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Audit Wales

Review of Quality Governance Arrangements – Welsh Ambulance Services NHS Trust

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About this report

1 Quality should be at the 'heart' of all aspects of healthcare and putting quality and patient safety above all else is one of the core values underpinning the NHS in Wales. Poor quality care can also be costly in terms of harm, waste, and variation. NHS organisations and the individuals who work in them need to have a sound governance framework in place to help ensure the delivery of safe, effective, and high-quality healthcare. A key purpose of these 'quality governance' arrangements is to help organisations and their staff both monitor and where necessary improve standards of care.

2 The drive to improve quality has been reinforced in successive health and social care strategies and policies over the last two decades. In June 2020, the Health and Social Care (Quality and Engagement) (Wales) Act became law. The Act strengthens the duty to secure system-wide quality improvements, as well as placing a duty of candour on NHS bodies, requiring them to be open and honest when things go wrong to enable learning. The Act indicates that quality includes but is not limited to the effectiveness and safety of health services and the experience of service users.

3 Quality and safety must run through all aspects of service planning and provision and be explicit within NHS bodies integrated medium-term plans. NHS bodies are expected to monitor quality and safety at board level and throughout the entirety of services, partnerships, and care settings. In recent years, our annual Structured Assessment work across Wales has pointed to various challenges, including the need to improve the flows of assurance around quality and safety, the oversight of clinical audit, and the tracking of regulation and inspection findings and recommendations. There have also been high profile concerns around quality of care and associated governance mechanisms in individual NHS bodies.

4 Given this context, it is important that NHS boards, the public and key stakeholders are assured that quality governance arrangements are effective and that NHS bodies are maintaining an adequate focus on quality in responding to the Covid-19 pandemic. The current NHS Wales planning framework reflects the need to consider the direct and indirect harm associated with Covid-19. It is important that NHS bodies ensure their quality governance arrangements support good organisational oversight of these harms as part of their wider approach to ensuring safe and effective services.

5 Our audit examined whether the organisation's governance arrangements support delivery of high quality, safe and effective services. We focused on both the operational and corporate approach to quality governance, organisational culture and behaviours, strategy, structures and processes, information flows and reporting. This report summarises the findings from our work at the Welsh Ambulance Services NHS Trust (the Trust) carried out in 2021/22.

Key messages

6 The Trust continues to deal with extreme service pressures driven by whole system issues that are resulting in unprecedented ambulance handover delays, and associated difficulties in responding in a timely fashion to calls for an emergency ambulance. Staff are working under significant pressure and sickness absence levels are high. More than ever, therefore, the Trust needs to have robust governance arrangements that allow it to maintain the necessary oversight and scrutiny on the quality and safety of its services.

7 **In overall terms we found that whilst many facets of the Trust's quality governance arrangements are working well, improvements are required in a number of key areas to ensure the Trust is fully informed on issues relating to the quality and safety of its services. The Trust also needs to play its part in the improvements that are required to serious incident reporting across organisational boundaries.**

8 The Trust has renewed its Quality Strategy, is strengthening its risk management arrangements and has invested in quality improvement processes. Lines of accountability for quality governance are clear, and there are good arrangements to listen to and act upon the experiences of patients and staff.

9 The role of Quality Patient Experience and Safety (QuESt) Committee is clearly defined, and its work is supported by a good suite of performance information. The Trust has correctly identified opportunities to rationalise the working groups that support the Committee and must also deliver on commitments in its Quality Strategy to improve its quality management systems.

10 However, the necessary attention given to responding to Covid-19 and wider service pressures have caused delays in pursuing the Trust's quality agenda, constraining its ability to successfully deliver its renewed Quality Strategy. A key area for improvement is the need to address the significant backlog of mortality reviews, and to keep the QuESt Committee adequately sighted of progress in this area. There is also a need to better triangulate information from different sources to ensure there is a full understanding of patient outcomes and avoidable harms associated with long waits for an emergency ambulance.

11 Patient safety walkabouts by Board members need to be reinstated and undertaken on a more systematic basis across the Trust's operations and locations. Action is also needed to ensure clinical audit becomes a recognised and visible source of assurance within the Trust's quality governance framework, beginning with approval of a clinical audit plan for 2022-23.

12 The work that is being done on organisational culture and behaviours needs to understand and address concerns around incident reporting, appraisal rates and to ensure adequate responses to any incidents of bullying and harassment.

13 Whilst the Trust's internal system for managing concerns and serious incidents is sound, the joint escalation framework for managing serious incidents across

organisational boundaries is no longer effective, and the Trust must work with its commissioners and health board partners to improve this.

Recommendations

14 Recommendations arising from this audit are detailed in **Exhibit 1**. The Trust's management response to these recommendations is summarised in **Appendix 1**.

Exhibit 1: recommendations

Recommendations
Quality Strategy delivery R1 We found that delivery of the Trust's renewed Quality Strategy (2021-2024) has been severely hampered by resource pressures caused by the pandemic and a lack of funding to support four senior quality lead posts which are central to delivery. The Trust should update its implementation plan outlining how it will deliver its quality ambitions.
Clinical Audit Plan R2 We found that the clinical audit plan is not approved in a timely manner and the QuESt Committee does not have adequate oversight of progress and delivery. The Trust should ensure that: • the QuESt Committee scrutinises and approves a clinical audit plan ahead of each financial year. • the QuESt Committee receives quarterly updates on delivery of the approved clinical audit plan, assurance reports including learning and improvement actions resulting from this work.
Mortality reviews R3 The QuESt Committee does not receive adequate assurances on mortality reviews. The Trust should ensure the QuESt Committee receives quarterly update reports to include: • the number of reviews undertaken, and the numbers of reviews required but not yet complete. • any significant concerns, lessons learned and what changes have been made as a result. • updates on actions to address the mortality review backlog

Recommendations

- updates on progress implementing the all-Wales Learning from Mortality Reviews Framework

R4 The Trust has a significant backlog of mortality review. The Trust should develop an action plan to reduce the backlog, reporting progress at each QuESt Committee.

Personal Appraisal and Development Reviews (PADR)

R5 The Trust has low PADR compliance rates, for example in June 2022 the Trust's compliance was 59% against the 85% target. As part of embedding its new behaviours, the Trust should ensure that PADR rates are improved and set out the actions it will take to achieve this.

Board member walkabouts

R6 Prior to the pandemic, Board members regularly participated in ambulance ride-outs and station visits, but these were ad-hoc in nature and feedback was not collated in a structured way. Now that visits can restart the Trust should develop a standard operating procedure which clarifies the process, frequency of the visits and ensures coverage across the Trust's operations and geographical areas. It should also include a standard template to capture feedback and learning.

Joint Escalation Framework

R7 The joint escalation framework in place with health bodies is no longer effective. The Emergency Services Ambulance Committee is coordinating action to strengthen those arrangements. The Trust must ensure that the recommendations made by the Delivery Unit are effectively responded to in a timely fashion and progress reported regularly to the Board and QuESt Committee.

Quality performance reporting and learning

R8 We found that the QuESt Committee is well served with quality information, but there are opportunities for improvement. The Trust should:

- develop a system to triangulate learning themes across its quality assurance reports. This should ensure clarity about what improvement actions have been taken as a result and how learning has been disseminated across the organisation.

Recommendations

- enhance Covid-19 reporting in the integrated quality and performance report by including information about the harm caused to patients by ongoing service pressures caused by the virus.
- work with health bodies so that there are systems to determine the outcomes for patients who have received emergency ambulance services. This should particularly seek to understand the consequence and harm resulting from service failures such as long ambulance waits.
- develop patient outcome measures to support its existing quality measures.

Detailed report

Organisational strategy for quality and patient safety

15 Our work considered the extent to which there are clearly defined priorities for quality and patient safety and effective mitigation of the risks to achieving them.

16 We found that **while the Trust has a renewed Quality Strategy and is strengthening its risk management systems, resource constraints threaten the progress of its ambitions.**

Quality and patient safety priorities

17 **Resource issues caused by the Covid-19 pandemic and funding challenges poses a risk to the Trust successfully delivering its renewed Quality Strategy.**

18 The Board approved its 2021-24 Quality Strategy (the Strategy) in May 2021. The Trust had begun work to renew its quality strategy in 2019, which it paused in 2020 to enable it to respond to the Covid-19 pandemic and restarted in 2021. The strategy, developed through engagement with stakeholders including patients and staff, sets out six quality priorities based on the Health and Care Standards. These are:

- **Person-centred Care** – Our services will respond to people's needs and choices. We want people to have a positive experience and value the services and care we provide.
- **Timely Care** – People will have timely access and response to services based on clinical need and will be actively involved in decisions about their care.
- **Efficient Care** – We will ensure that we provide the best quality care through the most efficient use of the resources available.
- **Safe Care** – We will ensure that people using our service are protected from avoidable harm.
- **Effective Care** – The care and treatment we provide will achieve good outcomes and will be based on the best available evidence. We will embrace opportunities to learn, grow and improve.
- **Equitable Care** – We will ensure that the quality of service meets the needs of individuals, taking into account individual characteristics and circumstances.

19 The Strategy includes actions the Trust is taking to comply with the Health and Social Care (Quality and Engagement) (Wales) Act 2020. Specifically:

- developing a culture of candour;
- ensuring robust quality management systems; and
- listening and learning from patients and service users.

20 The Strategy is a high-level document which supports the Trust's long-term strategic framework, Delivering Excellence 2030. The long-term strategic framework states the Trust's aim to ensure 'quality is at the heart of everything we do'. The Trust's 2022-25 integrated medium-term plan is aligned to this and includes deliverables to help achieve its wider aim.

21 There was a long gap between Board approval of the strategy and the subsequent approval of the strategy implementation plan. In February 2022, the QuESt Committee received the Quality Strategy implementation plan, following endorsement by the Assistant Director Leadership Team. This is nearly a year after the Board approved the overarching Strategy. The Trust reported that service and resource pressures cause by Covid-19 and wider system pressures delayed the implementation plan. Many actions in the implementation plan are scheduled for 2022-23 but the compressed timetable introduces risks to delivery. Commencement dates for some actions are yet to be confirmed. These generally relate to workshops due to be delivered by Welsh Government on compliance with the Health and Social Care (Quality and Engagement) (Wales) Act 2020. Wider progress of strategy implementation in the Trust has also been delayed because of the pandemic.

22 The Trust's Resource Escalation and Action Plan (REAP) arrangements enable it to manage its resources at times of extreme pressure. When the Trust is at its highest level of escalation, REAP 4, all non-essential work is paused, and resources are diverted to aid frontline services. This was the case for most of quarters 3 and 4 of 2021-22. The consequence of this is that the implementation of the 2021 quality strategy has been slow to progress. Given the strategic priority the Board has given to quality, the Trust needs to find a way of delivering its important quality improvement actions alongside managing, what might be, sustained service pressures. To ensure the Strategy delivery progresses, the Trust has convened a cross-discipline Quality Strategy Implementation Working Group, this should help to strengthen the actions taken to deliver the Strategy. The group was established in late 2021, so it is too early to measure the groups impact. However, the Trust reported that operational and staffing pressures have had an impact on the group's effectiveness.

23 The QuESt Committee received regular updates as the Strategy developed, and more recently updates on delivery. The reports routinely highlight resource challenges posed by service pressures. But in May 2022 the update report also highlighted financial challenges. The Trust has plans to recruit four senior quality leads to help deliver the quality strategy. However, the update report stated that the Chief Ambulance Service Commissioner's (CASC) office informed the Trust that it will not fund these posts on a recurrent basis. If the Trust is to successfully deliver its strategy, it will need to revisit its strategy implementation plan (**Recommendation 1**).

Risk management

24 **The Trust is taking steps to strengthen its risk management systems and it clearly articulates quality and patient safety risks. But given the levels of risk the Trust faces and its improvement ambitions, resources for risk management are low.**

25 In December 2021, the Audit Committee endorsed the Trust's risk management and Board Assurance Framework (BAF) transformation programme. Its aims include improving risk management by better defining risks, implementing the once for Wales Datix module, developing risk appetite statements and training staff and board members.

26 While the Trust's risk management strategy and framework expired in 2021, it appropriately covers clinical and non-clinical risks and remains extant. The Trust has decided not to refresh the strategy, instead, it will develop a risk management framework and associated policies, procedures, and training as part of its transformation programme by December 2022.

27 The Trust does not have a dedicated risk management team. In 2020, responsibility for risk management transferred from the health and safety department to the corporate governance team, but resources did not transfer with the responsibility. The previous corporate governance manager, now Head of Risk / Deputy Board Secretary is responsible for risk management. At the time of our fieldwork, risk management capacity only equated to a 0.4 WTE employee. We are aware that the Trust is recruiting to two vacancies within the corporate governance team; a band 6 Risk Officer and a Corporate Governance Manager, who is joining the Trust in October 2022. At operational levels, there are no risk managers, instead senior leaders are responsible for risk management. Risk registers are reviewed at fortnightly assistant directors' meetings and monthly at executive team meetings. Given the level of risk the Trust carries, along with its ambition to deliver its risk transformation programme, resources for risk management are limited.

28 We reviewed the Trust's updated corporate risk register, reported to the Audit Committee in June 2022, and four of the top risks clearly articulate quality and patient safety risks. The Trust uses a 'if', 'then', 'resulting in' model to describe each risk, this clearly shows the consequence of not taking any mitigating actions. For each risk, the register sets out the controls, assurances mechanisms and actions to reduce gaps in controls and the risk score. However, the risk scores for these risks remain high. The risks, which are assigned to the relevant committees for scrutiny are:

- the Trust's inability to reach patients in the community causing patient harm and death (risk score 25).
- significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service (risk score 25).

- high absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service (risk score 20).
- failure to embed an interdependent and mature health and safety culture which could cause harm and a breach in compliance with Health & Safety statutory legislation (risk score 20).

29 In May 2022, the Trust received a reasonable assurance internal audit report on risk management systems. The review made five recommendations, one high priority, two medium and two low. The high priority recommendation related to the operations directorate risk management and escalation arrangements. Internal audit found that whilst risk is a regular agenda item at the newly established Senior Operational Team meeting, this is limited to corporate and directorate level risks and does not include high scoring local risks. It also found unclear escalation processes and inconsistent monitoring and management of Operations Directorate risks. The Trust is responding to these recommendations as part of its risk transformation programme.

Organisational culture and quality improvement

30 NHS organisations should be focused on continually improving the quality of care and using finite resources to achieve better outcomes and experiences for patients and service users. Our work considered the extent to which the Trust is promoting a quality and patient-safety-focused culture, including improving compliance with statutory and mandatory training, participating in quality improvement processes that are integral with wider governance structures, listening and acting upon feedback from staff and patients, and learning lessons.

31 We found that **the Trust is investing in operational quality improvement, is taking steps to improve its organisational culture and the Board regularly hears from service users and staff. However, there is a worrying backlog of mortality reviews, which needs greater Board visibility as does delivery of the clinical audit; there is also a need to improve Board member walkabout arrangements.**

Quality improvement

32 **The Trust is investing in quality improvement, however, a recent funding challenge is hindering further investment. Clinical audit needs strengthening and the there is a need to address the substantial backlog of mortality reviews.**

Resources to support quality improvement

33 The Trust's Quality Improvement (QI) Team supports operational staff on quality improvement challenges, projects, and training. The Trust expanded the team of two to seven in 2019 after successfully securing funding through the Healthier

Wales and Regional Improvement and Innovation Coordination Hub funds. The Healthier Wales funding is recurring and specifically to implement a programme for improving the experience of care for older people. Welsh Government awarded Regional Improvement and Innovation Coordination Hub funding has been extended annually, on a fix-term basis, since 2020. The Trust is currently reviewing the QI Team. The Trust had also planned on further expanding quality improvement support by recruiting four senior quality leads by the start of 2022-23. These roles were central to delivering the Trusts quality strategy. However, as highlighted in **paragraph 23** the Trust was unable to secure recurrent funding for these posts, so will need to seek alternative funding and alternative delivery methods.

34 The Trust launched the WAST Improvement and Innovation Network (WIIN) in 2017 to drive consistent quality improvement across the organisation. The cross-directorate network, coordinated by the Quality Improvement Team, supports staff with quality improvement projects, training, and communications. The network is also a key link for improvement bodies and teams across other organisations and health bodies, aiding cross working. In March 2019, the Trust established an online portal for WIIN. Hosted on the Trust's intranet, the portal allows staff to submit suggestions and ideas for improvement proposals. Once ideas are submitted, the WIIN Business Group formally review the ideas using a scoring matrix and categorise into areas of research, audit or clinical improvement. Clinical improvement proposals are generally taken forward by the Clinical Improvement Team. The Trust reports the number of project ideas submitted in its integrated quality and performance report. In June 2022 there were 22 submissions. The Trust reported that the WIIN platform is currently focusing on improving patient handover delays at hospital and rolling out the Electronic Patient Care Record (see paragraph 75). During the height of the pandemic, the Trust redeployed members of the Quality Improvement Team to support core Trust services and paused much of the quality improvement activity, this is now slowly resuming.

35 Improvement in Practice is the national quality improvement training programme for NHS staff in Wales, it replaced Improving Quality Together (IQT) in January 2020. The goal of the programme is to develop quality improvement capability within NHS Wales using a common language for quality improvement. About a fifth of Trust staff (20.5%) completed the bronze IQT training and 1.1% completed silver training. The Trust reported that completion of silver IQT projects was impacted by the pandemic, accounting for the low compliance. As IQT was ending the Trust started offering training delivered by the Scottish Improvement Leader to broaden training opportunities for staff. The Trust has not set a target for staff completing this training, but it is working with Improvement Cymru to understand and maximise training opportunities.

Clinical audit

36 Clinical audit is an important way of providing assurance about the quality and safety of services. The Trust's Clinical Audit Team, employing 12.73 WTE staff, provides training and support to clinical team leaders such as senior paramedics. The type of support provided by the team includes developing audit proposals, preparing and collating data (for example patient clinical records) and writing audit reports. The Trust does not have a clinical audit policy but following an internal audit recommendation has developed a clinical audit guide and audit proposal template to support staff.

37 We found that Board level reporting on the Trust's clinical audit plan is sporadic and not timely. After pausing clinical audit work during the pandemic, the Trust reinstated it by mid-2021. During 2021-22, the QuESt Committee received brief updates on clinical audits through the quality assurance report. However, we have found no evidence of an approved 2021-22 clinical audit plan. Without an approved plan it is difficult to understand the extent of delivery and the level of assurance on the risks faced. A clinical audit plan has been produced for 2022-23 but the timeliness of its approval remains an issue. The Clinical Intelligence Assurance Group and Clinical Quality Governance Group have both reviewed the 2022-23 clinical audit plan in April 2022, but the QuESt Committee did not receive it for formal approval until August 2022.

38 Operational groups and forums consider progress of clinical audit activity, and the Trust provides updates on its intranet for staff to access. However, there is insufficient coverage of clinical audit progress and any risks the work highlights at the QuESt Committee (**Recommendation 2**).

Mortality reviews

39 Mortality review meetings provide a systematic approach for the peer review of patient deaths to reflect, learn and improve patient care. Mortality reviews are conducted when a patient dies whilst in the Trust's care, including whilst waiting for an ambulance to arrive. To aid learning the Trust also reviews cardiac arrests where patients have survived. A Serious Case Incident Forum scrutinises issues identified through mortality reviews.

40 The Trust aims to present mortality reviews and lessons learned to the QuESt Committee quarterly. But our review of QuESt Committee papers shows there is inadequate reporting on mortality reviews (**Recommendation 3**). Whilst mortality reviews feature regularly in QuESt Committee papers, through the quality assurance and, more recently, the integrated quality and performance reports, papers include no substantial detail. Officers periodically report on the backlog of cases, but reporting does not include the number of reviews conducted or detail lessons learned. This means the committee is not receiving assurances that mortality reviews are taking place or how they are helping to improve quality and patient safety. The committee does, however, receive details on coroner's activities

through the patient safety highlight report. The report details case numbers, outline of hearings and lessons learned for cases where the Trust was an interested person.

41 Since May 2021, the Trust has highlighted challenges in undertaking timely mortality reviews. This is due to several issues, namely the volume of reviews, lack of clinical resources to conduct the reviews when the Trust is working at its highest escalation level (REAP 4), and issues downloading data from the Trust's patient monitoring system (Corpuls). Together these issues have caused a backlog of reviews. The Trust has not reported its mortality review backlog to the QuESt Committee since September 2021, at the time it stood at 450 cases (**Recommendation 4]**. By August 2022, the backlog had grown to 800 cases. The Trust reported that it is working with the Corpuls support team and its internal IT team to resolve the data issues.

42 The Trust has recognised that its current mortality review process needs to improve. In March 2022, the Trust held a workshop to review the All-Wales Learning from Mortality Reviews Framework (the Framework) and consider how the Trust could implement it. The Framework recommends mortality reviews follow the Putting Things Right process. While adopting the Framework, the Trust would like to retain an element of their current system to review the care provided to patients who die in their care. Officers presented the outcome of this workshop to the QuESt Committee in August 2022.

Values and behaviour

43 **There are important cultural issues to address around incidents reporting, appraisal rates, and perceptions of bullying and harassment, which the Trust has the opportunity to address through embedding its refreshed organisational behaviours.**

44 Clearly articulated values and behaviours are central to ensuring strong quality and patient-safety-focused culture, promoting continuous improvement, openness, transparency and learning when things go wrong. In March 2021, the Trust commissioned external psychologists to review and refresh its organisational behaviours. The work, supported by a panel of representative staff, included extensive staff engagement through focus groups, interviews and surveys. In November 2021, the People and Culture Committee received the outcome of the review and an action plan for embedding the refreshed behaviours. Officially launched in March 2022, the refreshed behaviours focus on wellbeing, inclusion, belonging and leadership with compassionate conversations. Subsequent committee papers show that the Trust is starting to use the behaviours to improve organisational culture, for example recruitment practices and how it manages sickness management. Nevertheless, sickness absence has been and continues to be a long-standing challenge.

45 All staff have access to and are encouraged to use the Datix system to report incidents and near misses. The Trust's Concerns Team provide operational staff

with regular and ad-hoc training on using the Datix system and a variety of other concerns management skills (for example, undertaking root cause analysis, completing patient clinical records, and taking witness statements). Of the 30 staff who completed our survey[1], most (23 out of 30) agreed or strongly agreed that the organisation encourages staff to report errors, near misses or incidents. However, worryingly, less than half agreed or strongly agreed that staff involved in an error, near miss or incident are treated fairly by the organisation (14 out of 30), that the organisation acts to ensure that errors, near misses or incidents do not happen again (12 out of 30); and that the organisation gives staff feedback about changes made in response to reported errors, near misses and incidents (11 out of 30). This reveals a potentially concerning picture in relation to the culture around reporting errors, near misses or incidents and raising concerns.

46 It is worrying that Trust staff responding to the 2020 NHS Wales staff survey[2] reported high levels of bullying, harassment, or abuse by a member of the public (25.5%), a colleague (19.1%) or line manager (11.3%) over the past year. And fewer than half (46.2%) agreed or strongly agreed that the organisation takes effective action. The Trust recognises that bullying and harassment is an issue, and it is encouraging to see action taken through its work to embed its refreshed organisational behaviours. For example, the Trust's 'With Us, Not Against Us' campaign aims to tackle violence and aggression against staff and initiatives such as the 'Warm WAST Welcome' aim to engender a welcoming and open culture. In addition, the Trust has committed to a harassment and bullying review through its Behaviours Delivery Plan.

47 Statutory and mandatory training is important for ensuring staff and patient safety and wellbeing. In June 2022, the Trust met the 85% statutory and mandatory training compliance target. While the Trust is progressing with mandatory training, Personal Appraisal and Development Reviews (PADR) needs strengthening. PADR is a two-way discussion which helps staff understand what the Trust expects of them in their role and become more engaged and take responsibility of their own performance and development. The NHS target for PADR compliance is 85%, the Trust consistently falls below this target, compliance in June 2022 was 59%. Between July 2020 and June 2022, the highest compliance rate the Trust achieved was 65% and the lowest 45%. This target is generally unmet across health bodies. To improve compliance the Trust is encouraging staff to engage in their personal development through campaigns promoted on its intranet (#WASTMakeItHappen) and where appropriate increasing access to e-learning. However, given the low

[1] We invited staff working across operational services to take part in our online attitude survey about quality and patient safety arrangements. The Trust publicised the survey on our behalf. Although the findings are unlikely to be representative of the views of all staff across operational services, we have used them to illustrate particular issues.

[2]The NHS Wales staff survey ran for three weeks in November 2020 at the same time as the second surge in Covid-19 transmission and rising numbers of hospital admissions. The survey response rate was 39%.

compliance rates, the Trust should look at whether staff are given enough time for PADR activities and, through its refreshed behaviours, ensure leaders and managers encourage compliance (**Recommendation 5**).

Listening and learning from feedback

48 **The Trust has good arrangements for listening and learning from service users and staff, who the Board hear from regularly, but there is scope to improve Board member walkabouts.**

Patient experience

49 Patient experience is integrated into the Trust's existing strategies and plans. For example, one of the three quality drivers in the Trust's Quality Strategy is 'to ensure a positive patient outcome and experience', through 'embracing the contribution of patients and service users'. To support this approach the Trust uses a continuous engagement model to drive patient and service user engagement.

50 Each quarter, the QuESt Committee receives several reports which highlight aspects of patient experience. At each meeting, the committee receives:

- the patient experience and community involvement report, which highlights the work of the Patient Experience and Involvement Team;
- The patient safety highlight report which updates the committee on key information related to Putting Things Right and patient safety; and
- the integrated quality and performance report that includes some indicators related to patient experience.

51 While each of these reports individually highlights lessons learned, it would be beneficial to triangulate learning themes and improvement priorities across the reports (**recommendation 8a**).

52 The Trust's Patient Experience and Involvement team (11.8 WTE) use a range of techniques to seek patient and user feedback such as the 'have your say' facility on its website, feedback through social media channels, documenting patient stories, running engagement events and patient experience surveys for non-emergency patient transport service users. The Trust also has a People and Community Network, which is a service user panel made up of members of the public, service users, patient group representatives and other interested services and organisations. The network informs service improvement through activities such as commenting on the readability of leaflets, completing surveys, undertaking mystery shopping exercises and attending meetings. As at June 2022, the network had 95 members, which the Trust is continuing to grow.

Patient and staff stories

53 The Board, QuESt Committee, and more recently the People and Culture Committee, routinely receive patient and staff stories. The Trust actively seeks out

patient stories, both from its emergency response and 111 services. The Patient Experience and Involvement Team actively contact service users that make a complaint to involve them in patient stories. In some cases, the complainant is offered the opportunity to record their experience for the Board. The Trust alternate patient and staff stories, so the Board and committees also regularly hear staff stories. Recently the Board has heard from a nurse working in the 111 service, a senior paramedic, 999 call-takers and the son of a frequent faller.

54 The Trust uses a driver diagram to ensure the learning and actions from patient stories are making a difference. In addition to summarising the story, the driver diagrams helpfully outline what the Trust aims to do, what this requires, ideas to make this happen, and action points. This is a good process to ensure learning from patient stories, although the Trust explained that some changes can take a long time to action because the issues are complex in nature.

Board member walkabouts

55 As with other health bodies, the Trust suspended its Board member patient safety walkabouts during the pandemic. Prior to this, Board members regularly participated in ambulance ride-outs and station visits. But these were ad-hoc in nature and the Trust did not collate structured feedback. However, the Trust reported that Board member engagement has enhanced during this period. Where restrictions allow, Board members continue to engage with staff, for example through site visits, CEO roadshows and long service awards. Now that restrictions have eased the Trust will be restarting formal patient safety walkabouts. This is a good opportunity for the Trust to develop a standard operating procedure for walkabouts which clarifies the process, frequency of visits and ensures coverage across the Trust's operations and geographical areas. The standard operating procedure should also include a standard template to capture feedback and set out how it will be reported (**Recommendation 6**).

56 The Trust reported that it will adopt the all-Wales principle being drafted for Board level walkabouts and this should be included in the standard operating procedure.

Governance structures and processes

57 Our work considered the extent to which organisational structures and processes at and below board level support the delivery of high-quality, safe, and effective services.

58 We found that **the Trust has a clear quality governance structure, and it is taking steps to improve the QuESt Committee sub-structures. While the Trust's internal arrangements for managing concerns and serious incidents operates well, the interface with other bodies and handling of incidents through the joint escalation framework is not effective.**

Organisational design to support effective governance

59 The Trust is commissioned by the Emergency Ambulance Services Committee (EASC). EASC is a joint committee of the seven health boards in Wales. Each health board chief executive is a member of EASC. Collectively, the committee commissions the Trust to deliver safe, quality driven services. Ultimately, EASC is responsible for overseeing the quality and improvement of the services it commissions. The committee has some quality assurance processes in place. For example, in 2016, it introduced ambulance quality indicators[3]. EASC review the quality indicators at each joint committee meeting alongside other performance reports. The committee also receives other ad-hoc quality and safety reports and routinely reviews the EASC risk register.

60 The Quality and Performance Framework states that overall accountability for quality and performance rests at Trust Board level, but everyone in the Trust has a responsibility for quality and performance. At a practical level, the Executive Director of Quality and Nursing is the executive lead for quality and patient safety, but the responsibility is shared with the Executive Medical Director who holds responsibility for clinical effectiveness. Assistant directors and heads of service support the Trust's executive team providing day to day leadership on a range of functions such as quality governance, quality improvement, patient experience, patient safety and concerns and clinical effectiveness.

61 Oversight and assurance on quality and safety matters within the Trust takes place through its QuESt Committee. The Trust is in the early stages of reviewing the number and make-up of the groups which inform the QuESt Committee with the intention of improving the connection to frontline operations, this is a commitment in the Trust's Quality Strategy. Currently, there are seven groups which feed into the Clinical and Quality Governance Group, which reports up to the Executive Management Team. These groups are:

- Clinical & Quality Governance Group
- Patient Safety Learning and Monitoring
- Serious Case Incident Forum
- Complex Case Management
- Scrutiny Panel
- Health and Safety Committee
- Infection Prevention and Control Steering Group

62 Issues covered and escalated by the groups above inform update reports to the QuESt Committee and the Board. However, the current number and remits of

3 EASC and the Trust jointly developed the Ambulance Quality Indicators to monitor the quality of patient care as well as response times. Indicators are reported along the Five Step Ambulance Care Pathway; help me choose, answer my call, come to see me, give me treatment and take me to hospital.

these groups creates a risk of duplication and the current review creates an opportunity to rationalise the structure.

63 The Trust has a straightforward organisational structure. It has one Operations Directorate which houses the majority of clinical contact centre and response team staff. The other directorates perform enabler, support, and research functions, including the Quality, Safety & Patient Experience Directorate. Quality guidance, policy and information is cascaded operationally, however the geographical spread of operational staff and shift patterns can make this difficult.

Handling complaints and incidents

64 The Trust has sufficient capacity for managing complaints and concerns in accordance with the Putting Things Right process. There are 18.4 WTE staff in the Concerns Team, who manage complaints and provide concerns management training to operational staff. The team work closely with the patient safety team to help identify near-misses and adverse events, which feeds into organisation-wide learning. During the pandemic, the Trust deployed members of the Concerns Team to support the Trust's pandemic plan. During this time, the team's activity reduced because volumes of concerns received were lower and coroners' inquests were paused. Now that activity has resumed, the team's workload has increased, stretching its capacity. In June 2021, the Trust received a substantial assurance report from internal audit on its concerns and serious incident management systems.

65 In 2019, the Trust and all trusts and health boards agreed a joint investigation framework for serious patient safety incidents. The framework sets out the process for escalating serious incidents where the main cause is a factor outside of the Trust's control or because of health board hospital handover delays.

66 The Trust identifies cases for escalation through its Serious Case Incident Forum (SCIF). In these cases, the Trust completes an incident referral form (known as an Appendix B form) and sends it to the appropriate health body for investigation, copying in the Welsh Government's Delivery Unit. In May 2022, the Trust received a report from the Delivery Unit outlining findings from their analysis of 'Appendix B' reports. The review found that the framework is no longer effective, given that significant numbers of Appendix B referrals are not investigated properly or reported nationally because of a breakdown in communications between the Trust and health boards. The report made four recommendations:

- to establish a task and finish group to revisit the Framework to ensure the process is fit for purpose and is updated to reflect current national policy regarding patient safety incidents.
- the task and finish group should be coordinated by the EASC, as the body responsible for the delivery of WAST services, and the commissioning arrangements between WAST and health boards and trusts.

- WAST and EASC should update their relevant committee and the Board and consider sharing to nurse directors so they may assess their position.
- the revised policy is endorsed via Nurse and Medical directors and relaunched at the earliest opportunity.

67 The Emergency Services Ambulance Committee is now coordinating action to strengthen arrangements. The Trust must work with its commissioners and partner health bodies to respond to the Delivery Unit's recommendations (**Recommendation 7**). This should ensure strong and effective approaches for quality assurance, escalation, and immediate improvement actions, and wider learning where quality issues cross organisational boundaries.

Arrangements for monitoring and reporting

68 Our work considered whether arrangements for performance monitoring and reporting at both an operational and strategic level provide an adequate focus on quality and patient safety.

69 We found that **the Trust recognises the challenges posed by Covid-19 and is taking steps to improve quality monitoring by improving the data it collates and quality management systems.**

Information for scrutiny and assurance

70 **The Trust has good resources for data analytics and is taking steps to improve the quality, timeliness and integration of data to support quality improvement. However, more needs to be done to ensure that patient outcomes and extent of avoidable harm are fully understood, especially for patients experiencing long waits for ambulance services.**

71 The Trust is clearly committed to assessing how Covid-19 is continuing to affect the service it provides. The quarterly integrated quality and performance report, presented to the Board and its committees, includes a Covid-19 activity dashboard. The metrics included in the dashboard have evolved over the course of the pandemic, with more detail provided during significant waves. It includes information such as cases per 100k population, hospital and ventilated bed occupancy rates and service demand linked to Covid-19. Narrative in performance and assurance reports outline the impact of the pandemic on key performance measures and remedial actions.

72 Whilst there is sufficient information about the effect of Covid-19 on service delivery, there is less about the harm caused to patients by issues such as long ambulance waits or people avoiding accessing emergency services (**Recommendation 8b**). The Delivery Unit report (paragraph 65) highlighted that there is a lack of national data to capture and understand the harm caused by the Trust's inability to respond and treat seriously unwell patients in the community during periods of high handover delays. Much more needs to be done to ensure

quality systems join up, so that the patient outcomes are fully understood particularly when there are service failings such as extensive delays in access to ambulance services (**recommendation 8c**). Linked to this issue, the Trust will need to ensure that it complies with the new Duty of Candour, which requires clear quality standards, underpinned by quality data, that act as a trigger for the duty of candour when services fall short of expected levels.

73 The Trust has good data analytics support. The Health Informatic Team employs 22 WTE staff and supports the organisation by developing daily, weekly and monthly performance reports. The team coordinates live reports through information management systems such as Qliksense, Report Manager and Microsoft Power BI. The Team also supports service delivery and decision making through data analysis, modelling and forecasting.

74 In February 2022, the Trust received a reasonable assurance Internal Audit report on information management. The Internal Audit review focused on 999 calls, specifically information on patient discharges through 'Consult and Close', 'See and Treat' and 'Can't Send' treatment pathways and how this is analysed to inform patient safety and quality improvement. The Trust received two medium priority recommendations. These related to making greater use of referral data captured in incident records to improve referral pathways and to reduce the risk of patient harm, extend the sample review of ‘Can’t Send’ call response to include ‘See and Treat’ and ‘Consult and Close’ and ensure learning is routinely reported at an appropriate group.

75 The Trust is improving its system for collating clinical indicators. Until recently, the Trust was using Digi Pen, a semi electronic patient records system. One of the main issues with Digi Pen was limited integration with health board systems. This meant it was difficult to track a patients’ journey and outcome after they have been handed over to an emergency department. The Trust is in the process of rolling out the Electronic Patient Care Record. This new system, which will be fully implemented by March 2023, is fully electronic and integrated with NHS Wales systems such as health board emergency department systems and the Welsh Care Records Service. The Trust is also working with Digital Health Care Wales on an interface with GP records. The Electronic Patient Care Record provides opportunities for better and more timely data and enables sharing of information between NHS bodies to improve the patient journey. The data from the new system will inform the clinical indicators as part of the ambulance quality indicators[4] and metrics within the Trust’s clinical strategy.

Coverage of quality and patient safety matters

76 **The QuESt Committee is well served with quality information but reporting on mortality reviews and clinical audit needs greater focus. There are**

opportunities to better triangulate data and learning presented in different quality assurance reports and to develop patient outcome measures.

77 The Trust's Integrated Quality and Performance report focuses on key national measures and is broadly aligned to the quadruple aims within A Healthier Wales. The Board and its committees, including QuESt, receive the report at each meeting. One of the four sections in the report called 'our patient' covers quality, safety, and patient experience. It includes measures such as 111 and 999 call handling, stroke, and acute coronary care, over 12 hour waits, nationally reportable incidents and concerns response in 30 days. The report has a clear format with written analysis against each measure, remedial actions and expected performance trajectory. A cover report highlights key issues. Whilst the report gives a good overview of quality and patient safety performance, there is scope to include patient outcome measures and to better triangulate data (**Recommendation 8b**). It is particularly important to understand the outcomes for patients who have waited excessively, outcomes for those who called for an ambulance but cancelled due to long waits, and how outcomes are affected positively or negatively by, for example, implementation of the new Clinical Safety Plan. This will require joining up of systems across organisational boundaries between the Trust and health boards.

78 Aside from the Integrated Quality and Performance report, the QuESt Committee regularly receives other quality and patient safety assurance reports. These include:

- Patient Safety Report
- Quality Highlight Report
- Patients Experience and Community Involvement Highlight Report
- Red review activity
- Operations directorate quarterly report
- Quality Strategy progress report

79 Until September 2021, the QuESt Committee received a Quarterly Quality Assurance report which reported in line with the health and care standards. Since then, as stated on paragraph 76, the integrated performance report has included a section for 'quality, safety and patient experience', whilst this provides a good high-level summary, some of the quality focus and detail in the original Quality Assurance report has been lost. Quality metrics are available separately in the reports listed above but there is merit in the committee receiving a quality assurance report which highlights and triangulates key themes, trends and learning points (**Recommendation 8a**). Also as highlighted in paragraphs 37 and 40, the committee should receive regular and detailed updates on the Trust's clinical audit plan (**Recommendation 2)** and mortality reviews (**Recommendation 3)**.

80 The Trust is in the process of improving its performance reports. Since March 2022, the QuESt Committee highlight report received by the Board uses an 'Alert, Advise and Assure format:

- Alert – alert the Board to areas of escalation.
- Advise – details any areas of on-going monitoring, approvals, or new developments.
- Assure – details any areas of assurance the Committee has received.

81 This format is an improvement on the previous highlight report as it aims to draw Board members to the committee's key concerns. The format is still new, so the Trust is keeping it under review with a view to strengthening it further.

Appendix 1

Management response to audit recommendations

Exhibit 2: management response

Recommendation	Management response	Completion date	Responsible officer
Quality Strategy delivery R1 We found that delivery of the Trust's renewed Quality Strategy (2021-2024) has been severely hampered by resource pressures caused by the pandemic and a lack of funding to support four senior quality lead posts which are central to delivery. The Trust should update its implementation plan outlining how it will deliver its quality ambitions.	Following discussion by the Trust Quality Committee in August 2022, a revised implementation action plan will be developed.	November 2022	J Turnbull-Ross

Recommendation	Management response	Completion date	Responsible officer
Clinical Audit Plan R2 We found that the clinical audit plan is not approved in a timely manner and the QuESt Committee does not have adequate oversight of progress and delivery. The Trust should ensure that: • the QuESt Committee scrutinises and approves a clinical audit plan ahead of each financial year. • QuESt Committee receives quarterly updates on delivery of the approved clinical audit plan, assurance reports including learning and improvement actions resulting from this work.	The Annual Clinical Audit Programme will be incorporated into the Committee's cycle of business ensuring it is presented to QuEST for scrutiny and approval ahead of each financial year. The Clinical Audit Programme will then be monitored on a quarterly basis by the Clinical Intelligence Assurance Group and updates providing assurance on learning will be submitted to the Clinical and Quality Governance Group. This group will escalate matters for information, assurance, or alert/action to QUEST Committee.	Q3 2022/23	D. Robertson

Recommendation	Management response	Completion date	Responsible officer
Mortality reviews R3 The QuESt Committee does not receive adequate assurances on mortality reviews. The Trust should ensure the QuESt Committee receives quarterly update reports to include: • the number of reviews undertaken and the numbers of reviews required but not yet complete. • any significant concerns, lessons learned and what changes have been made as a result. • updates on actions to address the mortality review backlog	Monthly oversight of the All Wales Mortality Review Framework now occurs at the Clinical Quality Governance Group on a monthly basis via the Alert / Advise / Assure process (Executive led) with onward assurances / updates to QuEST through the CQGG reporting mechanisms. Detailed reporting including organisational and system learning will be included in the Quarterly Patient Safety Report (standing agenda item at QuEST) from Q2 2022/3.	CQGG oversight commenced Q1 2022/23. QuEST reporting from November 2022.	M Jenkins / J Palin

Recommendation	Management response	Completion date	Responsible officer
• updates on progress implementing the all-Wales Learning from Mortality Reviews Framework			
Mortality reviews R4 The Trust has a significant backlog of mortality review. The Trust should develop an action plan to reduce the backlog, reporting progress at each QuESt Committee.	Action will be taken to establish the challenges in this area and implement process improvement to resolve future backlog. A report will be provided to CQGG on progress.	Q3 2022/23	M Jenkins / J Palin
Personal Appraisal and Development Reviews (PADR) R5 The Trust has low PADR compliance rates, for example in March 2022 the	The Trust acknowledges compliance is below the 85% target. The Trust is currently assessing current PADR process, with a view to development. Performance is improving, with a positive trajectory.	Q4 2022/23	L Rogers

Recommendation	Management response	Completion date	Responsible officer
Trust's compliance was 51% against the 85% target. As part of embedding its new behaviours, The Trust should ensure that PADR rates are improved and set out the actions it will take to achieve this.	The People & Culture Committee will continue to receive progress reports on a quarterly basis.		
Board member walkabouts R6 Prior to the pandemic, Board members regularly participated in ambulance ride-outs and station visits, but these were ad-hoc in nature and feedback was not collated in a structured way. Now that visits can restart the Trust should develop a standard operating procedure which clarifies the process, frequency of the visits and ensures	The SOP is in development and will include a formal feedback mechanism to facilitate any learning.	March 2023	T Mills

Recommendation	Management response	Completion date	Responsible officer
coverage across the Trust's operations and geographical areas. It should also include a standard template to capture feedback and learning.			
Joint Investigation Framework R7 The joint escalation framework in place with health bodies is no longer effective. The Trust must ensure that the recommendations made by the Delivery Unit are effectively responded to in a timely fashion and progress reported regularly to the Board and QuESt Committee.	The Trust is actively contributing to work with partners across Emergency Services Ambulance Committee regarding the Joint Escalation Framework. Recommendations and/or actions arising on this matter will be reported accordingly to QUEST Committee.	Q4 2022/23	W Herbert

Recommendation	Management response	Completion date	Responsible officer
Quality performance reporting and learning R8 We found that the QuESt Committee is well served with quality information, but there are opportunities for improvement. The Trust should: • a) Develop a system to triangulate learning themes across its quality assurance reports. This should ensure clarity about what improvement actions have been taken as a result and how learning has been disseminated across the organisation. • b) Enhance Covid-19 reporting in the integrated quality and performance report	• a) The Trust, through the Quality Strategy, is seeking to develop a quality management system. This will improve triangulation of information, clarity of position, and impact of improvement effort. • b) The recommendation will be considered by the MIQPR team; considering the accessibility and accuracy of this data noting the changes to approach due to 'living with covid' context. • c) The Trust will continue to share information and intelligence with partners that detail the consequences of system failures. Whilst particularly evident where experience or outcome is poor and results in complaint or adverse incident. The Trust will pursue patient outcome data through development of the ePCR over 2022/23.	Q4 2022/23	J Turnbull-Ross W Herbert H Bennett

Recommendation	Management response	Completion date	Responsible officer
by including information about the harm caused to patients by ongoing service pressures caused by the virus. • c) Work with health bodies so that there are systems to determine the outcomes for patients who have received emergency ambulance services. This should particularly seek to understand the consequence and harm resulting from service failures such as long ambulance waits. • d) Develop patient outcome measures to support its existing quality measures.	• d) The Trust is often limited by data accessibility where the patient journey extends beyond the organisational boundary. The Trust will pursue patient outcome data through development of the ePCR over 2022/23, which will enable 'joining up' of patient records. Furthermore, the Trust will further consider accessibility and governance matters for wider adoption of Patient Reported Outcome Measures, and Patient Reported Experience Measures.		

Appendix 2

Staff survey findings

Exhibit 3: staff survey findings

Attitude statements	Number of staff agreeing or disagreeing with statements						Total respondents
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know	
Delivering safe and effective care							
1. Care of patients is my organisation's top priority	11	11	3	4	1	0	30
2. I am satisfied with the quality of care I give to patients	0	12	1	7	7	3	30
3. There are enough staff within my work area/department to support the delivery of safe and effective care	1	1	5	14	8	1	30
4. My working environment supports safe and effective care	2	15	6	3	2	1	30

Attitude statements	Number of staff agreeing or disagreeing with statements						
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know	Total respondents
Delivering safe and effective care							
5. I receive regular updates on patient feedback for my work area / department	2	3	4	11	6	4	30
Managing patient and staff concerns							
6. My organisation acts on concerns raised by patients	5	21	1	1	0	2	30
7. My organisation acts on concerns raised by staff	2	10	6	9	1	2	30
8. My organisation encourages staff to report errors, near misses or incidents	3	20	2	3	1	1	30
9. Staff who are involved in an error, near miss or incident are treated fairly by the organisation	4	10	6	1	4	5	30

Attitude statements	Number of staff agreeing or disagreeing with statements						Total respondents
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know	
Managing patient and staff concerns							
10. When errors, near misses or patient safety incidents are reported, my organisation acts to ensure that they do not happen again	2	10	12	3	2	2	30
11. We are given feedback about changes made in response to reported errors, near misses and incidents	2	9	4	9	2	4	30
12. I would feel confident raising concerns about unsafe clinical practice	6	15	3	3	2	1	30
13. I am confident that my organisation acts on concerns about unsafe clinical practice	7	9	6	5	1	2	30

Attitude statements	Number of staff agreeing or disagreeing with statements						Total respondents
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know	
Working in my organisation							
14. Communication between senior management and staff is effective	2	7	6	7	8	0	30
15. My organisation encourages teamwork	2	13	6	7	1	1	30
16. I have enough time at work to complete any statutory and mandatory training	3	10	6	6	5	0	30
17. Induction arrangements for new and temporary staff (eg agency/locum/bank/re-deployed staff) in my work area/department support safe and effective care	1	11	6	3	4	5	30

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