Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Governance Review

Welsh Ambulance Services NHS Trust

May 2017

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In writing:

Communications Manager
Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

Or via

Phone: 0300 062 8163
Email: hiw@wales.gsi.gov.uk
Fax: 0300 062 8387
Website: www.hiw.org.uk

Digital ISBN 978 1 4734 9763 4

WG 30950

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1. What we did

Healthcare Inspectorate Wales (HIW) has a responsibility to provide the public with independent and objective assurance of the quality, safety and effectiveness of healthcare services, making recommendations to healthcare organisations to promote improvements.

As part of its responsibility HIW needs to assure itself that NHS organisations have effective governance arrangements that promote safe and effective care.

HIW Review Outline

In order to test the effectiveness of governance arrangements, we considered how effectively Welsh Ambulance Services NHS Trust (WAST) is managing and learning from:

- Complaints/concerns from receipt to resolution;
- The reporting and management of incidents;
- Commissioned Reviews;
- Recommendations from External Bodies;
- Compliance with guidance and Welsh Government and Care Standards; and
- The role of the Quality, Patient Experience and Safety Committee in providing assurance regarding safeguarding and improving patient safety.

The review evaluated how WAST used this information to address safety, concerns and improve services.

HIW's methodology for the review consisted of:

- Document and data analysis;
- Analysis of a HIW issued self-assessment form and supporting documentation;

- Interviews with staff over a two week period[1];
- Liaison with the Board of Community Health Councils (CHC) in Wales regarding patient feedback;
- Observation of the Quality, Patient Experience and Safety Committee; and
- Observation of the Clinical Contact Centre for south east Wales.

The review team consisted of HIW Review Manager and a Peer Reviewer with extensive knowledge and expertise in relation to Governance.

[1] Job titles of those interviewed outlined in Annex B

2. Context

WAST was established in 1998, with NHS Direct Wales[2] becoming an integral part of the Trust in April 2007. WAST provides a service to a population of over three million.

Emergency Ambulance Services are commissioned on a collaborative basis underpinned by a national collaborative commissioning and delivery framework. All seven of Wales' Health Boards have signed up to the framework, with emergency ambulances provided by WAST.

In July 2015 Tracy Myhill was announced as Chief Executive of the Welsh Ambulance Services NHS Trust (WAST) having held the post on an interim basis since October 2014. The appointment of a new Chief Executive coincided with significant organisation development, much of which relates to the subject matter of this review. Furthermore, there was another significant change in service delivery, the implementation of the new Clinical Model.[3]

The new Clinical Model aims to prioritise patient care, helping to assess 999 callers from a more clinical perspective to ensure the most appropriate care and response is provided. The new model introduced three new categories of calls, Red for immediately life threatening, Amber for patients who may need treatment at the scene and Green for less-serious calls.

[2] NHS Direct Wales provides nurse triage and health information 24 hours a day, 7 days a week, 365 days a year.

[3] See: https://www.ambulance.wales.nhs.uk/assets/documents/2ec9121f-367b-4848-977e-d31934cedcee635824069256103900.pdf

Part of organisational development included the development of a new shared Trust vision, purpose and behaviours. The vision is a reflection of engagement with just under 1,000 Trust staff[4].

[4] See: http://www.was-tr.wales.nhs.uk/Default.aspx?pad=310&lan=en

3. Summary

Overall, we have found that WAST has been able to demonstrate effective governance and leadership in relation to the areas that we examined.

The Trust's Quality, Patient Experience and Safety Committee, which has delegated responsibility for all matters relating to the quality of care WAST provides, appears to be working well with clear governance structures below well defined reporting lines. Papers were presented in good time and comprehensive; the Committee was well chaired; discussion was both challenging and supportive; and overall the discussion was informed and patient/clinical focused. Our observation of the Non-Executive Directors presented a group of individuals who demonstrated complementing expertise combined with an appropriate level of challenge and support.

WAST has restructured the way that concerns are being managed within the Trust. The Putting Things Right team, Patient Safety team and Partners in Health team have all been brought under the responsibility of the Quality, Safety and Patient Experience Directorate[5]. This restructure has been positively received by all staff HIW have spoken to as part of its fieldwork, the overriding view of staff being that this has helped to clarify and standardise processes, improve focus and afford clarity regarding lines of responsibility.

Alongside the restructure there has been investment in the staffing of the central Patient Safety, Concerns and Learning Team, as well as the design of a Sustainable Concerns Improvement plan and the adoption of a WAST bespoke all Wales Concerns weekly Tracker. The implementation of these measures has resulted in improved management of concerns and an increase in compliance with timeframes outlined within Putting Things Right guidance. For example, for the period April 2016 to August 2016 the 30 day response rate stood at 17%, for 1 April 2016 – 31 March 2017 it stood at 37%[6].

An improvement in the handling of concerns has been mirrored by the approach to manage Serious Adverse Incidents (SAI). WAST has devised and

[5] Completed in September 2016

[6] WAST provided figures at time of publication that indicate for the period 1 October 2016 – 31 March 2017 the Trust averaged 65% response to concerns within 30 days.

adopted a Serious Case Incident Forum (SCIF) to identify SAIs notifiable to Welsh Government. SCIF adopts a multi-disciplinary approach towards investigation of incidents and this has helped improve the way incidents are investigated, tracked and awareness raised amongst staff. WAST also has in place a Quality Steering Group (QSG) whose primary focus is to act as the main forum for the triangulation of quality data, informing quality assurance, improvements and organisational learning. Taken together, SCIF and the QSG mechanisms and discussion with relevant staff provide us with assurance that systems are in place to ensure comprehensive investigation of SAIs.

However, we found that improvements are required in terms of ensuring effective learning when it comes to staff reporting incidents. We were told that staff were not always informed of the outcome of an incident they may have reported. Furthermore, it was highlighted to us that the Datix system can hinder staff recording incidents as there is no facility to commence inputting an entry and return to completion at a later time.

A key aspect to the management of concerns and incidents is to ensure appropriate organisational learning in response. Evidence of mechanisms to support this became apparent throughout our review, and was probably best demonstrated through the work undertaken by the Patient Experience and Community Involvement (PECI) team. The PECI team works directly with service users and within the community in order to gain feedback from their concerns and experiences. This feedback is then used to inform shared learning and management, an example of this was the presentation at the Quality, Patient Experience and Safety Committee of a patient story. This provided an insight into user experience, good and bad, so that management could reflect on current practices and develop and improve services offered.

Staff often reflected to us that WAST is currently on an organisational journey, the intention to be an organisation with a culture of openness and support. To reflect this WAST developed a shared vision, purpose and behaviours with the ultimate goal to be a leading ambulance service providing the best possible care. Almost overwhelmingly during our discussions with staff at all levels, was the embracing of this new direction. An indication of this support is the results of the NHS Wales Staff survey for 2016. Whilst below overall NHS Wales scores,

WAST's scores demonstrate positive improvements compared to staff survey results for 2013[7].

However, it was also identified during our fieldwork that pockets of middle management are yet to embrace this change in organisational culture. Senior staff supported this viewpoint and are in the process of taking steps to support and address this. For example WASTs forthcoming team leadership programme will look to develop leaders who understand their responsibilities and help empower their staff to raise concerns and take forward the challenge of embracing a new open and supportive culture.

Overall our review has demonstrated an organisation that has effective leadership and has improved how it responds to and learns from concerns and incidents. WAST is an organisation that has re-engaged with its staff and is heading in the right direction but still has challenges ahead in ensuring that it continues its positive trajectory.

[7] See: *http://www.ambulance.wales.nhs.uk/assets/documents/5da36e00-1e47-4285-854c-0fa55e788f50636175031416660627.pdf*

4. What we found

What is the governance around concerns and incidents?

Governance Structures

The WAST Board comprises 13 members: a Chairman; seven Non Executive Directors (NEDs); a Chief Executive; and four Executive Directors. The Board's role includes several aspects, including a need to:

"*Establish governance systems to enable it to effectively measure progress and performance, and to make sure this is achieved*. [8]"

Supporting the Board are a number of formal Committees, each chaired by an Independent Member, these comprise:

- Audit Committee
- Charitable Funds Committee
- Finance and Resources Committee
- Quality, Patient Experience and Safety Committee
- Remuneration Committee

Audit Committee

The Trust's Audit Committee plays a vital governance role, key duties including scrutiny of:

- Governance
- Risk Management and Control
- Internal Audit
- External Audit
- Financial Reporting.

Meetings are held not less than three times a year and membership comprises no less than three NED's, Director of Finance, Chief Internal Auditor, External

[8] The Board's role is to: Set the policy and strategic direction of WAST; Manage the Risk; Manage its people and resources; and Work in partnership with key stakeholders, both internal and external.

Auditor and Executive Directors normally attend. Other senior managers may attend as appropriate and the Chief Executive is invited to attend at least annually to discuss processes for assurance. Unfortunately timings of our fieldwork and audit committee schedule did not coincide, thus we did not observe an audit committee meeting.

Quality, Patient Experience and Safety Committee

The Quality, Patient Experience and Safety Committee has delegated responsibility for all matters relating to the quality of care WAST provides, including oversight of complaints and incidents.

Quarterly quality assurance reports are provided to the Committee outlining the latest position regarding high risk[9] concerns, with highlight reports produced which outline key issues, including concerns and incidents. Our review of documentation and interviews with staff suggests that the governance structures, in terms of line of sight and reporting lines, were clear and appear to work well.

Other groups, such as the Quality Steering Group (QSG), Serious Case Incident Forum (SCIF) and the Patient Safety and Concerns Team feed into the Quality, Patient Experience and Safety Committee in relation to the escalation of concerns and incidents.

We observed the January 2017 Quality, Patient Experience and Safety Committee and found the breadth of agenda to be comprehensive and more clinical and wide ranging than expected, with our examination of previous committee agendas supporting that this was the normal approach. Papers were presented in good time and were clear and understandable. The Committee was also well chaired, control was held and the Committee's focus maintained. NEDs demonstrated a range of complementary expertise combined with an appropriate level of challenge and support.

The overall discussion at Committee was informed, patient/clinically focused, supportive and challenging where appropriate. For example we observed good

[9] Within PTR Guidelines there are 5 levels of grading. High risk concerns are deemed as Grades 4 (Severe Harm) and 5 (Death). See pages 150-151 of PTR Guidelines: http://www.wales.nhs.uk/sitesplus/documents/861/Healthcare%20Quality%20-%20Guidance%20-%20Dealing%20with%20concerns%20about%20the%20NHS%20-%20Version%203%20-%20CLEAN%20VERSION%20%20-%2020140122.pdf

discussions regarding the issues impacting the quality of service provided, such as too many non-emergency calls, how best to support patients who have fallen and effective triage in terms of saving unnecessary dispatches.

Our overall impression of the Quality, Patient Experience and Safety Committee was positive, with members of the Committee appearing to form a cohesive group with each making valuable contributions.

Quality, Safety and Patient Experience Directorate

The Trust has brought concerns under the responsibility of the Quality, Safety and Patient Experience Directorate. This has had the benefit of improving concerns management performance through clarifying roles and responsibility, and implementing a more robust structure. Interviews with staff were overwhelmingly positive in terms of the benefits this restructure has provided. Furthermore, the implementation of WAST's own weekly all Wales concerns tracker was an area of improvement highlighted by a number of staff, specifically in relation to how this has improved scrutiny and ownership.

Within the Directorate, leadership in relation to concerns and incidents, is provided by the Assistant Director of Quality and Patient Experience, supported by the Head of Patient Safety, Concerns and Learning. In order to further support WAST's delivery and compliance with Putting Things Right, the Board has taken steps to increase supporting roles including the recruitment of a Datix systems administrator and three additional administrators.

The portfolio of the Director of Quality, Safety and Patient Experience also includes in addition to Concerns, Patient Safety & Learning: Health and Safety, Risk Management, Quality Assurance, Quality Improvement, Safeguarding, Infection Prevention & Control, Patient Experience & Community Involvement and the Professional Standards and Education & Nursing. It is the intention that the integration of these functions will help in developing the Trust's quality assurance framework, improving the structure and processes that support the triangulation of quality data, assurance, learning and improvement.

Putting Things Right

Putting Things Right[10] (PTR) guidance, produced for the NHS in Wales, enables responsible bodies to effectively handle concerns according to the

[10] See: http://www.wales.nhs.uk/governance-emanual/putting-things-right

requirements set out in the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations ("the Regulations")[11].

PTR guidance applies to all Health Boards, NHS Trusts in Wales, independent providers in Wales providing NHS funded care and primary care practitioners in Wales.

The PTR guidance[12], states that concerns are: "…*issues identified from patient safety incidents, complaints and, in respect of Welsh NHS bodies, claims about services provided by a Responsible Body in Wales*".

The management of all incidents, concerns and complaints is in accordance with WAST's own PTR Policy. Our analysis of WAST PTR guidance found clear processes that support the handling of concerns in an open and supportive manner. Furthermore, we found the guidance to be clear regarding how WAST approach shared learning. The policy itself is in accordance with the all Wales management of concerns PTR process.

Serious Adverse Incidents

A significant incident is defined as any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS funded healthcare, or significant harm to an employee or contractor working for WAST.

Significant incidents are potentially reportable[13] to Welsh Government as Serious Adverse Incidents (SAIs).[14] The classification of a serious patient

[11] See: http://www.legislation.gov.uk/wsi/2011/704/contents/made

[12] See: http://www.wales.nhs.uk/sitesplus/documents/861/Healthcare%20Quality%20-%20Guidance%20-%20Dealing%20with%20concerns%20about%20the%20NHS%20-%20Version%203%20-%20CLEAN%20VERSION%20%20-%2020140122.pdf

[13] In conjunction with Putting Things Right Guidance on dealing with concerns about the NHS…Serious Adverse Incidents that occur anywhere within the Welsh Ambulance Services NHS Trust must be reported whenever possible within 24 hours of the occurrence to Welsh Government using the relevant form to improvingpatientsafety@wales.gsi.gov.uk

related adverse incident, using a list supplied by Welsh Government, is defined within WAST's Adverse Incident Hazard Reporting Investigation and Learning Policy[15].

WAST has established the SCIF as a means of determining whether an incident meets the threshold to report to Welsh Government. SCIF seeks to "…*establish the facts and sequence of events leading up to the adverse incident (whether an incident, complaint or claim) to determine what happened, how it happened, why it happened, who was involved and to determine the impact on patients and/or staff*"[16].

The SCIF is chaired by the Executive Director of Quality, Safety and Patient Experience and attendance consists of professionals from the incident related area, patient safety and governance representatives and, if applicable, Health Board representation.

A multi-disciplinary approach is utilised to ensure a full investigation of incidents is undertaken with consideration for all involved parties. We were provided with an example of this multi-disciplinary approach via a recent SCIF meeting which had in attendance: Head of Patient Safety, Concerns & Learning, Patient Safety Manager, Executive Director of Quality, Safety and Patient Experience, Head of Operations, Locality Manager, Paramedic Lead, PTR team representative and the Assistant Medical Director.

In addition to the SCIF, WAST has recently established a monthly SCIF Panel as a means of ensuring that all ongoing SAI investigations are reviewed and tracked, that there is awareness of issues and that timeframes are adhered to.

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[14] See: http://www.wales.nhs.uk/sitesplus/documents/1064/Handling%20Serious%20Incidents%20Guidance1.pdf

[15] WAST Adverse Incident Hazard Reporting Investigation and Learning Policy purpose is to "…*encourage incident reporting, initiate investigations where appropriate and learn from adverse events this maintaining and improving the quality of patient care, reducing or eliminating the risk of loss, damage or injury to patients, staff and others*…"

[16] See: WAST Adverse Incident Hazard Reporting Investigation and Learning Policy

Staff Training – Concerns and Incidents

During 2016 WAST undertook an evaluation of concerns training, with the majority of staff providing positive feedback. WAST also supports Paramedic staff with a 52 protected hour allocation per year for training, consisting of part mandatory and part staff directed. Related to this, we were informed by some staff that no mental health training is currently provided to those staff working in the clinical contact centre. Should such training be provided, staff informed us that it would help them to assist callers with mental health issues in a more timely and effective manner.

Improvement needed

Trust to inform HIW how action will be taken to ensure that staff are provided with mental health training, specifically to assist clinical contact centre staff in the handling of callers with mental health issues

Concerns – Identification, analysis, investigation, resolution and support

Concerns Systems – Identification and Analysis

WAST has a central Patient Safety and Concerns Team that provides support and assistance to the Trust's operational teams. Our analysis of a random selection of concerns documentation, chosen by us, showed there to be consistency and timeliness in the Trust's responses. It was apparent that the Trust was gaining the benefit of having a central integrated concerns team co-ordinating and managing concerns rather than them being managed by the local, dispersed teams. Previously, differing teams[17] managing aspects of concerns in isolation from each other led to a hindrance in consistency and timeliness. Taken together, structured changes, staff feedback to HIW and statistics relating to compliance with Putting Things Right timeframes, all demonstrate the benefits of having a central and integrated concerns team.

Our analysis confirmed that, as specified within WAST Putting Things Right guidance, each complainant was assigned a named contact. This named contact was the link between the complainant and the Trust and could be used by the complainant should they wish to contact WAST regarding their concern.

The Patient Safety and Concerns Team provides a central point to assist the Trust in monitoring and data analysis. To assist with this, WAST has updated its version of Datix, introducing new fields that support the triangulation of information. A Datix System Administrator post has also been appointed, with the post holder having responsibility for developing the Datix System and analysing trends and themes. For example, work is underway to develop the coding of a Datix actions module, with the aspiration that this will assist with future shared learning by identifying training needs and common themes.

Staff informed us that there are some problems with Datix however. We were told that there is currently no facility for staff to save what they have input prior to completion. For example, if a staff member is in the process of updating Datix and receives a call, there is no facility to close and save. Therefore the risk exists that not all incidents can be updated to the Datix system.

[17] Complaints, Patient Safety, Safeguarding and Partners in Health.

Further assistance with analysis of concerns data is provided by the Patient Safety and Concerns Team via the provision of a weekly all WAST Wales concerns tracker[18]. This tracker provides relevant Heads of Operations with data relating to the progress of concerns alongside information such as who the investigation officer is and timescales.

Since the all Wales tracker first came into operation it has made an impact. Through our discussions with staff we were informed that the tracker has played an important part in improving team engagement and ownership of concerns. Alongside structural changes, it is evident that the tracker has proven to be a positive development. For example, the concerns tracker for the week commencing 27 February 2017 highlighted WAST responded to 80% of all formal concerns within 30 days, this excluded those in the Redress process. Prior to this, when concerns management was structured differently and no tracker was in place, WAST had annual compliance to the 30 day target of 14% in 2014/15 and 16% in 2015/16.

Using the tracker to provide the latest weekly position regarding Putting Things Right compliance and trend analysis, the Assistant Director of Quality and Patient Experience holds weekly team meetings with the senior concerns and patient safety team. This meeting serves the purpose of reviewing and updating any issues as appropriate.

Improvement needed

Trust to provide an update on action taken to improve Datix system that would provide a facility to close and save input prior to completion

Concerns Systems – Political Correspondence

WAST has introduced a process map for the handling of concerns that originate from political correspondence. Whilst processes were outlined for on the spot concerns and formal complaints, nothing previously existed for concerns of a political nature. We were informed that this lack of designation hindered the timeliness of responses as it led to a lack of clarity around responsibility for handling. Clarification of this process has led to a better quality dialogue with

[18] Weekly Tracer provides details relating to Open Complaints per Health Board, Closed complaints, grade 4 or 5 open complaints, political involvement in complaints, concerns inquests upcoming and new claims opened.

political stakeholders and this, as Figure 1 shows, has reduced the number of concerns of this type. Additionally feedback given to us from staff indicated that WAST's improved communication and handling of political concerns, had resulted in the perception that WAST is no longer the subject of high levels of political concern, the knock-on result being an increase in staff confidence in the work they and the organisation are undertaking.

Figure 1: Complaints with political involvement

	1 August 2016	17 March 2017
Number of cases	**31**	**6**
Number of above cases with Minister involvement	**8**	**0**

Concerns Systems – Quality Steering Group (QSG)

Another mechanism supporting identification and analysis of concerns and incidents is the Trust's QSG. The QSG has been refocused during the past year with more structured agendas, and with attendance being more representative of the whole organisation. The QSG is chaired by the Executive Director of Quality, Safety and Patient Experience and following restructure, staff feedback suggests that this group now has an increased focus on organisational learning.

The QSG is the main forum for the triangulation of quality data and information to inform quality assurance, quality improvements and learning to continuously improve outcomes for patients. This also informs learning and development, clinical audit and provides assurance to the Board.

A quarterly quality assurance report, which includes concerns/serious incidents, is co-ordinated by the QSG and tabled at each Quality, Patient Experience and Safety Committee. Our analysis of this report shows data that allows for the monitoring of WAST's position in regards to implementing the Health and Care

Standards (2015)[19], specifically in terms of quality strategy commitments[20]. We believe the quality of the report to be good; it presented a clear picture of how quality, safety and patient experience information assists WAST in informing priorities and improvements. Furthermore, the report also outlined how WAST strategic aims are aligned to Health and Care Standards and the Commissioning Quality Core Requirements.

Concerns – Effective Investigation

During our fieldwork we chose and inspected a random sample of 11 concerns from a time period dating back over the previous 36 months. Our analysis encompassed hard copy records, e-records, and discussions with members of the concerns team. All of the concerns documentation we analysed had a detailed description, clarity regarding investigation approach, received timely responses and there was evidence of appropriate action having been taken.

Statistics regarding the reduction in a backlog of complaints (*Figure 2*) is further evidence that the handling of complaints is continuing to improve from that reported in WAST's 2015/16 Concerns Annual Report.

[19] See: http://www.wales.nhs.uk/sitesplus/documents/1064/24729_Health%20Standards%20Framework_2015_E1.pdf

[20] These commitments included the provision of quality metrics and progress information regarding Staying Healthy; Safe Care; Effective Care; Dignified Care; Timely Care; Individual Care; and Staff and Resources.

Figure 2: Open complaints by type

	1 August 2016	17 March 2017
Total Open	**264**	**103**
Of which:		
Formal	**124**	**44**
Joint[21]	**29**	**9**
Redress	**53**	**37**
On-The-Spot	**58**	**13**

Complainants are provided with a copy of the PTR guidance with their acknowledgement letter which advises on expectations and timeframes. *Figure 3* provides a breakdown of improvements related to compliance with PTR timeframes. We also witnessed how the Patient Safety and Concerns Team were proactive in advising complainants that their concern has potential for becoming part of the redress[22] process.

[21] Joint refers to joint investigations with one or more Health Boards.

[22] WAST Redress Process relates to situations where the patient may have been harmed and harm was caused by WAST. Redress comprises one or a combination of: The offer of financial compensation and/or remedial treatment, with the provision that the person will not seek to pursue the same via civil proceedings; Giving of an explanation; Written apology; and Report on the action which has or will be taken to prevent similar concerns arising.

Figure 3: Complaints' compliance

	As of August 2016	As of March 2017
Acknowledgement	**82%**	**96%**
On-The-Spot 2 Day	**39%**	**58%**
30 Day Response	**17%**	**37%***
Investigation within 20 Days	**24%**	**35%**

***indicates period April 2016 – March 2017. To note: WAST performance against the 30 day target as of 21 March 2017 is 80%, however, figures from the beginning of 2016/17 have impacted the overall figure to where it currently stands.*

Our fieldwork showed evidence of lead contacts making personal contact with complainants, and in some circumstances, advising them by letter that there may be delays in order to complete a thorough investigation. We also verified how individuals who had raised a concern were provided with a number to contact should they have any issues or questions regarding the investigation of their concern.

Concerns - Support

WAST's PTR policy outlines the importance of supporting those involved in the concerns process. The policy details the importance of communication being open, keeping a complainant updated in a timely manner and that "*apologising to patients is not an admission of liability. Being open is about good communication and trust, which is fundamental to the relationship between healthcare professionals and patients*."

WAST's Putting Things Right policy advises that individuals who raise concerns are also signposted to Community Health Councils (CHCs) in Wales in order to access the appropriate advocacy services. Details of how to contact CHC services are included within acknowledgement letters sent to complainants.

Feedback from the Board of CHCs in Wales about WAST was broadly positive and reflected that the number of WAST related concerns were relatively low. Furthermore, the majority appear to be handled promptly and sensitively, and that WAST is sometimes complemented in complaints made about other NHS organisations. The CHCs reported that WAST attempts to deal with a lot of

complaints as ‘on the spot’ cases. Of the few complaints received they generally fell into two categories: time taken to arrive; and attitude of staff.

WAST provided us with an historic example of where it did not support a family as well as it could. WAST acknowledged that it had learnt from this and subsequently improved and/or implemented:

- Its own investigation process via staff development and training, for example, the provision of training in regards to the drafting of clear statements for inquests;
- Improvements in the timeliness and clarity of communications; and
- A family support model providing clarity regarding the provision of signposting to the appropriate bereavement support and clearer communication.

Our interviews provided an overall positive picture in terms of the support staff felt they, and their colleagues, received or was available. We were told that this had not always been the case and the overall theme of the feedback we received was that senior management are moving the organisation’s culture away from being focused on blame to being open and supportive.

There was acknowledgement and awareness from senior management of the fact that the open culture was yet to embed fully across the organisation. We were informed that steps are underway as the Trust had committed to invest in and develop the team leadership programme for clinical and non clinical team leaders across the Trust in order to support the changing culture. This new leadership programme has was commencing in April 2017 and the aim of WAST’s new leadership programme will be helping to develop leaders that will, for example, understand their responsibilities and help empower staff to raise concerns and take forward the challenge of embracing a new open and supportive culture.

It is clear from our review and time spent talking to staff that the culture at WAST has changed and continues to change for the better, becoming more open and supportive. However, as staff informed us, it will take time for this to fully embed throughout a national organisation with widely dispersed staff.

Incidents – Identification, analysis, investigation, resolution and support

Significant Incidents Systems – Identification and Analysis

WAST records all incidents, near misses[23] and never events[24] via the Datix system. Trends are also monitored and measured via Quarterly Assurance Reports[25]. These reports are provided to the Quality, Patient Experience and Safety Committee and present key quality safety and patient experience information which inform priorities and improvements.

Near misses are captured and identified in several ways including through adverse incident reporting via Datix; staff clinical supervision; staff reflective practice; and through patient feedback via complaints.

Our discussions with staff identified that, since the arrival of the current Chief Executive and the reorganisation of concerns structures, Board scrutiny of complaints and serious incidents has strengthened.

Identification of patient safety trends and risks

In accordance with the WAST Risk Management Strategy & Framework 2016-19 and WAST Adverse Incident/Hazard Reporting Investigation and Learning Policy and Procedure, risks are identified and placed on the risk register in the following ways:

- Patient safety and concerns managers review all Datix incidents entered onto the system, identifying and assessing any patient safety risks;
- QSG triangulates patient safety information to inform risk management as well as improvements;

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[23] A Near Miss is an incident which but for luck, skilful management or evasive action, would have become an adverse incident.

[24] A Never Event is a serious, largely preventable patient safety incident that should not occur if the available preventative measures had been implemented.

[25] For example, the September 2016 Quarterly Assurance Report provided information regarding SAI's since April 2014; figures relating to patient safety incidents, near misses and hazards for the two previous quarters; and figures relating to non-patient safety incidents for the two previous quarters.

- Clinical audit of Patient Clinical Records (PCRs);
- Staff clinical supervision; and
- Staff reflective practice.

The corporate risk register is reported to the Audit Committee each quarter which reviews the adequacy and effectiveness of assurance processes for managing key risks, as well as monitoring the overall arrangements for governance, risk management and internal control.

A Clinical Risk Assurance Review was undertaken by the Emergency Ambulance Service Committee (EASC)[26] and a report is due before the Quality, Patient Experience and Safety Committee on 23 May 2017. However, we were informed that initial feedback from commissioners was that the WAST risk register was "…*an excellent and comprehensive document*".

Prior to any formal feedback from EASC, WAST has undertaken work to address outstanding risks that were longstanding on the risk register, obtaining local ownership and agreeing a new risk management strategy[27]. Board development sessions have been undertaken with a focus and review of the corporate risk register.

Our view of the quality, safety and patient experience and corporate risk registers were that they were comprehensive in scope and clear regarding responsibility and scoring.

Reporting Systems

In accordance with WAST PTR Guidance, SAIs, no surprises[28] and near misses are reported to Welsh Government via the patient safety portal[29]. WAST

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[26] See: http://www.wales.nhs.uk/easc/about-us

[27] Risk Management Strategy approved by the Board in March 2016

[28] No surprises alert and inform Welsh Government of any adverse publicity or reputational issues.

[29] Patient Safety Wales website supports NHS organisations to improve patient safety. The website incorporates tools, guidance and solutions as well as providing a portal for reporting patient safety concerns. http://www.patientsafety.wales.nhs.uk/home WAST also report SAI's to the National Reporting and Learning Service.

also reports SAIs to the National Reporting and Learning Service (NRLS), a NHS central database of patient safety incident reports. The NRLS uses such information to develop advice for the NHS that can help ensure the safety of patients[30].

Welsh Government are pleased with WAST's reporting of No Surprises, particularly how it often report incidents to them from a WAST perspective when the actual associated Serious Incident is reportable by a Health Board. Welsh Government finds this useful as it provides an opportunity to triangulate whether the Health Board actually reports the incident, allowing them to chase with the Health Board if necessary.

Regarding the reporting to Welsh Government of WAST serious incidents, Welsh Government report that these are done in a timely manner. However, there are concerns about the quality of some of their closures. Whilst small in comparison to Health Boards, as of the end of March 2017 the Trust had 37 closures overdue, an increase from the 22 that existed in November 2016. Of these overdue closures, Welsh Government has specified that the same issues regularly occur. For example, no information on the adequacy of call handling; no confirmation that the family had been involved; and no confirmation of the status of the patient. At the time of writing Welsh Government planned on corresponding with WAST to address serious incident closure queries.

Incidents – Effective Investigation

The relevant Head/s of Service are notified of all SAIs, an investigation officer appointed and SCIF implemented. SCIF has a set agenda[31] in which to direct and monitor an investigation, and determine if the incident meets the Welsh Government reportable threshold as a SAI.

Based on feedback from staff and our evaluation of documentation, we are satisfied that the measures in place support the effective investigation of

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[30] When issues arise advice/alerts (for example regarding vaccines to patient identification) are issued directly to NHS Wales.

[31] Set Agenda: Chronology of Events; Immediate Actions Required/Already Taken; Terms of Reference of the Investigation, including conformation of the investigating officer; Being Open – patient safety/family support and communication; Staff Management and Support; Identification of any other Internal Stakeholder; Any Media/Communications Implications; Communication with External Stakeholders (WG, POVA, etc.); and Any Other Business.

incidents. SCIF adds importance to the process through a multi-disciplinary approach that ensures consideration from all parties. This helps to ensure a thorough investigation that has procedures in place to ensure all aspects of investigation are given due consideration and progress against timeframes reviewed and tracked.

Incidents - Support

WAST has developed a process outlining how patients and staff are supported after the identification of/or having been involved with SAIs or near misses. The SCIF has a standing agenda item regarding communication with those affected and consideration for any support they may require.

In terms of a non-staff[32] involved with SAIs, the SCIF identifies who will contact these individuals and how in order to ensure that they are fully aware of the concerns that are being investigated and reported to Welsh Government. The SCIF process seeks to allow those involved or affected to potentially influence the investigation with issues that they wish to raise, whilst seeking to tailor support and provide assurances regarding the comprehensiveness of investigation.

Those staff involved with investigation are also afforded support by WAST; the Trust seeks to ensure that staff have a clinical debrief together with any clinical supervision and reflective practice deemed necessary. Those staff involved with Procedure Response to Unexpected Deaths in Childhood (PRUDiC) are supported by a safeguarding debrief.

In terms of how staff are kept informed of progress and outcomes, we were informed that the Head of Operations for the relevant area, alongside operational teams, are engaged throughout the process, sharing progress and outcomes. In addition, staff can contact the Patient Safety and Concern Team[33] directly to ask for feedback. However, we heard that this is not always the case. We learnt that individuals who report an incident do not always get feedback outlining what has happened as a result of their submission of the incident form. Those we spoke to explained that if feedback was provided it would then allow

[32] Non-staff means patients, visitors or members of the public

[33] The Central Patient Safety and Concerns Team works with operational teams to undertake the investigation.

them to inform other staff of the outcome and aid with improving practice. This is an issue the Trust needs to ensure is addressed.

Improvement needed

Trust to inform HIW how action will be taken to ensure that staff who report an incident receive feedback outlining the outcome of their submission

What Shared Learning has occurred from concerns and incidents?

External Source

Professor Siobhan McClelland's review '*A Strategic Review of Welsh Ambulance Services*'[34] made a number of key recommendations which were to be "…*underpinned by a clearly articulated and commonly agreed vision of the future delivery of ambulance services*". Review conclusions and recommendations were the catalyst for several significant changes. Two of the recommendations were particularly significant in terms of impact upon WAST.

Firstly, that the model for how the ambulance service delivers a robust clinical model for Emergency Medical Services (EMS) needed to change. Of the three options[35] proposed, the one chosen was to see ambulance services commissioned directly by health boards. This resulted in the establishment of EASC and a framework that provides a mechanism to support the recommendations contained within the McClelland review.

Secondly, building on the McClelland strategic review, was the introduction of the new Clinical Model, replacing the response targets based approach. Implemented in October 2015, the new model was brought in with the aim of prioritising patient care, helping assess 999 calls from a more clinical perspective.

WAST's own recent review of its Putting Things Right guidance, resulted in recommendations to improve how it handled concerns. Implementation of these has helped remove silo working, bringing under the responsibility of one directorate all the teams handling concerns. Together with other changes such as the increase of administration staff, the statistics suggest that concerns are now being handled in a more timely, quality driven manner.

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[34] See: http://www.ambulance.wales.nhs.uk/assets/documents/f06e69f9-3921-4946-a55a-aad53637c282635179619910478381.pdf

[35] Three options, outlined on page 69 onward within the McClelland Strategic Review, included: A "Special Health Board" Model; Commissioning Model; and Local Management and Delivery Model.

At the time of this report WAST Internal Audit was developing an internal plan for a proposed audit of complaints and incidents in 2017/18.

Patient Experience &Community Involvement Team

WAST has a Patient Experience and Community Involvement Team (PECI) which works directly with service users and community groups to gain service user feedback and inform analysis of trends in concerns or complaints.

During the course of our review, PECI organised and held a '*Learning and Celebration Event*' which focused on celebrating the contribution WAST community learning disability champions play in sharing key WAST messages, and facilitating community feedback. The event highlighted some of the issues people with learning disability encounter when trying to access healthcare services, especially in an emergency.

We saw evidence of the PECI Team actively seeking service user feedback regarding their experience of emergency services. The PECI highlight reports, which are presented at the Quality, Patient Experience and Safety Committee, demonstrate a varied and proactive approach to community/patient engagement. This included patient surveys, 26 community events for the period October – December 2016, school campaigns and visiting various patient representative groups[36].

During our attendance at the January 2017 Quality, Patient Experience and Safety Committee, it was apparent that themes identified from complaints and incidents were discussed. For example, patient falls was the theme that had been identified for further discussion at the January Committee. Furthermore, PECI presents a standing item at the committee; the presentation of patient stories. Patient stories are brought to the committee by the Head of Patient Experience and Community Involvement and afford the opportunity to demonstrate how WAST has learnt from concerns or incidents and where future learning is required.

Highlight reports presented to the Committee feature feedback from service users. Feedback is broken down into what service users perceive WAST do well and what WAST could improve upon. The highlight report we analysed

[36] As of December 2016 the PECI team had, through community engagement and patient experience, engaged with 11,903 people. Such groups included sight loss, sensory loss, lesbian, gay, bisexual, trans (LGBT), Diverse Cymru, learning disability and older people.

showed positive feedback from service users in terms of how professional staff are. Regarding areas of improvement, service users highlighted response times, and how 999 control room questions can be viewed as unnecessarily repetitive. In terms of the learning cycle, we were able to see how PECI engages with patient groups, how learning is shared and future learning identified. It became evident in our discussions with staff of the positive work PECI undertakes in terms of identifying and sharing learning. We were able to verify this feedback via October–December 2016's Highlight Report which documented the Trust's engagement with a Dementia Service User Review Panel. As a result of this dialogue the group are due to visit WAST's contact centre in Cwmbran to increase knowledge and awareness of the needs of those individuals with dementia. The aim of this initiative is for staff to be more confident and provide a better service to individuals with Dementia who use the 999 service.

A further example of shared learning from WAST's engagement with a family following a tragic incident and listening to feedback resulted in the implementation of the following:

- The introduction of the SCIF model
- Improved communication and early engagement with families
- Staff training in the recording of statements and written guidance
- The use of NEDs to test and feedback on the implementation of learning.

Internal Sources

In terms of staff providing feedback, there are various avenues available including social media, executive management walkabouts, team meetings or via staff-side representation. Another channel comes from the Trust's NEDs who are aligned to Health Board areas and regularly visit their 'patches' to hear more from staff and help address any queries they may have. Furthermore, at each Board meeting, there is a session which includes a staff story and feedback from a NED and Executive who have either ridden out with a team or visited a Trust facility with staff in the days before the Board meeting. This affords the opportunity to offer their observations to a wider audience of staff and stakeholders.

Interviews with staff highlighted how senior management have adopted a more open and visible style of leadership, for example via regular ride outs and visits to stations, contact centres and engaging with staff. Staff informed us that this was invaluable in terms of understanding the experience of staff and allowed the sharing of views and concerns. Furthermore both the Chair and Chief Executive undertake a regular programme of visits across Wales, providing staff the opportunity to meet and discuss issues with senior management.

We believe that the development of WAST's Quarterly Quality Assurance Report also supports the presentation, monitoring and measurement of themes and trends.

WAST has also introduced Quality Reports for each Health Board to improve partnership working. We were informed that the overall feedback from Health Boards was positive, welcoming the quality data and information the reports contained, for example linking emergent trends from concerns and system delays highlighting opportunities for improvement and learning.

WAST's Policy and Procedure for Organisational Learning and Promoting Improvements in Patient Safety specifically relates to shared learning from concerns and SAIs and details how outcomes from audits, inspections, and complaints are analysed. Furthermore, in terms of line of sight, each Board meeting includes the distribution and discussion of a highlight report which details concerns and serious incidents.

Our review has identified that WAST has several methods of monitoring shared learning. These include internal and external review action plans, staff reflective practice, staff clinical supervision, monitoring and feedback via locality managers and patient surveys[37].

[37] In October 2016 WAST sent 700 surveys to people who used their Non Emergency Transport service

5. Conclusion

WAST is a national organisation with a dispersed workforce. This presents challenges in terms of the delivery of effective governance, leadership and accountability. However our review has identified an organisation where overall feedback from staff has been positive in terms of the cultural and structural changes that have been made. We have found WAST to be an organisation with effective leadership in place in relation to concerns and incident management.

We have seen an organisation that has re-engaged with its staff to change its direction towards a more open and supportive culture. Whilst this change in culture is good and clearly embraced by those staff we spoke to, challenges exist in terms of fully embedding acceptance throughout all levels of the organisation. WAST acknowledges the challenge ahead in terms of it establishing these changes.

There have been improvements in regards to the management of concerns. We have seen the positive impact that a change in structure and increased ownership of concerns has had. Compliance with the 30 working day response target for formal complaints has risen from 16% in 2015/16, to 37% at the date of compiling this report[38]. We've also heard positive feedback from the CHCs on WAST's handing of concerns. Our analysis of concerns documentation, including WAST response to concerns, showed a consistency in terms of detail, clarity of action and timeliness The challenge for the Trust will be to sustain this level of improvement over a longer period of time.

We've also seen improvements in the handling of SAIs through the establishment of the SCIF. Through the SCIF and the QSG, learning in response to incidents has improved, with evidence of improvement being identified and changes implemented. WAST demonstrated that it is promoting a learning culture through the work of the PECI team. The engagement with patients and the community and the feeding of this back into WAST through, for example the Quality, Patient Experience and Safety Committee, supports the ethos of shared learning and the adoption of the more open and supportive organisation that WAST is seeking to become.

[38] Report compiled March 2017

Overall our review findings indicate an organisation that is moving in a positive direction. It is clear that strong leadership is helping to promote a culture of learning which was previously underdeveloped within WAST. Further time is needed for this culture to fully embed across the whole organisation.

6. What next?

This review has resulted in the need for WAST to complete an improvement plan (Appendix B) to address key findings

The improvement plan should:

- Clearly state when and how the findings identified will be addressed, including timescales
- Ensure actions taken in response to the issues identified are specific, measureable, achievable, realistic and timed
- Include enough detail to provide HIW with assurance that the findings identified will be sufficiently addressed.

As a result of the findings from this review WAST should:

- Ensure that findings are not systemic across other departments/units within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The Trust`s improvement plan, once agreed, will be published on HIW's website.

Appendix A – Improvement plan

Governance Review: Improvement Plan

NHS Wales Trust: WAST

Date of review: 19 December 2016 – 17 March 2017

Page Number	Improvement needed	WAST Action	Responsible Officer	Timescale
13	***Trust to inform HIW how action will be taken to ensure that staff are provided with mental health training, specifically to assist clinical contact centre staff in the handling of callers with mental health issues***	The Trust has developed a Mental Health Improvement Plan (2017 – 2019) to be approved by the Quality, Patient Experience and Safety Committee on 23rd May 2017. The Trust is working with the Commissioner and Welsh Government to secure funding to implement the plan. This includes provision of mental health training to staff across the Trust to commence July 2017.	Executive Director of Quality, Safety & Patient Experience	Approve plan May 2017 Commence staff training July 2017
15	***Trust to provide an update on action taken to improve Datix system that would provide a facility to close and save input prior to completion***	The Trust has engaged in the Welsh Government review of Datix systems across NHS Wales to address and improve effectiveness of a system for incident reporting.	Executive Director of Quality, Safety & Patient Experience	March – September 2017

Page Number	Improvement needed	WAST Action	Responsible Officer	Timescale
		The Trust has appointed a Datix Systems Administrator to support the Datix system changes to improve effectiveness of the system. The Trust is working on a technical solution that will allow all staff the facility of saving an incident to complete later		April 2017 12 months
25	***Trust to inform HIW how action will be taken to ensure that staff who report an incident receive feedback outlining the outcome of their submission***	The Trust Team Leadership development programme commenced April 2017 and will strengthen the focus on the responsibilities of team leaders across the Trust in providing timely feedback to staff who have reported incidents. This will be monitored through staff engagement and feedback during Executive visits.	Executive Director of Quality, Safety & Patient Experience	From April 2017

WAST Representative:

Name (print): .....CLAIRE BEVAN.....

Title: .....EXECUTIVE DIRECTOR OF QUALITY, SAFETY & PATIENT EXPERIENCE .....

Date: **...10TH May 2017.....**