Agenda Item
5.2

Quality Safety and Outcomes Sub-Committee

Director of Commissioning for Ambulance Services & 111 Report

Dyddiad y Cyfarfod / Date of Meeting	02/06/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
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Pwrpas yr Adroddiad / Report Purpose	For Noting Choose an item.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	Choose an item.

Acronyms / Glossary of Terms	
CSD	Clinical Support Desk
ED	Emergency Department
GDPR	General Data Protection Regulation
HSE	Health and Safety Executive
ICO	Information Commissioners Office
IG	Information Governance
JCC	NHS Wales Joint Commissioning Committee
NEPTS	Non Emergency Patient Transport Services
NRI	National Reportable Incident

PSOW	Public Service Ombudsman Wales
QMS	Quality Management System
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
ROSC	Return of Spontaneous Circulation
WAST	Welsh Ambulance Service University NHS Trust

1. SITUATION/BACKGROUND

The purpose of this report is to provide members with an update on quality and safety matters within the Ambulance Services and 111 commissioning portfolio.

The Quality Dashboard has been produced and is structured around the domains and enablers in the Duty of Quality. This is attached as **Appendix 1** to this report.

2. SPECIFIC MATTERS FOR CONSIDERATION

2.1 Quality Oversight

The Welsh Ambulance Service University NHS Trust (WAST) has produced a refreshed Quality and Performance Management Framework, which was approved at WAST Board in March 2025. The framework forms part of WAST's wider Quality Management System (QMS) and includes strengthened wording in terms of its relationship to the broader Duty of Quality and a number of the organisational requirements.

An Audit Wales review of quality governance follow up report was published in February 2025 and noted that WAST has made improvements to its quality governance structures. The report noted there is scope for further improvements in some areas to strengthen assurance relating to the quality and safety of its services, and the Quality, Patient Experience and Safety Committee is monitoring actions to address areas such as policy, mortality reviews, training and the new Quality Plan which will be going through an approval process in 2025.

2.2 Concerns and complaints

WAST's compliance against the target for 75% of concerns to have a response issued within 30 working days had seen an improving trend, but dropped to 52% in February 2025 with only a slight improvement in March 2025 (55%). Open complaint volumes have also continued to grow however, this trend continues to reflect the challenges associated with increased pressures across the organisation during the winter period.

2.2 Patient Safety Incidents

Incident reporting volumes increased in March 2025, to a level comparable to March 2024. Closed incidents continue to demonstrate that validated levels of severe or catastrophic harm remain consistently low, however in March 7,229 people cancelled an ambulance after calling 999 and being given a timeframe for

a response. In addition, modelling undertaken by the Association of Ambulance Chief Executives indicates that in March 2025 of the 5,903 patients who waited outside an ED for over an hour to be handed over to the care of the hospital, WAST could assume that 15% (885 patients) would experience no harm, 53% (3,128 patients) would experience low harm, 23% (1,357 patients) would experience moderate harm and 9% (531 patients) would experience severe harm.

2.3 National reportable incidents

WAST has reported a 'winter peak' following a period of critical incident declaration and sustained high levels of operational activity, with six incidents reported in March, down from seven in February. The overall number of NRIs open with the NHS Wales Executive has increased to 53, reflective of the number reported in the last quarter.

Historically high volumes of incidents are being shared with health boards under joint investigation arrangements, with 33 referred to health boards in March 2025, reflective of the number of incidents that occurred while patients were waiting prolonged times for an ambulance.

2.4 Never Events

There were no never events reported between June 2024 and March 2025.

2.6 Duty of Candour

Duty of candour was triggered six times in March 2025 down from a peak of 11 in January 2025.

2.7 Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) indicators

There were two incidents requiring reporting under RIDDOR during March 2025, both were for an injury requiring over 7 days off work.

100% of the RIDDOR's were submitted within the HSE reporting timelines.

2.8 Patient experience and engagement

Four core patient experience surveys, covering the WAST's main service delivery areas are undertaken:

- 999 EMS Response (incorporating clinical support desk (CSD))
- Ambulance Care (NEPTS)
- NHS 111 Wales Telephony
- NHS 111 Wales Online

Within the NEPTs survey the response provided did not hit the benchmark in relation to the question 'How long did you wait for your transport to take you home after your appointment, while the question 'Were you happy with the transport your received', came out above the 85-benchmark figure (n=96).

In the 999 survey, the only question to achieve its 85-benchmark was 'The 999-call taker who answered your call explained what was going to happen next' (n=100).

Within 111 survey the only question to achieve its 85-benchmark was 'Did you follow the advice given by NHS 111 Wales?'.

Response rates to the 999 and 111 surveys remain low and it's acknowledged that these do not reflect an entirely representative picture based on overall call volumes.

2.9 Mortality

WAST continues to mature its learning from mortality approaches, through a quarterly meeting on thematic learning, weekly triage of Medical Examiner referrals and fortnightly learning panels for Medical Examiner feedback.

Following the publication in May 2024 of the All-Wales Learning from Mortality Reviews Model Framework (Second Edition) (the Framework), WAST has established an effective clinical governance structure to discharge all 5 levels of the Framework, 226 referrals were received from the MES between 1st October 2024 and 31st March 2025.

Cases are triaged promptly at Level 1 with 26 cases have been triaged as requiring further review and investigation under the PTR guidance. Level 2 Medical Examiner Learning Panels will now run at increased frequency to address cases awaiting review.

There is a decreasing number of Medical Examiner referrals since April 2024 which is believed to be due to relational work undertaken with other health bodies to reduce the duplication of cases.

2.10 Public Services Ombudsman

In March 2025, the Ombudsman issued two public interest reports relating to WAST, which highlighted concerns about triaging and categorisation of 999 calls and the Trust's complaints handling procedures. WAST contributed to the collaborative development of the Ombudsman's recommendations. The recommendations have largely already been undertaken, with evidence of completion being provided to the PSOW.

2.11 GDPR

In March 2025, there were 20 information governance (IG) related incidents reported on Datix Cymru categorised as an Information Governance (IG) breach. Of these 20 breaches, 5 related to Equipment / Devices, 5 Records/Information, 4 IG/Confidentiality, 2 IT, 2 Behaviour/Aggression, 1 Access/Admission, and 1 Transfer/Discharge.

During the reporting period, of the 20-information governance related incidents reported on Datix, no incidents were reported to the Information Commissioner's

Office (ICO). WAST's IG Team continues to monitor, and review reported incidents where applicable.

3. KEY RISKS/MATTERS FOR ESCALATION

Members have regularly discussed the challenges in commissioning the provision of safe, effective and timely emergency ambulance services.

The commissioning team will continue to work with WAST and health board colleagues to understand the level of harm within the system and to develop additional processes for the committee to assure itself that it is discharging its statutory responsibilities for the planning and securing of emergency ambulances.

4. ASSESSMENT

Objectives / Strategy	
Dolen i Amcan (au) Strategol CBC / Link to JCC Strategic Objectives(s)	Not Applicable
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below: A more equal Wales
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Data to Knowledge
	If more than one applies please list below: Whole systems perspective Leadership Learning, improvement and research
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality**	Effective
	If more than one applies please list below: Efficient Equitable Patient centred Timely Safe

(*Duty of Quality Statutory Guidance (gov.wales)*)	
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Reporting on quality matters from last JCC meeting.
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Reporting on performance matters and the impact on the wider health system. Quality and safety matters also considered.
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	Yes (Include further detail below)	
	Ambulance performance of significant concern to the public and impacts on health boards reputation	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. RECOMMENDATIONS

Members are asked to:

- **Note** the report; and
- **Receive** the report as assurance.

6. NEXT STEPS

Further enhancements of the availability of quality information, with a specific focus on understanding the outcome impact for patients and creating greater alignment between quality and safety and performance reporting.