

## WELSH AMBULANCE SERVICES NHS TRUST

### CONFIRMED MINUTES OF THE OPEN SESSION OF THE MEETING OF THE QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE HELD ON 12 May 2022 VIA TEAMS

#### PRESENT:

Bethan Evans	Non Executive Director and Chair
Paul Hollard	Non Executive Director
Ceri Jackson	Non Executive Director

#### IN ATTENDANCE:

Julie Boalch	Head of Risk and Deputy Board Secretary
Hugh Bennett	Assistant Director, Commissioning and Performance
Craig Brown	Trade Union Partner
Lee Brooks	Executive Director of Operations
Mark Cadman	Head of Patient Safety
Andrew Clement	Visual Design Specialist
Wendy Herbert	Interim Director of Quality and Nursing
Peter Hindley	Community Health Council
Fflur Jones	Audit Wales
Gerallt Jones	Health Inspectorate Wales
Lee Joseph	NHS Wales Delivery Unit
Alison Kelly	Business and Quality Manager
Trish Mills	Board Secretary
Steve Owen	Corporate Governance Officer
Jane Palin	Assistant Director of Quality and Nursing
Hugh Parry	Trade Union Partner
Angela Roberts	Trade Union Partner
Duncan Robertson	Assistant Director of Research, Audit and Service Improvement (North)
Chris Scott	Internal Audit
Andy Swinburn	Director of Paramedicine
Gareth Thomas	Patient Experience and Community Involvement Manager
Jonathan Turnbull-Ross	Assistant Director of Quality Governance

#### Apologies:

Professor Kevin Davies	Non Executive Director
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Hannah Rowan	Non Executive Director

#### 16/22 PROCEDURAL MATTERS

The Chair extended a warm welcome to everyone. Attendees were advised that the

meeting was being audio recorded. The Chair referred the Committee to the standing declaration of interest of Ceri Jackson as a Trustee of the Stroke Association.

## **Minutes**

The minutes of the meeting held on 17 February 2022 were confirmed as a correct record subject to amending the correct title of Leanne Hawker to read Head of Patient Experience and Community Involvement.

The action log was considered:

Action Number 16/21: Viability of Community First Responders to administer pain relief. Brief update was provided by Andy Swinburn. Further update to be provided at 11 August meeting.

Action Number F and P 1/21-22: Focused review of performance related to clinical outcome metrics. Andy Swinburn commented that the Commissioner has indicated there may be amendments to the quality indicators which required measuring going forward. Duncan Robertson added that further deep dives on several clinical indicators were being undertaken. More updates will be provided at the 11 August meeting.

Action Number 20/21a: Update on improving functionality of symptom checkers on the Website. Update deferred to 11 August meeting.

Action Number 09/22: Provide more clarity on the interpretation of Post Production Lost Hours. Detail was included in later Agenda item. Hugh Bennett added that a PPLH deep dive was being presented to the Finance and Performance Committee next week. It was agreed that the presentation would be circulated to Quest members following that meeting.

Action Number 12/22: Was there a capacity in the CSD to focus on the categorisation of ineffective breathing as a major issue? Lee Brooks advised that agenda Item 9 would provide further analysis. Action Closed

### **RESOLVED: That**

- (1) the Minutes of the Open meeting held on 17 February 2022 were confirmed as a correct record subject to the minor amendment as described;**
- (2) the standing declarations of Ceri Jackson as a Trustee of the Stroke Association were noted; and**
- (3) consideration was given to the Action Log as described above.**

## **17/22 PATIENT EXPERIENCE**

1. Gareth Thomas introduced the patient experience which was a video showing Mr Martin Hughes who had started a Go Fund Me page to raise money to buy a Mangar Elk lifting chair. Mr Hughes' mother suffered a series of falls where she was thankfully uninjured. On one occasion, after a six hour wait for the ambulance to arrive only to get his mother on her feet again after 10 minutes using the chair.
2. Following this episode he decided to purchase a chair for use in the community and to reduce the strain on the ambulance service in circumstances where someone who has had a fall was uninjured.
3. The chair was purchased with money raised and has been used three times since last

November. Mr Hughes added that should these chairs be in use in the community it would be of great benefit and free up more ambulance resources.

4. Andrew Clement added there was approximately 700 lifting chairs allocated to care homes across Wales. Wendy Herbert agreed to take forward an action to look into the availability of lifting chairs in care homes and the possibility of their use in the community via the Older Person's Steering Group.
5. Whilst it was recognised that these chairs should be used with caution, particularly where a patient may be injured, the Committee commended Mr Hughes for his actions and thanked him for sharing his story.
6. Bethan Evans thanked Mr Hughes for sharing his story with the Committee.

**RESOLVED: That**

- (1) the patent experience was noted; and**
- (2) it was agreed Wendy Herbert would update the Committee at its next meeting on the availability of lifting chairs in care homes.**

**18/22 PATIENT EXPERIENCE AND COMMUNITY INVOLVEMENT HIGHLIGHT REPORT**

1. Gareth Thomas updated the Committee on the contents Patient Experience and Community Involvement (PECI) quarterly report for January to March 2022. The Committee was assured that through the Continuous Engagement Model the Trust was appropriately engaging with patients and the community, capturing their experiences and reporting back to them to give them confidence they were being listened to. He drew the Committee's attention to the following highlights:
2. The Team had continued to receive many compliments on the care received; and also feedback was received for areas in which the Trust could improve.
3. The majority of Covid restrictions had ended which allowed the Team to restart several face to face engagements in the community; which included refugee groups and the development of 'A welcome to Wales' pack which had been translated into several languages.
4. The annual defibrillator campaign was again a great success which was partly online and in person. Going forward the Team was considering ways to implement training on defibrillators and CPR for the sight loss community
5. The blue light hub app continues to be really successful with a lot more people downloading and using it with their children; further development of the app continued to be explored with Cardiff University and primary schools in Cardiff.
6. Surveys on the experience of patients continued and in particular the feedback received from the Non-Emergency Patient Transport Service (NEPTS) survey scored 8 out of 10 or higher.

Comments:

1. Members thanked the Team for the very comprehensive report appreciating the work involved in producing it.
2. The Committee considered the overall approach to accessibility, commenting it would

be useful to explore the possibility of adding audio visual description to future communications.

3. Bethan Evans read out the comments from the report which related to a palliative care patient and the experience of the wish ambulance service. A note of thanks for the staff involved and their sterling work on the wish ambulance was recorded which was fully endorsed by all Members. Andy Swinburn commented that the staff conducted this work voluntarily and personally praised them for their efforts.

**RESOLVED: That the Committee noted the findings and that the report would be shared with external stakeholders.**

## **19/22 COMMITTEE PRIORITIES**

1. Trish Mills explained that the Committee's priorities had been set earlier in the year which had been designed to embed the duty of quality and the duty of candour in all that it does.
2. In order to provide clarity, the Committee's priorities for 2022/23 were amended to read "to further embed oversight of patient safety, openness and transparency, the Committee will monitor the Trust's readiness for the introduction of the Duty of Quality and Duty of Candour when the Health and Social Care (Quality and Engagement) (Wales) Act comes in to force in the Spring of 2023". The Committee will review progress quarterly.
3. Bethan Evans added that the Committee should be transparent and following a discussion at the Chairs Working Group meeting agreed on the elongated version of the Committee's priorities which was felt would be more user friendly for members of the public and provide more clarity.

Comments:

The Committee supported this version of the Committee's priorities

**RESOLVED: That the Committee agreed the revised wording as described.**

## **20/22 OPERATIONS CURRENT/FORWARD LOOK**

The Committee received the quarterly Operational Update from Lee Brooks as a standing agenda item. The following highlights were brought to the Committee's attention:

1. The number of staff sickness relating to Covid continued to decrease; as of today this was below 60.
2. The Resource Escalation Action Plan (REAP), whilst still at a high level had been reduced to 3 from 4.
3. It was anticipated that the Emergency Communication Nurse System (ECNS) would go live very soon.

Comments:

Following a query in terms of the benefits for the Reset, Lee Brooks apprised the Committee where extending schemes such as the pilot of the Advance Paramedic Practitioner navigator role had been beneficial.

The Committee noted the expansion of the Clinical Support Desk and the roll out of the 111 service across the whole of Wales.

The Mobile Testing Unit (MTU) was due to end by the end of June 2022; were there any risks in terms of the exit strategy? Lee Brooks advised the Committee of the potential opportunities for MTU staff within WAST and didn't anticipate any risks going forward.

**RESOLVED: That the update was noted.**

## **21/22 RED REVIEW ACTIVITY**

1. Lee Brooks explained that the report considered in detail the drivers for increased red demand and the actions the Trust has undertaken to comprehend and respond to the situation.
2. The Committee were reminded of the change applied to the Medical Priority Despatch System (MPDS) (introduction of the code: unconscious patients with abnormal breathing) back in 2019, and since then audits had been undertaken to gain assurance on call handler compliance. Whilst there has been an increase in ineffective breathing, particularly in red calls, the audits have given assurance that the process has been applied as intended by the International Academy of Emergency Despatch.
3. An analysis was undertaken on the top 10 red priority protocols in terms of activity;
  - a. Breathing Problems (Protocol 6)
  - b. Cardiac/Respiratory Arrest (Protocol 9)
  - c. Unconscious/Fainting (Protocol 31)
  - d. Overdose/Poisoning (Protocol 23)
  - e. Pandemic Flu (Protocol 36)
  - f. Pregnancy/Childbirth/Miscarriage (Protocol 24)
  - g. Falls (Protocol 17)
  - h. Running Call (Override)
  - i. Convulsions Fitting (Protocol 12)
  - j. Allergies/Envenomation (Protocol 2)
4. In terms of breathing problems as a chief complaint, there had been an increase in the number of incidents referred to by other healthcare professionals. There would be further focused audits relating to unconscious/fainting and trauma; this work was underway. In respect of convulsions and fitting the Committee were advised that, should the patient be fitting for a period of more than 20 minutes, this would be upgraded to red.
5. Lee Brooks summarised it was unlikely that in the immediate term, red activity demand would decrease.

### Comments:

1. Was there an update on the increase in demand correlating to other services? Lee Brooks that the same issues, themes and demands were being experienced across the UK.
2. Was there any further information in terms of allergic reactions? Lee Brooks explained that this was subject to a clinical review and the output of this was awaited.
3. How would the findings of the clinical audits be linked into Public Health Wales? Lee

Brooks advised that should these findings provide a positive change in population health, this would be considered.

**RESOLVED: The Committee:**

**(1) Noted the outcome of the analysis of the red activity review, including some additional work including:**

- a. **111/QSPE undertake further review of the origins and outcomes for 0-4yrs demand to understand any learning or systems changes that could better address this increasing Red emergency demand.**
- b. **A clinical review of Red demand was commissioned to understand increased incidents associated with allergic reaction and to identify any trends in allergy triggers or clinical outcomes.**
- c. **Emergency Medical Services Coordination continued to use focussed audit to explore areas identified for potential Emergency Medical Dispatch learning; and**

**(2) Noted there was no indication as a result of this review, save for some seasonal shifts for breathing problems, that red activity was likely to reduce to levels seen pre-International Academy of Emergency Dispatch process change in 2019.**

**22/22 QUALITY HIGHLIGHT REPORT QUARTER 4 (JANUARY –MARCH 2022) and MONTHLY INTEGRATED PERFORMANCE REPORT**

Jonathan Turnbull-Ross gave an outline of the Quality Highlight Report for Quarter 4 report and drew the Committee's attention to the following areas:

1. 104 cases had been discussed at 18 Serious Case Information Forums (SCIF); 42 of these cases were referred to the respective Health Board.
2. 2 Coroners cases resulting in a Regulation 28 (Prevention of Future Deaths) had been received during the quarter.
3. Handover hours lost this quarter were approaching 25,000; the Trust continued to meet with other health board colleagues to seek improvements in this area.
4. In terms of the Clinical and Quality Governance Group activity, updates were given on the Physician response Unit and the process of the management of expected deaths.
5. In response to a query at the last meeting regarding Post Production Lost Hours (PPLH) to provide more analysis, Jonathan Turnbull-Ross described in detail how PPLH were accounted for and the reasons for the lost hours. 83% of PPLH were attributed to 3 main reasons; Return to Base Stand Down Meal Break, Hospital Ambulance Liaison Officer Duties and Operations Manager Duties. These 3 categories accounted for over 12,910 PPLH. Going forward further work was being undertaken to understand in more depth the expected number of hours lost.

Hugh Bennett updated the Committee on the details within the Monthly Integrated Quality Performance report and drew out the following points:

1. The demand on the 111 service was expected to stabilise as the pandemic eased.
2. Call answering performance remained an issue; the Trust was addressing this by way

of improving the technical side.

3. There had also been issues with the call answering in respect of the Non Emergency Transport Service and further recruitment as one of the solutions to address this was being considered. Having said this the call answering performance remained above the target.
4. In terms of EMS, the benchmark for hear and treat has been exceeded, the roster review was due to be implemented, staff absence and absences had remained high.
5. The Trust was not in receipt of the investment for the transition plan which would have offset the levels of handover delays. Hugh Bennet explained that the mitigations in place by the Trust to offset the levels of handover was not enough to reduce it.

#### Comments:

1. Lee Brooks gave an overview of the Trust's position in relation to its ability to respond; red performance continued to be unsatisfactory. The last two months, March and April had been extremely challenging for the Trust. It was noted that in some regions in Wales, a no send policy was used 60% of the time. Delays in response have resulted in some patients dying before an ambulance could reach them. This does not necessarily indicate that the delay in response was directly attributable as the primary cause of death but was obviously a massive worry for the Trust. Call handlers, as they were dealing at the front end of the calls, were finding the current situation extremely disconcerting. He further commented on other areas of concern for the Trust which included staff sickness and PPLH. The former was currently at around 11%, the target was around 6%. PPLH would never be zero and would normally be around 6-7% as there were always unavoidable factors affecting this figure.

Currently, due to handover delays, the Trust was experiencing a 30% loss in conveying capacity. He added that at this precise moment, 40% of the Trust's ambulances were outside an Emergency Department. For the Trust to respond to patients in the Community in a timely manner was therefore almost impossible. Unless there was seismic shift in improving the lost hours, the Trust will not be able to reach patients in time.

2. The impact on the Trust's ability to respond to patients in the Community due to the handover delays was of grave concern. There were areas where the Trust had implemented various initiatives to improve the situation but clearly this was not enough and urgent remedial action was required. The Committee recognised it was a system wide problem and that the Trust was part of the system.
3. Members were deeply concerned with the overwhelming lost hours due to handover delays which were not only having a profound impact on patient safety but also on all staff in terms of their wellbeing, stress and anxiety.
4. The Committee were assured that the Trust was doing everything possible to alleviate the situation but were still staggered by the incredible number of hours being lost due to hand over delays.
5. The Trade Union Partners recognised the work the Trust was undertaking to improve staff welfare and the support given to them and thanked the Committee for its help

and appreciation.

6. The Committee discussed the possibility of compiling a combined escalation report to the Board which would be generated from this Committee, the People and Culture Committee and the Finance and Performance Committee, given the continuing and increasing Patient Safety concerns. It was agreed to discuss this further on in the meeting.

**RESOLVED: That the Committee considered, noted and discussed the contents of the reports**

## **23/22 QUALITY STRATEGY PROGRESS REPORT**

1. Jonathan Turnbull-Ross explained that the plan had been delayed due to the Trust's response to the pandemic, and whilst work has commenced, the Committee were apprised of resourcing issues for the planned senior quality leads' roles, which may delay progress.
2. The key intentions of the strategy was around responsiveness, making it more local and bringing expertise to the local leadership structures. Funding for the latter however will not be provided on a recurrent basis. Opportunities for internal funding were being explored and the Committee would review this in more detail at their next meeting.

Comments:

1. The Committee recognised that the lack of funding to recruit the senior lead quality posts would have an overall impact on the strategy and welcomed the work being undertaken to address this through other internal avenues.
2. It was agreed that the progress report at the next meeting would include further details on the delivery of the strategy.
3. Furthermore, the practical elements of promoting and integrating the Quality Strategy into everyone's role be a topic of discussion on future Board development day

**RESOLVED: That the Committee noted the report, including the financial challenge that directly affected the delivery of the strategy.**

## **24/22 DELIVERY UNIT, ANALYSIS OF THE JOINT INVESTIGATION FRAMEWORK (APPENDIX B)**

1. Lee Joseph, the Quality and Safety Manager in the Delivery Unit presented the Delivery Unit's Analysis of Appendix B report which covered the period 14 June to 30 November 2021. He noted that the Delivery Unit and Welsh Government receive copies of the Appendix B referrals, but they did not form part of any assessment by the Delivery Unit, with only the numbers being tracked and with responsibility on the Health Boards to receive, analyze and assess if a patient incident occurred. However the Delivery Unit noted the lack of translations of these referrals to patient safety incidents and that is what triggered the audit.
2. The analysis had focused on identifying any trends and themes of potential patient harm caused by the Trust's inability to respond to calls due to NHS Wales's system pressures.
3. The Delivery Unit reviewed 85 Appendix B reports received in the timeframe and the

following findings were identified:

- a. Outcome was death: 71
  - b. Recognition of life extinct on arrival (ROLE): 61
  - c. Initial grading Red: 3
  - d. Initial grading Amber 1: 64
  - e. Total number upgraded following patient deterioration: 57
  - f. Number upgraded to red following patient deterioration: 46
  - g. WAST operational contributory factors identified: 0
4. At the time of the report none of the 85 referrals had been converted to National Reportable Incidents by Health Boards, and as at today's meeting that number is two. Lee Joseph indicated that following their own review it is possible that 16 of the 85 referrals could be classified as National Reportable Incidents.
  5. It was noted that the average response time for the patients in the Amber 1 category was 6 hours 29 minutes and the average response time once upgraded to red was 6.5 minutes.
  6. There was clear evidence that the majority of patients had been given the appropriate response of Amber 1; however there were cases where the target response time was not being met and patients were deteriorating in the community.
  7. Cross analysis of the Appendix B's, with nationally reported patient safety incidents, indicates the high likelihood that incidents of avoidable patient safety harm and death were not being adequately investigated and reported nationally.
  8. The Delivery Unit has formalised several recommendations which include the setting of a task and finish group by the Emergency Ambulance Services Committee (EASC) to revisit the Framework to ensure the reporting process was fit for purpose improved upon, and working with the Health Boards to ensure the Appendix B referrals are reviewed.
  9. WAST has a healthy and open reporting culture and when there are contributory factors from the Trust they are reported routinely and in a timely way. Lee Joseph indicated he has also attended the Serious Case Incident Forum (SCIF) meetings and has observed the ways in which incidents are discussed and reported.

Comments:

1. Lee Brooks sought, in the absence of some events not being reported, what was the understanding of system risk? Lee Joseph explained that since this report has been published, there has been a slight increase in Appendix B reports being submitted by the Health Boards as they consider their reporting arrangements. In terms of understanding the risk there was a need to clearly identify where the harm or avoidable harms were occurring and what the impact was i.e. rather than the issue being about Appendix B referrals, it is about the risk of patient safety incidents due to system pressures.
2. Following a query in terms of regulatory requirement, Lee Joseph explained that once the incident was reported it was at that point it became a regulatory requirement to follow a sequence of events where it was investigated appropriately. His opinion was currently, as the evidence may suggest, some Appendix B reports being sent were not being appropriately assessed to determine whether it was a patient safety incident. Health Boards are therefore not fulfilling their regulatory requirements to undertake

these investigations. At the moment the Joint Investigation Framework is not policy and is based on goodwill in terms of following it and is inherently a culture issue.

3. Will the recommendations in the report really deliver the change that will reduce the levels of patient harm and what were the timescales in achieving them? The report has identified the problem and has suggested the appropriate mechanism to reduce harm through those recommendations. A timeline was yet to be confirmed but there will be continued liaison with EASC to identify membership of the task and finish group.
4. Given the length of time since the report was delivered and the timespan of the audit, had the report being considered by Health Boards? Lee Joseph explained that the report had been shared with Nurse Directors and they were required to assure the Delivery Unit that they will submit a return having made their assessment and updated with their input. Once this was received the Delivery Unit would recommend it is shared with the Health Boards' quality committees, however he was unaware as to whether the relevant committee/Board had seen the report, but would seek that information from Health Boards. In the meantime, Lee Joseph confirmed that Welsh Government colleagues are aware of the contents of the report.
5. Serious concern was expressed by the Committee that health boards were not reviewing these reports and the clear consequences of patient safety as a result. The Delivery Unit had identified 16 out of 85 referrals under Appendix B as potentially being National Reportable Incidents, however as the referrals had increased from November 2021 to date, potentially there are a similar number not yet reported. It was agreed that the issue would be escalated to the Board as a matter of urgency.
6. Wendy Herbert explained that the Trust had, in collaboration with the Delivery Unit and Welsh Government developed the Joint investigation framework. Whilst the process can be changed, the problem was the impact on patients should an investigation not be carried out. She encouraged an urgent piece of work, across all health boards, be carried out to improve the current situation as at the moment patients were coming to harm.

**RESOLVED: That the update was noted.**

## **25/22 QUARTER 4 PATIENT SAFETY REPORT**

Wendy Herbert updated the Committee and drew attention to the following points:

1. The number of patient safety incidents had increased significantly in those that had initially been categorised as catastrophic and continued to do so.
2. Timeliness to respond to concerns under Putting Things Right Regulations has increased in the quarter, ending with the target of 75% within 30 days being exceeded in March.
3. Coroners requests for further information has increased markedly, the Team were currently working on around 170 cases; the majority of these were in respect of timeliness to respond. In North Wales, the senior coroner has requested the Trust complete an individual organisational statement which may result in the Chief Executive being called to and inquest in the next few months.
4. A continued increase in levels of hospital handover delays has also seen an increasing number of nationally reportable adverse incidents with hospital handover delays being the root cause of not providing a timely response.
5. Patients were continuing to wait longer for an Amber response and this had an

impact on the Red categorisation.

6. During this quarter, a total of 1,346 patient safety incidents were reported, 407 in January, 440 in February and 499 in March. This was a significant increase in comparison to the same period last year where there were 750 incidents reported.
7. There were a total of 1,623 Immediate Release Requests made to Health Boards. Of these, 882 were accepted (54.3%) and 741 were declined (45.7%).
8. The Putting Things Right (PTR) Department continued to receive a steady number of concerns within this reporting period (238). This was an increase in comparison to the same reporting period last year where 163 concerns were received.
9. This quarter has seen a decrease in the number of political concerns being received. Of the 28 new concerns, 9 related to an issue other than the timeliness of EMS responses.
10. 14 incidents had been reported as National Reporting Incidents to the Delivery Unit; the main themes and trends were identified as call categorisation

Comments:

1. The Committee acknowledged with grave concern the stark situation against the backdrop of hospital handover delays and unrelenting red and amber pressure, with particular concern voiced over the approval rates for Immediate Release requests.
2. Following a query on the funding for Patient Safety Manager, Wendy Herbert confirmed that they had been recruited and also 2 Band 3 administrators had been appointed into the Team.
3. In response to a question regarding catastrophic incidents being very high and significantly above that of the previous quarter. Wendy Herbert explained that Patient safety incidents classed as 'catastrophic' have increased significantly in Quarter 4, totalling 75 compared to 52 in Quarter 3, and up by more than 50% on the same time last year when the number was 29. Whilst the Committee understood that the classification of 'catastrophic' given at the outset may change as a result of an investigation, this upward trajectory nevertheless highlighted an increase in patient safety incidents.

**RESOLVED: That the report was received for assurance and discussion.**

## **26/22 RESPONSE TO CORONER – REGULATION 28, PREVENTION OF FUTURE DEATHS**

Wendy Herbert explained that the report informed the Committee that the Trust had received 2 Regulation 28 Prevention of Future Deaths Reports. These Reports were issued to the Trust alone and did not include the Health Boards. The Committee recorded its condolences to the families affected. The Trust has provided responses and Improvement Plans to the respective Coroners. The improvement plan was monitored through the Assistant Directors Leadership Team.

**RESOLVED: That the report was received.**

## **27/22 COMMITTEE ASSURANCE REPORT**

Julie Boalch drew the following key highlights for the Committee's attention:

1. There were currently 4 of the 16 corporate risks assigned to the Quest Committee for

overview. Each of these risks had been rearticulated as part of the risk transformation programme.

2. No new risks had been escalated to the Corporate risk register; however one risk had been closed which was reported to Trust Board in March 2022 (ID 316 (Potential for a high volume of personal injury claims due to work acquired Covid infection))

Comments:

1. Should risk 199 (Failure to embed an interdependent and mature Health and Safety culture which could cause harm and a breach in compliance with Health & Safety statutory legislation) be transferred to the People and Culture Committee for oversight, given that responsibility for Health and Safety had now moved to the People and Culture Committee. Yes, this would be transferred.
2. Trish Mills explained that work continued to rearticulate the risks particularly the higher scoring risks ensuring the appropriate governance procedures were carried out. Furthermore, the Trust will liaise with other health boards on a reciprocal basis to advise on how to mitigate risks going forward. Part of the risk management programme will increase risk maturity.
3. Does the Trust have sight of the top risks presented to Health Boards? It was agreed to share this, it had been presented recently to EMT

**RESOLVED: The Committee received assurances on the report and specifically noted:**

- a. The rearticulating of the 4 Corporate Risks assigned to the Committee for oversight as part of the risk transformation work programme.**
- b. The closure of Risk 316, reported to Trust Board in March 2022.**
- c. The pause of the Board Assurance Framework (BAF) for 3 months.**

## **28/22 INTERNAL AUDIT TRACKER REPORT**

1. Julie Boalch explained that the purpose of the report was to provide the Committee with an update in relation to recommendations resulting from Internal Audit reviews and also give the Committee sight of the Internal Audit plan activity.
2. One high priority recommendation was overdue (Role of the Advanced Paramedic Practitioner) and one medium priority recommendation which was still outstanding from 2019/2020 which related to the Trust's risk appetite statement that formed part of the transformation programme which was currently underway.

**RESOLVED: That the Committee:**

- a. Noted and consider the contents of the report.**
- b. Considered the Internal Audit Plan activity.**
- c. Received one current Internal Audit Report relevant to the Committee.**
- d. Considered the Trust's proposals to address each recommendation with the inclusion of revised completion dates.**

## **29/22 PATIENT EXPERIENCE DRIVER DIAGRAM**

**Resolved: This Item was received for information.**

**30/22 PRACTICAL OBSTETRIC MULTI-PROFESSIONAL TRAINING (PROMPT)**

**Resolved: This Item was received for information.**

**31/22 KEY MESSAGES TO BOARD**

The Chair and Trish Mills would review and finalise this after the meeting and gave a brief overview of the expected content. Clearly, the key message was the level of concerns voiced by this Committee around patient safety, patient harm and avoidable harm, as well as staff welfare.

**RESOLVED: That the Committee noted the update.**

**30/22 ANY OTHER BUSINESS**

1. The Committee held a discussion which focused on how to escalate the issues regarding the current service pressures discussed, to the Board. There needed to be wider group of people to discuss broader escalation.
2. It was suggested that a combined escalation report following this Committee's, the People and Culture Committee, and the Finance and Performance Committee discussions on the overall situation be articulated and submitted.
3. From a Trade Union perspective, the seriousness of the concerns reflected on patients and staff and that the Committees were taking the issue extremely seriously was welcomed. It was suggested that a message be circulated to staff to articulate the current situation and, whilst the Trust was unable to resolve it, it was trying its best to improve. It must be a collaborative response from the Committees. Trade Union Partners strongly supported this.
4. The issues presented around Appendix B reports and the non-compliance of the framework must be part of the escalation report going forward. Furthermore, what were the opportunities for deep dives and what was the evidence around immediate release. This should also link in with the other key messages for the Board
5. One of the key points to raise must be around how we can communicate and engage collaboratively with our colleagues in Health Boards, so that we can discuss and identify system wide solutions.
6. The comments, concerns and points raised throughout the meeting would be escalated to the Chair of the Trust Board and the Chief Executive in the first instance and feedback would be provided to the Committee in due course.

**Date of Next meeting: 11 August 2022**