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Quality Governance Follow-up Review – Welsh Ambulance Services University NHS Trust

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Summary report

Introduction

1 Quality should be at the ‘heart’ of all aspects of healthcare and ‘putting quality and safety’ above all else is one of the core values underpinning the NHS in Wales.

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 2020 (the Act) became law. The Act has strengthened 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 During 2021-22, the Auditor General reviewed quality governance arrangements across all Health Boards and Trusts in Wales. That work focused on:

- operational and corporate approaches to quality governance;
- organisational culture and behaviours;
- strategy, structures, and processes; and
- information flows and reporting.

4 Our 2022 review of quality governance at the Welsh Ambulance Services NHS Trust (the Trust) found that whilst many facets of its quality governance arrangements were working well, improvements were required to ensure the Trust is fully informed on issues relating to the quality and safety of its services. We also found the Trust also needed to strengthen serious incident reporting across organisational boundaries. We made eight recommendations for the Trust to address, which are shown in **Appendix 1**.

5 Since undertaking our 2022 review, the specific requirements underpinning the Duties for Candour and Quality (introduced under the Act) have been agreed, and all health bodies should have made good progress to implement arrangements to meet those requirements.

6 This quality governance follow-up review therefore will not only assess the Trust’s progress in implementing the recommendations we made in our 2022 quality governance review but will also consider the assurance provided to the Board that the Trust is taking steps to respond to the requirements of the Act.

7 The methods we used to deliver our work are summarised in **Appendix 2**.

Key findings

8 Overall, we found **the Trust has made some improvements to its quality governance structures, including responding to the duties of quality and candour. However, there is scope for further improvements in some areas to strengthen assurance relating to the quality and safety of its services**.

Implementation of previous audit recommendations

9 We found **whilst the Trust can demonstrate some progress in implementing previous audit recommendations, there remains more to do to fully address the recommendations**.

10 Our review of progress against our 2022 quality governance review recommendations found that three of the past eight recommendations have been completed. The completed recommendations relate to the Trust's information on and monitoring of clinical audits, developing better arrangements for board member visits and implementing recommendations relating to the joint investigation framework. We superseded our recommendation on monitoring the delivery of the Quality Strategy 2021-24.

11 For four recommendations, we found that, whilst action has been taken to address them, there is more to do to consider them complete. These included reaching the Trust's target for Personal Appraisal and Development Reviews (PADRs), progressing its plans to address the mortality review backlog, increasing its triangulation of quality performance information across metrics, and continuing to work with partners to join up information to support identifying outcomes and information. We will continue to monitor progress to implement these four remaining recommendations alongside the new recommendations arising in this review.

Responding to the requirements of the Duty of Candour and Duty of Quality

12 We found **the Trust has taken steps to implement the duties of quality and candour, however, there are weaknesses in the clarity of reporting progress and there is scope to improve training uptake and monitoring**.

13 Prior to the implementation of the Health and Social Care (Quality and Engagement) Act 2020 came into effect in April 2023 the Trust assessed its readiness against the Welsh Government baseline.

14 The Trust held Board sessions to raise awareness of the new Act. Staff were supported via e-learning modules to help understand and respond to the new requirements. However, there remain challenges. While training is in place for the duties of quality and candour, low compliance rates and difficulties understanding

how many staff had completed some training creates a risk that there is insufficient staff understanding.

15 The Trust told us it tracks progress to implement requirements under the duties of Candour and Quality using the Welsh Government roadmap and has developed an implementation plan. However, there is scope to strengthen assurance through greater clarity within progress reports to the Quality, Patient Experience and Safety (QuESt) committee. Finally, due to a backlog of policies overdue for review, the Trust has yet to review and update key policies as appropriate to reflect the requirements of the duties of quality and candour.

Recommendations

16 The status of our 2022 audit recommendations is summarised in **Exhibit 1**. **Appendix 1** contains our assessment of progress for each of our 2022 recommendations.

Exhibit 1: status of our 2022 recommendations

Completed	In progress	No action	Superseded	Total
3	4	0	1	8

17 **Exhibit 2** details the new recommendations arising from this review. The Trust's response to our 2024 recommendations is summarised in **Appendix 3,** which also contains updated management actions against the 2022 recommendations that we considered to be incomplete (ie in progress) at the time of our review.

Exhibit 2: 2024 recommendations

Recommendations
Quality Strategy R1 As the Trust develops a new Quality Plan in 2024, it should ensure that delivery is achievable within the resources available. The plan should clearly detail the funding required, the risks of under-delivery (due to capacity and resource constraints) and be underpinned with an implementation plan.
Quality Strategy monitoring R2 There is scope to strengthen quality strategy implementation plan delivery reporting. To enhance clarity, the Trust should, in its progress reports:

Recommendations

2.1 provide timescales for the expected delivery of each action;

2.2 differentiate between the progress of individual actions and strategic outputs; and

2.3 ensure that progress reports are reported regularly and are included in the QuESt cycle of business.

Clinical Audit Plan

R3 There are opportunities to further enhance reports on the Trust's Clinical Audit function, by:

3.1 more clearly highlighting any changes made to the approved Clinical Audit Plan; and

3.2 capturing key findings, outcomes and learning from completed audits.

Duty of Candour and Quality training

R4 The Trust should take steps to increase uptake rates for duty of quality and duty of candour training, to ensure staff have a good understanding of their responsibilities under the requirements.

Policy review

R5 The Trust should ensure that its Putting Things Right and Adverse Incident policies are updated to reflect the requirements of the Duty of Candour and Duty of Quality as soon as is reasonably possible.

Detailed report

Implementation of 2022 audit recommendations

18 We considered the Trust's progress in implementing each of our 2022 audit recommendations.

Quality Strategy delivery recommendation

2022 Recommendation 1

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.

19 We considered whether the Trust had taken additional steps to outline how it will deliver its Quality Strategy. We expected to see the following:

- a resourced supporting Quality Implementation Plan with suitable monitoring arrangements.

20 We found **delivery of the Quality Strategy 2021-2024 has continued to be slower than planned due to ongoing resourcing and capacity issues, and there is scope to improve progress reporting**.

21 The Trust monitors delivery of its Quality Strategy 2021-2024 via an implementation plan. This implementation plan was updated in May 2023 and February 2024, and delivery reported to the Quality, Experience and Safety Committee (QuESt) as part of an implementation plan progress report. The Board is kept up to date of progress by QuESt's 'Alert, Assure, Advise' reports which highlight key issues discussed during each meeting and are discussed at Board meetings.

22 However, progress in delivering the Quality Strategy 2021-2024 has been slower than intended, with the May 2023 progress report showing that only half of the actions were complete or on-track. The report to QuESt in February 2024 showed improved progress, in that nearly two-thirds of the listed actions for delivering the quality implementation plan were either complete or on track at the time of reporting. Outstanding actions as of February 2024, included actions such as developing training on the Trust's new quality management system and undertaking an evaluation of roles and responsibilities for quality across the organisation.

23 The Trust told us there are several reasons for why delivery has been off-track for some actions, including pressures caused by ongoing waves of COVID-19, winter

peaks in demand, and workforce industrial action. However, the most significant issue has been a continued lack of capacity. In 2022, we commented on issues in securing funding for the four senior quality lead posts set out in the Quality Strategy 2021-2024. Since that time, the Trust has undergone an internal restructure to provide two of these posts which have now been filled, as well as a senior quality governance lead, and invested into its Putting Things Right team. However, the inability to fund and recruit to these posts at the outset of the Strategy lifecycle has impacted the Trust's ability to deliver all of the actions of its Quality Strategy at the pace it intended.

24 As the Trust looks to develop a new Quality Plan in 2024[1], it should take steps to ensure that its ambitions are achievable and resourced. The Trust should be clear at the outset what the cost implications are for delivering its quality ambitions, as well as the risks associated with under-delivery (such as capacity and resource constraints). **We have superseded our 2022 Recommendation 1 with 2024 Recommendation 1 to reflect ongoing quality resource challenges and because a new Quality Plan is being developed**.

25 There is significant scope to improve the clarity of reporting progress to deliver the implementation plan. The progress reports presented in May 2023 and February 2024 did not detail the expected timescales for achieving actions listed within the implementation plan. Consequently, it was difficult for committee members to understand how off-track actions were at the point of reporting and the associated risks. It was also unclear as to whether the reports measure the completion of specific actions or delivery of strategic outputs, as, in some instances multiple actions were grouped together and, in others, multiple strategic outputs were grouped together. Progress reporting to QuESt has been irregular to date, with only two updates [in May 2023 and February 2024] at the time of writing, however, during our fieldwork, the Trust informed us that it is intending to introduce quarterly updates from August 2024 **(2024 Recommendation 2**).

Clinical Audit Plan recommendations

2022 Recommendation 2

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:

2.1 The QuESt Committee scrutinises and approves a clinical audit plan ahead of each financial year.

[1] The Quality Strategy 2021-2024 will be replaced with a Quality Plan.

2.2 The QuESt Committee receives quarterly updates on delivery of the approved clinical audit plan, and assurance reports including learning and improvement actions resulting from this work.

26 We considered whether the Trust has an annually approved clinical audit plan with routine reporting on delivery progress and resulting improvement actions. We expected to see the following:

- annually approved clinical audit plans, with regular progress reports received by QuESt; and
- evidence of learning from clinical audit and associated improvement actions.

27 We found **the Trust approves the Clinical Audit Plan annually and there are regular updates on progress of the Plan to QuESt, although there remains scope to improve reporting of outcomes and learning**.

28 The Clinical Audit Plan is informed by a variety of sources, including discussions at internal clinical groups, submissions from clinical managers and clinical directorates and identified as required due to clinical service changes. The Trust's Clinical Audit function was reviewed in March and April 2024 by Internal Audit which provided a reasonable assurance opinion. Amongst the key matters raised in the report was a need to strengthen the alignment between the Clinical Audit Plan and the Trust's Clinical Strategy, the operational risk register, and strategic priorities as set out in the Integrated Medium Term Plan. The Trust has identified actions to address Internal Audit's recommendations and plans to implement them during 2024-25.

29 QuESt approved the Clinical Audit Plan in both 2023-24 and 2024-25. **We consider 2022 Recommendation 2.1 to be completed**.

30 However, whilst the Trust emphasises in the Clinical Audit Plan that it may adjust the audit programme when it is appropriate to do so (for instance, to appropriately prioritise a new clinical audit), delivery progress reports have not consistently highlighted changes to the Plan and QuESt is not asked to approve any changes **(2024 Recommendation 3**).

31 QuESt has received quarterly delivery progress updates against the Clinical Audit Plan since May 2023. **We consider 2022 Recommendation 2.2 to be completed**.

32 Whilst more recent clinical audit progress reports have provided a better summary of progress, there remains scope for reports on clinical audit to provide stronger assurance to the QuESt on its activity. The accompanying clinical audit tracker provides members with an update on recommendations arising from clinical audits, however, our review found that papers could more clearly identify the key issues raised as they only capture recommendations, and progress reports do not currently highlight any findings from clinical audits. The Internal Audit review found that actions to address recommendations are monitored via relevant internal

groups. However, it remains difficult for QuESt members to be assured about the outcomes of clinical audit activity, and whether learning from clinical audits is becoming embedded to improve the Trust's performance without the inclusion of further narrative within progress reports **(2024 Recommendation 3**).

Mortality review recommendations

2022 Recommendation 3

The QuESt Committee does not receive adequate assurances on mortality reviews. The Trust should ensure the QuESt Committee receives quarterly update reports to include:

3.1 The number of reviews undertaken, and the numbers of reviews required but not yet complete.

3.2 Any significant concerns, lessons learned and what changes have been made as a result.

3.3 Updates on actions to address the mortality review backlog.

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

2022 Recommendation 4

The Trust has a significant backlog of mortality reviews.

The Trust should develop an action plan to reduce the backlog, reporting progress at each QuESt meeting.

33 We considered whether QuESt receives adequate assurance on mortality reviews[2], including progress to address the significant 2022 backlog, and implement lessons learnt from reviews. We expected to see the following:

- the all-Wales learning from mortality reviews framework implemented[3];
- evidence of learning from mortality reviews;
- a reduction in the mortality review backlog; and
- regular mortality review updates received by QuESt.

34 We found **the Trust has implemented the new national framework for mortality reviews, however, it has not yet progressed as planned, as there is fluctuating performance relating to delivering timely mortality reviews and**

[2] Mortality reviews are conducted when a patient dies whilst in the Trust's care, including whilst waiting for an ambulance to arrive.

[3] The All-Wales Learning from Mortality Review Model Framework was originally introduced in August 2021 and then revised in September 2022.

there is scope for more consistent reporting of mortality review activity, outcomes and learning.

35 The Trust has made improvements to the information presented to QuESt on mortality reviews since our last review. However, while QuESt receives regular information on mortality reviews, the information is not consistently reported, which makes it difficult to understand progress and ongoing challenges. Our review of papers found that the Trust has reported its backlog figure to four of the past six meetings, and only in August 2023 did QuESt receive data on how many referrals had been received compared to how many were awaiting review. **We consider 2022 Recommendation 3.1 to be in progress**.

36 Challenges in undertaking timely mortality reviews at the time of our 2022 review had led to a backlog which stood at 800 in August 2022. Data reported to QuESt since 2022 suggests that performance has fluctuated significantly. The reported backlog in August 2023 was 298, which increased to 800 in February 2024 and then reduced to 600 in May 2024. This position will be exacerbated by the deteriorating performance within the broader urgent and emergency care system, and further pressure is likely to arise from the new statutory role of the Medical Examiner introduced in September 2024. Whilst the backlog is lower than it was at the time of our 2022 review, it remains high. We have not seen evidence of an action plan with a clear trajectory to reduce the backlog and sustainably keep it at a more manageable level. However, QuESt does receive assurance that all referrals are screened on receipt by a member of the patient safety team and escalated as required. **We consider 2022 Recommendations 3.3 and 4 to be in progress**.

37 Key themes arising from mortality reviews have been reported through various reports to QuESt in three of the six meetings held between November 2022 and May 2024. The May 2023 report indicated that identified learning from mortality reviews was being provided to paramedics. The August and October 2023 reports highlighted key themes largely relating to delays in the community, call categorisation and end of life care. However, there was no reference to lessons learned and resulting actions. **We consider 2022 Recommendation 3.2 to be in progress**.

38 In September 2022, the Trust's Clinical Quality Governance Group (CQGG) approved the all-Wales Learning from Mortality Reviews Framework. The Framework provides a co-ordinated and systematic all-Wales approach to the mortality review process to enable local and national implementation of learning. To implement the Framework, in October 2023 the Trust established a Learning from Deaths Forum which reports to the CQGG. **We consider 2022 Recommendation 3.4 to be complete.**

Appraisal and Development Review recommendation

2022 Recommendation 5
The Trust has low Personal Appraisal and Development Reviews (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.

39 We considered whether the Trust has improved completion rates for its Personal Appraisal and Development Reviews (PADR), which were achieving 59% against the 85% target at the time of our review in 2022. We expected to see the following:

- improved PADR compliance; and
- robust plans in place to achieve further improvements and the required 85% target.

40 We found **whilst PADR completion rates have improved since our original review, they continue to be below the Trust's target rate**.

41 PADR rates have improved since our original review, with reported monthly rates remaining above 70% since August 2022, and at an average of 74% for the year 2023-24. However, performance continues to remain below the Trust's target of 85%.

42 There is regular monitoring of PADR compliance. The Trust's People and Culture Committee continues to monitor PADR compliance via the workforce scorecard at each meeting. However, there are ongoing challenges which make reaching the 85% target difficult. Lower compliance continues to be primarily within operational Emergency Medical Services, where staff are required to be booked out of operational duties to attend the PADR meeting with their manager. This is recognised as an ongoing logistical barrier to improving PADR performance, particularly given the service pressures currently facing the Trust. The Trust has plans to further improve performance by gaining insights into how it can increase rates in areas with lower compliance. However, The Trust informed us that it was also considering re-evaluating its target within this context. **We therefore consider 2022 Recommendation 5 to be in progress**.

Board member walkabout recommendation

2022 Recommendation 6
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.

43 We considered whether the Trust has developed a clear process for visits by Board members across the organisation's business and to consistently capture learning by hearing directly from patients and staff. We expected to see the following:

- a clear standard operating procedure in place, with a standard template to capture feedback and learning; and
- a schedule of Board walkabouts covering all areas of service delivery.

44 We found **the Trust has a standard operating procedure for Board members conducting visits, however, the frequency and coverage of visits, whilst increasing, are variable, and it currently does not consistently capture and report feedback and learning to the Board**.

45 The Trust has a clear process to support Board members to undertake visits. In 2022, the Trust established a Standard Operating Procedure for Board Visits which includes prompts and a template for capturing feedback and suggested actions.

46 Our observations of Board and committee meetings show that Board members highly value opportunities to hear from staff and patients directly, such as via staff and patient stories. However, although the Standard Operating Procedure for Board Visits includes a form for capturing feedback, the Trust does not currently require Board members to complete it, with it tending to be used only to raise a formal concern. The Trust said this is to avoid the process becoming too bureaucratic. Instead, Board members often provide direct informal feedback or seek further information to the relevant directors via email or during Board development meetings. However, this provides only limited feedback and the Trust would likely benefit from providing further opportunities for reporting back on learning from visits, such as via Non-Executive Director meetings or regular sessions at board development. This would strengthen the Board's ability to triangulate the intelligence gathered with other information, to highlight any areas of concern or risk or to celebrate and share good practice.

47 The Trust's Chair refers to recent visits he has undertaken via the Chair's report to each Board meeting. More recently this report also includes a list of visits undertaken by the Vice-Chair. As part of its Standard Operating Procedure for visits, the Trust also has a process for recording the location and timing of Board visits, which provides an interactive heat map. The heat map shows visits in real time and overseen via bi-annual updates to the Executive Leadership Team and the Board. The 2023-24 heat map shows significant variation in the geographical and service area coverage, as well as the number of visits made by each Board member. Generally, rural areas received fewer visits, with higher numbers of visits

in urban areas, and particularly in Cardiff and Swansea. In addition, the frequency of visits to administrative service areas was higher than to ambulance stations and 111 centres. Except for the Chair, Non-Executive Directors conducted fewer visits than other Board members, due in part to the limited time contractually available for Non-Executive Directors to undertake their roles. We are aware that there has been an increase in the number of visits since April 2024, as well as increased coverage of areas in central Wales.

48 While the Trust does not currently have a forward schedule for board visits, at the time of our fieldwork, it was considering how to increase the number and geographical coverage of future visits. The Trust told us it was considering resuming its pre-2023 practice of geographically rotating its Board meetings around Wales to provide greater opportunities for Board members to meet and engage with Trust staff across Wales. **We therefore consider 2022 Recommendation 6 to be complete**.

Joint Escalation Framework recommendation

2022 Recommendation 7

The Joint Investigations 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.

49 We considered whether the Trust has strengthened the process for addressing serious incidents where other organisations are involved in the care of the patient. We expected to see the following:

- an effective Joint Investigations Framework in place for serious patient incidents; and.
- recommendations made by the Delivery Unit addressed, with evidence of progress being reported to Board and the QuESt committee.

50 We found **compliance with the new national process for jointly investigating serious incidents with partners is strong, with activity regularly monitored by the QuESt committee**.

51 In 2022, the Delivery Unit raised concerns around the application of the Joint Investigation Framework in place to address serious patient safety incidents. In response, a task and finish group was established between partners to refine the Joint Investigations Framework. The NHS Wales National Policy on Patient Safety Incident Reporting and Management was updated in April 2023 to ensure consistent practices across Wales. QuESt approved the adoption of the National Policy and its supporting appendices in August 2023.

52 QuESt did not receive updates against the recommendations made by the Delivery Unit in 2022 by way of its audit tracker, as the audit tracker is limited to recommendations made by internal and external audit and Healthcare Inspectorate Wales. However, we understand that the Trust considers each of the four recommendations (which included the establishment of a task and finish group to review the Joint Investigations Framework) to have been completed.

53 The numbers and general themes of incidents falling under the Joint Investigations Framework (both shared and received) are reported to each QuESt meeting within the quarterly Putting Things Right Report. Interviewees felt confident that the Joint Investigation process has improved due to stronger governance arrangements, including weekly meetings between the Trust and health boards to discuss each incident.

54 There has not, to date, been an assessment of the effectiveness of the new Joint Investigations Framework for managing incidents with health bodies. However, in late 2023, Internal Audit undertook a review of the Trust's compliance with the Joint Investigation Framework and provided a reasonable assurance opinion. The report was received by the Audit, Risk and Assurance Committee in May 2024. It included six recommendations, two of which were medium priority and four of which were low priority. One of the key matters raised in the report related to a need for the Trust's Adverse Incident and Reporting Policy to be more aligned to the NHS Wales National Policy on Patient Safety Incident Reporting and Management. The Trust has committed to a full policy review once the Welsh Government updated Putting Things Right Regulations are available (due Autumn 2024). **We therefore consider 2022 Recommendation 7 to be complete**.

Quality performance reporting and learning recommendation

Recommendation 8

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

8.1 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.

8.2 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.

8.3 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.

8.4 Develop patient outcome measures to support its existing quality measures.

55 We considered whether the Trust has enhanced its performance information by triangulating information from different sources and developing a greater number of patient outcome measures. We expected to see the following:

- enhanced performance reporting and monitoring arrangements which support triangulation and identification of themes;
- effective joint working with health boards to monitor outcomes for patients, including focus on the consequences of long ambulance waits; and
- patient outcome measures in place, which are routinely monitored.

56 We found **the Trust continues to face challenges in reporting patient outcomes due to difficulties in joining up information across organisations. However, there is more the Trust can and should do to triangulate themes across metrics and identify learning**.

57 The Trust has established mechanisms for monitoring and reporting on performance data, but could do more to identify themes and analysis. Quality metrics are mainly reported via the Monthly Integrated Quality and Performance Reports (MIQPR) and quarterly Putting Things Right Reports. The MIQPR contains data on clinical outcomes, such as, the percentage of 'Stroke Patients with Appropriate Care', as well as quality indicators, such as, percentage of 'Concerns Response within 30 Days', and numbers of patients who did not receive an ambulance due to receiving a 'Can't Send' response. The Putting Things Right Report includes data relating to the numbers and trends of concerns and incidents. Both reports are received at each QuESt meeting. The Putting Things Right report summarises some of the key themes from joint investigations and incidents, but not others, such as, concerns or mortality reviews. However, neither reports provide triangulation across metrics to identify main themes, and there is limited information on what is being done to address challenges and identify and implement learning. **We therefore consider 2022 Recommendation 8.1 to be in progress**.

58 Our review of the Trust's MIQPR found that it continued to report on COVID-19 in relation to its impact on staff, sickness absence rates, and vaccination rates. We did not find any measures within the report relating to the impact of COVID-19 on harm to patients. However, given the decreased level of risk posed by COVID-19 since 2023, **we consider 2022 Recommendation 8.2 to be superseded**.

59 The Trust has good arrangements to engage with the public through its People Engagement and Community Involvement Team and hear feedback from patients. Patient feedback is considered alongside complaints and incidents information. However, there is a significant data weakness, because information governance rules do not enable the Trust to track outcomes for patients who were treated via Consult and Close or referred to an alternative (non-ambulance) pathway, ie

whether they later required and accessed further services. The Trust informs us that it is proactively engaging with the Information Commissioners Office to try and find solutions that enable better systematic access to patient feedback.

60 The Trust has implemented the electronic Patient Clinical Record (ePCR) which links up information between the Trust and health boards, and allows feedback on patient outcome for some conditions (such as, return of spontaneous circulation, stroke bundles, fractured neck of femur), however, these indicators are limited in number. The Trust has plans to develop further measures for falls and older people, however, at present there continue to be issues with the completeness of records in ePCR, which is inhibiting the quality of data. **We consider 2022 Recommendation 8.4 to be in progress**.

61 Currently, the Trust's performance reports provide some information on potential harm to patients, such as modelled scenarios on the level of harm likely to occur due to the level of handover delays experienced in the preceding month. However, as discussed in **paragraph 59,** the identification of actual patient harm across the whole Urgent Care Pathway is challenging, partly due to incomplete ePCR records, and also because impacts to patients are not always immediately apparent. The Trust is taking steps to provide more clarity on actual harm caused, such as, by working with colleagues from the All-Wales Tissue Viability Network to determine how to identify avoidable harm across the system in respect of pressure damage. The Trust is also working on developing a Civica Patient Experience dashboard which will provide improved level of detail on experiences, including actionable improvements that the Trust could make, for instance, in how they move and handle patients. **We consider 2022 Recommendation 8.3 to be in progress**.

Responding to the requirements of the Duty of Candour and Duty of Quality

62 We considered the extent to which the Trust has taken steps to implement both the Duty of Quality and Duty of Candour. We expected to see the following:

- the Trust has considered what it needs to do to implement the duties of Quality and Candour, with plans in place to address any gaps.
- the Trust has clear arrangements in place for monitoring implementation which reflects the timescales and risks associated with delivering the plan.
- progress in implementing the duties of quality and candour is routinely reported to the Board and its committees.
- board members have sufficient awareness and have received appropriate training in relation to the duties of quality and candour.
- roles and responsibilities in relation to implementing the duties of quality and candour at all levels of the organisation are clearly documented and understood. The Trust has assessed the skills/capability and capacity required to implement the duties of quality and candour at both a corporate

and operational level and has put appropriate arrangements in place to address any shortfalls and gaps.

- staff training has been delivered to raise awareness of the requirements under the two duties. The Trust has identified appropriate strategic, senior, and operational leadership to oversee and deliver the duties. All staff understand their respective responsibilities.
- the Trust has reviewed and appropriately updated its existing policies and standing operating procedures as required.

63 We found **the Trust has taken steps to implement the duties of quality and candour, however, there are weaknesses in the clarity of reporting progress and there is scope to improve training compliance and monitoring**.

64 The Health and Social Care (Quality and Engagement) Act 2020 came into force on 1 April 2023. The Trust assessed its preparedness for complying with the requirements of the Duty of Quality and Duty of Candour using an assessment against the Welsh Government baseline position, which it reported in February 2023. It subsequently assessed itself against the Welsh Government implementation road map in August 2023 and developed an implementation plan in October 2023. Within the Trust's self-assessment against the implementation road map in August 2023, it marked its progress as 'yellow' (organisation has identified that delivery is at risk but manageable or behind schedule but within tolerance) and indicated confidence in being compliant with the Act in relation to specific aspects, such as, falls prevention, but concerns remain related to the pace of implementation due to resources, particularly in relation to the Duty of Candour.

65 The Trust's implementation plan is monitored at an operational level by the Trust's Quality Management Group, but there is scope to better describe progress to QuESt. Monitoring of the Trust's response to the Act has been listed as QuESt's key priority for 2022-23, 2023-24 and 2024-25. However, our review of papers received by QuESt found that it is not always easy to understand the Trust's progress. Despite the October 2023 update report stating that QuESt would have oversight of the implementation plan, the plan has not been formally received by the committee to date. Therefore, updates to QuESt in 2023-24 have mainly commented on the ongoing activity of the Trust, rather than providing a balanced view of progress to implement actions within timescales. While minutes evidence some challenge from members to clarify progress, papers could better highlight progress and ongoing issues and risks to better equip members' understanding in advance of meetings.

66 The Trust has taken steps to provide Board members with an understanding of the new requirements under the duties of quality and candour. It organised a Board development session in March 2023, prior to the enforcement of the legislation, and, at the time of our review, further separate sessions on each duty were planned for later in 2024.

67 The Trust has identified appropriate strategic and senior leadership to the implementation of the duties of quality and candour across the organisation. The

Executive Director of Quality and Nursing is the identified strategic lead for the duties, whilst the duty of quality is assigned at a senior level to the Assistant Director of Quality Governance, and the Duty of Candour is assigned at a senior level to the Assistant Director of Quality and Nursing. As discussed in **paragraph 23**, the Trust undertook a restructure and secured investment into its quality and Putting Things Right teams, including a Senior Quality Governance Lead and a Quality Governance Lead for Putting Things Right during 2023 and early 2024.

68 Training for staff has also been delivered to support compliance. External training on quality management systems was procured for a select number of staff, which interviews suggest was helpful. In January 2024, the Trust introduced e-learning modules on both duties, which staff across the organisation are asked to complete. However, a technical error has meant that the system failed to recognise the completion of the Duty of Candour course by participants, meaning completion rates are unavailable. Completion rates for the Duty of Quality training were 33.2% as at June 2024. The Trust was considering options for increasing compliance at the time of our fieldwork, such as, making the training mandatory, making it more user-friendly and more visibly promoted by leaders in the organisation **(2024 Recommendation 4**). More broadly, the Trust has raised awareness amongst its staff of the new requirements through its intranet site, as well as during its annual Chief Executive Officer Roadshow sessions. The training has been incorporated into induction training for new starters.

69 Reports to QuESt during 2023 stated that, going forward, policies due for renewal should consider and reflect the requirements under the duties of quality and candour. Positively, as the Trust undertakes policy review, its clinical quality governance group ensures a quality lens is applied during the process. The Putting Things Right policy and Adverse Incident policy (due to be reviewed in March and April 2023 respectively) were highlighted as key policies to be updated considering the Act. However, whilst the Trust did adopt the National Patient Safety Policy and supporting appendices, we could find no evidence that the two policies (Putting Things Right policy and Adverse Incident policy) have been updated (**2024 Recommendation 5**).

Appendix 1

Our 2022 quality governance recommendations

Exhibit 3 sets out the recommendations we made in our 2022 review of quality governance arrangements at the Trust and our current assessment of progress made to meet those arrangements.

2022 Recommendations	Audit Wales assessment of completeness (as at August 2024)
Recommendation 1 – Quality Strategy delivery 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.	**Superseded**
Recommendation 2 – Clinical Audit Plan 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: 2.1 the QuESt Committee scrutinises and approves a clinical audit plan ahead of each financial year; and 2.2 the QuESt Committee receives quarterly updates on delivery of the approved clinical audit plan and assurance reports, including learning and improvement actions resulting from this work.	**Completed**

2022 Recommendations	Audit Wales assessment of completeness (as at August 2024)
Recommendation 3 – Mortality reviews The QuESt Committee does not receive adequate assurances on mortality reviews. The Trust should ensure the QuESt Committee receives quarterly update reports to include: 3.1 the number of reviews undertaken, and the numbers of reviews required but not yet complete; 3.2 any significant concerns, lessons learned and what changes have been made as a result; 3.3 updates on actions to address the mortality review backlog; and 3.4 updates on progress implementing the all-Wales Learning from Mortality Reviews Framework.	**In progress**
Recommendation 4 – Mortality reviews The Trust has a significant backlog of mortality reviews. The Trust should develop an action plan to reduce the backlog, reporting progress at each QuESt Committee.	**In progress**
Recommendation 5 – Personal Appraisal and Development Reviews (PADR) 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.	**In progress**

2022 Recommendations	Audit Wales assessment of completeness (as at August 2024)
Recommendation 6 – Board member walkabouts 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 and 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.	**Completed**
Recommendation 7 – Joint Escalation Framework The joint investigations 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.	**Completed**

2022 Recommendations	Audit Wales assessment of completeness (as at August 2024)
Recommendation 8 – Quality performance reporting and learning We found that the QuESt Committee is well served with quality information, but there are opportunities for improvement. The Trust should: 8.1 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. 8.2 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. 8.3 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. 8.4 develop patient outcome measures to support its existing quality measures.	**In progress**

Appendix 2

Audit methods

Exhibit 4 sets out the methods we used to deliver this work. Our evidence is limited to the information drawn from the methods below.

Element of audit approach	Description
Documents	We reviewed a range of documents, including: • Quality Strategy 2021-24; • Internal Audit reports (namely relating to Clinical Audit and Joint Investigation Framework); • Mortality Review reports: • Putting Things Right reports; • MIQPRs; and • Annual Quality Report.
Interviews	We interviewed the following: • Executive Director of Quality and Nursing; • Executive Director of Paramedicine; • Assistant Director of Quality Governance; • Senior Quality Governance Lead; • Assistant Director of Clinical Development; • Chair of Quality, Experience and Safety (QuESt) Committee; • Board Secretary;

Element of audit approach	Description
	• Assistant Board Secretary; and • Senior Workforce Transformation Manager.
Observations	We observed the following meeting(s): • QuESt February 2024 • QuESt May 2024 • Board May 2024

Appendix 3

Organisational response to 2022 and 2024 audit recommendations

Exhibit 5 sets out the Trust's response to our new audit recommendations.

Ref	Recommendations	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R1	**Quality Strategy** As the Trust develops a new Quality Plan in 2024, it should ensure that delivery is achievable within the resources available. The plan should clearly detail the funding required, the risks of under-delivery (due to capacity and resource constraints) and be underpinned with an implementation plan.	The Quality Strategy is now in development with a change of nomenclature to Quality Plan, acknowledging that the long-term organisational strategy is Delivering Excellence: Our vision for 2030. The approach to development has been approved by committee including engagement with internal and external stakeholders and is expected to be approved in Q4 2024-25 for implementation in Q1 2025-26. The quality plan is intended to identify deliverables that follow the principles of the duty of quality being efficient and effective, as well as demonstrating commitment to value based health care. With this in mind the intention is to deliver the quality plan within our	30 June 2025	Assistant Director of Quality Governance

Ref	Recommendations	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
		existing structures without additional investment and through use of our existing infrastructures and networks. The approval of the Quality Plan including the executive summary which sets out the need to ensure that the plan is deliverable within existing establishment constraints will close this action. This will be demonstratable through approved papers and minutes from QuESt committee.		
R2	**Quality Strategy monitoring** There is scope to strengthen quality strategy implementation plan delivery reporting. To enhance clarity, the Trust should, in its progress reports: 2.1 provide timescales for the expected delivery of each action;	The approved Quality Plan will be supported by a robust implementation plan clearly articulating measurable actions and timescales for delivery against responsible and accountable owners. Updates will be provided via the governance structures to ensure regular updates are provided to QuESt via the cycle of business. The Assistant Director of Quality Governance will work with Corporate Governance leaders to	30 March 2026	Assistant Director of Quality Governance

Ref	Recommendations	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	2.2 differentiate between the progress of individual actions and strategic outputs; and 2.3 ensure that progress reports are reported regularly and are included in the QuESt cycle of business.	ensure a clear cycle of updates and escalation is included within the implementation plan. The review of minutes from QuESt committee which includes these progress reports, through four cycles of business will close this action.		
R3	**Clinical Audit Plan** There are opportunities to further enhance reports on the Trust's Clinical Audit function, by: 3.1 more clearly highlighting any changes made to the approved Clinical Audit Plan; and 3.2 capturing key findings, outcomes and learning from completed audits.	We will review the communication lines between CQGG, ELT and QuESt to provide clearer visibility on the key findings, outcomes and learning identified through Clinical Audit reports. Whilst amendments to approved clinical audit plans should not be delayed as a result of timescales associated with the cycle of business, quarterly updates will include more detail on the changes to the approved plan including the rationale.	31 March 2026 31 March 2026	Head of Clinical Intelligence and Assurance

Ref	Recommendations	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
		The review of minutes from QuESt committee which includes these findings, through four cycles of business will close this action.		
R4	**Duty of Candour and Quality training** The Trust should take steps to increase compliance rates for duty of quality and duty of candour training to ensure staff have a good understanding of their responsibilities under the requirements.	Access to both Duty of Quality and Duty of Candour training is available via ESR, with Duty of Quality training also available via Learning@Wales. It is important to balance not just the compliance to the training request but also the impact that training has. In order to increase uptake rates the Duty of Quality training, content has been duplicated onto Learn365 which allows the training to be more accessible and stress-free increasing uptake and engagement. Quality Management Group are now monitoring a similar approach for the Duty of Candour training.	30 September 2025	Assistant Director of Quality Governance

Ref	Recommendations	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
		Engagement with the training is monitored via the Education and Development Team as well as by the Quality Management Group. Local teams will receive regular updates on their compliance with this training and will receive support via QMG on how to improve uptake rates of training. Highlight reports from QMG to CQGG which include the actions taken to increase uptake rates alongside the current completion rates across the organisation will close this action. This will be demonstrable through three Alert, Advise, Assure (AAA) Highlight reports.		
R5	**Policy review** The Trust should ensure that its Putting Things Right and Adverse Incident policies are updated to reflect the requirements of the Duty of Candour and	The Putting Things Right Policy and the Adverse Incident Policy were both updated and approved through the Policy Group to include references to the Duty of Quality and Duty of Candour on 25 April 2023. These updated	Complete	Assistant Director of Putting Things Right

Ref	Recommendations	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	Duty of Quality as soon as is reasonably possible.	policies were subsequently published on 1 June 2023. Both Policies have been subject to a content check by the Assistant Director of Putting Things Right to confirm this content is in place. **This action is complete**		
2022 R3	**Mortality reviews** The QuESt Committee does not receive adequate assurances on mortality reviews. The Trust should ensure the QuESt Committee receives quarterly update reports to include: 3.1 the number of reviews undertaken, and the numbers of reviews required but not yet complete; 3.2 any significant concerns, lessons learned and what changes have been made as a result;	The learning from deaths forum and associated sub groups' Terms of Reference include the sharing of learning at a local level as well as contributing to learning on a national basis. This information is shared via the Alert, Advise, Assure (AAA) highlight report. The content of the highlight report will be reviewed through governance processes to ensure consistency of reporting aligned to the Agendas of these fora. Four highlight reports which include this consistency of data alongside QuESt committee minutes will close action 3.1.	31 December 2025. 31 December 2025.	Assistant Director of Putting Things Right.

Ref	Recommendations	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	3.3 updates on actions to address the mortality review backlog; and 3.4 updates on progress implementing the all-Wales Learning from Mortality Reviews Framework.	A twice yearly paper communication learning from mortality is shared with QuEST committee to provide assurance on the process, completion rates, themes and associated improvements. The QuESt committee minutes where these papers are discussed will close action 3.2 The Trust recognises that further development work is required on the national electronic Mortality Review module in the Datix Cymru system to improve the recording of trends and themes that in turn support learning and improvement. The Trust is engaged regularly in the National Mortality Safety and Learning Network and the Once for Wales Datix Cymru Mortality Review workstream to inform this development work and ensure that the unique nature of our services within the Welsh context is being appropriately represented. Updates provided on engagement with the all-Wales Learning from Mortality Reviews framework demonstrated through QuESt committee	31 December 2025. 3.4 assessed as Complete during 2024 review	

Ref	Recommendations	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
		minutes across two cycles of business will close action 3.4 A PTR Improvement plan is currently in place which includes actions to address the backlog of ME referrals. Following the introduction of governance forums ME referrals are contemporaneously triaged in line with framework. The organisation acknowledges the need to fully mature the structures and learning themes and believes these will occur over time within the new governance structures. Updates provided on the PTR improvement plan which specifically set out the work undertaken to reduce the backlog demonstrated through QuESt committee minutes across two cycles of business will close action 3.3		

Ref	Recommendations	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
2022 R4	**Mortality Reviews** The Trust has a significant backlog of mortality reviews. The Trust should develop an action plan to reduce the backlog, reporting progress at each QuESt Committee.	A PTR Improvement plan is currently in place which includes actions to address the backlog of ME referrals. Following the introduction of governance forums ME referrals are contemporaneously triaged in line with framework. The organisation acknowledges the need to fully mature the structures and learning themes and believe these will occur over time within the new governance structures. Updates provided on the PTR improvement plan which specifically set out the work undertaken to reduce the backlog demonstrated through QuESt committee minutes across two cycles of business will close this action.	31 December 2025	Assistant Director of Putting Things Right.
2022 R5	**Personal Appraisal and Development Reviews (PADR)** 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	We are implementing a range of measures aimed not only at increasing compliance but also at enhancing the quality and value of PADR conversations. The Trust is committed to improving PADR compliance while also ensuring that these reviews provide real value to staff and managers. We will continue to	31 December 2025	Head of Culture and Organisational Development

Ref	Recommendations	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	behaviours, the Trust should ensure that PADR rates are improved and set out the actions it will take to achieve this.	monitor progress and adjust our strategies as necessary, while also considering how our target metrics or measures of success can better reflect our commitment to meaningful and impactful conversations. Minutes of People and Culture committee where updates are received regarding compliance to target and actions taken to improve the value to staff and managers across three cycles of business will close this action.		
2022 R8	**Quality performance reporting and learning** We found that the QuESt Committee is well served with quality information, but there are opportunities for improvement. The Trust should:	Through our Quality Performance Management Framework we will explore how we can draw focus across departments and directorates to triangulate information identifying themes for learning and improvement. This will be used either for internal continual improvement where this is within our boundaries or to share as part of external collaborative working both with		Assistant Director of Commissioning and Performance

Ref	Recommendations	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	8.1 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. 8.2 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. 8.3 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	health boards and commissioners. Committee minutes containing reference in both the MIQPR and PTR report which includes triangulation of metrics across two cycles of business will close action 8.1. Action 8.2 has been superseded the audit report will provide evidence of closure of this action. Whilst we remain limited by data accessibility we continue to pursue patient outcome data through ePCR as well as linking our critical systems to the Welsh Demographic Service allowing the first steps into linking remote clinical assessment with patient outcomes. The ability to achieve truly robust outcome measures without data linkage is limited, we continue to work with DHCW to resolve barriers to data sharing across NHS Wales. Three Alert, Advise, Assure (AAA) Highlight reports from Information Governance Steering	30 September 2025 8.2 Superseded in 2024 review. 30 September 2025	

Ref	Recommendations	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	from service failures such as long ambulance waits. 8.4 develop patient outcome measures to support its existing quality measures.	Group will provide evidence of this ongoing work and will close both action 8.3 and 8.4	30 September 2025	

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We welcome correspondence and telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.