Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Gwirio bod pobl yng Nghymru yn derbyn gofal da

Checking people in Wales are receiving good care

# Welsh Ambulance Services NHS Trust Annual Report from Healthcare Inspectorate Wales 2016-17

July 2017

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# Contents

**Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales**

# Our purpose

**To check that people in Wales are receiving good care.**

# Our values

- **Patient-centred: we place patients, service users and public experience at the heart of what we do**
- **Integrity: we are open and honest in the way we operate**
- **Independent: we act and make objective judgements based on what we see**
- **Collaborative: we build effective partnerships internally and externally**
- **Professional: we act efficiently, effectively and proportionately in our approach.**

# Our priorities

**Through our work we aim to:**

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| **Provide assurance:** | **Provide an independent view on the quality of care.** |
| **Promote improvement:** | **Encourage improvement through reporting and sharing of good practice.** |
| **Influence policy and standards:** | **Use what we find to influence policy, standards and practice.** |

# 1. Purpose

This annual report has been produced as a summary of the activity that HIW carried out between 1 April 2016 and 31 March 2017 in relation to the Welsh Ambulance Services NHS Trust.

# 2. Overview

During the year, HIW conducted a governance review of the Trust.

# 3. Key messages

The governance review that was conducted at the Welsh Ambulance Services NHS Trust indicated that overall the Trust is an organisation that has effective leadership and has improved how it responds to and learns from concerns and incidents. It also indicated that it 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.

An improvement plan was promptly submitted by the Trust following our governance review.

# 4. Inspection findings

During the year, HIW did not conduct any inspections; however a few of our health board inspections covered unscheduled care and had observations relating to WAST. More information on their observations for WAST are summarised below.

HIW completed an unannounced inspection of the Emergency Department (ED) of the Royal Gwent Hospital within Aneurin Bevan University Health Board in March 2017:

- During our inspection we asked patients to complete HIW questionnaires to gain formal feedback. Of the eight patients who had been brought into the department by ambulance, all patients were unanimously positive about the ambulance crew in terms of their manner, upholding of privacy and dignity, explanation of treatment and control of pain.
- During the evening visit, we found that patients in the corridor area were not being sufficiently monitored by staff. On investigation we

found that the ambulance liaison officer monitored patients in this area by day. However, during the night time there was no designated staff member(s) monitoring the corridor area. The health board have reported that a number of measures are being taken to improve patient flow. One of these was to agree a Local Escalation Policy with WAST, which identifies the actions to be taken when there are delays in handover to maintain patient safety.

HIW completed an unannounced inspection of the Emergency Unit (EU) at the University Hospital Wales, Cardiff within Cardiff and Vale University Health Board in March 2017:

- During the inspection, ambulances were viewed outside the EU but no patients had to wait any significant length of time to be admitted to the EU.

HIW completed an unannounced inspection of the Emergency Department of Ysbyty Glan Clwyd within Betsi Cadwaladr University Health Board in November 2016:

- On arrival during the initial day, there were no ambulances waiting at the door. Although there were no patients waiting on ambulances that day, we were told that when this happens the patients would be assessed and prioritised as soon as they arrive at the ED.

# 5. Special reviews, investigations and thematic findings

We did not undertake any investigations or thematic reviews at the Welsh Ambulance Services NHS Trust during 2016-17.

However, HIW conducted a governance review of the Welsh Ambulance Services NHS Trust. A summary of the key findings from this are summarised below:

- The Trust's Quality, Patient Experience and Safety Committee, which has delegated responsibility for all matters relating to the quality of care the Trust provides, appears to be working well with clear governance structures below well defined reporting lines.
- Welsh Ambulance Services has restructured the way that concerns are managed within the Trust which has been positively received by all staff HIW spoke to as part of its fieldwork. The overriding view of staff was that this has helped to clarify and standardise processes, improve focus and afford clarity regarding lines of responsibility.

- Welsh Ambulance Services has improved its approach to the handling of Serious Adverse Incidents (SAIs). It has devised and adopted a Serious Case Incident Forum (SCIF) to identify SAIs notifiable to Welsh Government which adopts a multi-disciplinary approach and has helped improve the way incidents are investigated and tracked. 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.

- 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.

- Evidence of mechanisms to support appropriate learning was 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 reflected to us that the Trust is currently on an organisational journey, the intention to be an organisation with a culture of openness and support. To reflect this, the Trust developed a shared vision, purpose and behaviours. Almost overwhelmingly, during our discussions with staff at all levels, the embracing of this new direction was noted. However, it was identified during our fieldwork that pockets of middle management are yet to embrace this change in organisational culture. Senior staff are in the process of taking steps to support and address this.

# 6. Follow up and immediate assurance

No follow up or immediate assurance letters were issued to the Trust.

# 7. Governance

During 2016-17, the Trust had a number of opportunities to demonstrate that it is a learning organisation. As issues arose, the Trust responded soundly, seeking clarification where necessary and engaging with HIW to ensure that it could improve services where necessary.

HIW also carried out a governance review during the year, see Section 5 for key findings. As a result of this work, we found that the Trust has been able to demonstrate effective governance and leadership in relation to the areas that we examined.

# 8. Engagement

During 2016-17, the Relationship Manager presented HIW's 2015-16 annual report for the Welsh Ambulance Services NHS Trust at a meeting with the Chief Executive and Chair of the trust and Chief Executive of HIW.

During the year, the Relationship Manager, and staff undertaking the governance review, attended Quality, Patient Experience and Safety meetings. The Relationship Manager also attended a Board meeting and met with the Director of Quality, Safety and Patient Experience to exchange information and, where relevant, discuss any further assurance required.

On all occasions, the Trust has responded to requests for meetings and various documents, positively and promptly. These meetings have formed part of the ongoing liaison with the Trust.

# 9. Inspection, special review, investigation and thematic activity

### Governance review

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| 1. Welsh Ambulance Services NHS Trust | 15 October 2016 |