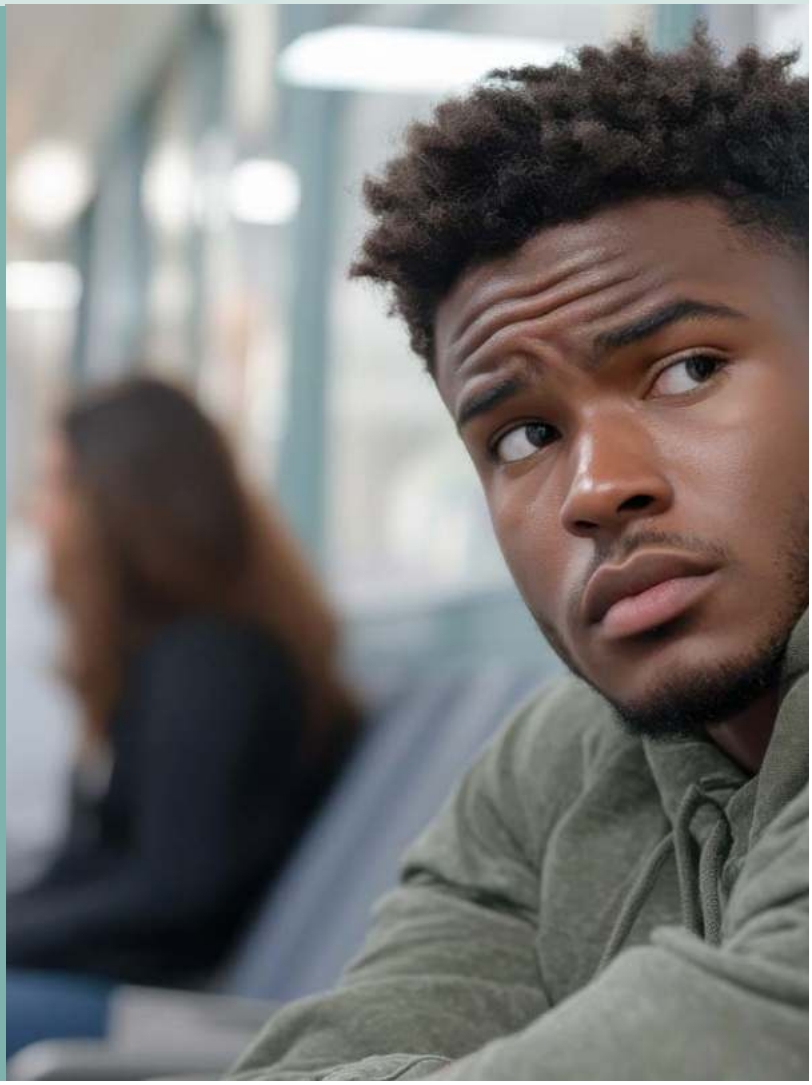
Others didn't get the support they needed.

"Awful. I'm autistic and particularly noise sensitive. The waiting room was crowded. I'd been on dialysis for four hours and already tired. I waited around 45 minutes to be assessed and then another 3 hours for a blood test. After that I was told it could be another 6 – 9 hour wait. I left – if anything serious happened I'd go back. There is no provision for neurodivergent people at any hospital I've been treated. There needs to be a quiet room."

The Grange University Hospital A&E

"The wait and not knowing hasn't been ideal, but what's affected me the most is, a patient came in this morning who is completely deaf. I used to support him in my job. Unfortunately, there was no equipment for the staff to use with him for communication and it didn't look like they were bothered either. I had to support him with BSL, just so he could get some help. This needs to be urgently looked at."

University Hospital of Wales Assessment Unit



Communication

When NHS staff explained things clearly, like what was going to happen or what the plan was, people felt less nervous.

"Brilliant, reassuring and was kind to my son who was quite stressed. They did a quick x-ray which ruled out a break, put strapping on his ankle and gave clear advice on what he should and shouldn't do."

Cardigan Integrated Care Centre Minor Injuries Unit

People liked being included in decisions and knowing what would happen next.

Some people praised the teamwork among staff, moving from one place or step to the next smoothly, without any problems or confusion e.g., between triage, treatment, and follow-up care.

"They were very helpful, though I could see they were rushed for time, were taking the time to make sure I was heard, things were thoroughly checked and my anxiety alleviated. The last one who spoke to me about my results was extremely comforting and because I was an odd case, even checked with her boss to make sure it was thorough."

University Hospital of Wales A&E

"I thought they were very thorough, saw lots of teams. They seemed to be communicating well with each other, and I was kept in the picture, always clear what was happening next. I had to tell the same story to lots of people."

Bronglais General Hospital A&E

However, some raised issues with communication where they had a pre-existing condition or were receiving specialist care elsewhere. They felt they weren't listened to or that communication with other departments or specialists who had previously treated them wasn't happening.

Lack of staff and resources

Lots of people felt that there aren't enough doctors, nurses, or beds, with too many people needing help all at once. People felt it wasn't the staff's fault, but it still made things harder for everyone.

"Feels quite traumatic like being treated in [...] a war zone where doctors are having to make do with limited equipment and support available. Drs and nurses are rushed off their feet. Not fair on patients or staff."

University Hospital of Wales Assessment Unit

Sometimes, doctors and nurses were so busy that they couldn't spend much time with patients, or things were forgotten. A few people felt like their problems weren't taken seriously, especially when they were in pain.

A lot of people said their pain wasn't taken care of quickly enough.

"When in severe pain, struggled to get pain relief."

Glan Clwyd Hospital A&E

"Numerous times I had to remind nurses they'd forgotten something. Once they're (nurses) called off to do something, they're so busy they forget"

Glangwili General Hospital A&E

"Not acceptable in fact disgusting wasn't given any pain relief or anything for the horrendous spasms I was having I told them that the symptoms I was experiencing was the same as the last time I had spinal surgery and had a haematoma still didn't do anything for me accept give me water... I was sent home with diazepam for the spasms didn't even get a spinal doctor to come and see me so I went home in the same state as I got there so who knows what 12 hours sitting on a wooden chair done to me."

Morriston Hospital Emergency Department

Privacy and dignity

Sometimes, how people were treated depended on who was helping them or what time they were there.

"There is no consistency and seems to be dependent on the individual's own values and they don't seem to have any values put into them by the NHS."

West Wales

There weren't enough hospital beds, so people had to wait a long time in uncomfortable spaces, and some had to be treated in corridors, which made them feel embarrassed or like they had no privacy.

"The doctors and nurses were kind, knowledgeable and polite but there just wasn't enough room or an appropriate environment to be seen in and they were under a lot of pressure. Being in a corridor with vomiting and diarrhoea was an horrendous experience."

The Grange University Hospital A&E

"The storing of patients in corridors has become so routine that the dignity of the patients is not even considered. The system is chaotically inefficient and is in desperate need of a review."

Glan Clwyd Hospital A&E

Leaving hospital

Some felt they were sent home too soon without enough information or help to get better properly.

"I eventually got home at 2am in the same pain and without any answers I visited my GP the following morning they wanted to send me back [...] but I refused to go. 12 months later I have not been followed up in clinic."

The Grange University Hospital Acute Medical Unit

Particularly for those being sent home late at night or very early in the morning, finding transport home was a problem for some people.

"1:30am came and Dr came too see me, explained it's a possible kidney infection and discharged me with antibiotics. This was at 1:40am and I had no way of getting home as I live over 45 minutes away. Had to stay by the table and chairs of Morriston hospital entrance until the morning."

Morriston Hospital Acute Medical Unit

Others felt they could have gone home sooner if there were more efficient processes in place for checking test results.

"Needs a discharge team as so many could have gone home if they weren't waiting on a consultant to check results."

Glangwili General Hospital A&E

Some people we heard from highlighted communication issues between emergency care and their GP, with details not being passed on in a timely way.

"I eventually got home at 2am in the same pain and without any answers... My GP was eventually able to discover that I had a damaged liver as a result of surgery."

The Grange University Hospital Acute Medical Unit

"It took 20 days for notes to come through to GP."

West Wales

What needs to happen next?

We know there are lots of things in place setting out what should happen to make everyone's experience of NHS emergency care a good one – A Healthier Wales, the Six Goals for Urgent and Emergency Care, The Duty of Quality, Care in Emergency Departments: A Quality Statement, and The Well-being of Future Generations Act all call for long-term, integrated, people-centred solutions.

The reality of what we've heard and seen over recent months makes it difficult for people to see how any of these commitments and requirements are helping to make things better for those of us who need emergency care now, and in the weeks and months ahead.

Emergency care in Wales isn't working for far too many people. Urgent action is needed to restore and rebuild confidence in the ability of our NHS to care for us when we need it in an emergency.

People need to know:

- **What is being done to fix it?**
- **When will things start improving?**
- **Who is responsible for making sure this happens?**

We know that things are happening nationally to focus on improving things. For example, the Ministerial Advisory Group on performance and productivity is looking at what can be done to make things better in urgent and emergency care in Wales.

We know that some health boards have trialled new approaches, such as additional walk-in services and minor injury units to ease the pressures on emergency departments. Others have worked to speed up triage or improve transport options.

But the real issue is that these efforts appear to us to be fragmented, do not seem to be part of a single, coordinated programme with clear leadership. Fundamentally, they are not making a difference quickly enough.

Llais is calling on the Welsh Government and NHS Wales to:

Act on what can be changed now, while laying the foundations for long-term transformation.

Focus on joined up action and accountability. People want:

- visible improvements – showing that changes are being made, not just discussed.
- clear timelines – so people know when things will improve and what steps are being taken now.
- co-ordinated action – making sure all parts of the system are working together and delivering results.

Provide clear leadership and accountability

- Use existing partnerships, oversight and escalation mechanisms to drive real improvements.
- Make responsibilities clear for everyone – who is making sure emergency care improves, and what happens when standards are not met.

Reduce waiting times and overcrowding

- Improve coordination across health and social care to prevent system bottlenecks.
- Make sure emergency care spaces are accessible for everyone, focused on meeting people's individual needs.

Prioritise dignity and comfort

- Make sure everyone is cared for and treated in appropriate, dignified spaces.
- Provide and maintain clean, safe, and comfortable environments that respect people's dignity.
- Do the small things that make a big difference to people's experience, like food and drinks and comfortable chairs.

Embed people's voices in change

- Use real-time feedback to drive on-going action and improvement.
- Introduce new measures of performance that focus on the things that matter most to people needing emergency care.
- Make emergency care data on people's experiences and outcomes publicly available so it's easy to see what people are saying and what action is taken in response.

Spread what works

- Share and implement what works well for people across Wales, not just in individual health boards.
- Move forward with a "justify or adopt" approach, a, so changes that make things better happen faster across Wales.

We believe everyone living and working in Wales has a part to play in helping to make our NHS better. At Llais, we will do everything we can to drive the improvement needed so people get the care and treatment they need where and when they need it, and in the way they need it.

Appendix: Visits made

Hospitals visited

Cardiff & The Vale of Glamorgan Region
University Hospital for Wales Assessment Unit
University Hospital for Wales A&E
Barry Hospital Minor Injuries Unit

Cwm Taf Morgannwg Region
Prince Charles Hospital A&E
Royal Glamorgan Hospital A&E
Cwm Cynon Hospital Minor Injuries Unit
Prince Charles Hospital A&E
Cwm Rhondda Hospital Minor Injuries Unit
Princess of Wales Hospital A&E

Gwent Region
The Grange University Hospital Acute Medical Unit
The Grange University Hospital A&E
Ysbyty Ystrad Fawr Minor Injuries Unit
Nevill Hall Hospital Minor Injuries Unit
Royal Gwent Hospital Minor Injuries Unit
Ysbyty Aneurin Bevan Minor Injuries Unit

North Wales Region
Ysbyty Gwnedd Acute Medical Unit
Glan Clwyd Hospital Acute Medical Unit
Wrecsam Maelor Hospital Acute Medical Unit
Ysbyty Gwynedd A+E
Glan Clwyd Hospital A+E
Wrecsam Maelor Hospital A+E
Penrhos Stanley Hospital Minor Injury Unit
Bryn Beryl Hospital Minor Injury Unit
Ysbyty Alltwen Minor Injury Unit
Tywyn Hospital Minor Injury Unit
Llandudno Hospital Minor Injury Unit
Denbigh Hospital Hospital Minor Injury Unit
Holywell Hospital Minor Injury Unit
Mold Community Hospital Minor Injury Unit

Neath Port Talbot & Swansea Region
Morriston Hospital Emergency Department
Morriston Hospital Acute Medical Unit
Neath Port Talbot Hospital Minor Injuries Unit

Powys Region
Victoria Memorial Hospital Minor Injuries Unit
Ystradgynlais Community Hospital Minor Injuries Unit
Breconshire War Memorial Hospital (Brecon) Minor Injuries Unit
Llandrindod Wells County War Memorial Hospital Minor Injuries Unit

West Wales
Glangwili General Hospital
Withybush General Hospital
Bronglais General Hospital
Prince Philip General Hospital
Cardigan Integrated Care Centre
Llandovery Hospital

Thanks

We thank everyone who took the time to share their insights, views and experiences with us about emergency care.

Feedback

We'd love to hear what you think about this publication, and any suggestions about how we could have improved it, so we can use this to make our future work better.

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LLAIS

Eich llais chi mewn iechyd a gofal | Your voice in health and social care

CAEL GOFAL IECHYD BRYS YN YSBYTAI CYMRU

CHWEFROR 2025


Emergency

Amdano Llais

Rydym ni'n credu mewn Cymru iachach lle mae pobl yn cael y gwasanaethau iechyd a gofal cymdeithasol sydd eu hangen arnyn nhw mewn ffordd sy'n gweithio orau iddyn nhw.

Rydym yma i ddeall eich barn a'ch profiadau o iechyd a gofal cymdeithasol, ac i sicrhau bod y rhai sy'n gwneud penderfyniadau yn defnyddio'ch adborth i lunio'ch gwasanaethau.

Rydym yn chwilio am straeon da a drwg fel ein bod yn deall beth sy'n gweithio'n dda a sut y gallai fod angen i wasanaethau wella. Ac rydym yn ceisio siarad yn arbennig â'r rhai nad yw eu lleisiau'n cael eu clywed yn aml.

Rydym hefyd yn siarad â phobl am eu barn a'u profiadau trwy gynnal digwyddiadau yn eich cymunedau lleol neu ymweld â chi ble bynnag yr ydych yn derbyn eich gwasanaeth iechyd neu ofal cymdeithasol. Rydym hefyd yn gweithio gyda grwpiau cymunedol a grwpiau â diddordeb ac yn unol â mentrau cenedlaethol i gasglu barn pobl. A phan aiff pethau o chwith rydym yn eich cefnogi i wneud cwynion.

Mae 7 Rhanbarth Llais yng Nghymru. Mae pob un yn cynrychioli llais "claf a chyhoeddus" mewn gwahanol rannau o Gymru.

Fformatau Hygyrch
Mae'r ddogfen hon hefyd ar gael yn Saesneg. Os hoffech gael y cyhoeddiad hwn mewn fformat a/neu iaith arall, cysylltwch â ni.

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Cael gofal iechyd brys yn ysbytai Cymru

Dros y flwyddyn ddiwethaf mae Llais wedi bod yn clywed llawer am heriau sydd gan bobl wrth gael mynediad i ofal brys yng Nghymru.

Gan ddechrau ddiwedd mis Medi 2024, dros gyfnod o 5 wythnos, ymwelodd timau Llais ledled Cymru â'r Adrannau Achosion Brys, Unedau Mân Anafiadau ac Unedau Asesu Meddygol yn eu hardaloedd lleol. Cynhaliwyd 42 o ymweliadau gennym.

Gwnaethom hefyd gynnal arolwg ar–lein a chynnal grwpiau ffocws i gasglu profiadau pobl. Yn ystod y cyfnod hwn o 5 wythnos clywsom yn uniongyrchol gan dros 700 o bobl am eu profiad o ofal iechyd brys.

Gwyddom fod 'pwysau'r gaeaf' yn ei gwneud hi'n anoddach darparu gofal brys. Roedd yr hyn a welsom ac a glywsom yn y cyfnod cyn y gaeaf yn dangos yn glir sut mae'r problemau mawr gyda'r ffordd y mae gofal iechyd brys yn gweithio gyda gwasanaethau iechyd a gofal eraill ac yn effeithio ar ansawdd y gofal iechyd y mae pobl yn ei dderbyn – ym mron pob ffordd sy'n bwysig i bobl.

Mae hyn yn syml yn annerbyniol. Rhaid peidio â chaniatáu iddo gael ei weld fel ein "normal newydd".

Er bod llawer o bobl yn ddiolchgar am ymroddiad a gwaith caled staff gofal iechyd, roedd heriau fel diffyg staff, amseroedd aros hir anghyfforddus anurddasol, a chyfathrebu gwael yn rhy aml yn cysgodi profiadau cadarnhaol.

Er nad oedd profiad pawb y clywsom amdano yn un gwael, mae'n amlwg bod gofal brys yng Nghymru yn methu â diwallu anghenion pobl, a'r disgwyliadau sydd gennym oll ar gyfer ein GIG.

Mae profiad pobl o ofal iechyd brys yn llawer is na'r ymrwymiadau a nodir yn 'Cymru Iachach, y Chwe nod ar gyfer gofal brys ac argyfwng' a'r dyletswyddau cyfreithiol sydd gan y GIG a Llywodraeth Cymru i "wella ansawdd y gwasanaethau a ddarperir ganddynt yn barhaus".

Ers i ni gynnal ein hymweliadau, mae 'digwyddiadau critigol busnes' wedi'u datgan gan Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru[1] a Bwrdd Iechyd Prifysgol Aneurin Bevan[2] am ofal brys.

Mae byrddau iechyd eraill, gan gynnwys Bwrdd Iechyd Prifysgol Bae Abertawe[3] a Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg[4], wedi rhyddhau datganiadau yn tynnu sylw at y pwysau ychwanegol yr oeddent yn ei wynebu yn eu hadrannau achosion brys. Agorodd Bwrdd Iechyd Prifysgol Hywel Dda uned mân anafiadau dros dro i geisio ymdopi â'r galw[5].

Yn gynharach y mis hwn rhyddhaodd y Coleg Nyrsio Brenhinol ei adroddiad '*On the frontline of the UK's corridor care crisis*'[6]. Roedd yr adroddiad hwn yn cynnwys adroddiadau brawychus o arferion anurddasol ac anniogel.

Yma, rydym yn nodi'r pethau allweddol a glywsom gan bobl am eu profiadau o ofal brys mewn ysbytai ledled Cymru.

Mae'r lleisiau hyn yn galw am weithredu brys gan y rhai sy'n gwneud penderfyniadau yn lleol ac yn genedlaethol i wneud pethau'n well i bawb.

1. Welsh Ambulance Service declares Critical Incident – Welsh Ambulance Services University NHS Trust
2. NHS Pressures: Critical Incident Declared – Updated 15/01/2025 – Aneurin Bevan University Health Board
3. Exceptional pressure on Morriston Hospital – Swansea Bay University Health Board
4. Health Board asks public to help it manage exceptionally high demand – Cwm Taf Morgannwg University Health Board
5. Health board opens pop-up weekend minor injuries unit to deal with overloaded hospital A&E – Wales Online
6. https://www.rcn.org.uk/Professional-Development/publications/

Yr hyn a ddysgwyd – Cymru Gyfan

Cyrraedd yr ysbyty

Roedd profiadau pobl o gyrraedd yr ysbyty yn eithaf amrywiol, gyda chymysgedd o nodweddion da a drwg yn ymwneud â chludiant, parcio, a chyflwyno i'r adran.

Materion trafnidiaeth

Yn aml roedd yn rhaid i bobl aros amser hir – hyd at 12 awr – i ambiwlans ddod i'w helpu.

"Mae hysbysebion yn dweud wrthym am weithredu ar frys gyda chleifion strôc a dyna wnaethon ni ond cymerodd gymaint o amser i ambiwlans gyrraedd er ein bod wedi esbonio symptomau. Bu farw ein mam wythnos yn ddiweddarach."

Uned Feddygol Acíwt Ysbyty Treforys

"Cefais lifft yma. Fe wnes i ffonio am ambiwlans ond dywedwyd wrthyf y byddwn i'n aros dros 12 awr."

Damweiniau ac Achosion Brys Ysbyty Athrofaol Cymru

"Fe wnes i yrru oherwydd bod 'eta' ambiwlans yn 7/8 awr, ond roedd gen i boen difrifol yn y frest ac ni allwn aros mor hir a hynny."

Adran Achosion Brys Ysbyty Treforys

Roedd yn rhaid i'r rhan fwyaf o bobl ofyn i rywun yr oeddent yn eu nabod i'w gyrru, neu roedd rhai yn mentro gyrru eu hunain, er gwaethaf bod yn sâl.

Roedd yn rhaid i bobl nad oedd ganddynt fynediad i gar ddefnyddio trafnidiaeth gyhoeddus neu dalu am dacsi, a oedd yn cymryd mwy o amser ac yn gwneud iddynt deimlo fwy o straen.

"Erchyll. Y tro cyntaf i mi ffonio 111 aethon nhw â mi i Glangwili a oedd yn 45 munud i ffwrdd heb unrhyw feddygon asgwrn cefn na T (trawma) ac O (orthopaedeg) yno, er fy mod yn dweud bod gen i hanes asgwrn cefn cymhleth ac mae angen mynd i Abertawe a dyna le mae fy nghyfeiriad preswyl, a dim ond 15munud o yrru. Yn methu cerdded roedd rhaid i mi gael tacsi yn ôl am 3.30yb gyda chost o £130. Adroddodd y gyrrwr tacsi nifer o straeon am bobl oedrannus ac yn amlwg anabl yn cael eu gorfodi i gael tacsis adref, un hyd yn oed i Hwlffordd am dros £250. Sioc ofnadwy."

Adran Achosion Brys Ysbyty Treforys

Roedd yn rhaid i rai teithio am awr neu fwy, a dewisodd rhai ysbytai penodol dros eraill oherwydd eu bod yn poeni am enw da rhai lleoedd, hyd yn oed os oedd angen teithio hirach.

"Wedi dod i PCH oherwydd enw gwael ysbyty'r Faenor a fyddai wedi bod yn agosach."

Damweiniau ac Achosion Brys Ysbyty Tywysog Siarl

Problemau parcio

Roedd meysydd parcio yn aml yn llawn, felly roedd hi'n anodd dod o hyd i le. Roedd hyn yn arbennig o anodd i bobl hŷn neu bobl anabl os nad oedd lleoedd hygyrch yn agos at yr ysbyty.

"Dim lle i barcio ceir, roedd rhaid parcio ffordd sylweddol i ffwrdd o'r ysbyty a gadael claf ar ei ben ei hun fel y gallwn gael cadair olwyn i'r claf roeddwn i gyda. Dim cadeiriau olwyn ar gael, roedd rhaid aros tra bod gwarchodwr diogelwch yn cael ei anfon i ddod o hyd i un."

Damweiniau ac Achosion Brys Ysbyty Prifysgol Y Faenor

"Roedd parcio – yn enwedig ar gyfer y rhai mewn cadeiriau olwyn – arfer bod wrth y brif fynedfa yn YPC, mae hynny bellach wedi'i dynnu i ffwrdd, felly os nad oes lleoedd yn y maes parcio 2 stori gyferbyn â Damweiniau ac Achosion Brys, yna mae'n golygu taith o'r maes parcio aml-stori arall, nad yw'n hawdd wrth wthio cadair olwyn. Mae'r cyfan yn creu sefyllfa straenus iawn i gleifion a'u gofalwyr/teuluoedd ddelio gyda, ar ben pryder bod rhywun rydych chi'n ei garu, yn sâl iawn."

Damweiniau ac Achosion Brys Ysbyty Athrofaol Cymru

Roedd rhai lleoedd parcio ymhell o ddrysau'r ysbyty, ac nid oedd arwyddion ar gael nac yn glir bob amser, a oedd yn ei gwneud hi'n anoddach i bobl nad oeddent yn teimlo'n dda.

"Roedd parcio yn anodd oherwydd roedd yn gyfnod prysur o'r dydd, nid oedd dod o hyd i'r ysbyty yn broblem, ond dim arwyddion clir ar gyfer yr adran mân anafiadau.

Uned Mân Anafiadau Ysbyty Cwm Cynon

"Wedi dod mewn car... cyrhaeddais am 14:45. Nawr y 17:14. Nodwyd amser aros ar yr Arddangosfa fel 3 1/2 awr. Mae parcio yn ofnadwy. Wedi gorfod parcio mewn maes parcio cyhoeddus. Wedi gorfod parcio mewn maes parcio cyhoeddus."

Damweiniau ac achosion brys Ysbyty Cyffredinol Llwynhelyg

Nid oedd terfynau parcio arhosiad byr yn rhoi digon o amser i bobl oedd yn gorfod aros i gael eu gweld yn yr ysbyty.

Cyflwyno i'r adran

Roedd rhai pobl yn hoffi defnyddio'r sgriniau hunan–gofnodi oherwydd eu bod yn gyflym, ond roedd eraill yn eu gweld yn anodd eu defnyddio, yn enwedig os oeddent yn sâl neu mewn poen.

Nid oedd y ffordd i gyflwyno bob amser yn glir, a oedd yn gwneud i bobl deimlo'n fwy pryderus.

"Roedd yr iPads yn anhrefn llwyr i'w defnyddio. Mae'r cwestiynau maen nhw'n eu gofyn yn chwerthinllyd ac yn ymwthiol. Ni chewch ofyn y cwestiynau hynny gan y ddesg. Ni allwch hyd yn oed ddewis eu hepgor, ni fydd yn gadael i chi fynd ymhellach oni bai eich bod wedi eu hateb. Y peth olaf rydych chi am ei wneud yw brwydro gyda rhywbeth fel yna pan fyddwch chi'n sâl."

Damweiniau ac Achosion Brys Ysbyty Athrofaol Cymru

"Croeso cynnes gan y dderbynfa, wedi gwneud fy niwrnod."

Damweiniau ac Achosion Brys Ysbyty Gwynedd

"Roedd aelodau staff y dderbynfa yn hyfryd, cwrtais ac yn ddymunol ac roedd yr ardal aros yn lân ac yn eang ac roedd seddi taclus a chyfforddus am gyfnod fy aros."

Uned Mân Anafiadau Castell–nedd Port Talbot

Gwnaeth staff cyfeillgar wahaniaeth mawr; pan oedd y staff yn garedig ac yn gymwynasgar, roedd yn gwneud i bobl deimlo lai o straen a bod rhywun yn gofalu amdanynt.

Aros i gael eich gweld

Brysbennu cyflym

Roedd llawer o bobl yn cael eu gwirio gan nyrs neu feddyg yn fuan ar ôl iddynt gyrraedd, weithiau mewn ychydig funudau yn unig. Os oedd rhywun yn wirioneddol sâl, cawsant help yn gyflymach, ac roedd pobl gwir yn gwerthfawrogi hyn.

"Daeth rhai pobl i mewn gyda phroblemau a oedd yn amlwg yn frys a oedd wedi gwneud eu ffordd eu hunain i mewn ac yn cael eu hystyried fel blaenoriaeth a oedd yn gysurus iawn."

Damweiniau ac Achosion Brys Ysbyty Athrofaol Cymru

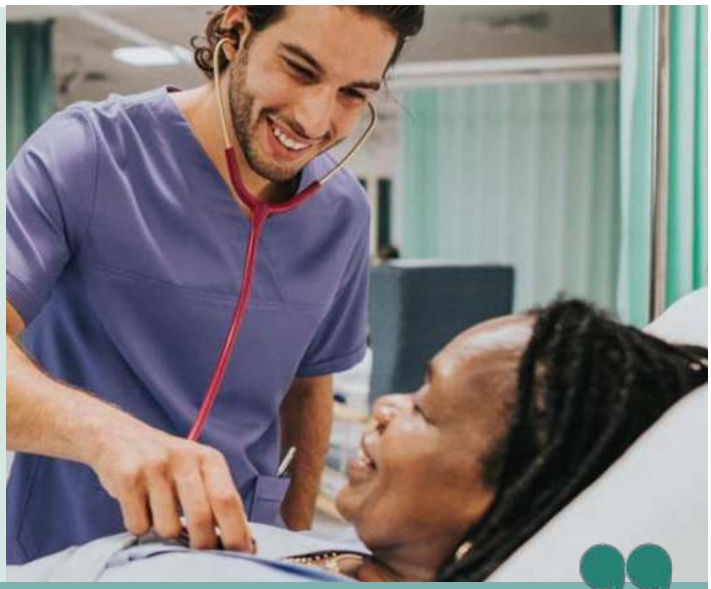
Mae pobl yn gwerthfawrogi gallu cael eu gweld yn lleol mewn ysbytai llai am bethau nad oes angen i adrannau brys mwy o faint ymdrin â nhw.

"Mae cael eich gweld yn UMA Llandrindod wedi arbed taith i Henffordd sydd ag amseroedd aros hir iawn. Wedi'i weld yma mewn tua 30 munud heb wneud apwyntiad ymlaen llaw. Defnyddiwyd cyfleusterau yma sawl gwaith dros y blynyddoedd ac i gyd yn wych."

Uned Mân Anafiadau Ysbyty Coffa Rhyfel Sir Llandrindod

Staff caredig a gofalgar

Roedd y meddygon a'r nyrsys yn garedig, er eu bod yn wirioneddol brysur. Roeddent yn gweithio'n galed i ofalu am bawb, a wnaeth i bobl deimlo'n llai poeni a rhwystredig.



"Caredig a Gofalgar. Hawdd siarad â nhw."

Uned Mân Anafiadau Ysbyty Nevill Hall

Arhosiadau hir

Roedd yn rhaid i rai pobl aros amser hir iawn i gael eu gweld —roedd llawer yn aros 8–12 awr, rhai cyhyd â 24 awr.

"Mae amseroedd aros yn ofnadwy, ond mae'r staff wedi bod yn arbennig ac yn ceisio eu gorau i gael cleifion i mewn i welyau"

Damweiniau ac Achosion Brys Ysbyty'r Tywysog Siarl

"Rydw i wedi bod yn aros 12 awr ac ond wedi cael fy mrysbennu a sampl dŵr. Yn anffodus roeddem yn disgwyl aros ac nid ydym wedi cael cynnig bwyd na diod. Cymerwyd ail 'obs' ar ôl 12 awr. Rwy'n aros mewn coridor, sy'n ardal aros bediatrig ac mae'n anghyfforddus iawn"

Damweiniau ac Achosion Brys Ysbyty Brenhinol Morgannwg

Roedd yn wirioneddol anodd i bobl oedd mewn poen, yn teimlo'n sâl, neu'n gofalu am blant neu eraill oedd angen cymorth ychwanegol arnynt. Roedd pobl niwroamrywiol yn aml yn gweld yr ardal aros yn llethol oherwydd y sŵn, y goleuadau llachar a nifer y bobl o'u cwmpas.

"Mae fy mab yn awtistig ac yn anaml iawn yn gadael y tŷ. Wedi cael crawniad perianal a oedd wedi torri mor anodd eistedd neu sefyll. [Mae ganddo] bryder cymdeithasol felly ni all ymdopi â phobl, golau sŵn ac ati. Dywedwyd wrthym y gallwn aros yn y car gydag ef a byddai'n cael ei alw'n syth drwodd i frysbennu. Pan alwyd ei enw, ac nid oedd yno ar unwaith symudasant ymlaen at y claf nesaf a bu raid iddo aros yn sefyll ac mewn poen."

Damweiniau ac Achosion Brys Ysbyty Gwynedd

Dywedodd llawer o bobl eu bod yn teimlo'n anniogel neu fel nad oedd neb yn talu sylw iddynt.

Nid oedd pobl bob amser yn gwybod pa mor hir y byddai'n rhaid iddynt aros na beth fyddai'n digwydd nesaf. Ar ôl gweld y nyrs ar y dechrau, roedden nhw'n teimlo'n anghofio weithiau ac nid oeddent yn cael unrhyw ddiweddariadau.

Cefais wybodaeth ffug gan feddyg a ddywedodd y byddwn yn cael fy ngweld a chael yr iawn i fynd adref gan fod y canlyniadau'n glir – 3 awr yn ddiweddarach cefais wybod fy mod yn mynd i fyny i ward i aros dros nos – ystyriais fy mod yn fwy diogel gartref a rhyddhau fy hun."

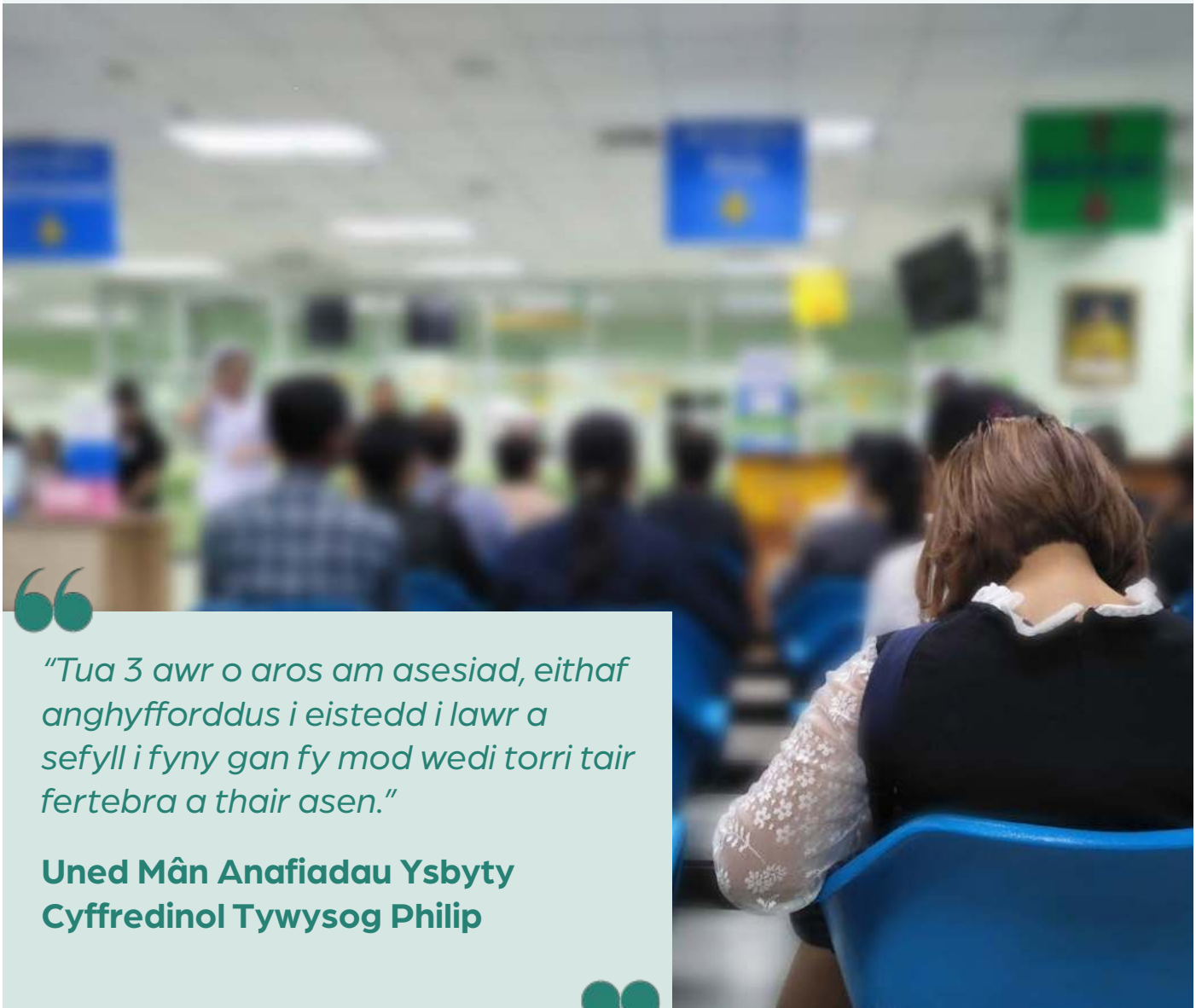
Damweiniau ac Achosion Brys Ysbyty Athrofaol Cymru

"Nid ydym yn rhy siŵr beth sy'n digwydd. Fe wnaethon ni siarad â nyrs ychydig dros awr yn ôl. Rydym yn dal i aros. Nid ydym wedi cael unrhyw esboniad o beth yw'r driniaeth i fod. Neithiwr fe wnaethon ni ffonio am ddiweddariad, ond ni roddwyd un gan fod fy ngŵr yn dal yn yr ambiwlans. Rydym yn meddwl ei fod wedi cael pelydr-x, ond ddim yn siwr os yw hyn yn wir, neu os yw wedi cael unrhyw beth arall."

Damweiniau ac Achosion Brys Ysbyty Cyffredinol Bronglais

Gorlawn ac anghyfforddus

Roedd yr ystafelloedd aros yn aml yn llawn iawn, heb ddigon o gadeiriau. Roedd yn rhaid i rai pobl sefyll neu eistedd ar y llawr. Dywedodd llawer fod cadeiriau yn galed ac anghyfforddus, ac nid oedd unrhyw leoedd i orwedd i lawr os oedd yn rhaid i rywun aros amser hir.



"Tua 3 awr o aros am asesiad, eithaf anghyfforddus i eistedd i lawr a sefyll i fyny gan fy mod wedi torri tair fertebra a thair asen."

Uned Mân Anafiadau Ysbyty Cyffredinol Tywysog Philip

"Roeddwn i'n aros 24 awr ar un achlysur a 26 awr ar un arall, rwy'n anabl ac roeddwn mewn llawer o boen ond roedd rhaid i gysgu mewn cadair anghyfforddus. Ar un achlysur, roeddwn i ar gadair swyddfa gan nad oedd yn cael ei ragweld y byddai pobl yn aros am wely felly, nid oedd cadeiriau cysur/recliner."

Damweiniau ac Achosion Brys Ysbyty Prifysgol Grange

Roedd bod yn agos at eraill a oedd yn ofidus neu wneud llawer o sŵn yn gwneud y sefyllfa'n waeth fyth i lawer.

"Mor ofidus. Pobl mewn ofn, anobaith, poen. Cyd-gleifion yn helpu cyd-gleifion gan nad oedd neb i helpu. Dychmygais pe baech chi mewn poen, trallod, ofn... unwaith i chi ei wneud drwy'r drysau Damweiniau ac Achosion Brys hynny, y gallech daflu'ch hun at drugaredd yr ysbyty. Fe wnaethoch chi ei wneud. Nid yw'r achos. Pobl yn aros am driage, dal clwyfau mewn tyweli te, ymrwymo, crio allan mewn poen. Yn hollol ofnadwy. Teimlo fel brysbennu mewn parth rhyfel. Es i gyda diffyg anadl difrifol. Arhosais tua 2 awr i weld y nyrs brisio cychwynnol. Rwy'n credu yn onest y bydd pobl yn marw yn yr ystafell aros. Yn hollol erchyll."

Damweiniau ac Achosion Brys Ysbyty Athrofaol Cymru

"Gadawyd pobl hynod o sâl yn yr ystafell aros a gwelais fam gyda mab yn ei arddegau yn gofyn am help gan ei fod yn wirioneddol sâl ac mewn poen ac yn cael gwybod y bydd yn rhaid iddo aros dim ond pan ddechreuodd chwydu tafluniad ymddangosodd 4 nyrs yn sydyn a mynd ag ef i mewn i giwbicl. Roedd yn amlwg i bawb roedd angen help ar y dyn hwn gan ei fod yn sgrechian!"

Damweiniau ac Achosion Brys Ysbyty Athrofaol Cymru

Roedd rhai mannau aros yn braf ac yn lân, gyda chadeiriau cyfforddus ar gyfer eistedd, ond yn aml roedd peiriannau gwerthu yn torri, ac nid oedd dŵr na bwyd ar gael bob amser.

"Ar un pwynt ar ôl bod mewn A+E am 14 awr gofynnais i'r derbynnydd a allwn i gael paned o ddŵr poeth roedd hi mor ddig a dywedodd nad ydym yn rhoi allan cwpanau o ddŵr poeth bydd rhywun allan gyda throli te rhwng 8 a 9 yh. Yn anffodus roedd y staff mor brysur ni ddigwyddodd hyn yr holl dra roedd y derbynnydd yn eistedd yno yn sgwrsio. 3 awr yn ddiweddarach gofynnais i'r derbynnydd a allwn roi fy ffôn iddyn nhw a mynd i'r ffreutur a chael rhywfaint o fwyd poeth gan fy mod yn llwglyd i gael gwybod yn sydyn na allwn i fel y gellid fy ngalw a dwi'n deall."

Damweiniau ac Achosion Brys Ysbyty Prifysgol Grange

"12 awr ar ôl cael ei anfon gan y meddyg teulu cafodd fy ngŵr ei dderbyn o'r diwedd.. Yn ystod yr holl amser hwn, ni chafodd fy ngŵr gynnig unrhyw beth mwy nag un paracetamol. Bob tro y gelwid ef i fyny, collodd ei sedd a'i law i sefyll yn yr ystafell aros, nes y daeth cadair arall ar gael. Doedd y peiriant coffi ddim yn gweithio, a dim ond sothach siwgr oedd y peiriant byrbrydau yn cynnig."

Damweiniau ac Achosion Brys Ysbyty Gwynedd

Roedd cael pethau fel ystafelloedd ymolchi glân a diodydd wrth aros yn gwneud y profiad ychydig yn well.

"Mae'n braf yma, yn lân, yn daclus. Mae'n ymlaciol."

Uned Mân Anafiadau Canolfan Gofal Integredig Aberteifi

Derbyn gofal a thriniaeth

Ansawdd gofal

Dywedodd llawer o bobl "diolch" wrth y meddygon a'r nyrsys am weithio mor galed, hyd yn oed pan oedd pethau'n anodd iawn. Roedd y staff yn aml yn gwneud mwy na'r disgwyl i sicrhau bod cleifion yn teimlo'n gyfforddus ac yn cael eu parchu, gan fynd "uwchlaw a thu hwnt".

"Roedd pob un o'r staff, o'r glanhawyr i'r ymgynghorwyr yn anhygoel. Gallwn weld pa mor brysur oedd pawb felly dwi ddim yn meddwl fy mod i'n mynnu ond os oeddwn eisiau neu angen cymorth neu ofal, roedden nhw ar gael. Roedden nhw hefyd yn poeni am fy lles a chan fy mod yn cael trafferth bwyta felly roedd staff y nos yn gwybod hyn a phob nos byddwn yn cael fy llaeth a'm bisgedi!!"

Damweiniau ac Achosion Brys Ysbyty Prifysgol Grange

"Mae'r system wedi torri ond mae'r staff yn wych."

Damweiniau ac Achosion Brys Ysbyty Tywysog

Disgrifiwyd staff y GIG yn aml fel rhai caredig, amyneddgar a gofalgar, hyd yn oed pan oeddent yn wirioneddol brysur.

"Cadarnhaol, dymunol, gofalgar, addfwyn a chymwynasgar"

Uned Mân Anafiadau Ysbyty Aneurin Bevan

"Pob aelod o staff yn hynod garedig, yn brysur iawn ond er gwaethaf hyn roedd yr holl staff yn sylwgar..."

Uned Feddygol Acíwt Ysbyty Gwynedd

Roedd pethau bach, fel gwrando yn ofalus, rhoi sicrwydd, ac esbonio'r hyn oedd yn digwydd, yn gwneud i bobl deimlo'n well.

"Cadarnhaol iawn am staff, yn ddefnyddiol iawn ac yn garedig. Rwyf wedi teimlo fy mod yn derbyn gofal. Cyfathrebu da ac yn glir am y broses."

Damweiniau ac Achosion Brys Ysbyty Brenhinol Morgannwg

Clywsom gan rai pobl fod plant, pobl niwroddargyfeiriol, neu'r rhai ag anghenion penodol yn cael eu cefnogi'n dda, gyda staff yn dangos amynedd, dealltwriaeth, yn newid pethau lle bo angen i'w helpu i deimlo'n fwy cyfforddus neu i wneud pethau'n haws iddynt.

"Ardderchog! Mae fy merch yn awtistig, ac roedd pawb yn amyneddgar ac yn ddeallus iawn."

Damweiniau ac Achosion Brys Ysbyty Prifysgol Grange

"Eglurais fod fy merch (yr oeddwn wedi ei chymryd i gael ei gweld gan staff meddygol) yn dioddef o bryder a chawsom ein gweld gan y nyrs brisio bron yn syth. Nid oedd yn rhaid aros yn rhy hir wedyn i gael ei gweld. Roedd y profiad cyffredinol yn ardderchog – gwelwyd yn gyflym ac yn teimlo bod staff yn deall anghenion fy merch."

Uned Mân Anafiadau Ysbyty Llandudno

Ni chafodd eraill y cymorth yr oedd ei angen arnynt.

"Ofnadwy. Rwy'n awtistig ac yn arbennig o sensitif i sŵn. Roedd yr ystafell aros yn orlawn. Roeddwn i wedi bod ar ddialysis am bedair awr ac wedi blino'n barod. Arhosais tua 45 munud i gael fy asesu ac yna 3 awr arall am brawf gwaed. Ar ôl hynny dywedwyd wrthyf y gallai fod yn aros am 6 – 9 awr arall. Gadewais – pe bai unrhyw beth difrifol yn digwydd byddwn yn mynd yn ôl. Nid oes unrhyw ddarpariaeth ar gyfer pobl niwroddargyfeiriol mewn unrhyw ysbyty yr wyf wedi cael triniaeth. Mae angen ystafell dawel."

Damweiniau ac Achosion Brys Ysbyty Athrofaol y Grange

"Nid yw'r aros a dim gwybod wedi bod yn ddelfrydol, ond yr hyn sydd wedi effeithio fwyaf arnaf yw, daeth claf i mewn y bore yma sy'n gwbl fyddar. Roeddwn i'n arfer ei gefnogi yn fy swydd. Yn anffodus, nid oedd unrhyw offer i'r staff ei ddefnyddio ar gyfer cyfathrebu ag ef ac nid oedd yn edrych fel eu bod yn poeni chwaith. Roedd yn rhaid i mi ei gefnogi gyda BSL, dim ond er mwyn iddo gael rhywfaint o help. Mae angen edrych ar hyn ar fyrder."

Uned Asesu Ysbyty Athrofaol Cymru

Cyfathrebu

Pan esboniodd staff y GIG bethau'n glir, fel beth oedd yn mynd i ddigwydd neu beth oedd y cynllun, roedd pobl yn teimlo'n llai nerfus.

"Gwych, yn galonogol ac yn garedig â fy mab a oedd yn eithaf dan straen. Fe wnaethon nhw belydr-x cyflym a ddiystyrodd doriad, rhoddant strapio ar ei ffêr a rhoi cyngor clir ar beth ddylai ac na ddylai wneud."

Uned Mân Anafiadau Canolfan Gofal Integredig Aberteifi

Roedd pobl yn hoffi cael eu cynnwys mewn penderfyniadau a gwybod beth fyddai'n digwydd nesaf.

Roedd rhai adborth yn canmol gwaith tîm ymhlith staff, gyda symud o un lle neu gam i'r nesaf yn esmwyth, heb unrhyw broblemau na dryswch e.e. rhwng brysbennu, triniaeth, a gofal dilynol.

"Roeddent yn barod iawn i helpu, er y gallwn weld eu bod yn cael eu rhuthro am amser, yn cymryd yr amser i sicrhau fy mod yn cael fy nghlywed, bod pethau'n cael eu gwirio'n drylwyr a bod fy mhryder wedi'i leddfu. Roedd yr un olaf a siaradodd â mi am fy nghanlyniadau yn hynod gysurus ac oherwydd fy mod yn achos rhyfedd, holodd ei bos hyd yn oed i wneud yn siŵr ei fod yn drylwyr."

Damweiniau ac Achosion Brys Ysbyty Athrofaol Cymru

Fodd bynnag, cododd rhai materion yn ymwneud â chyfathrebu lle'r oedd ganddynt gyflwr yn barod neu pan oeddent yn derbyn gofal arbenigol yn rhywle arall. Roeddent yn teimlo nad oedd neb yn gwrando arnynt neu nad oedd cyfathrebu ag adrannau neu arbenigwyr eraill a oedd wedi eu trin yn flaenorol yn digwydd.

"Roeddwn i'n meddwl eu bod yn drylwyr iawn, gweld llawer o dimau. Roedden nhw fel petawn nhw'n cyfathrebu'n dda â'i gilydd, ac roeddwn i'n cael fy nghadw yn y llun, bob amser yn glir beth oedd yn digwydd nesaf. Roedd yn rhaid i mi ddweud yr un stori wrth lawer o bobl"

Damweiniau ac Achosion Brys Ysbyty Cyffredinol Bronglais

Diffyg staff ac adnoddau

Roedd llawer o bobl yn teimlo nad oes digon o feddygon, nyrsys, na gwelyau, ac mae gormod o bobl angen help i gyd ar unwaith. Roedd pobl yn deall nad bai'r staff oedd hynny, ond roedd yn dal i wneud pethau'n anoddach i bawb.

"Mae'n teimlo'n eithaf trawmatig fel cael eich trin mewn [...] parth rhyfel lle mae meddygon yn gorfod gwneud hynny gydag offer a chymorth cyfyngedig sydd ar gael.. Mae Drs a nyrsys yn cael eu rhuthro oddi ar eu traed. Ddim yn deg ar gleifion na staff"

Uned Asesu Ysbyty Athrofaol Cymru

Weithiau, roedd meddygon a nyrsys mor brysur fel na allent dreulio llawer o amser gyda chleifion, neu roedd pethau'n cael eu hanghofio. Roedd ychydig o bobl yn teimlo nad oedd eu problemau yn cael eu cymryd o ddifrif, yn enwedig pan oeddent mewn poen.

Dywedodd llawer o bobl nad oedd eu poen yn cael ei ofalu yn ddigon cyflym.

Pan mewn poen difrifol, roedd yn cael trafferth cael rhyddhad poen."

Damweiniau ac Achosion Brys Glan Clwyd Hospital A&E

"Nifer o weithiau roedd yn rhaid i mi atgoffa nyrsys eu bod wedi anghofio rhywbeth. Unwaith y byddan nhw (nyrsys) yn cael eu galw i wneud rhywbeth, maen nhw mor brysur maen nhw'n anghofio."

Damweiniau ac Achosion Brys Ysbyty Cyffredinol Glangwili

"Ddim yn dderbyniol mewn gwirionedd, ffiaidd ni roddwyd unrhyw leddhad poen nac unrhyw beth ar gyfer y sbasmau dychrynllyd roeddwn i'n eu cael dywedais wrthyn nhw bod y symptomau roeddwn i'n eu profi'r un fath â'r tro diwethaf i mi gael llawdriniaeth asgwrn cefn a chael haematoma dal ddim yn gwneud unrhyw beth i mi dderbyn rhowch ddŵr i mi. Cefais fy anfon adref gyda diazepam am nad oedd y sbasmau hyd yn oed yn cael meddyg asgwrn cefn i ddod i'm gweld felly es i adref yn yr un cyflwr ag y cefais yno felly pwy a ŵyr beth oedd 12 awr eistedd ar gadair bren wedi ei wneud i mi."

Adran Achosion Brys Ysbyty Treforys

Preifatrwydd ac urddas

Weithiau, roedd sut roedd pobl yn cael eu trin yn dibynnu ar bwy oedd yn eu helpu neu pa amser yr oeddent yno.

"Does dim cysondeb ac mae'n ymddangos eu bod yn ddibynnol ar werthoedd yr unigolyn ei hun ac nid yw'n ymddangos bod ganddyn nhw unrhyw werthoedd a roddwyd ynddynt gan y GIG."

Gorllewin Cymru

Nid oedd digon o welyau ysbyty, felly roedd yn rhaid i bobl aros amser hir mewn mannau anghyfforddus, a bu'n rhaid trin rhai mewn coridorau, a oedd yn gwneud iddynt deimlo cywilydd neu fel nad oedd ganddynt breifatrwydd.

"Roedd y meddygon a'r nyrsys yn garedig, yn wybodus ac yn gwrtais ond nid oedd digon o le nac amgylchedd priodol i gael eu gweld ynddo ac roedden nhw o dan lawer o bwysau. Roedd bod mewn coridor gyda chwydu a dolur rhydd yn brofiad dychrynllyd."

The Grange University Hospital A&E

"Mae storio cleifion yn y coridor wedi dod mor arferol fel nad yw urddas y cleifion yn cael ei ystyried hyd yn oed. Mae'r system yn aneffeithlon o aneffeithlon ac mae angen dirfawr am adolygiad."

Damweiniau ac Achosion Brys Ysbyty Glan Clwyd

Gadael yr ysbyty

Teimlai rhai eu bod yn cael eu hanfon adref yn rhy fuan heb ddigon o wybodaeth na chymorth i wella'n iawn.

"Cyrhaeddais adref yn y pen draw am 2 yn yr un boen a heb unrhyw atebion ymwelais â fy meddyg teulu y bore canlynol roeddent am fy anfon yn ôl [...] ond gwrthodais fynd. 12 mis yn ddiweddarach nid wyf wedi cael apwyntiad dilynol yn y clinig."

Uned Feddygol Acíwt Ysbyty Athrofaol y Grange

Yn enwedig i'r rhai oedd yn cael eu hanfon adref yn hwyr yn y nos neu'n gynnar iawn yn y bore, roedd dod o hyd i gludiant adref yn broblem i rai pobl.

"Daeth 1:30yb a ddaeth Dr i fy ngweld, esboniodd ei fod yn haint arennau posibl a rhyddhaodd fi â gwrthfiotigau. Roedd hyn am 1:40yb a doedd gen i ddim ffordd o gyrraedd adref gan fy mod yn byw dros 45 munud i ffwrdd. Gorfod aros wrth fwrdd a chadeiriau mynedfa ysbyty Treforys tan y bore."

Uned Feddygol Acíwt Ysbyty Treforys

Teimlai eraill y gallent fod wedi mynd adref yn gynt pe bai prosesau mwy effeithlon yn eu lle ar gyfer gwirio canlyniadau profion.

"Angen tîm rhyddhau gan y gallai cymaint fod wedi mynd adref pe na baent yn aros am ymgynghorydd i wirio'r canlyniadau."

Damweiniau ac Achosion Brys Ysbyty Cyffredinol Glangwili

Amlygodd rhai pobl y clywsom ganddynt broblemau cyfathrebu rhwng gofal brys a'u meddyg teulu, gyda'r manylion heb eu trosglwyddo mewn modd amserol.

"Cyrhaeddais adref yn y pen draw am 2yb yn yr un boen a heb unrhyw atebion... Yn y pen draw, llwyddodd fy meddyg teulu i ddarganfod bod niwed i'm hiau o ganlyniad i lawdriniaeth."

Uned Feddygol Acíwt Ysbyty Athrofaol y Grange

"Cymerodd 20 diwrnod i nodiadau fynd drwodd at y meddyg teulu."

Gorllewin Cymru

Beth sydd angen digwydd nesaf?

Gwyddom fod llawer o bethau ar waith sy'n nodi'r hyn a ddylai ddigwydd i wneud profiad pawb o ofal brys y GIG yn un da – Mae Cymru Iachach, y Chwe Nod ar gyfer Gofal Brys ac Argyfwng, Dyletswydd Ansawdd, Gofal mewn Adrannau Brys, ac mae Datganiad Ansawdd, a Deddf Llesiant Cenedlaethau'r Dyfodol i gyd yn galw am atebion hirdymor, integredig sy'n canolbwyntio ar bobl.

Mae realiti'r hyn yr ydym wedi'i glywed a'i weld dros y misoedd diwethaf yn ei gwneud yn anodd i bobl weld sut mae unrhyw un o'r ymrwymiadau a'r gofynion hyn yn helpu i wneud pethau'n well i'r rhai ohonom sydd angen gofal brys yn awr, ac yn yr wythnosau a'r misoedd i ddod.

Nid yw gofal brys yng Nghymru yn gweithio i lawer gormod o bobl. Mae angen gweithredu ar frys i adfer ac ailadeiladu hyder yng ngallu ein GIG i ofalu amdanom pan fydd ei angen arnom mewn argyfwng.

Mae angen i bobl wybod:

- **Beth sy'n cael ei wneud i'w drwsio?**
- **Pryd fydd pethau'n dechrau gwella?**
- **Pwy sy'n gyfrifol am sicrhau bod hyn yn digwydd?**

Gwyddom fod pethau'n digwydd yn genedlaethol i ganolbwyntio ar wella pethau. Er enghraifft, mae Grŵp Cynghori'r Gweinidog ar berfformiad a chynhyrchiant yn edrych ar yr hyn y gellir ei wneud i wella pethau mewn gofal brys yng Nghymru.

Gwyddom fod rhai byrddau iechyd wedi treialu dulliau gweithredu newydd, megis gwasanaethau galw i mewn ychwanegol ac unedau mân anafiadau i leddfu'r pwysau ar adrannau achosion brys. Mae eraill wedi gweithio i gyflymu brysbennu neu wella opsiynau trafnidiaeth.

Ond y mater go iawn yw ei bod yn ymddangos i ni fod yr ymdrechion hyn yn dameidiog, nad ydynt i'w gweld yn rhan o un rhaglen gydgysylltiedig ag arweinyddiaeth glir. Yn y bôn, nid ydynt yn gwneud gwahaniaeth yn ddigon cyflym.

Mae Llais yn galw ar Lywodraeth Cymru a GIG Cymru i:

Weithredu ar yr hyn y gellir ei newid yn awr, wrth osod y sylfeini ar gyfer trawsnewid hirdymor.

Canolbwyntio ar weithredu cydgysylltiedig ac atebolrwydd. Mae pobl eisiau:

- Gwelliannau gweladwy – sy'n dangos bod newidiadau'n cael eu gwneud, nid dim ond eu trafod.
- Llinellau amser clir – fel bod pobl yn gwybod pryd y bydd pethau'n gwella a pha gamau sy'n cael eu cymryd nawr.
- Gweithredu cydgysylltiedig – sicrhau bod pob rhan o'r system yn cydweithio ac yn cyflawni canlyniadau.

Darparu arweinyddiaeth ac atebolrwydd clir

- Defnyddio partneriaethau sy'n bodoli eisoes, a mecanweithiau goruchwylio ac uwchgyfeirio i ysgogi gwelliannau gwirioneddol.
- Gwneud cyfrifoldebau'n glir i bawb – pwy sy'n sicrhau bod gofal brys yn gwella, a beth sy'n digwydd pan na chaiff safonau eu cyrraedd.

Lleihau amseroedd aros a gorlenwi

- Gwella cydgysylltu ar draws iechyd a gofal cymdeithasol i atal tagfeydd yn y system.
- Sicrhau fod mannau gofal brys yn hygyrch i bawb, yn canolbwyntio ar ddiwallu anghenion unigol pobl.

Blaenoriaethu urddas a chysur

- Sicrhau fod pawb yn cael gofal a thriniaeth mewn mannau priodol ac urddasol.
- Darparu a chynnal amgylcheddau glân, diogel a chyfforddus sy'n parchu urddas pobl.
- Gwneud y pethau bach sy'n gwneud gwahaniaeth mawr i brofiad pobl, fel bwyd a diodydd a chadeiriau cyfforddus.

Gwreiddio lleisiau pobl mewn newid

- Defnyddio adborth amser real i ysgogi gweithredu a gwelliant parhaus.
- Cyflwyno mesurau perfformiad newydd sy'n canolbwyntio ar y pethau sydd bwysicaf i bobl sydd angen gofal brys.
- Sicrhau bod data gofal brys ar brofiadau a chanlyniadau pobl ar gael i'r cyhoedd fel ei bod yn hawdd gweld yr hyn y mae pobl yn ei ddweud a pha gamau a gymerir mewn ymateb.

Rhannu'r hyn sy'n gweithio

- Rhannu a gweithredu'r hyn sy'n gweithio'n dda i bobl ledled Cymru, nid mewn byrddau iechyd unigol yn unig.
- Symud ymlaen gyda dull "cyfiawnhau neu fabwysiadu", fel bod newidiadau sy'n gwneud i bethau'n well ddigwydd yn gyflymach ledled Cymru.

Credwn fod gan bawb sy'n byw ac yn gweithio yng Nghymru ran i'w chwarae i helpu i wella ein GIG. Yn Llais, byddwn yn gwneud popeth o fewn ein gallu i ysgogi'r gwelliant sydd ei angen fel bod pobl yn cael y gofal a'r driniaeth sydd eu hangen arnynt lle a phryd y mae arnynt ei angen, ac yn y ffordd y maent ei angen.

Atodiad: Ymweliadau a wnaed

Ysbytai yr ymwelwyd â hwy

Rhanbarth Caerdydd a Bro Morgannwg
Uned Asesu Ysbyty Athrofaol Cymru
Adran Damweiniau ac Achosion Brys Ysbyty Athrofaol Cymru
Uned Mân Anafiadau Ysbyty'r Barri

Rhanbarth Cwm Taf Morgannwg
Adran Damweiniau ac Achosion Brys Ysbyty'r Tywysog Siarl
Adran Damweiniau ac Achosion Brys Ysbyty Brenhinol Morgannwg
Uned Mân Anafiadau Ysbyty Cwm Cynon
Adran Damweiniau ac Achosion Brys Ysbyty'r Tywysog Siarl
Uned Mân Anafiadau Ysbyty Cwm Rhondda
Adran Damweiniau ac Achosion Brys Ysbyty Tywysoges Cymru

Rhanbarth Gwent
Uned Feddygol Acíwt Ysbyty Athrofaol y Grange
Adran Damweiniau ac Achosion Brys Ysbyty Athrofaol y Grange
Uned Mân Anafiadau Ysbyty Ystrad Fawr
Uned Mân Anafiadau Ysbyty Nevill Hall
Uned Mân Anafiadau Ysbyty Brenhinol Gwent
Uned Mân Anafiadau Ysbyty Aneurin Bevan

Rhanbarth Gogledd Cymru
Uned Feddygol Aciwt Ysbyty Gwynedd
Uned Feddygol Aciwt Ysbyty Glan Clwyd
Uned Feddygol Aciwt Ysbyty Wrecsam Maelor
Adran Damweiniau ac Achosion Brys Ysbyty Gwynedd
Adran Damweiniau ac Achosion Brys Ysbyty Glan Clwyd
Adran Damweiniau ac Achosion Brys Ysbyty Wrecsam Maelor
Uned Mân Anafiadau Ysbyty Penrhos Stanley
Uned Mân Anafiadau Ysbyty Bryn Beryl
Uned Mân Anafiadau Ysbyty Alltwen
Uned Mân Anafiadau Ysbyty Tywyn
Uned Mân Anafiadau Ysbyty Llandudno
Uned Mân Anafiadau Ysbyty Ysbyty Dinbych
Uned Mân Anafiadau Ysbyty Treffynnon
Uned Mân Anafiadau Ysbyty Cymunedol yr Wyddgrug

Rhanbarth Castell-nedd Port Talbot ac Abertawe
Adran Achosion Brys Ysbyty Treforys
Uned Feddygol Acíwt Ysbyty Treforys
Uned Mân Anafiadau Ysbyty Castell Nedd Port Talbot

Rhanbarth Powys
Uned Mân Anafiadau Ysbyty Coffa Victoria
Uned Mân Anafiadau Ysbyty Cymunedol Ystradgynlais
Uned Mân Anafiadau Ysbyty Coffa Rhyfel Sir Frycheiniog (Aberhonddu)
Uned Mân Anafiadau Ysbyty Coffa Rhyfel Llandrindod

Gorllewin Cymru
Ysbyty Cyffredinol Glangwili
Ysbyty Cyffredinol Llwynhelyg
Ysbyty Cyffredinol Bronglais
Ysbyty Cyffredinol y Tywysog Philip
Canolfan Gofal Integredig Aberteifi
Ysbyty Llanymddyfri

Diolch

Diolchwn i bawb a roddodd o'u hamser i rannu eu dirnadaeth, eu barn a'u profiadau gyda ni am ofal brys.

Adborth

Byddem wrth ein bodd yn clywed eich barn am y cyhoeddiad hwn, ac unrhyw awgrymiadau ynghylch sut y gallem fod wedi'i wella, fel y gallwn ei ddefnyddio i wneud ein gwaith yn y dyfodol yn well.

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