WELSH AMBULANCE SERVICES NHS TRUST

CONFIRMED MINUTES OF THE OPEN SESSION OF THE MEETING OF THE QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE HELD ON 10 NOVEMBER 2022 VIA TEAMS

PRESENT:

Bethan Evans	Non Executive Director and Chair
Professor Kevin Davies	Non Executive Director
Paul Hollard	Non Executive Director
Ceri Jackson	Non Executive Director
Hannah Rowan	Non Executive Director

IN ATTENDANCE:

Lee Brooks	Executive Director of Operations
Andrew Clement	Partners in Healthcare, Resource Development Coordinator
Leanne Hawker	Head of Patient Experience and Community Involvement
Wendy Herbert	Assistant Director of Quality and Nursing
Peter Hindley	Community Health Council
Ian James	Trade Union Partner
Alison Johnstone	Partners in Healthcare Manager
Bethan Jones	Midwife (on secondment from BCUHB) - Observer
Mark Jones	Consultant Mental Health Nurse
Alison Kelly	Business and Quality Manager
Dr Brendan Lloyd	Executive Medical Director
Bethan Lowry	Concerns Admin Support
Mark Marsden	Trade Union Partner
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Trish Mills	Board Secretary
Steve Owen	Corporate Governance Officer
Hugh Parry	Trade Union Partner
Alex Payne	Corporate Governance Manager
Felicity Quance	Internal Audit
Duncan Robertson	Assistant Director of Research, Audit and Service Improvement (North)
Leanne Smith	Interim Director of Digital Services
Gaynor Sollis	Patient Safety Manager
Andy Swinburn	Director of Paramedicine
Gareth Thomas	Patient Experience and Community Involvement Manager
Lisa Trounce	Business Manager
Jonathan Turnbull-Ross	Assistant Director of Quality Governance
Liam Williams	Executive Director of Quality and Nursing
Debbie Young	Executive Assistant

Apologies:

Non Recorded

49/22 PROCEDURAL MATTERS

The Chair extended a warm welcome to everyone with a special welcome to: Alex Payne, Bethan Jones, Bethan Lowry, Gaynor Sollis and Felicity Quance.

Minutes

The Minutes of the meeting held on 11 August 2022 were approved.

Action Log

The action log was considered:

Action Number 16/21: To provide updates on the viability of Community First Responders (CFR) to administer pain relief. An update was provided by Andy Swinburn; action to remain open to receive further updates going forward.

Action Number F&P 1/21-22: Review of performance related metrics, action was closed with a further update to be provided once information was available with an update at the February meeting.

Action Number 50/21a: Ongoing work in improving symptom checkers on website. A comprehensive update was attached to the action log, action was closed.

Action Numbers 32/22a and 33/22b: Both related to patient experience; a written update had been provided and the actions were closed.

Action Number 35/22: To strengthen the wording on the Monthly Integrated Quality Performance Report (MIQPR) recommendation: Agreed that this action was to be closed.

Action Number 36/22a: Collaboration with the private sector in relation to older people; an update was provided on the action log and the action closed.

Action Number 36/22b: Update on care home focused improvements. A detailed update was on the action log, and it was agreed to remain open until the next meeting pending further details.

RESOLVED: That

(1) the Minutes of the Open meeting held on 11 August 2022 were confirmed as a correct record; and

(2) consideration was given to the Action Log as described above.

50/22 OPERATIONS DIRECTORATE QUARTERLY REPORT – 2022 -23 Q2

Lee Brooks introduced the revised format of the Operations Quarterly Report as read, and drew attention to the latest position on the current pressures.

Comments:

1. Members welcomed the revised format of the report adding that it read well and clearly demonstrated the extreme pressure the whole NHS continued to sustain. Members queried whether this report had been sent to Commissioners; Lee Brooks stated it had not, and agreed to share it with the Chief Ambulance Services Commissioner going forward.

2. It was asked whether volunteers received a Performance Appraisal and Development Review (PADR). Lee Brooks commented that in his view, PADRs were not completed, however he was confident that scheme coordinators were in frequent contact with volunteers. He agreed to confirm the reporting mechanism for volunteers at a future meeting.

3. In response to a query regarding roster reviews and rural response in Powys, Lee Brooks advised that overall the roster review was on track to be deployed by the end of the year. Work was ongoing in terms of rural response in that the Trust was considering different models of care, and whether this would improve patient care in rural areas.

4. It was asked whether the 111 rostering activity had been successful. Lee Brooks stated that it was too early to comment, but ensured it would be included in the next update.

5. With respect to Emergency Medical Despatcher (EMD) recruitment and retention were there any themes or trends which were contributing to the high level of turnover. Lee Brooks explained that the rate of attrition was in the region of 23% which was high; part of this was due to existing vacancies which increased the workload and pressure on staff.

   The Trust has continued to recruit and was confident that by the winter period sufficient staff will be in place; adding there were around 50 currently in training. Paul Hollard added that the next People and Culture Committee meeting will receive a report on the EMD turnover rates, which should provide further information regarding recruitment and retention patterns.

RESOLVED: That the report was received.

51/22 PATIENT EXPERIENCE

1. The Committee were shown a video in which Fiona Philpott told of the extremely poor patient experience of her 99-year-old mother Brenda Patton, who fell at home in the bathroom and waited 8.5 hours for an emergency ambulance to arrive.

2. During that time Brenda was crying in pain and her condition deteriorated. Fiona told the Committee of the stress and anguish this caused both her and her mother, particularly as there was no-one available to administer pain relief while they waited for the ambulance to arrive. Fiona recognised the ambulance service was under a huge amount of pressure and expressed her outrage that the service did not afford her mother the care expected, adding that in her opinion the NHS service was not fit for purpose.

Comments:

3. Leanne Hawker informed the Committee that following an investigation it was noted there had been a high number of 999 calls and long delays in handovers at hospitals within the Betsi Cadwaladr University Health Board (BCUHB). Leanne added that

work was underway jointly with BCUHB to develop the falls response service; and a second falls response vehicle was due to start in November, covering Conwy and Denbighshire, subject to funding being confirmed. Liam Williams added that a commitment had been made from the Executive Director Nursing (EDN) network to expedite the falls level 2 work across Wales. Further to this he commented that the EDN's had sent correspondence to NHS Wales Chief Executive, supported by the Chief Operations Officers and Medical Director, network to focus on the high impact issues. Additionally, Liam Williams stated that linking patient data analysis effectively would provide the basis to better align resources to meet the needs of the population of Wales. Jonathan Turnbull-Ross assured the Committee that extensive engagement was ongoing, particularly with BCUHB in terms of the falls work. It was noted that the outcomes of the investigation had been shared with Fiona Philpott.

4. Members felt the severe impact of Fiona and Brenda's powerful experience, particularly in the context of the very long delays currently being experienced by so many patients in the community, and the very real prospect of the delays deteriorating over the winter months. The Committee also recognised that during the 8.5 hour waiting period there was nothing different the Trust could have done, and this was extremely worrying. Members felt that the Trust had done everything in its power to improve the system but were becoming increasingly frustrated that it was futile and could not see any improvements in the near future.

5. Members asked what, if anything further they could meaningfully do to escalate the issues raised and were assured that the Trust was doing all it could within its gift. Liam Williams advised that the risks were high up on the Board agenda. He added that the Trust Chair has escalated the issue of handover delays to the Minister for Health and Social Services, and that the Trust Chief Executive continues to discuss the issue in other forums. He added that recruitment across the Trust was continuing with a view to increasing front line capacity. Furthermore, Audit Wales was carrying out work to look at patient flow in hospitals and how to seek improvement; it was hoped this would lead to an improvement in patient flow and release more ambulance resource to respond to patients in the community.

   It was asked whether there were further actions that could be taken within the Trust to improve the situation. For example, when someone calls repeatedly, instead of going through the same questions, to divert them to a dedicated phone number. Lee Brooks outlined details of the Medical Despatch Priority System (MDPS) explaining it was process driven and the caller would only have to repeat the same answers if there was a change to the patient's condition.

6. The Committee expressed their thanks to Fiona and Brenda for sharing this story and would review the learning that was taken from this incident at its meeting in February.

RESOLVED: That the patient story was noted and recognised that discussions on the severe delays and system pressures would be heard at the Trust Board meeting later this month.

52/22 RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK REPORT

1. Trish Mills informed the Committee there were three corporate risks assigned to the Committee, two of which were rated as high risks with no changes to scores since the last review. Risk 223: 'the Trust's inability to reach patients in the community causing patient harm and death', and risk 224: 'significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service', were both rated at 25. These

risks continued to be actively managed and are monitored and reviewed regularly by the Assistant Directors Leadership Team and the Executive Management Team.

2. The management and mitigation of these risks were discussed significantly throughout earlier items in this meeting, and the Committee noted that despite further controls being applied in the last quarter, there was no movement on either the likelihood or consequence scores for either ; therefore they remain at the highest score of 25.

3. The Committee agreed to the closure of risk 303, 'delayed administration of chest compressions to patients as part of resuscitation', as all actions have been completed, and the score reduced to its target.

RESOLVED: The Committee accepted the status of the three corporate risks which it has been assigned to oversee the management of – risk 223, 223 and 303. The Committee received the relevant sections of the Board Assurance Framework and noted the ongoing mitigating controls. The Committee agreed to close risk 303.

53/22 MONTHLY INTEGRATED QUALITY PERFORMANCE REPORT

Rachel Marsh presented the Monthly Integrated Performance Report (MIQPR) for September, and reviewed in detail with the following to note:

1. 111 clinical ring back had improved greatly following the introduction of tactical actions as part of the recent business continuity incident. This improvement is despite the difficulty to recruit the right numbers and types of clinicians into post.

2. Hospital handover delays continued to worsen with over 28,000 ambulance hours lost in October, which represented 37% of the Trust's capacity to respond. From a patient experience perspective one of the impacts was that the number of patients cancelling ambulances was over 10,000 per month.

3. Rachel Marsh referenced the workforce related metrics contained within the report which include sickness, staff training and PADR completion rates, all of which were improving.

Comments:

1. Members queried whether staff were being encouraged to have the Covid booster vaccination, as the uptake seemed low. Andy Swinburn confirmed that messages had been sent to staff.

2. It was asked whether there was an update on the immediate release requests. The Committee were advised that whilst during this quarter 47% of immediate release directives were declined, there has been an improving position proportionately across Wales for red releases in September. However, the number of amber releases declined was of concern. A process was in place to investigate those declined with details being reported to Health Board Chief Executives weekly. The Committee is due to receive an internal audit review on immediate release requests at its next meeting, which will test the Trust's compliance on process to determine any internal improvements. Brendan Lloyd added that until the culture in health boards changes, and while ambulance waits were the most intolerable part of the patient flow, some Emergency Departments (ED) will continue to feel justified in declining immediate release requests on the basis that ED's were already overcrowded.

3. In terms of strokes, it was asked whether there were opportunities to capture patient outcomes. The Committee were advised that work on capturing stroke patient outcomes, as well as the call to door target - which was reviewed by the Emergency Ambulance Services Committee – and further progress on linking the end-to-end pathway, would be reported back to the Committee at a future date. Going forward the ambition is to align the data between the Electronic Patient Care Record (ePCR) and the Computer Aided Dispatch (CAD) system, and look at the time segments to see where improvements could be made the Trust's performance. Brendan Lloyd added that the Trust does not currently have the ability to link the data with its patients through to the outcome. It was noted that Digital Healthcare Wales were working on improving this link.

4. Andy Swinburn outlined the improvements to the fact that the Trust was conveying fewer patients to ED's as it was managing more patients at home.

5. Liam Williams commented that he and Rachel Marsh would welcome any feedback from colleagues in improving this report going forward.

RESOLVED: That the report was considered and provided sufficient assurance of progress against the 24 key performance indicators detailed, which demonstrate how the Trust is performing against the following areas of focus: - Our Patients (Quality, Safety and Patient Experience); Our People; Finance and Value; and Partnerships and System Contribution.

54/22 PATIENT SAFETY REPORT Q2 2022/23

Wendy Herbert gave an outline of the report and drew the Committee's attention to the following areas:

1. Continued high numbers of concerns being received and whilst there was a slight improvement in 30-day response times, they were significantly behind the 75% target, at 28%. The Trust have invested additional resources into the Putting Things Right team, and as a result the 2-day acknowledgement time had improved significantly.

2. Coroner activity remained significantly high which has impacted on Clinical Contact Centre staff particularly in responding to requests for information in a timely manner.

3. Serious Case Incident Forums (SCIF) continued to meet on a twice weekly basis due to the volume of incidents being reviewed. During this reporting period there were 20 SCIFs which considered a total of 111 incidents.

4. There had been an increase in the number of Appendix B incidents being forwarded to Health Boards.

5. In order to improve the Trust's position with concerns, £100k of additional funding has been made available to increase resources in key posts.

6. During this reporting period a total of 1,257 patient safety incidents were reported; 538 in July, 416 in August, and 303 in September. This is a decrease in comparison to the previous quarter, but an increase in comparison to the same period last year where there were 1099 incidents reported.

7. During the quarter there were a total of 2,883 Immediate Release Requests made to Health Boards. These requests were made to release an emergency ambulance to respond to a patient in the community who had a potentially life threating or serious condition. Of these, 1,528 were accepted (53%) and 1,355 were declined (47%).

Comments:

1. The Committee recognised the work involved and asked for a note of thanks to all those involved with concerns to be recorded, also noting that the report demonstrated the Trust's Duty of Candour, which was welcomed.

2. With respect to clinical incidents and where errors had occurred, the Committee were advised by Andy Swinburn that there was clear support for staff, despite the ongoing pressures. This position was echoed by Paul Hollard and Liam Williams. Liam Williams added that for the next meeting a report would be provided that gave front line staff assurance that the Trust was a learning organisation which would be aligned to the ongoing all Wales work on preceptorship and clinical supervision.

RESOLVED: That the update was received, recognising that several issues had been discussed in previous items.

55/22 AUDIT WALES - REVIEW OF QUALITY GOVERNANCE ARRANGEMENTS

Liam Williams presented the report and informed the Committee that a further update would be provided at the next meeting which will include the work conducted by other organisations. Jonathan Turnbull-Ross added that the update report would include the work from Health Inspectorate Wales and Internal Audit, the Trust's work around Duty of Candour, Duty of Quality, and the Health Care standards.

Comments:

1. Members recognised that the Trust's business as usual work had already identified some of the issues raised at this review.

2. It was asked whether the revised implementation was plan due for completion in November. Jonathan Turnbull-Ross explained that it had been drafted and would be concluded on 21 November, with the final report being published on 12 December.

3. It was asked whether there was an update available regarding internal resources. The Committee were advised that several roles have been included in the plan which were expected to be agreed.

RESOLVED: The Committee noted the update and recognised that a more conclusive update would be provided at the February meeting.

56/22 HEALTH INSPECTORATE WALES ANNUAL REPORT 2021-2022

Liam Williams explained that the report acknowledged the significant pressure across NHS Wales, specifically noting the challenges for the Trust in staff abstractions impacted by COVID-19 related absence. The report also detailed the work undertaken by Health Inspectorate Wales (HIW) which included seeking assurance on the safety and quality of care provided by the Trust. The report also detailed the system-wide recommendations made by HIW for improvement on this issue, including a need for collaboration with Health Boards across Wales.

Comments:

1. The Committee noted that the HIW Annual Review would be presented to the Trust Board at its meeting on 24th November.

2. Members also acknowledged in particular, the work of the Operational Delivery Unit to manage variance across EDs and Health Boards. Andy Swinburn explained this work should not be underestimated, adding that each ED would have different structures to improve its patient flow.

3. The Committee sought clarification in terms of who had ultimate responsibility for the patient inside an ambulance waiting outside the ED; it was agreed that this would be raised at the Board meeting later in the month. Furthermore, clarification would also be sought on the strategic collaboration and the statement on collaborative working within the report.

RESOLVED: That the Committee received the report and noted that the issues contained in bullet point 3 above would be raised at the Board meeting later in the month.

57/22 PATIENT EXPERIENCE AND COMMUNITY INVOLVEMENT (PECI) QUARTERLY REPORT

Leanne Hawker outlined several areas within the report and drew the Committee's attention to the following:

Feedback from the communities was very positive with patients showing a high regard for Trust staff; however, there were some negative experiences especially around long waits for an ambulance. This also impacted on relatives of patients, and the Trust continued to review its resources, for example, several projects were in the pipeline aimed at improving the overall patient experience going forward.

Comments:

It was unclear what was meant by non-applicable in the graph illustrating patient experiences of calling 999. The Committee asked that in future reports that the ratings included in such info graphics be clearer.

RESOLVED: The Committee approved the Highlight Report for release to the NHS Wales Patient Experience Network, WAST People & Community Network and external stakeholder; and noted and support the actions being taken forward.

58/22 NHS WALES SAFEGUARDING ANNUAL REPORT 2021-22

The Committee noted the report was presented for information purposes.

RESOLVED: That the Committee noted the contents of the report

59/22 DEMENTIA UPDATE

Alison Johnstone drew the following to the Committee's attention:

1. The All Wales Dementia Care Pathway of Standards was published by Improvement Cymru in 2021, following extensive engagement with individuals living with dementia, carers, voluntary organisations and health and care professionals. The implementation of the standards was supported nationally and regionally by the Dementia National Steering Group, and by five work streams which are: Community Engagement, Memory Assessment Services, Dementia Connector, Hospital Charter and Workforce / measurement.

2. The Trust was working on a software pilot called Reminiscence Interactive Therapy Activities (RITA). RITA is an all-in-one touch screen solution which offers digital reminiscence therapy to blend entertainment with therapy, and to assist patients (particularly with memory impairments) in recalling and sharing events from their past through various media outlets.

3. Work was also ongoing with Alzheimer Society Cymru, looking at a referral process to dementia connect; this will allow members of staff to provide an onward referral into the society.

4. A great deal of work has been achieved to connect the WAST dementia agenda with other services to improve personal, home and community safety; emergency response to dementia calls; joint learning and development opportunities, and engagement across services.

Comments:

1. The Committee welcomed the update, and the team were commended on the significant number of achievements and its alignment to the Trust's strategy to provide more care closer to home.

2. It was asked if the Trust was aware of the prevalence of dementia in Wales. Alison Johnstone advised there was an ability within the system to extract raw data and going forward it was anticipated this would be refined further.

3. The Committee also recognised the link to a previous QUEST patient story with respect to the work underway to develop dementia training for 111 and the Clinical Support desk (CSD) staff.

RESOLVED: The Committee noted the work and progress against national dementia programme work streams.

60/22 INTERNAL AUDIT TRACKER REPORT

Trish Mills provided the update and asked the Committee to note the following:

There were two overdue high priority recommendations that related to the Committee; ID 460, 'Role of the Advanced Paramedic Practitioner' and ID 527, 'Respiratory Protective Equipment' discussions were ongoing with the Infection Prevention Control Strategic Group to consider if the latter risk could be closed. In respect of the other eight recommendations, these have all been reviewed and actions were in progress.

RESOLVED:

(1) Noted and considered the contents of the report;

(2) Considered the Internal Audit Plan activity; and

(3) Considered the Trust's proposals to address each recommendation with the inclusion of revised completion dates, specifically those relevant to Committee.

61/22 JOINT INVESTIGATIONS PILOT

1. Liam Williams outlined the report and explained that following a sustained period of operational pressures across Wales and increasing numbers of National Reportable Incidents relating to catastrophic or severe harm, the Appendix B process was implemented for WAST Serious Incidents.

2. Several meetings and work occurred over the summer to agree the Joint Investigations framework through a Task and Finish Group that has had membership from every Health Board, WAST and wider NHS Partners. A key outcome of the process was the requirement for a joint meeting to confirm a serious incident had occurred, confirm if a joint investigation was required and subsequently, which organisation would lead the investigation.

3. Implementation of the Joint Investigations Process was due to take place through a Pilot that would report to the Emergency Ambulance Services Committee and the NHS Wales Delivery Unit. Further work was required on the supporting performance metrics for the new process, and there was an urgent requirement for development time in the All-Wales web-based DATIX platform to enable efficient cross-organisational working.

4. It was not expected that this process would have a significant impact on WAST in reporting or investigating incidents; however, it was expected that there will be an impact for Health Boards seeking higher levels of engagement from General Practice and Social Care.

Comments:

1. Rachel Marsh commented that as a word of caution with the Trust being the lead investigator, this may impact on the Trust's resources.
2. It was asked how the national policy was endorsed, and to what extent the Trust had engaged with other stakeholders, such as General Practitioners and local authorities. - Liam Williams advised that the National Delivery Unit had oversight. In terms of the level of engagement being sought from health board colleagues and adult social care, at this stage it was unclear whether the timescales will be met.
3. Wendy Herbert advised this was nothing new, and had been signed off several years ago as an approved process; provided the process was robust that was the main thing.
4. Liam Williams explained that the learning from this process was critical to improving the quality of service going forward. Further to this the Trust would demonstrate its learning through the Duty of Candour.

RESOLVED: The Committee approved that the revised Joint Investigation Pilot be implemented.

62/22 PATIENT STORY DRIVER DIAGRAM

This was presented for information and to note is was Matt Hughes' story

RESOLVED: The Committee noted the update

63/22 COMMITTEE PRIORITIES UPDATE

This was presented for information.

RESOLVED: The Committee noted the update.

64/22 KEY MESSAGES FOR BOARD

The Chair advised that Trish Mills would provide a detailed report for the Board's attention.

RESOLVED: This was noted.

65/22 ANY OTHER BUSINESS

The Committee noted it was Kevin Davies' last meeting and thanked him for his support over the past years.

Date of Next meeting: 9 February 2023