Welsh Ambulance Services University NHS Trust

Duty of Quality Annual Report 2023-2024

GIG CYMRU NHS WALES

Ymddiriedolaeth Brifysgol GIG
Gwasanaethau Ambiwlans Cymru

Welsh Ambulance Services
University NHS Trust

Version 1.0
Released: 19th July 2024

by Quality, Safety & Patient Experience Team

Contents

To Support.
To Serve.
To Save.

Welsh Ambulance Services University NHS Trust

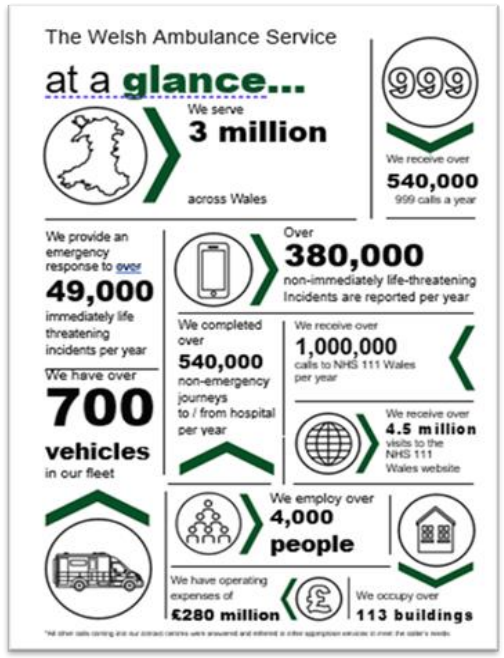
Introduction

We are pleased to present our first annual Duty of Quality Report, sharing with you information that describes the quality of services we provide, the systems in place to identify and implement improvements and the story of our journey through 2023-24.

The Health & Social Care (Quality & Engagement) (Wales) Act 2020 came into force in April of 2023. While this new legislation places a Duty of Quality and a Duty of Candour upon the Trust, the wider NHS in Wales and our Ministers, providing person-centred, positive experiences for our service users and our teams has been central to our culture at WAST for far longer.

Our Quality Strategy focuses on continuous improvement as a quality driven clinically led organisation. We are committed to hearing our communities voice and working collaboratively across NHS Wales to improve the services you receive, ensuring our leadership teams and systems of work enable our people to provide excellent care and experiences across our range of services. We are incredibly proud of the people who work for WAST, either as employees or volunteers, to help care for the population of Wales but we know there are always opportunities to improve. You have told us about the challenges you have experienced and we are working hard across the organisation to respond to this feedback, identifying new and innovative ways of working to help improve your experience and those of our teams. We look forward to hearing from you telling us what you think of our report and also for feedback on any areas you think we could improve in what we do.

Thankyou for taking the time to read this report and learn about our organisation's performance.



Liam Williams
Executive Director of Quality & Nursing

Bethan Evans
Non-Executive Director

The Welsh Ambulance Services University NHS Trust is made up of **three key points of access** for our patients;

- 999 Emergency Medical Services
- Ambulance Care including our Non-Emergency Patient Transport Service (NEPTS)
- Integrated Care which supports remote clinical decision making such as NHS 111 Wales and our Clinical Support Desk

The Trust also supports volunteers: Community First Responders (CFRs), Co-Responders and Uniformed Responders to provide additional response resource to emergency calls and a volunteer car service to aid patient transport to planned appointments.

This is our first annual report linked to the new Duty of Quality, it is aimed at informing our service users and stakeholders about our quality journey, what steps we have taken to improve, the progress we have made and the challenges we have experienced along the way. As this is our first report of this kind, we have also included information about the services we provide and how we monitor the quality of these services.

Over the next year we will introduce 'Always On' reporting that will provide regular quality updates throughout the year and will link each annual quality report together.

Elements of the report will also be produced as an interactive video in English and Welsh.

What is Quality?

The Health & Social Care (Quality & Engagement) (Wales) Act 2020 came into force from 1st April 2023. This new law includes the Duty of Quality and defines quality as:

'Continuously, reliably and sustainably meeting the needs of the population we serve'

This includes but is not limited to the effectiveness of health services; the safety of health services; and the positive experience of individuals to whom health services are provided.

We use 12 Health & Care Quality Standards as a framework to guide and measure quality across the services we provide to the population. The 12 Quality Standards include 6 key enablers to help deliver against the 6 domains of quality (safe, effective, efficient, person centred, equitable and timely care to our population).

The approach promotes;

- Leadership and culture focused on good quality
- A workforce that has the skills and knowledge to meet the needs of the population
- Quality driven decision-making supported by digital capability
- A positive quality culture where learning through feedback, knowledge from our information systems and research is embedded in everything we do.
- Quality outcome measures that guide practice, identifying best practice and where there may be a risk or need to improve.
- A System-wide approach to quality and strengthened Quality Management Systems

Trust Approach

We have a network that enables all teams to communicate, the network is made up of staff from across the business, several different groups and committees, collectively known as our governance infrastructure. Our Quality, Patient Experience & Safety Committee provide assurance to our Trust Board on the Duty of Quality.

The governance infrastructure is supported by digital tools & systems to help us collaborate, monitor, and report on the services we offer to the population of Wales.

By doing this, we can share quality information and intelligence in a timely manner, identify best practice, risks and/or priorities for improvement, or it may be just for reporting purposes.

Our website includes information on our services, our committees and our Trust Board. You can also find documents and papers that have been discussed and the decisions we have taken over the last year. There is also a section dedicated to our response to the Duty of Quality.

Our Quality Management System

Our Quality Management Group encompasses quality and clinical improvement leaders from across the Trust who collaborate with leaders from keys service areas. This collaborative approach provides assurance against the quality requirements of the Health & Social Care (Quality & Engagement) (Wales) Act 2020 to ensure the Trust is compliant against the Duty of Quality, Duty of Candour and Citizen Voice.

The group undertakes this through considering a range of information, intelligence, and insight to promote improvement efforts & learning, and to mitigate risk. The group also enhances floor to board governance through development, delivery, and support of quality management systems, enabling effective quality management across the leadership level. This approach enhances our responsiveness to quality matters and ensures we consider quality at the heart of our decision making.

Quality & Performance Monitoring

The Trust is subject to a high level of external scrutiny through the Welsh Government accountability arrangements. EMS, NHS 111 Wales and NEPTS are services commissioned by Health Boards.

The majority (90%) of our workforce, work within our operational teams where there is evidence of robust practice and quality management processes in place. The focus for the Quality and Performance Management Steering group is to support both internal and external scrutiny, ensuring the spread of good practice and that the approach of local quality and performance frameworks is consistent across the Trust.

Assurance of our Quality & Performance Management Framework is provided to the Trust Board via regular updates to our Audit Committee.

The recent Audit Wales Structured Assessment(2023) stated:-

"The Trust's Performance and Quality Framework, approved in March 2022, is comprehensive and sets out clear roles and responsibilities for staff. The Quality and Performance Management Steering Group oversees the ongoing development of the framework which includes trialling and reviewing best approaches for effectively incorporating the new requirements placed by the Duty of Quality and Duty of Candour. Despite this, operational performance remains extremely challenged due to increased demand, wider system pressures and the consequential inefficiencies. Together, these challenges are leading to avoidable patient harm."

Quality Framework

Our organisational Quality, Performance and Management Framework provides a quality policy for the organisation setting out the building blocks for continual improvement. Our quality management system is built around these principles and aligns to the guidance set out by Welsh Government.

The Trust has completed an organisation wide self-assessment against the "organisational requirements" and has an associated work programme, that the Quality & Performance Management Steering Group is responsible for delivering.

Quality Management System in action

Quality Control

We have systems to monitor the quality of our services, identifying issues, promoting learning, identifying improvement and corrective actions.

The systems we use enable "Always On " reporting, to collect, analyse and monitor quality-related information and measures.

Systems such as

- Computer Automated Dispatch (CAD)
- Medical Prioritisation Dispatch System (MPDS)
- Emergency Communication Nurse System (ECNS)
- Datix Cymru
- Docworks
- ePCR
- Clinical Indicators
- PowerBI

Quality Assurance

We achieve quality assurance using intelligence gained from internal assurance processes and external assurance through validation. The aim is to identify and mitigate risk and assure intelligence to inform improvement priorities using our quality management systems as a vehicle.

Internal sources

- Self-Assessments
- Patient & Staff Feedback
- Clinical Audit
- Non-Clinical Audit
- Patient Reported Incidents
- Staff Reported Incidents (RLDatix)
- Learning from Deaths
- Serious Case Incident Forum
- Risk Registers

External Sources

- Internal Audit
- HIW Inspections
- Welsh Audit Office

Quality Improvement

We actively seek to identify opportunities for improvement. The WAST Improvement and Innovation Network (WIIN) is a cross-directorate network which supports colleagues with their improvement and innovation ideas offering guidance and support with Clinical Audit, Research, Quality Improvement and projects that require a more 'formal' approach.

Each year the Trust supports individuals to attend QI training at both a basic and advanced level.

There are members of the QI team who have gained the Scottish Improvement Leader Award, who can provide coaching, mentorship and support to implement Organisational Quality Improvement.

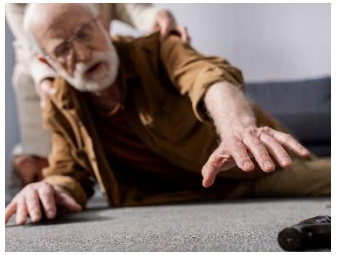
Quality Planning

We ensure all services meet the requirements of the Health & Social Care Act 2020 to meet the needs of the population through quality planning.

The key document that outlines our strategic plans is the Trust Integrated Medium Term Plan (IMTP). The plan is supported by a governance structure to monitor and report progress.

In addition, integrated Commissioning Action Plans are developed jointly with Health Boards to reflect NHS Wales strategic service changes.

Local Directorate Plans are focused on improvements and important changes at a local level that benefit the Trust, patients and Staff.



iStumble

"Non-Emergency staff have reported instances where they have attended routine transport requests to find a patient has fallen, or who falls whilst making their way to the vehicle. In these instances, it is often the process to contact EMS services to assist with patient assessment before getting the patient up. Use of the iStumble tool may assist NEPTS teams to assess and assist non-injury fallers reducing potential workload to the EMS environment and improving patient outcomes by reducing long lies". This training has now been incorporated into the mandatory in-service training for all operational staff.

Quality Agreement Framework

The Trust have developed a Quality Agreement Framework for its Third-Party Providers within Ambulance Care 365 referred to as the three Q's. The Framework allows for the monitoring and measurement of quality against a set of standards in line with the Duty of Quality. Providers will be allocated the appropriate award based on the overall quality and performance of their service provision.

Resource Work Management Portal

"We are in the process of developing a Proof of Concept for a Resourcing Work Management Portal to capture all non-urgent work requests via a single self-service portal. We have recently moved to a new telephone system, which has given us the ability to view call volumes to the resourcing teams, but this doesn't identify work requests made in other ways like email. This portal will also help gather feedback to monitor quality and improve the service if required."

Welsh Language

Having to access our services can sometimes be a stressful experience and so to make people feel at ease it is important to use the Welsh Language wherever possible if this is the patient's preference. This is particularly important for more vulnerable groups of patients. As a result, Welsh Awareness training is now available via our e-learning platform so that all our staff members are aware of the importance of making an 'active offer' of Welsh, wherever possible, and how the Welsh Language standards affect them.

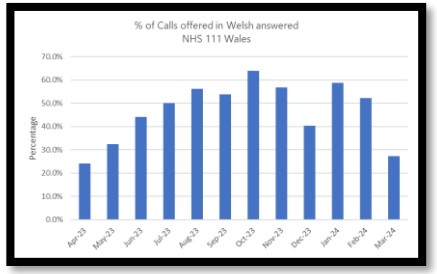
Centralising the Trust's internal translation service with the recruitment of a Welsh Language Translator has increased the Trust's ability to provide bilingual services to our service users.

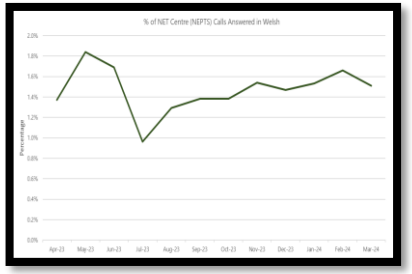
The Standard

On 30 May 2019, the Trust moved from implementing its Welsh Language Scheme under the Welsh Language Act 1993 to implementing new Welsh Language Standards under the Welsh Language Measure (Wales) 2011. As a result, the Trust must implement actions to comply with its Statutory Compliance Notice that was issued by the Welsh Language Commissioner.

Improving our Offer

In 2022 the percentage of NHS 111 Wales calls being answered in Welsh as the service users chosen language had reduced and whilst the number of calls requesting this service was low (less than 1% of 111 calls) the leadership team recognised the importance of the service it provided. As a result, an improvement plan was launched across our NHS 111 Wales service delivery team to improve the numbers of patients able to receive a service in Welsh if this was their preference. In addition, the Trust has developed 65 bilingual symptom checkers which are available on the NHS 111 Wales website allowing users to check their symptoms and receive online advice. In our Non-Emergency Transport centres 19% of our call handlers are Welsh Speakers. In order to improve our offer of Welsh Language call handling we are attempting to increase this to 23% by ensuring an ability to speak Welsh is an essential requirement for recruitment.





Wider Communities

Whilst we are committed to providing an offer in Welsh, we are also aware of the diversity of our communities and the desire to offer services that allow users to communicate with us effectively, particularly in an emergency.

As an organisation all staff have access to live interpreting services from Language Line Solutions® who offer remote on demand interpreting services in more than 240 languages, 24 hours a day, 365 days a year.

We also have arrangements in place with NHS England for British Sign Language service users to call 999 and 111.

The Wales Interpretation and Translation Service (WITS) provide in-person interpreters for events and can provide written translations for patient information such as leaflets.

Duty of Candour

The The Duty of Candour is a legal requirement for all NHS organisations in Wales to be open and transparent with Service Users when they experience harm. When service users have experienced harm whilst receiving health care we are committed to:

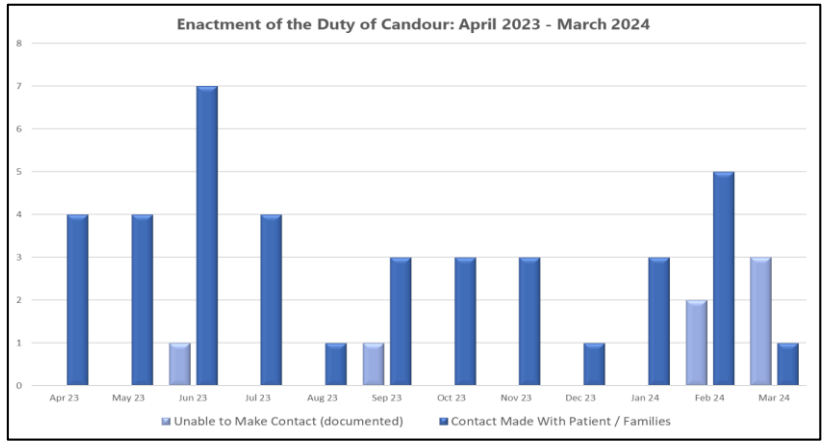
- **Talking to service users and families about incidents that have caused harm**
- **Apologising and supporting them through the process of investigating the incident**
- **Learning and improving from these events**
- **Find ways to stop similar events from happening again**

As an organisation this process was already embedded for Service Users who experienced severe or catastrophic harm. We are now building on these foundations to include those Service Users who experience moderate harm. The goal is to continue to embed a **culture of trust and openness** so that service users can feel confident in the care they receive from us. More information is available in the Duty of Candour section on our internet site.

Next Steps
The Trust recognises that we have more to do in respect of identifying patient harm including the impacts of delays responding in the community and handover of care delays outside hospitals. We have invested this year in our Patient Safety Team to support this, working with patients and families and health and social care system partners.

Notifiable Incidents
The Trust identified 46 patient safety incidents at the Serious Case Incident Forum which were notifiable and triggered the Duty of Candour threshold. A notifiable adverse outcome is any incident whereby harm (moderate harm, severe harm and death) is caused, which is unintended or unexpected and that the provision of the health care was or may have been a factor in the service user suffering that outcome.

The Duty was enacted on all occasions, although we were unfortunately unable to make contact with 7 patients or families, despite exhausting several routes, including contacting Health Board colleagues for contact details and attempting to make contact on multiple occasions.



Monitoring arrangements

Serious patient safety incidents are scrutinised at our Serious Case Incident Forum, which is a multidisciplinary meeting held at least weekly and is chaired by the Assistant Director of Quality & Nursing. Decisions regarding Duty of Candour are considered at the Forum.

Our Putting Things Right Report is presented and discussed at the Quality, Patient Experience and Safety Committee on a quarterly basis and includes details on our enactment of the Duty of Candour. This Report is available via the Committee papers on our internet site.

Listening to our Citizens

We have a dedicated Patient Experience & Community Involvement Team (PECI) which engages with the public, patients, their carers and families to understand how they experience the services provided by the Trust. PECI acts as the patient voice within the organisation – sharing lived experiences and feedback to influence service design and delivery.

The three main activities of the team are:

Patient Experience

- Using surveys to record people's feedback and experiences of using Trust services.
- Using Patient Stories to learn from and improve our services.

Community Involvement

- Meeting people face to face and through online events.
- Listening to people's views to help shape the way we deliver our services.
- Promoting the 'People & Community Network' to offer opportunities for people to become more involved in improving services.

Information & Education

- Signposting and providing information to help people make decisions about their health.
- Educating the public on range of services in the community that can help.
- Educating the public on what to do in an emergency.

We have a long-established record of capturing and listening to patient stories to better understand the people's experiences of what it feels like to use our services. The stories we capture are not just a sequence of events but include the emotional effects of the experience and the storytellers' expectations and needs. These provide a valuable insight into the quality of the healthcare they have received, and their opinion of the services we have provided.

While patient stories can show when we are providing a good service, they will also help to: Allow patients and carers' voices to be heard, encourage reflection, highlight any improvements that need to be made to the services we provide, be used as a valuable tool for staff training and put patients' needs at the heart of service development and improvement.

Stories are shared internally at various committees and our Trust Board. They are also shared, with the appropriate consent, with relevant Health Boards, the ambulance commissioner and NHS Executive. We identify key actions to take because of a story, these are monitored through a story tracker to ensure we are monitoring conversations, actions, and improvements.

Next Steps

We are currently researching opportunities for presenting extended patient experience stories through podcasting to extend the digital reach, particularly for our WAST staff. We are also in the process of launching a dedicated Patient Stories Page for staff on the WAST Learning Launchpad staff training portal.

Virtual Video booth

The Patient Experience and Community Involvement team can visit people to record their stories however, people have the option of recording and submitting their experience story themselves using our Virtual Video booth service. It's easy to use and is the quickest and most secure way to record a story. It works on most computers, tablets and smartphones with built-in cameras and microphones.

Engagement Activity over the Year.

We have continued 'targeted' face-to-face engagement with groups reporting the poorest experiences. Our engagement with the wider population has enabled us to develop ways to align our work with their needs and better understand their expectations.

Quality Assurance – Audit and Inspection

Joint Escalation and Intervention Arrangements
The Cabinet Secretary for Health and Social Care & Early Years determines the escalation status of NHS bodies. This is based on an evaluation by Health Inspectorate Wales, Audit Wales and Welsh Government. We were advised in January 2024 that following the most recent assessment the Trust remained in an unchanged position of 'routine arrangements'.

Inspection
Health Inspectorate Wales (HIW) published a ***'Review of Patient Flow – A Journey Through the Stroke Pathway'*** in 2023/24.

Recommendations for WAST included:
- We should engage with people to better understand the barriers to them accessing, or choosing, from the range of health care services in Wales.
- We must ensure that all relevant staff are fully aware of our Stroke pathway to minimise risks to patient safety.
- We must work collaboratively with Health Boards to identify a consistent approach to ensure handover of stroke patients is made within the Welsh Government 15-minute target.

Our actions to meet these recommendations will be monitored by our Quality, Patient Experience and Safety Committee.

External Audit (Audit Wales)
Audit Wales undertook a review of the ***workforce planning arrangements*** in 2023. The key focus of this review was on the Trust's approach to workforce planning. More specifically it looked at how we manage current and future challenges including monitoring and oversight arrangements.

It stated:
"We found that The Trust is proactively addressing its workforce challenges, based on a strong understanding of risks. However broader workforce transformation is constrained by resource availability."

"Overall, we found that the Trust is taking effective steps to mitigate current workforce challenges and clarify its longer-term strategic vision, however medium to longer-term resourcing is a significant and ongoing barrier."

Audit Wales Recommendations

Hazardous Area Response Team
The Emergency Preparedness, Resilience & Response (EPRR) & Specialist Operations team have undertaken a National Ambulance Resilience Unit (NARU) self-assessment to assess compliance against the English HART standards and develop any internal work programmes to address areas that need to be developed.

Internal Audit
The Trust develops an annual Internal Audit plan in conjunction with Internal Auditors. The plan is risk based, directing reviews to areas where management and our Audit Committee consider there may be potential weakness.

In 2023/24 we completed 18 internal audits across a range of subjects from estates condition to staff retention.

One example is an audit of ***the Senior Paramedic role*** to assess if they are achieving their key role objectives, this report was issued in November 2023.

The audit provided reasonable assurance but identified some areas of improvement including the team distribution to make sure Paramedics and Technicians receive appropriate levels of supervision and support, and monitoring of training compliance ensuring that the required clinical skill enhancements are provided.

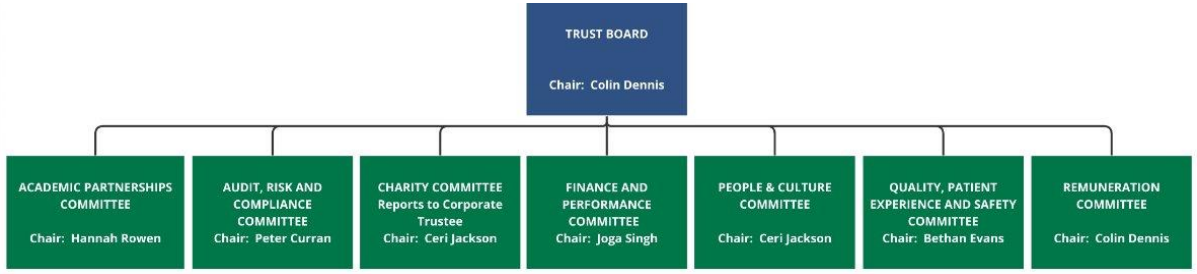
Trust Board and Committees

WAST Trust Board

The WAST board comprises the Chair, Vice-chair and six Non-Executive Directors. The Chief Executive and five Executive Directors are also voting members, with the board also including the remaining four Directors and two Trade Union Partners.

The role of the Board is to focus on key areas of our business and service delivery including our strategy, vision and purpose of the Trust. They shape the culture of the Trust in several ways embedding ethical behaviour, providing visibility to the organisation and by engaging with the staff, public and stakeholders. The Board sets the organisation wide expectations and accountability for quality and performance, and are also responsible for managing risk ensuring there are robust controls in place to mitigate these risks.

The Board is supported by a number of committees who meet in public to monitor our performance and provide assurance on the services we provide. Our Quality, Patient Experience & Safety committee is responsible for the oversight of the Duty of Quality.



Corporate Governance Framework

WAST's corporate governance framework creates a supportive environment where decisions are made transparently, resources are used wisely, and responsibilities and accountabilities are clearly defined. It involves providing strong leadership, guiding the service with a clear vision, maintaining high standards of care and ethics, and fostering a positive and inclusive culture that builds trust among our people, our patients, and our stakeholders. Additionally, it includes having robust controls and processes in place to ensure everything runs smoothly and safely, from our preparedness to respond to change, to our day-to-day operations.

Our board and committee structure is vital to ensure our corporate governance framework is operating effectively, ethically, and responsibly. Regular reviews of these structures ensures our governance remains fit for purpose and demonstrates our commitment to the duty of quality. In addition, the Trust's

Standing Orders and committee terms of reference require that the board and its committees self-assess and evaluate their effectiveness annually.

Emergency Medical Services (999) – How your calls are answered

When you call 999 in Wales and ask for the ambulance service your call will be passed to one of our EMS Coordination Centres, we have three centres located in Llanfairfechan, Carmarthen and Cwmbran. Ideally the call will be routed to your nearest centre but at times of high demand you may be connected with another centre to ensure we answer your call as quickly as possible.

Our qualified Emergency Medical Dispatchers (EMDs) will answer your call and ask you a series of questions to understand where help is needed and what has happened. These questions will not delay help being arranged but ensures that we prioritise our responses to help those most in need first and provide advice over the phone when it is appropriate to do so.

Sometimes sending an emergency ambulance is not the best way to help the patient and you may be told that a clinician will call you back, these are qualified paramedics and nurses who work in our contact centres and can complete an over the phone triage by asking you more specific medical questions. As a result of this clinical triage, you may be advised to see your GP, be given self-care advice or told to attend a minor injury unit rather than an Emergency Department, alternatively the clinical triage may identify that you need a more urgent response and will ensure that your priority reflects this.

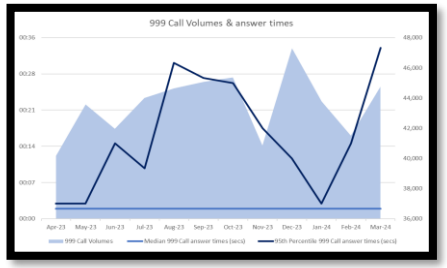
If a face-to-face clinical assessment is required or you need to go urgently to the nearest A&E unit an ambulance response will be sent, we have different types of responses that may be sent to you including Emergency Medical Technicians, Paramedics, Advanced Paramedic Practitioners and Community First Responders.

Accreditation

In September 2023 we achieved Accreditation as a Centre of Excellence for 999 call handling through the International Academy of Emergency Dispatch. WAST has held this accreditation since 2017.

Call Answering

Between April 2023 and March 2024, we continued to take high numbers of 999 calls. On average we answered calls within 2 seconds however some callers waited 34 seconds or longer when demand was high.



LifeX

In April 2023 we updated our system to communicate with EMS responders and across our coordination centres. The LifeX control room solution was implemented as part of a UK wide replacement programme. Welsh Ambulance Services University NHS Trust was the first large scale Ambulance Service to successfully implement this technology in the UK. This allows us to have the most up to date communication technology, with increased resilience and the ability to respond flexibly during periods of disruption.

Learning from Events

In summer 2023, the Operations Quality team developed a new process for the delivery of learning to EMS Coordination staff. Previously, learning which is often identified through concerns investigations, was included in coaching bulletins which were then circulated to staff within the centres. The new approach enables more interactive delivery of learning and development topics, and also enables live monitoring of compliance and competence across the service area. Staff are required to sign off their competence on completion of learning, providing data for monitoring by the quality team and senior managers within the centres, as well as more detailed information about individual compliance. Not only is this a useful way to monitor how learning topics embed, it also provides evidence of learning to key stakeholders where required. The team is continuing to look at other means of training delivery to ensure interactive, engaging and effective means of delivery is maximised.

Emergency Medical Services (999) – How we respond to your calls

The Trust use digital technology to respond efficiently and effectively to emergency calls. When a face-to-face response is required the call details are sent to a vehicle mobile data terminal (MDT) which immediately prompt the crew to go directly to the ambulance (if not already in it), and to travel to the incident. Once the crew press mobile the incident details are voiced to the crew and include the incident nature (i.e., heart attack), the location of the incident, and importantly the response priority of the incident.

The response priority helps the crew to determine the severity of the emergency and if they need to respond to the call with blue lights and sirens. Our Clinical Response Model has four main categories Red (Immediately Life Threatening), Amber (Serious but not life threatening), Green (Neither serious or life threatening, Green HCP (urgent requests from Health Care professionals).

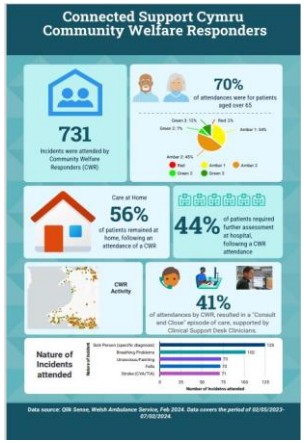
The crew will use the initial call information and any updated information to help them determine what equipment they need to take directly to the patient's side to support their needs, and whether any further support may be needed on scene. On arrival at the incident, the patient is quickly assessed and treated in accordance with the presenting condition. There isn't always a need to convey a patient to hospital, and quite often this isn't in the patient's best interest, so the crew will make every attempt to safely treat the patient on scene or refer the patient to the most appropriate pathway to meet their needs.

EMS and Ambulance Care Quality Days

In December 2023, we introduced the first monthly Operations Directorate Quality Day. This entailed visiting many of the District General Hospitals, outpatient departments and stations to carry out snap audits with regards to Quality.

Microsoft forms were produced to record data on infection prevention control, dress code, seatbelt & restraint compliance and vehicle maintenance. Stations were checked for cleanliness, and general estates functions, there was also a focus on sexual safety.

Information and learning from these audits are shared across directorates through our governance infrastructure.



Community Welfare Responders

In May 2023 we introduced the Community Welfare Responders. The volunteer role of the CWR is to provide a face-to-face assessment of a patient's situation and connect with our remote clinicians in the Clinical Support Desk (CSD) providing the human-touch that healthcare requires. CWRs provide timely access to the right care, they empower our clinicians by providing critically important clinical observations (such as heart rate and blood oxygen levels).

Mobile Data Vehicle Solutions (MDVS)

The Ambulance Radio Programme is working with Trusts across the UK to improve digital technology in our responding vehicles in readiness for a new critical communication system for Great Britain's emergency responders. Our existing mobile data terminals are being replaced with modern, MS Windows-based tablets and wi-fi routers as well as a new software solution, the National Mobilisation Application (NMA). This new software ensures our responders comply with the Road Traffic Act (Regulation 109) and are not distracted by information screens whilst driving. 89% of our Emergency Fleet has been updated with this technology and, as we conclude this work, we are now installing these systems in our Non-Emergency Fleet.

EMS			NEPTS		
Total for Completion	Total Completed	Completed (%)	Total for Completion	Total Completed	Completed (%)
511	456	89.24%	280	11	3.93%

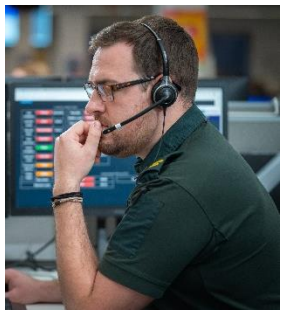
Integrated Care – Clinical Support Desk

The Clinical Support Desk (CSD) is a virtual function located across our EMS Coordination Centres (EMSC) and other satellite locations. The CSD is staffed by nurses, paramedics and mental health clinicians who undertake secondary telephone assessments of patients that have accessed 999.

The principal role of the CSD clinician is to provide clinical assessment, advice, and to signpost patients to ensure that they can access the most clinically appropriate care for their urgent and emergency healthcare needs, known as Consult and Close (C&C) or Hear and Treat (H&T).

Clinicians assess patients remotely using Computer Decision Support Software (CDSS) and advise on the most appropriate clinical outcome for patients, which may include ambulance response or referrals to alternative pathways of care.

In addition to this principal role, the CSD also undertake a range of other clinical functions in pursuance of maximizing patient safety for those awaiting an emergency ambulance and provides support to other staff groups such as newly qualified paramedics, paramedics, and a range of non-clinical responders such as emergency medical technicians, urgent care assistants, community first responders and falls assistants.



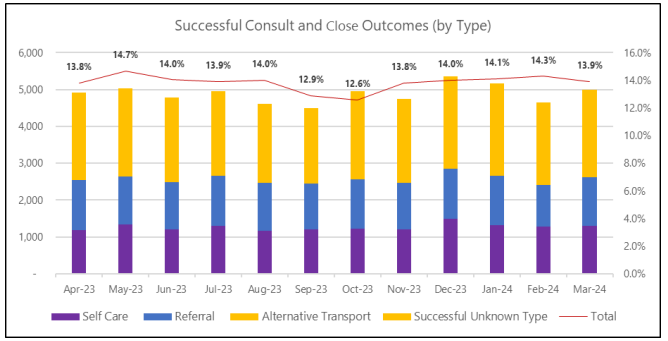
In 2023-24 we have worked to develop and grow CSD services including many exciting pilot projects which will see improvements for 999 services as well as supporting patients to get the right advice and right care.

Inbound Contact Concept
As CSD moved to Remote Clinical Support for Newly Qualified Paramedics, Community Responders and others, we introduced an inbound contact line. We also introduced a brand-new pilot to support Police colleagues waiting for face-to-face clinical assessments for patients as part of collaborative work with our Emergency Services partners.

Emergency Communication Nurse System
This year also saw the team achieve Accredited Centre of Excellence status in the use of ECNS in 999. As the first team ever to achieve this in the UK, this is a true reflection of the excellent work undertaken in CSD in remote clinical assessment and alternative pathway provision for patients in Wales. The ECNS system allows us to undertake Video consultations as well as support remote clinical assessment over the telephone.

Integrating Care
A new process for integrating assessments with clinicians in NHS 111 Wales has been developed which allows for electronic passing of appropriate incidents for clinical review which have not already been referred from the 999 call handling process. Previously a manual process, this has saved hours of manual activity, improved safety by reducing transcription errors and provided improved reporting of calls.

Consult & Close
We are committed to getting patients the right care in the right place, every time. One of the ways we measure this is to review the impact of our Clinical Support Desk. During this period on average 13.9% of 999 calls were resolved through telephone and video triage. We are committed to increasing this performance with a target of 17%.



Integrated Care – NHS 111 Wales

The NHS 111 Wales service is a free to call service which provides over the phone advice and online symptom checkers if you are feeling unwell and you don't know what to do, they also provide the first point of contact for urgent primary care services in Wales and offer information about local health services and different health conditions.

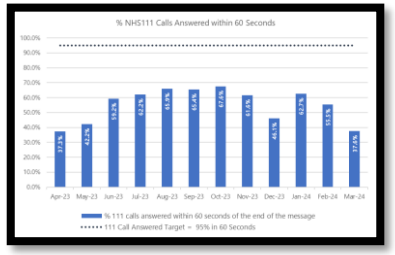
Our call handlers will answer your call and ask you a series of questions to understand what help you need, they may be able to help you straight away or you may need to speak to someone else such as a nurse or paramedic in our NHS 111 Wales contact centres, a dental nurse or a health information advisor. If they can't help you straight away the person you need will call you back as soon as possible.

Our NHS 111 Wales service might tell you how you can look after yourself, advise you to see a pharmacist in your local area, advise you to see your own GP or urgent Primary Care services, they may even tell you to go to a local hospital. If your problem is very serious they will transfer you to the Emergency Medical Services.

The NHS 111 Wales website can help you find services near you, access online symptom checkers which will provide you with information and advice or provide health information and information about your local health board services.

Call Answering

The time it takes to answer your call is a key part of a positive patient experience and helps to provide confidence in the service we provide. Over the last 12 months we have worked to improve our call handling performance, answering more calls within 60 seconds and reducing the numbers of calls abandoned by our callers. We still have improvements to make in order to meet our target, but we have seen greater stability in our service provision during winter months as a result of initiatives to make our teams more efficient and reducing our turnover of staff.

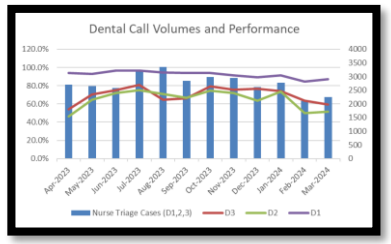


Call Prioritisation Streaming

We are working with an experienced clinical decision support system provider to develop the Call Prioritisation Streaming System (CPSS) for use in our NHS 111 Wales contact centres. Our existing system has been in operation for over 20 years, originally as part of NHS Direct Wales, and has been used as the basis to develop an updated, assured, safe and modern system. Using LowCode™ software to support the system will provide a robust auditable system to ensure quality assurance and learning improvements across our NHS 111 Wales service.

Virtual Queue

In an effort to improve service user experience when waiting to be answered we are trialing a new virtual queuing function. This will allow service users to hold their place in the queue whilst waiting to be connected through an automated ring back process.



Dental Calls

We have worked with our teams to improve the way in which we support dental services to improve the experience of our patients. This has included reviewing the way we roster our dental teams and training our general clinicians (both paramedics and nurses) to be able to support dental patients better. We have also reviewed our procedures and monitoring arrangements to ensure that our teams as well as our patients have improved experience. Different Health Boards commission different dental services so we are now working with the Six Goals programme to better determine Emergency Dental needs to make sure we can target these valuable services effectively. Improving access to emergency dental services 24/7 across the whole of Wales.

Ambulance Care – Non-Emergency Patient Transport

Our Non-Emergency Patient Transport service (NEPTS) operates from three Booking Centres coordinating and providing a service for patients across Wales who are unable, for medical reasons, to make their own way to and from their hospital appointments. There is an eligibility process (Patient Needs Assessment) that is used to assess all patients that request Ambulatory transport to ensure the limited resources are allocated to those patients with a medical need first.

Ambulance care have a range of vehicles that can be used to take a wide range of patients including those who need stretchers, who use wheelchairs or have limited walking mobility. For patients able to travel by car, the service uses a dedicated team of Volunteer Car Drivers, community services and private taxi services.

Cancellations
The service has worked closely with Health Boards to redesign systems and processes to reduce the number of cancellations processed and the negative experience caused to patients. This includes the introduction of a dedicated cancellation line so that services users don't need to queue when cancelling their booking.

We have also reviewed our text reminder service so that the reminder messages our patients receive are most helpful.

Performance Standards
We have reviewed our performance standards during this period and have introduced back stop measures for our Renal and Oncology patients to focus not only on arrival times but on long waiting patients.

Quality Dashboard
In order to develop and enhance our Quality Management System we have introduced a quality dashboard that brings together our workstreams with a quality focus. This is reviewed monthly as part of our governance infrastructure and is shared across the broader operational leadership teams.

Citizen Voice
Patient experience reports are telling us that some people feel they are waiting too long for transport to take them home after their hospital appointment. We are looking into this feedback to see which category of patients are experiencing long waits, from initial findings people attending outpatients are reporting unhappiness with the length of time they are waiting to go home. From April 1st we are changing the questioning on the experience survey to include an option for people to tell us more information as to why they answered the way they did.

Patient Safety
Following an incident in April 2021, where a patient was not secured within the vehicle appropriately, we have been working to improve our monitoring of safe systems of work. Close monitoring of seat belt use and compliance is achieved in Ambulance Care via programmed and mandatory all Wales vehicle spot checks taken by Operational Team Leaders. These spot checks are reviewed via a reportable data collection sheet which is collated with patient feedback forms specifically targeting seat belt compliance activity and is reported through our Quality Management System. Signs in each vehicle also highlight the importance of correct use of seat belts.

Quality Impact Assessments

The Trust use Quality Impact Assessments (QIAs) as a tool to understand the impact any decisions we make could have on the quality of the services we provide. These assessments are aligned to our 12 Health and Care Quality Standards.

During the period April 2023 to March 2024 18 service changes were approved through our senior leadership teams because of these impact assessments.

The types of decision being supported in this way include service improvement initiatives, patient safety improvements based on the latest evidence available, and activity to make sure we are using the public finances efficiently.

The Duty of Quality requires NHS bodies like the Welsh Ambulance Services University NHS Trust to ensure all our strategic decisions are made with the intention of improving the quality of health services and outcomes for the people of Wales.

Dyletswydd Ansawdd
Duty of Quality

GIG CYMRU NHS WALES

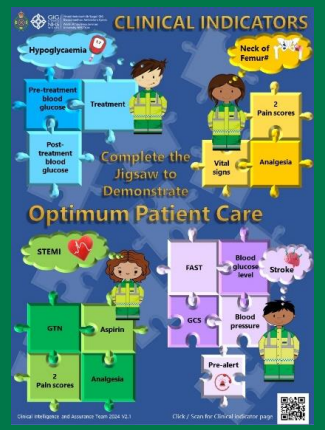
Connected Support Cymru (Luscii Pilot)
LUSCII is digital health software that has been introduced to enable the remote monitoring of patients accessing 999 that are deemed clinically suitable. LUSCII can assist the Clinical Support Desk based in the Trust Coordination Centres in enabling patients to get the right care, in the right place, every time. The Patient, supported by carers within specified Care Homes, is connected using wearable digital health software to the Clinical Support Desk in the Coordination Centres. This enables the CSD to undertake remote clinical assessment and monitoring, helping informed clinical decision-making and identification of suitable patients for referral into community-based teams within specific Health Board areas.

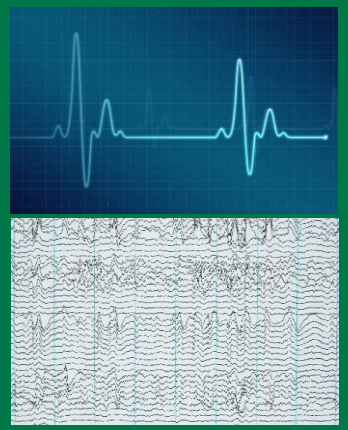
Stroke (CVA) Intervention
The Trust have recently made changes to its software system used to prioritise 999 calls, particularly those relating to symptoms that indicate a stroke. The change has incorporated the recommendation of the National Stroke Network advising that the Stroke window of intervention should increase from 5 hours to 12 for specific intervention i.e., the use of 'clot busting' (thrombolytic) drugs. Once outside the window of intervention the risks of the treatment start to outweigh those benefits.

Obstetric Red Phone
The Trust has introduced a new dedicated WAST Red Emergency Line direct to a healthcare professional within the obstetric unit in a couple of Acute Trusts obstetric units across Wales, with plans to expand to all Acute Trusts. This will improve communication during maternal/neonatal incidents, which will ensure that the ongoing care and transfer into the maternity/ obstetric unit is safe, and the patient(s) are conveyed to the most appropriate place, in a timely manner, with the correct teams informed. reducing any delay in accessing specialised maternity/ neonatal care which is considered a safety RISK for both the Ambulance service and for women, birthing people and neonates who may need immediate time critical interventions.

NHS Wales National Clinical Audit Programme
NHS Wales has set out a programme of national clinical audits. These are a series of measurements against an evidence-based standard, a patient must have been diagnosed with a specific condition to be able to undertake an audit. The range of diagnostic tests available to ambulance clinicians are limited, and do not reflect the types of tests available within a hospital site (such as a scan for stroke, an x-ray for a hip fracture, or an angiogram for a blocked coronary artery). However, ambulance clinicians are able to determine a clinical impression through history-taking and examination, which allows a patient to follow a particular pathway. Once a diagnosis is made, ambulance data from our clinical record is available to feed into the national audit information.

WAST has developed a separate programme of clinical audits and clinical indicators that enable us to measure audit compliance against a range of clinical conditions. These include Stroke pathways, and a pathway to treat suspected heart attacks. The Clinical Audit Plan is approved by our Quality, Patient Experience & Safety committee who monitor progress on a quarterly basis. We regularly monitor clinical indicators and audit outcomes to identify clinical improvement initiatives.



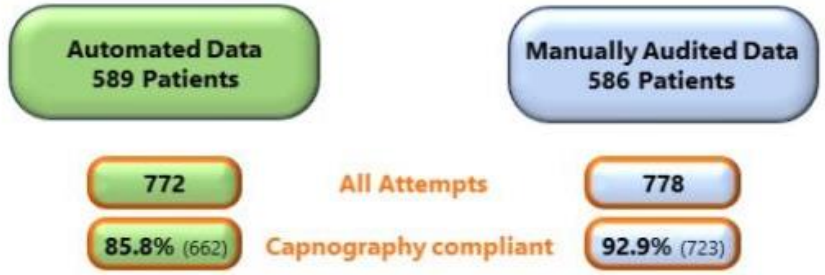


Clinical Audit

Included in the Trusts 2023/24 Clinical Audit Plan were two audits that supported improvement initiatives. These were for End tidal Carbon Dioxide (EtCO2) monitoring for advanced airway management, and the appropriate administration of Methoxyflurane (Penthrox®) an inhaled pain-relieving medicine to assist with pain management in trauma.

Pain Management
Penthrox® is an inhaled pain-relieving medicine that is self-administered by patients. It can be used by alternative responders working for WAST as well as WAST clinicians, improving patient care and pain relief for patients suffering traumatic injuries. Penthrox® was introduced in May 2023 once staff had completed the appropriate training. A clinical audit was planned to evaluate the safe and effective care for patients who were administered this medicine. Good practice was identified with 95.7% of patients administered Penthrox® within the protocol, there were no significant issues identified for those outside of protocol. Lessons learnt included the need to improve documentation of pain scores.

Airway Management
Ensuring that patients have a clear airway is essential and is the first step when attempting resuscitation. In many situations, an advanced approach is required by our clinicians to manage a patients airway using equipment such as an endotracheal tube (breathing tube). To ensure that the advanced equipment is correctly inserted and effective, a device is attached to measure carbon dioxide that the patient breathes out. This is known as End tidal Carbon Dioxide (EtCO2) monitoring. The clinical audit provided reassurance that 92.9% of patients who had advanced airway management, had this documented on the clinical record. This audit contributed to the development of a dashboard to enable compliance to be viewed promptly and provide opportunities for improving clinical practice and patient care when required.



Learning from Deaths

Mortality Reviews

Mortality reviews are a means of identifying problems in healthcare and areas of care which could be improved, such as early recognition and escalation of the deteriorating patient, and appropriate and timely end of life care. Reviews often highlight aspects of excellent care also, and it is important that learning from both areas of excellence as well as those in need of improvement, are shared across the Trust and the wider healthcare system. Our Serious Case Incident Forum reviews any cases of concern and report cases externally as a serious incident when appropriate.

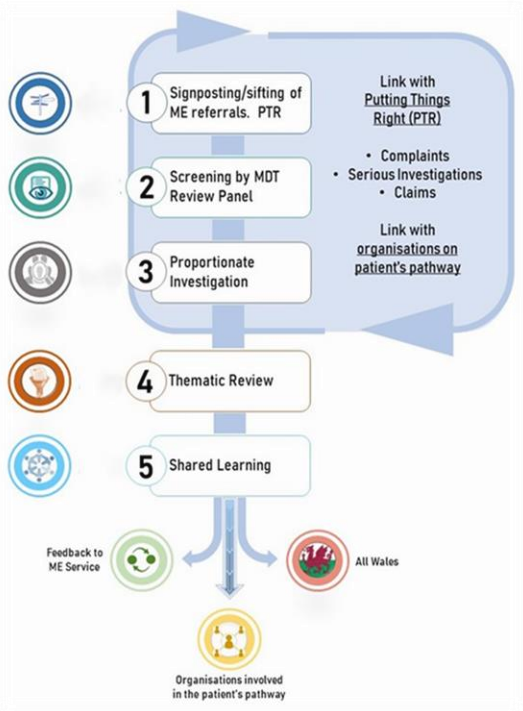
Next Steps

A multidisciplinary panel will be established from April 2024 to undertake the scrutiny of all referrals from the Medical Examiner and escalate as required to ensure a proportionate investigation occurs.

The Medical Examiner Service focus has been on deaths in acute care. From April 2024 the service becomes a statutory body and all deaths, apart from those referred to the Coroner, will be reviewed by the Medical Examiner Service, including community deaths.

National Medical Examiner Service

The National Medical Examiner Service provides independent scrutiny of all deaths that are not investigated by the coroner. A medical examiner is an experienced doctor with additional training in death certification and the review of documented circumstances of death. The Medical Examiners ensure that an accurate cause of death is recorded, identify any concerns surrounding the death itself which can then be further investigated if required, and take the views of the bereaved into consideration. The Medical Examiner will contact the Trust to raise any concerns from their reviews or to request information to inform their reviews.



Learning from Deaths Forum

The Trust's Learning from Deaths Forum has been recently established and will receive information on patient deaths from a number of sources and will consider strategies to improve patient safety and reduce avoidable deaths. This includes information received from Health Boards, Coroners and the outputs of the reviews of the Medical Examiner referrals at the Scrutiny Panel. Identifying any patterns, themes and trends through collective analysis will be a key function of the Forum.

Additionally, the Forum will oversee the implementation of the final version of the All-Wales Mortality Reviews Framework (learning from deaths) which is expected to be released by the NHS Wales Executive in April 2024.

As a national service the Trust is in an excellent position to identify learning and share this on a national basis. Examples of learning shared through this process to improve care include end of life care pathways which we share with our dedicated Palliative and End of Life Care Team. Key themes and trends from the feedback from the Medical Examiner Service following their interactions with families includes our timeliness to respond and handover of care delays at hospitals.

Our Putting Things Right Report is presented and discussed at the Quality, Patient Experience and Safety Committee on a quarterly basis and includes updates on the work of the Forum and this Report is publicly available on our internet site.

Our Patients Story

Required Action

1.Undertake **further review/discussion** to ensure opportunities for promoting equality and human rights for people with protected characteristics is recorded.
2.**Continue engagement with BCUHB** to action identified learning
3. **Undertake appraisal** with view to improving ability to flag records that patients have additional needs (LD, autistic and neurodiverse) on telephony systems and patient records/addresses.
4. Disseminate **up to date information** to HCPs on contact numbers, access routes
5. PECI to **capture PREMs** data of callers/patients with LD
6. Improve ability to capture LD data
7. Explore opportunities for LD expert within WAST/CCC
8. Explore training requirements of Mental Health Practitioners on LD and pathways

Progress

1. Change request submitted to make **improvements to EPCR** to record additional needs and reasonable adjustments
2. Funding application submitted to RCN Wales for video to train staff on best practice during observations and inform patients
3. Continued promotion of Paul Ridd online training modules

Themes

1. Lack of **clarity** regarding HCPs being able to request NEPTs Transport sooner than 24 hours notice
2a. Concern that the structure of the **999 script (AMPDS) is not flexible** - It does not have sufficient capacity to assess people with learning disabilities
2b. Each time a repeat call is made it 'wipes the slate clean'
3a. System pressure contributing to delayed responses to 999 amber calls
3b. Failings happened because **planned care became an emergency**

Alison's Story

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

Outcome

1.Prototype solution funded by Improvement Cymru LD team
2. 67.8% staff have completed Paul Ridd LD training
3. LD module on WAST's OnClick page completed by 642. Compliments the mandatory Paul Ridd foundation training.

Our Peoples Story

Required Action

1.Increase **cultural competencies**
2.Embrace **Anti-racist** stance and recognise that it is not enough to just not be racist
3.Continued delivery of **Allyship** programme and development of **Bystander** Training
4.Amplify employee **voices**
5.Recognise that this culture has an **adverse effect** on mental health, recruitment and retention
6.Ensure we consider access to prayer facilities at events, roadshows and development programmes

Examples

1.No suitable space for **prayer**
2.*"You don't **look** like you're from Cardiff"*
3.Adapting "Fatehullah" to **"Faz"**

Next Steps

1.Consider reviewing **bank holiday** provision (recognising these are tied to Christian holidays) and explore the possibility of implementing a more flexible approach
2.Further publicise and promote our colleague **networks**
3.Ensure we are pursuing our **Strategic Equality Objectives**

Themes

1. Lack of understanding regarding **faith**
2. Lack of understanding regarding **micro-aggressions**
3.Colleagues having to adjust and adapt to **fit the organisation**

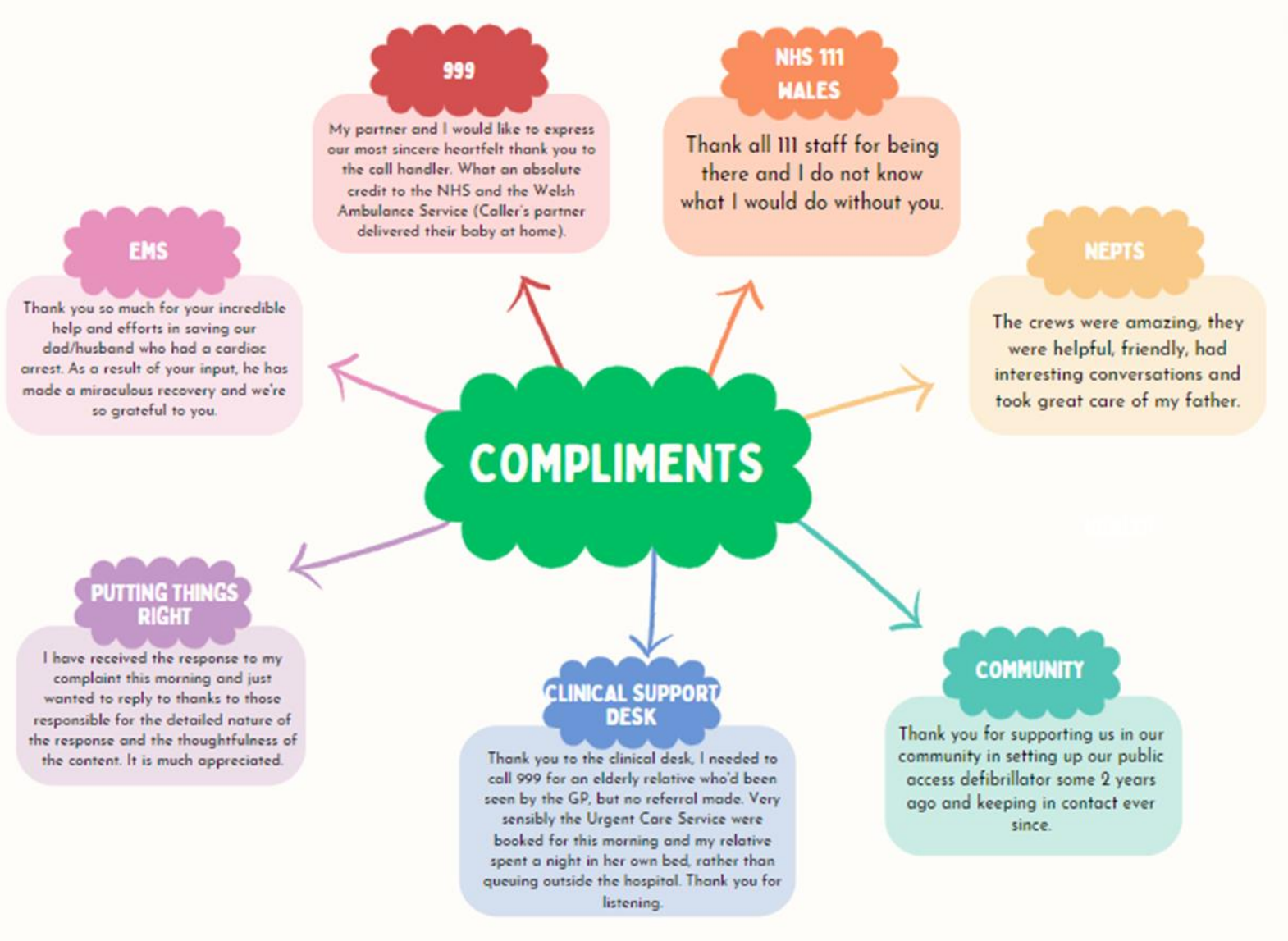
Fatehullah's Story

Given that our engagement activities have highlighted instances of discrimination, we invited one of our Corporate colleagues, **Fatehullah Tahir**, to share his experience of working in an organisation lacking in diversity in terms of ethnicity and faith. Fatehullah is a well respected member of the People and Culture Team and whilst the experiences he described are particularly uncomfortable, he has never asked for action to be taken. The themes shared highlight how important it is to continue listening to colleagues' experiences and recognising that we still have so much to learn. Providing and creating space and developing trust is crucial, so that our people feel safe to share other examples of discrimination and micro- aggressions.

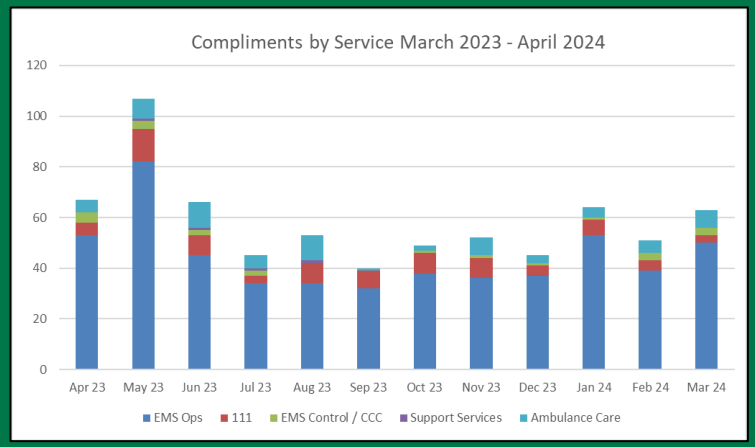
How is Faz now?

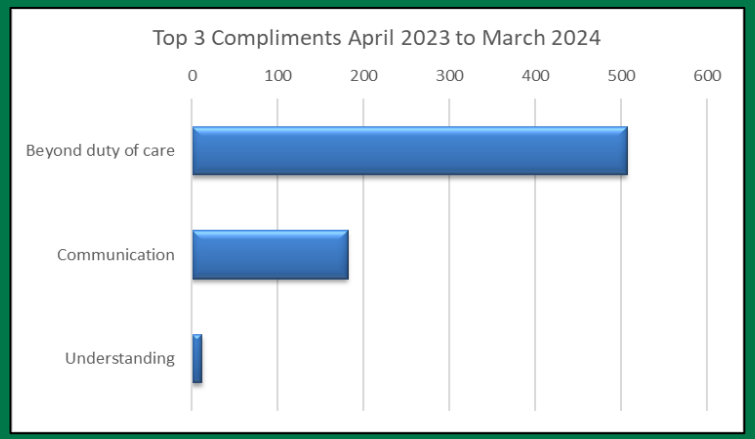
Faz feels it was helpful to share his story which was extremely powerful for colleagues to hear but fundamentally, nothing has changed in the system. Faz is not unhappy at WAST and whilst he's pleased to see these issues being taken seriously, he like the rest of us, is aware that this kind of change is slow.

Compliments



It is important for us to know when something has worked well. This information could assist us in sharing good practice and improving services and is also great for our teams to hear. There will of course be a significant number of compliments that our teams receive on a daily basis which are not necessarily captured in our systems.





Summary Health and Care Quality Standards


WG23-13

The Duty of Quality Statutory Guidance 2023
and Health and Care Quality Standards 2023

The Health and Social Care (Quality and Engagement) (Wales) Act 2020
The Health and Social Care (Community Health and Standards) Act 2003

Date of issue: 1 April 2023

Gweithlu Workforce

Commitments to our people

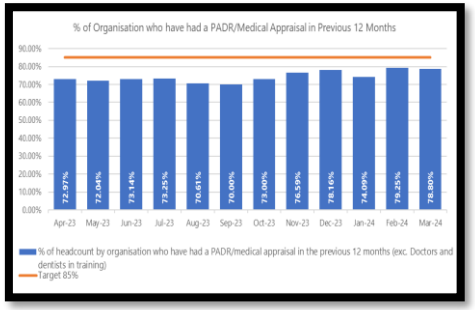
In our 2023-26 Integrated Medium-Term Plan we made a clear commitment to our people to address three key issues that came through feedback from them during engagement opportunities. These key issues were reducing shift overruns which occur primarily due to delays handing over patient care at Emergency Departments, improving their digital experience and improving opportunities for flexible working. Initiatives to improve these areas have made progress but from the feedback staff and volunteers have given us again this year we know these are still as important to them and we have further work to do.

Staff Stories

We have continued to work with a range of healthcare professionals, WAST staff and WAST volunteers to record their experiences as staff story videos. These staff stories highlight the challenges and positive experiences of working for the Trust. They are shared internally with the 'People and Culture' Committee and demonstrate areas of good practice, learning opportunities and organisational partnership working.

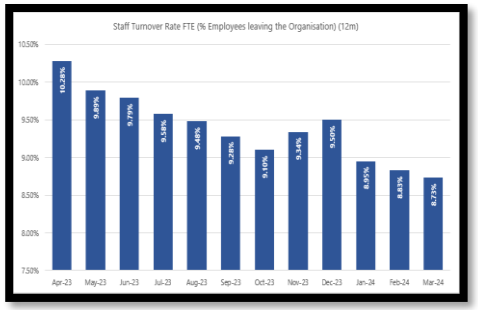
Personal Appraisal Development Review (PADR)

Our Quality & Performance Monitoring Framework requirements stipulate every member of staff should receive 1to1 feedback and an annual Personal Appraisal Development Review. Challenges achieving this include long term abstraction such as maternity leave or sickness absence. During 2023/24 we have worked to move closer to our target of 85%



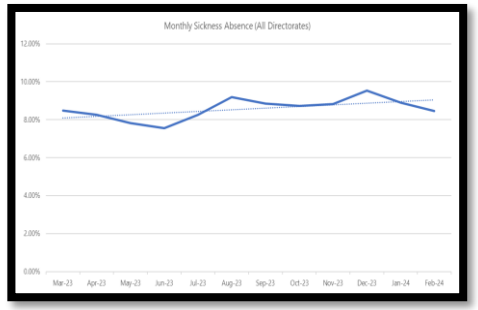
Staff Retention

The number of staff leaving the organisation has reduced throughout the year reporting a 2 year low of 8.8% in March 2024. We continue to focus on staff wellbeing with a number of initiatives in place to help our teams access support. Our wellbeing teams have introduced a new clinical record system that will improve our data around staff wellbeing themes so that we can provide more targeted support in the future.



Sickness Absence

A key workforce area which impacts our ability to deliver high quality services is sickness absence. Having seen an initial improvement during the first quarter of 2023/24 our sickness absence increased between July and December 2023 before improving again in the early months of 2024, some of this is likely to be attributed to seasonal illness. Absence rates are higher amongst our EMS staff and within our contact centre environments. There continues to be a focus on wellbeing activities across all areas of the Trust and in general there has been a downward trend in sickness absence over the last 2 years.



Diwylliant Culture

Throughout the 2023-24 period, our focus has remained on creating a workplace environment characterised by retention, growth, inclusivity, compassion and ethical conduct. At the core of our initiatives is the People and Culture Plan which articulates WAST's cultural aspirations, values and behaviours.

Building on this foundation, we have committed to strengthening employee voice and developing a culture of psychological safety.

Engagement

The introduction of the hive digital engagement survey platform has provided a robust mechanism for capturing invaluable insights and feedback from our employees, enabling us to continuously refine our practices and policies in response to feedback.

Freedom to Speak Up

Our commitment to creating a workplace where individuals feel safe and empowered to speak up has been demonstrated through the launch of the Freedom to Speak Up platform and the establishment of organisational Guardians. Complemented by the WAST Voices Network, these initiatives support in developing a culture of trust, transparency, and accountability, enabling individuals to voice concerns and contribute innovative ideas.

WAST Voices Network

The Voices Network is an employee-led network of advocates set up to provide a safe space for those with lived experience of inappropriate or discriminatory behaviour, bullying or harassment, to better understand the barriers to speaking up and to signpost colleagues to appropriate support.

Cultural Early Warning Score (CEWS)

Understanding whether our teams have a positive workplace culture can be difficult for our leaders and managers. To help make culture more tangible, the People and Culture team have developed a toolkit for managers which guides them through the process of culture change within their team. The CEWS tool uses indicators to help assess the cultural health of the team and is designed as an initial assessment to prompt more in-depth conversations about team culture and potential actions.

Sexual Safety

In 2022 we undertook a survey to understand sexism and sexual safety in the WAST workplace. As part of our commitment to change we shared our story with the media and in August 2023 BBC Wales interviewed a number of WAST staff on this subject. In November 23 we launched our Sexual Safety Guiding Principles, which were developed by our WAST Voices Network. These principles include actively working towards the eradication of sexual misconduct in the workplace and capturing data on prevalence and colleague experience which can be shared transparently. The Guiding Principles are supported by a Managers Toolkit for defining and dealing with safety concerns. The Association of Ambulance Chief Executives (AACE) are focused on reducing misogyny and improving sexual safety in the ambulance service. This is a four-nation programme of work which was launched at the Ambulance Leadership Forum held in Wales during October 2023.

Arweinyddiaeth Leadership

Through targeted training and development, we have started a programme of work to equip managers with the necessary tools and resources to navigate complex employee relations scenarios with compassion and fairness, and have prioritised the development of change management expertise, recognising the critical role managers play in supporting people through change.

The continued development and growth of the Culture Champions Network also helps to build change management capacity and to further embed our values and behaviours.

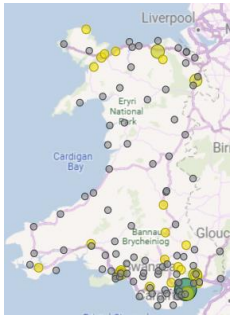
Another significant milestone in our journey towards developing a collaborative approach to change management is the launch and pilot of the 'Manager's Team Culture Toolkit', designed to provide practical resources and guidance for managers so that they are empowered to use collective insights and improve culture at a local level.

Insights™

Teams work better when they all understand each other and communicate with one another. As an organisation we have introduced the Colour Insights programme which works alongside our People & Culture plan by broadening our understanding of our local teams and having more 'in-tune' conversations. Senior Leaders have undertaken the Insights Discovery® process to understand their preferred leadership and communication styles and that of their colleagues. As leaders they can now share this with their team through the Insights Explore® process and understand how they work best together and how they can communicate better with each other and our service users.

Leadership Symposium

As part of our targeted training and engagement to support and develop our leaders we hold a Leadership Symposium twice a year. This allows our senior leaders from across the organisation to come together to share learning and engage on improvements across the organisation. In 2023 the focus was on broadening our understanding of our leadership styles, strengths and value as well as understanding regarding sexual safety.

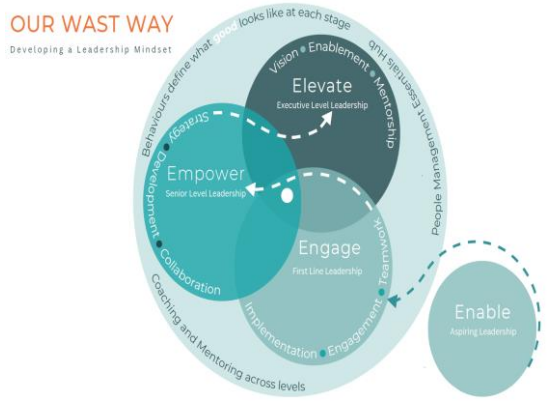


Visible Leadership

Between April 2023 and March 2024 members of the Trust Board have undertaken 104 visits to our ambulance stations and corporate buildings as part of engagement events, individual visits and observational ride-outs.
In addition, our Trust Board members have attended CEO Roadshow and award events engaging with team members across Wales.

Our Wast Way

The development of a Leadership Behaviours Framework and an aligned Development Framework is a significant initiative currently underway. This project represents a major step forward for us in establishing a comprehensive framework that enables targeted leadership development for leaders and managers at various stages of their careers. By integrating coaching and mentoring opportunities along with succession pathways, we aim to embed an inclusive, compassionate, and collaborative leadership culture. Currently, we are in phase 1 of the project and working with an external partner to define 'what good leadership looks like' in our organisation.



Gwybodaeth Information

WAST's Digital Directorate is home to data professionals that span the full data lifecycle - from acquisition and storage, to processing, usage and sharing, and to records management and destruction. Wrapped around this lifecycle are strong Data Quality practices and our Data Protection function.

All data professionals engage with domain experts and information asset owners around the Trust to ensure safe, secure and effective use of the data we hold.

Data into Knowledge

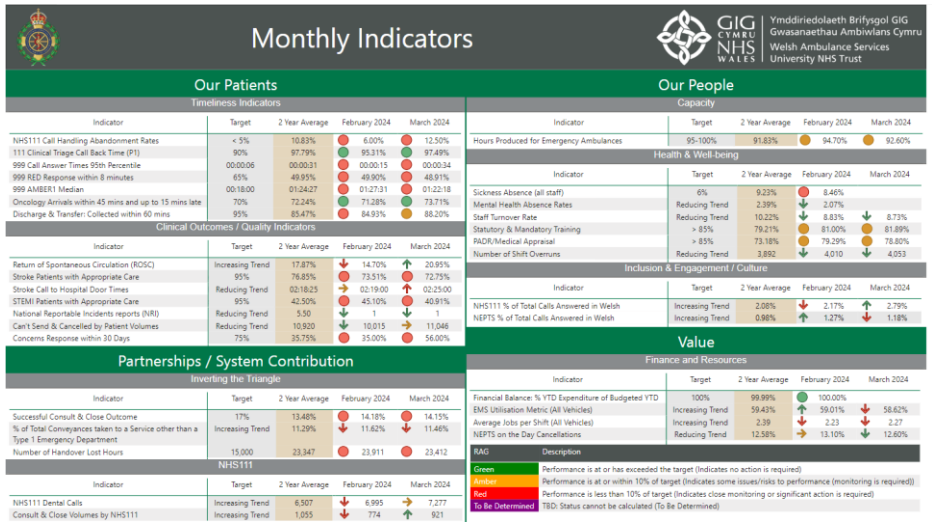
Information & intelligence is used widely throughout the Trust. Executive sub-groups and Board committees are supported in their decision making and escalation with rich reports, dashboards and/or internal Key Performance Indicators (KPI). This allows for triangulation of outcome based, performance based, and people-based intelligence in multiple forums drawing on a single source of truth.
We supply commissioners with an extensive suite of reports and dashboards, as well as direct data feeds to allow scrutiny of operations and inform decision making on performance, outcomes and service user experience.

Quality Management Group

Our Quality Management Group review information and data as part of Quality Control and Quality Assurance activity including service user feedback. This helps us inform and evaluate our Quality Improvement initiatives and plan our strategic intentions for future service delivery.

Data Protection

The Information Governance Steering Group, which meets monthly, has delegated authority from the Executive Leadership Team to cover all matters of information security, information governance, records management compliance and Caldicott Principles, and ensures that any data made available is done so lawfully and securely. The Trust's Data Protection policy was approved in the final quarter of 2023/24, and our Data Quality policy is planned to be reviewed by Policy group and go out for consultation in the first quarter of 2024/25.



Always On

Sharing information about the quality of services with the population is an important expectation within the Duty of Quality. 'Always On' means collecting, analysing, monitoring and making information about the quality of services readily available. It promotes openness and transparency with our population and our stakeholders. Our Monthly Integrated Quality and Performance Report (MIQPR) is shared with the Quality, Patient Experience and Safety Committee (QuESt). For our staff this is available on our internal information platforms including through a digital platform supplied by Microsoft called PowerBI. For our service users this is currently available on our website 'About Us' section.

You can also find information about our performance in the Ambulance Service Indicators monthly report from the Joint Commissioning Committee, the NHS Activity and Performance Summary document from Welsh Government and through StatsWales in the Health and Social Care section. The links for all these information sites are on our website 'About Us – Duty of Quality' section.

Next Steps

We are currently undergoing a huge refresh of our reporting functions, creating an internal data / report catalogue so colleagues can find the intelligence they need, and migrating from legacy dashboard tools to PowerBI to increase our accessibility to intelligence, provisions through a single source of truth. This is due to be complete in Autumn 2024.

Ymagwedd systemau cyfan
Whole systems approach

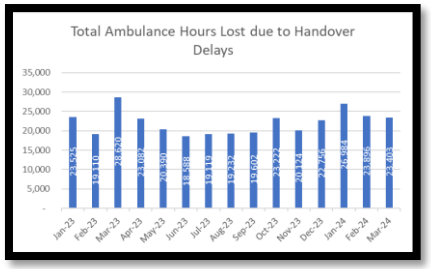
The Trust regularly meet with Health Board colleagues to discuss a variety of quality and performance items to identify best practice, areas of risk and priorities for improvement.

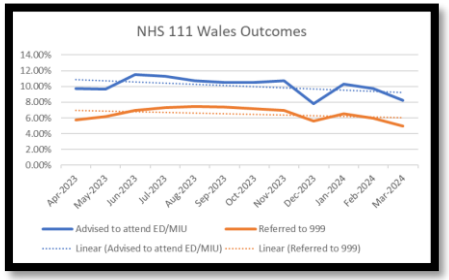
The items discussed include

- Nationally Reportable Incidents
- Joint Investigations & Duty of Candour.
- Mortality Reviews
- Patient Experience
- Falls & Frailty initiatives and progress.
- Safeguarding
- Clinical Indicators & Clinical Audit
- Mental Health, Dementia and Maternity Services

Mobile Xray (Urgent X-Ray Response Vehicle).
In August 2023 the trust, in collaboration with Betsi Cadwaladr University Health Board (BCUHB), delivered and reviewed the feasibility of an at home X-ray urgent response service. The x-ray response team consisted of a Paramedic and Radiographer (trained to undertake an x-ray), with image assessment being undertaken by the Glan Clwyd Hospital radiology team. Although the number of suitable patients during the trial were low portable x-ray was found to be feasible, with good image quality for limbs. The project demonstrated potential scope for system efficiencies but more data is needed.

Hospital Delays
The Trust aims to consider both its impact on the wider system, but also the wider system's impact on the organisation. The impact of delays handing over patient care at emergency departments can have catastrophic outcomes for patients. Whilst showing positive improvement through 2023/24, the length of time ambulance resources lost mean that patients are waiting longer to receive a face-to-face response.





Reducing Hospital Demand
The Trust is working across the whole system to reduce the number of patients taken to our Emergency Departments in an effort to reduce the impact of hospital delays.
Our NHS 111 Wales teams are resolving more calls through alternative outcomes rather than directing patients to Emergency Departments or referring them to EMS services.

Information Sharing
WAST recognise the power of the data we collect for the purposes of system-wide improvement and enhanced direct patient care. The data & analytics function are currently working with partner organisations across Wales, including Digital Health & Care Wales, to progress the strategic ambitions of Welsh Government for a more connected data layer informing our decision-making, learning and accountability. We are currently making the necessary Information Governance arrangements to allow sharing of WAST data with Health Boards and other NHS Wales bodies through the National Data Resource (NDR), with some data pipelines having been tested and the NDR environment ready to receive WAST data.

Palliative Care Paramedics
Our palliative care paramedics recently completed a project with SBUHB that saw them supporting avoidable emergency department admissions for residents of care homes. These highly skilled clinicians responded to care homes across the Health Board to assess and manage residents, working in partnership with SBUHB older persons services and the wider community teams to keep residents in their own care setting and avoid hospital admissions where appropriate.
Following a positive evaluation, WAST have now developed the project further to enable the palliative care paramedics skills to be utilised to the wider community. This dedicated resource is being dispatched to palliative and end of life care patients in all care settings that access 999, with the aim of supporting that patient in the community wherever possible if that is the persons preference.

Gwella, dysgu ac ymchwil
Learning, improvement and research

The Welsh Ambulance Service has had University Status conferred as of 1st April 2024. This is recognition of our longstanding commitment to education, research & innovation. The principles of the Learning Organisation and democratised, equitable development are the key stones of our approach, demonstrating our commitment to the Wellbeing of Future Generations Act 2015

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

Education & Assurance
The Workforce Education & Development function uses an established quality management system for all its Internal Quality Assurance (IQA) activity. The IQA hub provides central access to all those involved in the delivery of education in the Trust. The reporting tools in use have been crafted to meet the needs of all our Awarding Bodies reinforcing the focus on quality rather than specific preferences of individual external organisations. The records generated and stored within this space are then used to inform practice as part of scheduled standardisation activities.

Research & Innovation

WAST continues to be an international leader in ambulance services Research and Innovation (R&I) which it achieves through collaboration with many partners, including the NHS Research & Development Leadership Group, National Ambulance Research Steering Group, NHS Innovation leads group, Health and Care Research Wales (HCRW), Bevan Commission and others.

Research in Action
The WAST led Welsh NHS Medical Drone Delivery Network is conducting internationally significant R&I, attracting funding to conduct studies ranging from deployment of defibrillators in Out of Hospital Cardiac Arrest, to using drones in remote search and rescue, and delivering blood. We continue to collaborate with industry and health partners such as Snowdonia Aerospace, the UK Space Agency, Welsh Government, Resuscitation Council (UK), National Institute for Health Research, Welsh Blood Service and many more.

Accessible Learning
During this 2023/24 we have introduced a new Learner Management System (LMS365) that enables us to target and track engagement with eLearning. We have a growing catalogue of Ambulance related topics to better support the understanding and practice of our people.

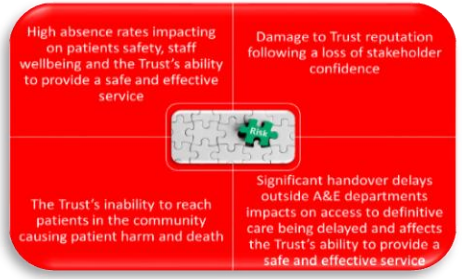
Next Steps
In relation to Duty of Quality learning, the Trust's vision is to contextualise the Duty to various functions within the organisation. Now all colleagues have the requirement to engage with Duty of Quality eLearning that is hosted on ESR; compliance performance will be measured on an ongoing basis.

To further enhance the understanding gained from accessing this generic eLearning, the Trust will create bite sized eLearning highlighting examples of what quality looks like within specific functions.

Additionally, all road-based staff attend an annual face-to-face Mandatory In-Service Training (MIST) refresher day where they encounter interprofessional scenario-based learning underpinned by the 6 domains of quality; learning experiences centre around provision of a safe, effective, person-centred, timely, efficient and equitable service for our patients.

This model is now in operation across our Volunteer workforce with early stages of extending this approach being considered across all clinical roles.

Diogel Safe

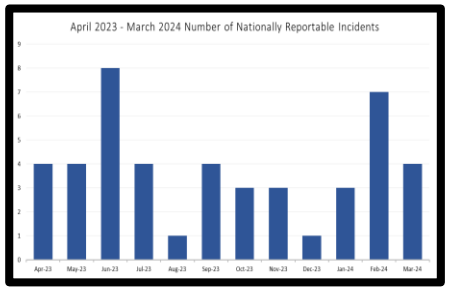


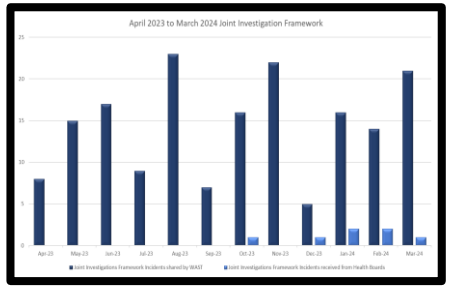
Managing Risks

The Trust monitors Risk within the organisation and the services we provide. Our Board Assurance Framework provides a clear line of sight to the controls, assurances and actions we are able to take to mitigate or reduce these risks for our Trust Board. Our Integrated Medium-Term Plan sets out what we are doing to address our range of corporate risks.

Incident Reporting

Incident reports can be a valuable signal to healthcare providers about where to focus resource and attention to improve patient safety. A good reporting culture in an organisation means that the organisation reports patient safety incidents frequently, reports the more serious incidents that occur but also reports many incidents involving low and no harm to patients, to learn and improve. The Trust reported 46 patient safety incidents which were notifiable under the Duty of Candour Regulations, and overall, 4400 patient safety incidents were reported during 2023/24.



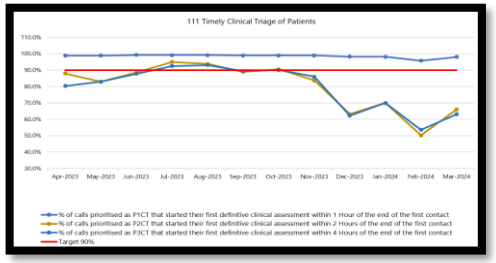


Patient Safety Investigations

The Putting Things Right Team has oversight of patient safety investigations, and these are undertaken internally only or with colleagues as part of the Joint Investigation Framework. During this period 173 investigations were shared with the Health Boards across Wales and 7 investigations were shared with the Trust from Health Boards. The majority of these related to extreme pressures across the healthcare system and handover of care delays

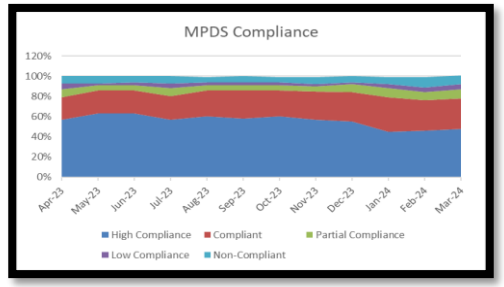
Clinical Assessment

We consistently achieved our target for clinical assessment times of our highest priority patients in the NHS 111 Wales service. Averaging 98.6% of clinical call back within an hour. We have also seen improvement in our lower priority calls compared to the previous year however this performance has deteriorated in the second half of the year following high levels of clinician sickness absence. We are focused on improving this through a number of recruitment and retention initiatives.



999 Call Handling

To prioritise 999 calls our qualified non-clinical call handlers are supported by the Medical Priority Dispatch System (MPDS). This is a scripted question and answer system which is licensed and regulated by the International Academies of Emergency Dispatcher (IAED). As part of our licensing agreement, we audit 1.5% of all 999 calls which helps us identify learning, for individuals and as an organisation, to improve the quality and safety of our services.



Safeguarding Children & Adults

As part of our responsibilities to protect the wellbeing and safety of children and adults who are vulnerable or at risk it is important to report concerns in a timely manner. Our Safeguarding team have continued to implement the digital platform 'Docworks Scribe' to make it easy for our people to submit referrals across the Health and Social Care system. This has now been extended to include prevention referrals for service users at risk of becoming terrorists or supporting terrorism.

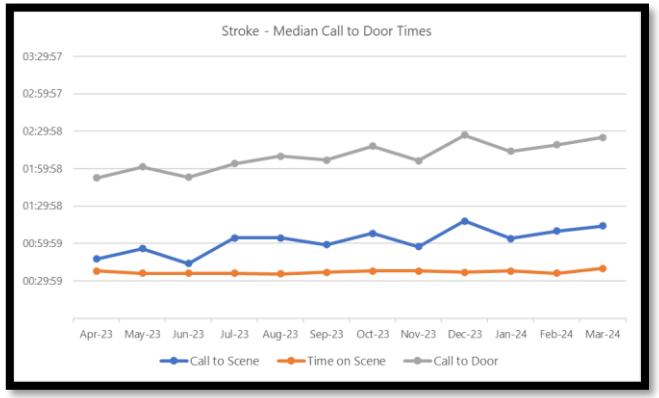
Amserol Timely

Call to Door

We have begun to regularly report on the timeframes associated with Stroke and Heart Attack. These timeframes measure the total time from the 999 call being received to the patient arriving at hospital. We know that timely treatment of these conditions can have a positive impact on patient recovery rates.

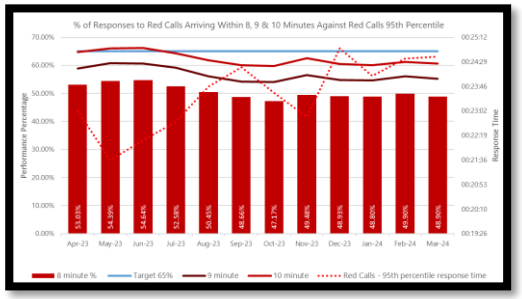
Stroke

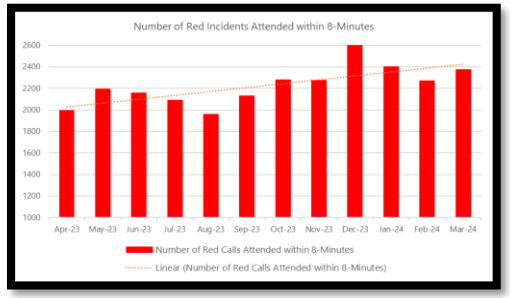
Whilst performance in this area has improved compared to 2022/23, we have seen a gradual decline in performance over the year which is related to the time from your call to our arrival at scene.



Immediately Life Threatening 999 Calls (Red Calls)

The Trust's target is to respond to 65% of immediately life threatening 999 calls within eight minutes. Unfortunately, despite some seasonal changes we have not been able to show long term improvement towards this target during 2023/24. The highest figures achieved was 54.64% in June 23. However, there is a clear increase in the volume of red incidents attended and the stable nature of our Red call performance means that we are getting to more immediately life-threatening calls within this time frame.



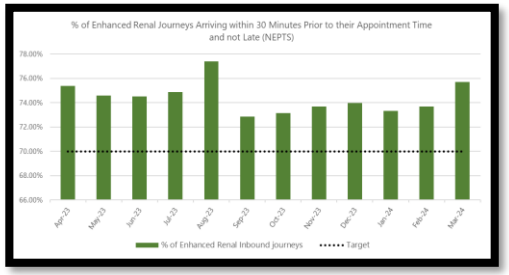


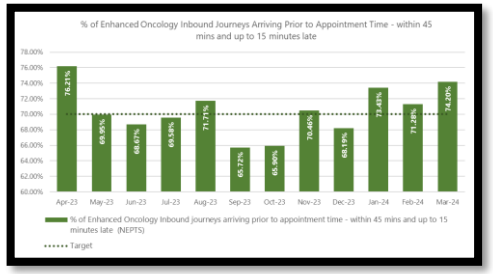
Non-Emergency Patient Transport

New performance standards monitoring whether patients are transported to and from their hospital appointments in a timely manner were introduced in April 2023.

For our Renal patients we have consistently met our target to arrive within 30 minutes of the appointment time and not late, this is despite increased numbers of Renal journeys being booked.

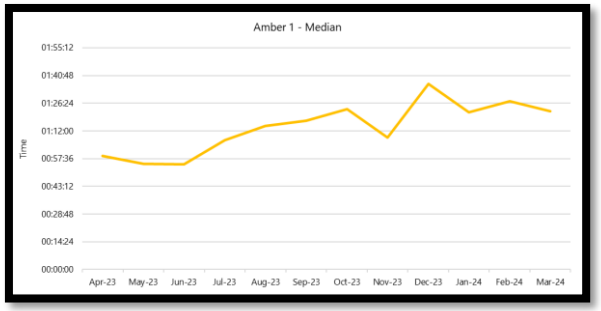
For our Oncology patients our performance has been less stable with our target having been met for 6 months out of the year, however the last quarter has indicated positive improvement, and we are continuing to work collaboratively with our health board partners and Trusts to provide an improved service to patients.





Amber 1

Our Amber 1 category is aligned to patients whose condition is serious but not immediately life threatening and includes stroke and cardiac related chest pain. Whilst there is no specific time-based target for these incidents we would want to respond as quickly as possible. During 2023/24 our response times have gradually increased our data tells us that this increase in response time is in part related to hours lost handing over patient care at Emergency Departments.

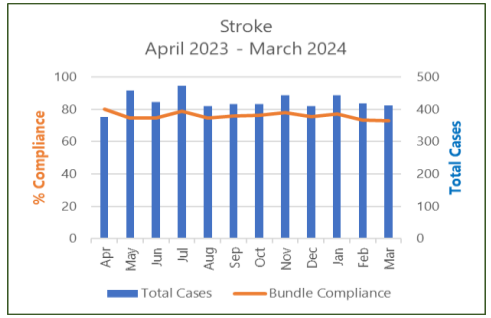


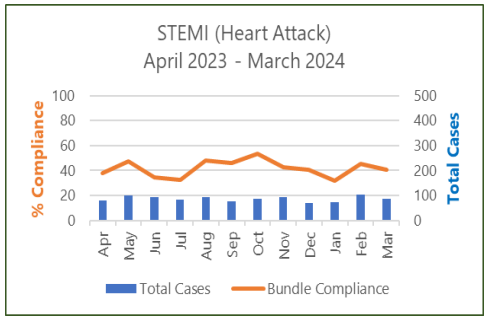
Welsh Ambulance Services University NHS Trust

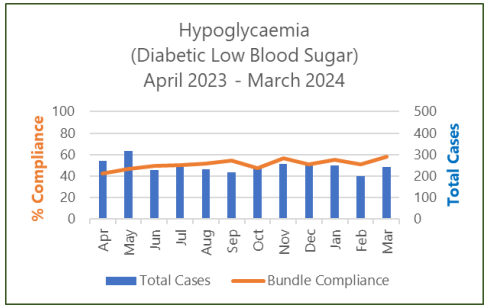
Effeithiol
Effective

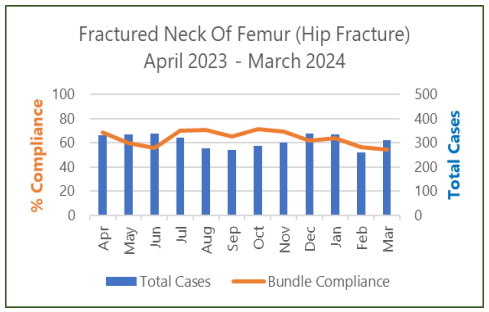
Cymru High Acuity Response Unit (CHARU)

The introduction of the CHARU service allowed experienced paramedics with additional training and medicines to be tasked to a broad mix of high acuity patients including out of hospital cardiac arrests and major trauma. Through 2023/24 we have seen an improvement in Return of Spontaneous Circulation (ROSC) associated with effective treatment for out of hospital cardiac arrests arriving at hospital on average 19.2% per month however this remains lower that we would want.









Clinical Indicators

Following the switch to the electronic Patient Clinical Record (ePCR) the way data is collected when with the patient has changed. These clinical indicator reports are automated and generated from data directly inputted onto electronic Patient Clinical Records by clinicians.

Some of the bespoke areas of the electronic Patient Clinical Record are not being utilised, clinicians are using only the clinical narrative instead. Having detailed information in a narrative has advantages and we encourage this but are also looking at ways to improve data being entered in the bespoke areas to improve data compliance.

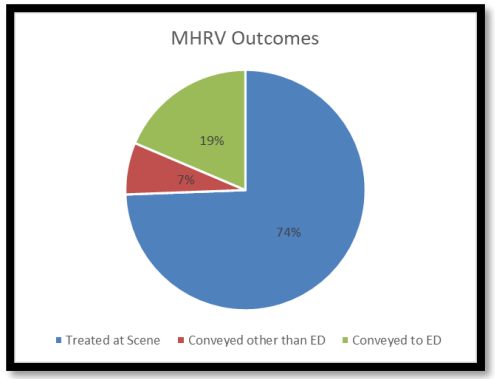
We are exploring options to improve electronic Patient Clinical Record completion and compliance to clinical indicators with prompts when a record is being closed to enable clinicians to easily return to the required area for completion.

A plan has been implemented to improve our clinical indicator compliance including focussed communication with clinicians, clinical workshops, improved clinical supervision and digital enhancements.

Data from ePCR has enabled us to look at developing systems for linking our clinical data with wider healthcare.

Mental Health Response

People experiencing mental health distress who cannot access he care they need often contact us or attend Emergency Departments. Calls involving mental health issues are often complex and take longer to resolve that other health issues, they can also be challenging to manage for general clinicians. In order to support these patients we have introduced a number of service improvements targeted to support patients in the community. We have Mental Health Practitioners on duty in our Clinical Support Desk team for 12 hours a day 7 days a week. This allows us to support patients and direct them to the right care referring them for psychiatric assessment when appropriate. We are also piloting a Mental Health Response Vehicle in partnership with Aneurin Bevan University Health Board to support more patients in the community.

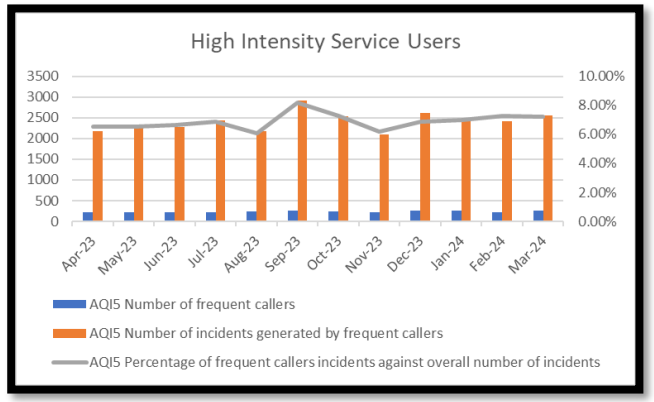


Effeithlon
Efficient

High Intensity Service Users

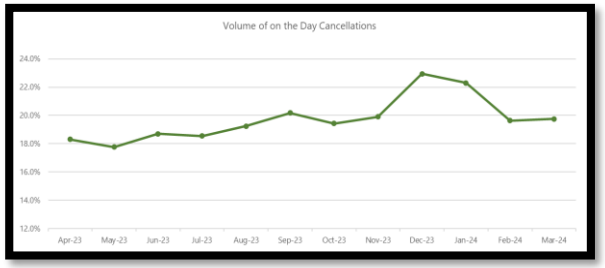
The national definition for a High Intensity Service User is a patient for whom we record 5 or more incidents a month. As an organisation we monitor frequency of contact in order to assess, identify and access appropriate care pathways for these patients to ensure that their needs are managed consistently and equitably through a multiagency approach where appropriate.

In our EMS environment we saw a slight increase in the number of incidents attributed to these patients. In October 2023 we introduced a digital referral system so that our people can identify patients quickly, allowing us to support service users appropriately whilst reducing inappropriate demand on our services.



Cancelling your Request

Our data and information shows that the number of journeys cancelled on the day is increasing.. Most cancellations occur from either on the day booked discharges where the patient is not ready or where the healthcare appointment has been cancelled but no one has updated the transport arrangements. We are working with health board colleagues and in response to your feedback to reduce these issues so that we can plan and utilise our resources efficiently. Improvements made to date have shown an improvement in the last quarter of the year and we continue to identify improvement initiatives to reduce cancellations further.

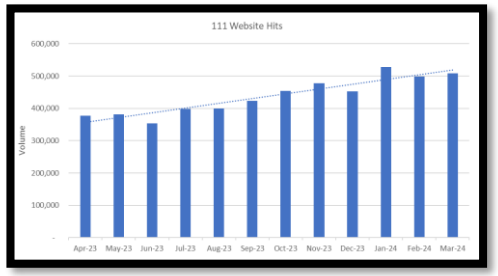


Admission Avoidance

Although we remain focused on supporting patients needs in the community and avoiding conveyance to Emergency Departments, the percentage of patients accessing our services via 999 increased slightly during this period from 34% in 2022/23 to 37.5% in 2023/24.

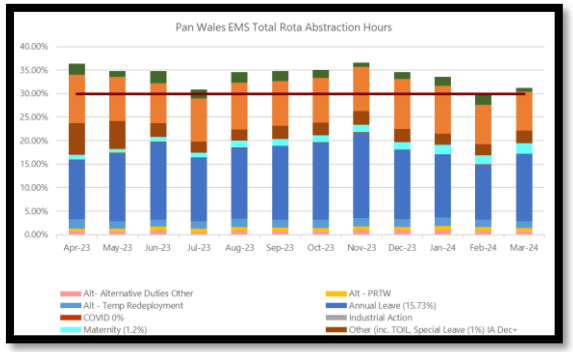
NHS 111 Wales Website

The NHS 111 Wales Website continues to be a source of information and advice for our service users offering advice, symptom checkers and information about local health services. Through 2023/24 we have seen increased use of this important service month on month however feedback from our service users have told us that their experience of using the website can be poor. We have listened to that feedback and in 2024 we have commissioned review of the current website to identify how we can improve the design, structure, content and reporting to make it a more useful tool.



EMS Rota Abstractions

We continue to focus on abstractions management and absence reduction, including a managing attendance programme. The amount of capacity lost due to abstractions has been consistently reducing year on year. In February 2024 we achieved our target for the first time in over four years.



Teg Equitable

Strategic Equality Plan

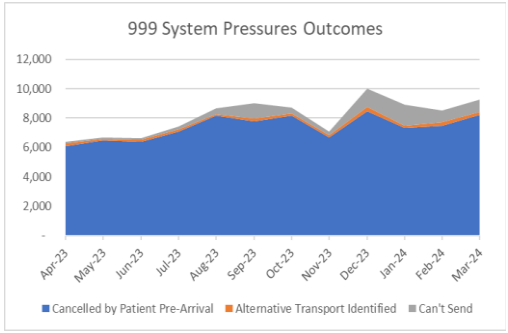
During the past 6 months we have reviewed our objectives and have undertaken consultation and engagement with staff, service users and stakeholders to help us develop a new plan for 2024-2028. We were keen to learn more about the challenges faced by people with a protected characteristic. We engaged with local sight loss groups, people from local religious groups, homeless cafés, LGBTQ+ communities, Youth Parliaments, Diverse Cymru, British Deaf Association, charitable organisations, and many more. We also engaged with staff, the Executive Leadership Team, Non-executive Directors, and NHS Wales organisations. This engagement has helped us to design a set of objectives that will help us to provide more equitable services and tailor our healthcare services to meet the needs of individuals. The plan also aligns with our new People and Culture Plan which aims to support employee health and wellbeing and improve employee experience.

Learning Disabilities

Our Patient Experience and Community Involvement (PECI) Team have continued to build relationships with people who have a learning disability to learn more about how we can improve access to services and communicate better with people. We have invested in training to develop easy read versions of our communications and have invested in digital technology to help make our website communications more accessible.

System Pressures

At times of high demand, including times when all our resources are already committed to patient activity, we may need to prioritise our services to those patients who need us the most. In these circumstances we may cancel non-emergency transport journeys or ask 999 callers to make other arrangements.



Dementia Friendly Environments

Feedback tells us that people affected by dementia can find it difficult being in our vehicles, particularly if they experience a long delay outside hospital. We are working to create more optimal ambulance environments for people affected by dementia with different pilots across Wales using art, music and reminiscence therapeutic interventions. New design features inside our NEPTS vehicles include dementia-friendly flooring, blinds and colour schemes. Images from the local community will be available on vehicle windows, such as this image of Aberystwyth beach.

Listening & Learning

We have taken steps to monitor concerns and queries being raised by service users and staff which indicate potential discrimination against people with a protected characteristic. We are using this information to identify trends to inform future training and support for staff. Examples of this include:

- Reviewing our procedures for transporting walking aids for our NEPTS patients
- Working with UK Ambulance Trusts to review our guidelines on assistance dogs and emotional support animals on our transport and in the workplace.

Equality Impact Assessments (EqIA)

We have introduced more robust equality impact assessment (EQIA) monitoring procedures with the introduction of a digital impact assessment tool, bespoke one-to-one advice sessions and an online suite of training. We have also strengthened our monitoring procedures via our Policy Monitoring Group who are developing a library of equality impact assessments. Robust impact assessments will help us to identify any negative impacts upon people with a protected characteristic and allow us to adapt our plans and put mitigating actions in place.

Person ganolog
Person centred

Learning from Concerns

Learning from concerns occurs across the Trust and more widely with system partners. Sharing of learning occurs through education & training, dedicated intranet sites and bulletins and notices .

Learning this year has included:

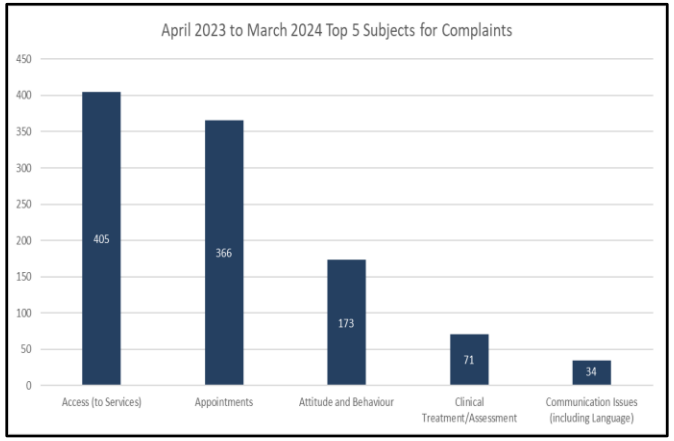
- Implementation / changes in education and training programmes
- Thermoregulation training and improved awareness of the importance of recording the temperature of a newborn and use of relevant equipment.
- Improving clinical documentation on ePCRs.
- Improved awareness of available patient pathways.
- Importance of pre-alert in patients with a reduced Glasgow Coma Scale and high National Early Warning Score (NEWS).
- Learning around criteria for referring patients to minor injury units.
- Awareness of Major Trauma Tool and referral to spinal immobilization guidance.

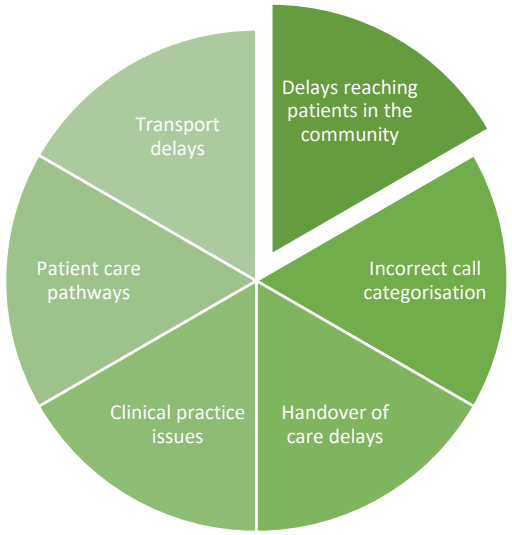
Concerns

The Trust received 1112 complaints during the 2023/24 period of these 26 concerns were referred to the Public Service Ombudsman Wales (PSOW) which is a reduction from the previous year (57). The majority of the issues raised related to timeliness of ambulance response.

The Trust continues to work to address the issues highlighted through our Integrated Medium-Term Plan and there has been significant investment into the Patient & Family Relations and Patient Safety Teams this year to ensure a timelier response to concerns.

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





Themes identified from Concerns

Value Based Health Care

We are committed to Value-Based Healthcare working with colleagues across Wales to determine investments that ensure the most effective use for improved population health outcomes. We are focused on developing meaningful outcome measures which represent what is important to our patients and which capture their experiences. These measures are a key part of our quality control arrangements.

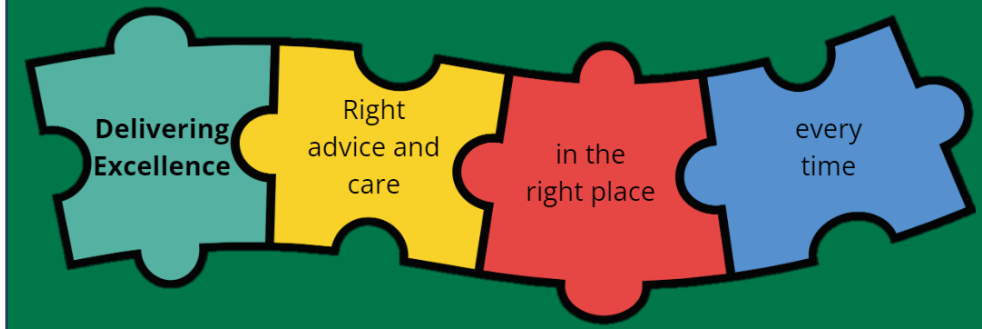
We have worked closely with the Value in Health Centre to understand how we can embed these principles through education and engagement.

Looking Forward 2024/25

Our Long-Term Strategic Framework for 2030, 'Delivering Excellence' set out our ambition to move from being a traditional ambulance and transport service to being a trusted provider of out-of-hospital high quality care, ensuring that patients receive the 'right advice and care, in the right place, every time', with a greater emphasis on providing care closer to home. Whilst we continue to make progress in delivering on these ambitions, the landscape within which we operate has changed considerably since we developed the strategy in 2019. It is clear to us that there remains a pressing requirement to change the way in which we meet our patients' needs. Too many patients continue to come to harm, and the difficulty in navigating our complex health and care system means patients are often not getting the quality of services we strive to provide. As an organisation we can identify improvements within our own practices to lessen the risk of patient harm but alone we can't resolve the wider system challenges, and so we must work collaboratively across NHS Wales to transform our services and reduce the risk to our patients.

Fundamental to delivering on service improvement is a need to support and enable our people to be the best that they can be. Alongside the work we are doing to improve our culture and develop our leaders, we must support our staff from the moral injury experienced when we are unable to provide the quality of service our patients deserve.

Our Integrated Medium-Term Plan sets out our intentions to improve the quality of our services and this year we are also refreshing our Clinical Plan. The next section of our report is a snapshot of just some of the activity planned for 2024/25 with a focus on improving the quality of our services.




Welsh Ambulance Services NHS Trust
Integrated Medium-Term Plan
2024-2027

Foreword from the Chairman and Chief Executive

2024/25 Transforming our Clinical Service Model

Remote Integrated Care
During the first quarter of 2024/25 we will introduce a new Clinical Assessment Software system to our NHS 111 Wales service, we have been working since November 2023 to bring in an up-to-date resilient infrastructure that will allow us to integrate effectively across our services and with urgent primary care providers to develop a more seamless experience for our service users. We will also expand our clinical workforce for remote clinical decision making to continue improvements delivered in 2023/24 and supporting our commitment to bring your care closer to home. The development of a Remote Integrated Care service would bring our Clinical Support Desk and NHS 111 Wales teams closer together working closely with health board remote clinical hubs to deliver a whole system approach to patient care.

Clinical Response Model
We will target our time to develop and agree a new clinical response model that will provide our patients with the right advice and care, in the right place, every time and reducing harm. This will include the development of clinically led dispatch decision making to ensure we use our responding resources efficiently and effectively.

Connected Support Cymru
We will continue our journey to connect patients with community-based responders and the clinical expertise available within our clinical contact centres to provide remote clinical assessment through technology enabled health solutions.

Digital Expansion
We will explore how we can enhance and develop our digital services for NHS 111 Wales listening to your feedback of your experiences and engaging with experts to improve our digital offer.

On Scene Community Urgent Response Service
We will explore how we can use our highly skilled clinicians such as Advanced Paramedic Practitioners to better support our patients at home. Having seen important impacts from our trial of Mental Health Response vehicles we will evaluate this and consider how we can further develop our offering to patients in crisis. This alongside our existing responses such as falls assistants and palliative care paramedics will help us provide face to face assessment and treatment, working with Health Boards to integrate with community response services and working with others to develop access to community pathways.

Ambulance Care
We will work with commissioners to agree a strategic vision for the future of Health Transport ensuring that we understand the demands for our services, our commissioning arrangements and the capacity we require to deliver these effectively. This will allow us to review how we align our people and resources to the times when you need us most.

Looking Forward 2024/25

Citizens Voice
We want to understand the experience of the public, patients, their carers and families to understand how they experience the services provided by the Trust. So we will be working to improve how you can give us feedback including QR codes on all fleet vehicles, sharing links to experience surveys through our Putting Things Right teams and exploring how we can share our experience surveys for all areas of our service with you.

Putting Things Right
A Putting Things Right Recovery Plan has been developed to ensure we improve our timeliness in our responses in all matters relating to Putting Things Right. Welsh Government are currently consulting on the Putting Things Right Regulations and following publication of the updated Regulations we will ensure local implementation and monitoring to deliver sustained improvements.

Safety Culture
The Trust Manual Handling Advisor is currently undertaking a deep dive investigation into manual handling incidents over a three-year period. They have identified a number of common causes of Manual Handling injuries including the use of a carry chair to move patients. They are currently undertaking investigations into these incidents to identify the mechanism of injury and associated human factors with the aim of producing an improvement plan to be rolled out across the Trust.

EMS Coordination
A range of transformation workstreams, initially identified in the 2019 Demand and Capacity Review, have recently been invested in and recommenced, designed to enhance the stability of the service, improve the experience of our people and deliver a range of efficiency improvements. This includes the implementation of a new career structure that offers more opportunities for the development and retention of staff who want an emergency call handling career. Alongside the enhanced management and career structure we are developing a single allocator model, which will ensure greater efficiency in the allocation and dispatch function, which is in line with the approach taken by other UK ambulances services.

To ensure that there is equity of workload across our three centres we are seeking to carry out a realignment of boundaries and dispatch desks to ensure an equitable flow of work across all of Wales. Finally, to ensure that our resources reflect our demand and workload across Wales we will work with colleagues to build rosters that align to the new structures. These changes together with investment in our estate will provide a structure and environment that will support our aim to deliver our target culture, and importantly, improve the experience of our colleagues working within the EMSC environment.'

Non-Emergency Patient Transport
We are currently reviewing our booking process to reduce the number of non-eligible patients in the system, which have a negative impact on our overall capacity to provide transport for those patients with a clinical need. Work continues to develop and strengthen the focus on delivering and reporting of improved patient experience and service quality.

Learning, Research and Innovation
As we move into University status we will continue to work collaboratively with key partners and research organisations developing research and innovation as a golden threat across all our activities.

Connected Support Cymru

The aim of Connected Support Cymru is to connect patients with community-based responders and the clinical expertise available within our clinical contact centres to provide remote clinical assessment through technology enabled health solutions.

CANOLFAN RAGORIAETH SBRI
SBRI CENTRE OF EXCELLENCE

SBRI Centre of Excellence
During 2023, WAST entered a partnership with the SBRI COE to invite industry and academic partners to develop innovative solutions to our challenge –

'Changing the way we deliver Emergency Care'.

This challenge seeks to use digital technology to enable the Trust to provide care to patients in their own home, in a community setting, or allow integration into Health Board services.

Safe Care Collaborative
Over a focused 15-month period, Improvement Cymru and the Institute for Healthcare Improvement (IHI) are providing services and teams throughout NHS Wales with tailored coaching and support to accelerate existing improvement projects enhancing safe and effective care across the country.

Teams are delivering projects across community, ambulatory and acute care workstreams. This is underpinned by a Leadership for Patient Safety Improvement workstream that is supporting the adoption of the organisational learning systems, culture and working environments required for improvement to flourish.

WAST have been working with Partners across the system to consider opportunities for system wide improvement.

Clinical Intelligence
Shared clinical intelligence will increase visibility of clinical risk and will enable effective prioritisation of resources dependent of clinical need.

Health Boards
Developing a 'care network' through integration will improve management of demand and prevents unnecessary Emergency Department attendances and subsequent inpatient stays.

GIG CYMRU NHS WALES

Social Care
Citizens will be supported to remain mobile and independent within their own homes through maintaining their mobility, reducing long-term demand on social care.

Patients
Clinical triage, assessment and consultation will be provided remotely, enabling the patients to receive care within their own home. If intervention is required, we will aim to support care in a community setting.

For more information about
Welsh Ambulance Services University NHS Trust
visit our website at

www.ambulance.nhs.wales

To provide us with feedback on our services you can follow the links below

Calling 999 Survey

Calling 111 Survey

111 website survey

Non-Emergency Transport Survey

Communicating in your language of choice

Virtual Video Booth

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