WELSH AMBULANCE SERVICES NHS TRUST

MINUTES OF THE OPEN SESSION OF THE MEETING OF THE QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE HELD ON 5 NOVEMBER 2024 VIA TEAMS

Meeting started at 09:30

PRESENT:

Bethan Evans	Non-Executive Director
Ceri Jackson	Non-Executive Director and Vice Chair of the Board

IN ATTENDANCE:

Claire Appleton	Assistant Director of Putting Things Right
Hugh Bennett	Assistant Director, Commissioning and Performance (Left during Item 76/24)
Julie Boalch	Assistant Director of Corporate Governance and Risk
Lee Brooks	Executive Director of Operations (Joined at Item 63/24)
Jonathan Chippendale	Consultant Paramedic (Joined at Item 75/24)
Leanne Hawker	Head of Patient Experience & Community Involvement
Wendy Herbert	Deputy Director of Quality and Nursing
Bethan Jones	Local Safety Champion (Item 75/24 only)
Alison Kelly	Business and Quality Manager
Greg Lloyd	Assistant Director of Clinical Delivery (Joined at Item 63/24)
Osian Lloyd	Head of Internal Audit, NWSSP
Trish Mills	Director of Corporate Governance/ Board Secretary
Edward O'Brian	Clinical Lead, Palliative Care (Attended for Item 62/24 only)
Steve Owen	Corporate Governance Officer
Hugh Parry	Trade Union Partner
Alex Payne	Corporate Governance Manager
Jonny Sammut	Director of Digital Services
Andy Swinburn	Executive Director of Paramedicine
Jonathan Turnbull-Ross	Assistant Director of Quality Governance
Liam Williams	Executive Director of Quality and Nursing (Joined at Item 66/24)

OBSERVERS:

Angela Mutlow	Director of Operations Llais
Lisa Trounce	Head of Compliance and Assurance

APOLOGIES:

Henry Garrard	Trade Union Partner
Mark Marsden	Trade Union Partner
Rachel Marsh	Executive Director of Strategy, Planning and Performance

61/24 PROCEDURAL MATTERS

The Chair extended a warm welcome to everyone advising that the meeting was being recorded. Apologies were noted from Henry Garrard, Rachel Marsh, and Mark Marsden.

Declarations of Interest
There were no further declarations of interest to those already listed in the Register.

Minutes
The Minutes of the meeting held on 13 August 2024 were confirmed as a correct record, save for the correction of Leanne Hawker's job title.

Matters Arising
The Committee received an update following the patient story from Linda Erro Castillo at the last meeting and noted progress against actions identified, including the ability to record learning difficulties/autism/neurodiversity and to prompt/record reasonable adjustments will go live on the electronic Patient Care Record (ePCR) in October 2024.

Action Log
The action log and the Committee Highlight AAA report from the last Quality, Patient Safety and Experience Committee (QuEST) meeting were considered:

Minute 41/24: Operations Update: *Review of terminology used, a recent questionnaire from Public Health Wales still referred to "NEPTS" (Non-Emergency Patient Transport Services). Since the name has been updated to "Ambulance Care," this outdated terminology could potentially cause confusion among the public. Peter Brown agreed to action.* Operations Colleagues will review, and update language as required on an ongoing basis. It was agreed to close this action.

Minute 51/24: Impact of the changes to the Stroke categorisation: *The Committee noted that updates on the location of stroke units will be provided in due course. Although the timeline was uncertain, Andy Swinburn agreed to keep the Committee updated.* It was confirmed by Andy Swinburn there were no updates for this meeting. It was agreed appropriate for this action to remain open.

Transfer from QuEST to the People and Culture Committee (PCC) In respect of the relief gap in Powys, update to PCC on the recruitment and management of abstractions. This matter was discussed at PCC, and it was resolved that the projected improvement across all gaps except for EMT1-2 (remains static) by Feb 25. By Feb 25, 4 of the 6 staff groups will be at full establishment, as opposed to only 2 groups at present. NB: this is the confirmed position passed on acceptances of positions already received (but not yet started). If QuEST content with remarks from PCC, then propose for closure. The PCC have closed this action. It was agreed to close this action.

Committee AAA report dated 13 August 2024

The Chair drew the Committee's attention to the contents of the AAA report for their information; this highlighted the key points from the Committee's last meeting on 13 August 2024.

RESOLVED: That

(1) Apologies were recorded for Henry Garrard, Mark Marsden and Rachel Marsh.

(2) The Minutes of the Open meeting held on 13 August 2024 were confirmed as a correct record, save for the correction of Leanne Hawker's job title.

(3) An update on the previous patient story was given which concerned Linda Erro Castillo and progress against actions identified was noted.

(4) Consideration was given to the Action Log and the AAA report as described above.

62/24 STAFF STORY – SIAN DAVIES-KUMAR, PALLIATIVE CARE PARAMEDIC (VIDEO)

Note: This item was received prior to the Operations update.

Leanne Hawker introduced Sian's experience which highlighted a crucial aspect of end-of-life care: the need to respect and fulfil the family's wishes while ensuring the patient's comfort.

The Committee were shown a video in which Sian Davies-Kumar shared her experience as a Palliative Care Paramedic. She described a specific case where she attended to a young gentleman with metastatic brain cancer. The family had called 999, and Sian was able to manage the patient's symptoms effectively, ensuring he could stay at home as per his and his family's wishes. She coordinated with the palliative care team, GP, and district nurses to set up the necessary syringe drivers for pain management. Sian emphasised the importance of communication with the family and ensuring the patient's comfort, which facilitated a good death, surrounded by loved ones.

Leanne Hawker added that Sian's story was a powerful testament to the importance of addressing both the emotional and physical needs of patients and their families. By ensuring that the young gentleman could stay at home and be comfortable, she not only managed his symptoms but also provided immense emotional support to his family. This holistic approach will leave a lasting, positive legacy and a meaningful experience for everyone involved.

Liam Williams highlighted that Sian's presentation exemplifies the ideal scenario many healthcare professionals strive for: providing the best possible death in the preferred place, with comprehensive support for both the patient and their family.

Wendy Herbert commented that the contrast between the ideal scenario Sian shared and the reality many families experience highlighted the gaps in our current system. The lack of preparation and support for end-of-life care can lead to distressing situations for both patients and their families.

Hugh Parry raised the point concerning the timely access to syringe drivers and the scaling up of Palliative Care Paramedics. Andy Swinburn explained that while buying syringe drivers could address the immediate issue, it was crucial to ensure that existing community services were used and supported to deliver the care they were commissioned for. Sian's expertise was a result of her extensive experience in palliative care, which was difficult to replicate through training alone. Ultimately, while ambulance services can fill gaps in palliative care, the goal should be to strengthen the existing community services to provide comprehensive end-of-life care.

Liam Wiliams expressed his concern at the lack of a robust electronic record system for end-of-life care in Wales. He added it was frustrating to see that while other regions have evolved their systems, the current reliance on outdated special notes can hinder the quality of care and support for families.

The Committee recognised the significant challenges going forward and expressed their concerns about the lack of immediate solutions and the increasing pressure on resources. Furthermore, the competition for funding in the charity sector and the shortage of district nurses and GPs were critical issues that need addressing.

Ed O'Brian commented that the role of Palliative Care Paramedics in preventing 999 calls was significant. By intervening early and providing specialised care, they can prevent unnecessary emergency responses and ensure that patients receive the appropriate care in a timely manner. This not only benefits the patients and their families but also helps to optimise the use of emergency services.

He added that many deteriorations and end-of-life situations were not recognised until a 999 call was made. Families often panic because they have not been prepared or informed about what to expect, leading to emergency calls that could have been managed differently with better planning and support.

The Chair, on behalf of the Committee, expressed appreciation for the work that Leanne, Sian, and the entire team were doing. Their dedication and compassion made a significant difference in the lives of patients and their families. Stories like Sian's not only highlighted the challenges, but also the incredible impact that committed healthcare professionals can have, even under pressure.

RESOLVED: The Committee received the staff story.

63/24 OPERATIONS DIRECTORATE QUARTERLY REPORT – 2024/25 Q2

Lee Brooks presented the report and drew the Committee's attention to the following: -

1. Volunteer Care Driver Oncology Pilot: This was progressing well with encouraging feedback being received, particularly from the drivers. The Trust has moved onto the second phase of the pilot which was ensuring that our oncology patients were paired up with the same volunteer driver for the entirety of their treatment.

2. Manchester Arena Inquiry: The completion of the actions was progressing well with most actions in a healthy place. The outstanding 20 actions were currently being reviewed by Commissioners.

3. Grenfell Inquiry Reports: The review did not bring additional work for the Trust.

4. Major Incident Declarations: There had been some positive early feedback from the debrief processes involving the incidents in Cardiff, which related to a call in which it was reported difficulty in breathing with reports suggesting that this incident was of a potential gas/carbon monoxide origin with several symptomatic patients; and Powys, in relation to a train accident.

5. The Medical Emergency Response Incident Team (MERIT) and the decision to not continue training MERIT nurses unless commissioned was noted by the Committee.

6. EMS Coordination: As part of the non-pay annex aspect of the 2023 pay and conditions work, the Trust agreed to focus on the culture of EMS Coordination. An action plan has been created in partnership with Trade Union colleagues and more recently the Director of People and Culture conducted a series of visits across the three centres to listen to staff and their experiences.

7. EMS Establishment: The under-establishment was largely due to the existing dispatch function, which was under-established due to changes required as part of the Organisational Change Policy (OCP) process.

8. Estates and Infrastructure: EMS Coordination has benefited from significant investment to improve the working environment for our centres in both Llangunnor and the relocation of staff from the existing Bryn Tirion site in North Wales.

9. Medical Transfer Protocol Suite (MTPS): MTPS went live on 30 July 2024 and external stakeholders were informed of the changes to inter-facility call processing. Up to the end of August 2024, 820 incidents were processed on these new protocols.

10. EMS Performance: The increase in red activity and concerns about amber patients waiting longer were brought to the Committee's attention.

11. Quality and Support Days: The quality and support days continued to be undertaken across all areas of the operations team, however, to further support operational staff these days will be subject themed moving forward.

12. Unscheduled Care Service (UCS) Transition: The UCS transition has remained challenging due to several factors that also affect the UCS team. While the modified code set which includes suitable calls has been agreed, the implementation will need to be timed to coincide with the new recruited EMS workforce that are operational from Mid-September.

13. End of Shift Overruns; While it is noted that the level of investigation of over 2-hour end of shift overruns has continued to improve, along with the uptake of utilising the options available to reduce the end of shift overrun, it was now evident that a number of these overruns were down to staff not correctly booking off duty.

14. The Clinical Model Transformation programme has been a significant focus for the Integrated Care team. Work is underway to align 111 and CSD, develop the Remote Integrated Care Service (RICS) model, develop new pathways and test the 111-call handling software in the wider operational environment.

Ceri Jackson asked about the direct recruitment for the Cymru High Acuity Response Unit (CHARU) rollout, expressing concerns about rurality and inequity. She wished to understand more about how the direct recruitment will be facilitated and when it will be in place. Lee Brooks advised that considerable effort into addressing the recruitment challenges for CHARU has been undertaken, especially in rural areas. However, despite making adjustments and trying to recruit internally, it was clear that external direct recruitment was now necessary to fill the remaining vacancies. Hugh Bennett added that the benchmark was to achieve 95% and the first round of internal recruitment was due to finish in November 2024.

Hugh Parry noted the improvement in end-of-shift overruns, noting a decrease in two-hour overruns, and queried if there was an appetite to start looking at reducing overruns to one hour or even less. Lee Brooks commented that progress in reducing end-of-shift overruns to 90 minutes for UCS investigations has already been made and there was a strong appetite to improve this further.

Hugh Parry acknowledged that MERIT training has been valuable over the years, especially in terms of the contributions from nurses and clinicians during major incidents and expressed concern about losing the benefits of networking and team involvement as it was not commissioned. Lee Brooks explained that the Trust had reviewed the MERIT training and found that current paramedic skills were sufficient for major incident responses.

The Chair sought an update on the recruitment of Advanced Paramedic Practitioners (APP) noting that the previous recruitment process did not meet the expected numbers. Andy Swinburn elaborated on the recent recruitment process for APP. He noted that there was significant interest from experienced APP, including those from outside the organisation and former staff. However, the recruitment process faced a challenge because the interested candidates were on higher pay bands than what was originally offered. It was a requirement for these candidates to start at the bottom of the offered pay band, which led to a substantial pay cut for them. This was a deterrent for many potential recruits. He acknowledged this as a misstep and expressed hope that the issue would be resolved in the next recruitment round.

RESOLVED: That the report was received.

64/24 CLINICAL TRANSFORMATION PROGRAMME CLINICAL GOVERNANCE AND CLINICAL ADVISORY GROUP TERMS OF REFERENCE

Liam Williams explained that the clinical governance model for the Clinical Transformation Programme will follow the existing architecture of the Clinical Quality Governance Group (CQGG). However, it should be noted that the complexity and pace of the programme required senior clinical colleagues from across the Trust to review and consider proposals / developments and ensure that they were securing a safer operating environment for our patients and our people.

To support this approach, a Clinical Advisory Group (CAG) has been formed. The CAG has been formed to provide critical clinical oversight and strategic support to the Clinical Model Transformation (CMT), strengthening the Trust's commitment to safe, high-quality healthcare through well-informed, clinically led decisions. Reporting to the Clinical and Quality Governance Group (CQGG) and the CMT Programme Board, the CAG will act as a core advisory body, ensuring clinical perspectives shape and guide the transformation process in real-time.

The CAG's remit will focus on providing Senior and Consultant-Practitioner level advice on clinical matters, supporting decision-making, and overseeing clinical safety of the CMT Programme. Liam emphasised the need for good clinical governance and decision-making, noting that the CAG will support this by providing critical appraisal, confirm and challenge, and expertise. This group will ensure consistency, identify gaps or overlaps, and advise on challenges. The goal is to maintain rigorous governance while implementing the new clinical model.

Terms of Reference for the Clinical Advisory Group

The Terms of Reference for the Clinical Advisory Group (CAG) were appended to the report and received by the Committee for noting. Jonny Sammut asked for clarity regarding the ethical considerations around the CAG. Specifically, he inquired whether the Artificial Intelligence (AI) ethics piece would be treated separately or if it would be included within the CAG ethics panel.

Liam Williams responded that the CAG was specifically related to the clinical model, with Dr. Penelope Cresswell Jones from Public Health Wales included to help address ethical

considerations. He clarified that the AI ethics work would reside in a separate ethics group for the Trust, which was in the process of being established.

RESOLVED: The Committee took assurance from the planned continuation of the existing clinical governance arrangements and the implementation of a Clinical Advisory Group in supporting the Clinical Model Transformation within the Trust and Noted the Clinical Advisory Group Terms of Reference.

65/24 RAPID CLINICAL SCREENING

Greg Lloyd provided an overview of the rapid clinical screening process. He explained that this process takes place after the final Medical Priority Dispatch System (MPDS) code was generated. Suitable calls then flow into a screening queue visible only to the Clinical Navigators, a senior clinical role that sits within the EMSC. Clinical Navigators will perform high acuity live reviews, provide remote clinical support, and oversee the EMSC response queue. They will also make decisions on dispatch out of time order based on clinical need and move calls back to integrated care if the patient's condition changes. They determine if a face-to-face response was required immediately or if the patient would benefit from further assessment. This process aims to involve clinicians early in decision-making to improve patient outcomes.

He also mentioned that calls with immediate threats to life were dispatched immediately, while others were screened for further assessment. having a clinician make early, informed decisions on suitable 999 calls was a game-changer. By increasing the number of patients undergoing remote assessment, the Trust can significantly enhance the chances of directing them to the right care from the outset.

Andy Swinburn explained that the approach for the rapid clinical screening set the Trust apart by innovating how emergency services were managed. Involving clinicians at the front end, the initiative aims to make more informed decisions about which patients need immediate ambulance services, thereby optimising resource use and reducing wait times.

Ceri Jackson expressed support for the rapid clinical screening model but also shared some concerns. She sought assurance on how the system would handle periods of high demand and asked for real-time visibility into the process, possibly through visits, to ensure the system's effectiveness during busy times.

Andy Swinburn acknowledged Ceri Jackson's concerns and agreed that it was important to be cautious. He stated that the current system was already failing to deliver optimal results, and the new model aims to add value and improve the situation. He highlighted that the rapid clinical screening would help identify which patients need immediate ambulance services and which can wait or receive alternative care. He also invited Ceri to visit and observe the process once the team has settled in, to provide assurance and see the system in action.

Lee Brooks noted that he is the Senior Responsible Officer (SRO) for this workstream. He added that his Team actively considered how to manage the system during busy periods,

especially with the rapid clinical screening work stream. The phased recruitment approach, with some staff joining by December and the rest in January, presented a challenge but also an opportunity to gradually transition to the new mode of operations.

The Chair expressed enthusiasm about the rapid clinical screening initiative, acknowledging the level of unknowns but emphasising the potential for significant positive impact. She noted the importance of monitoring the impact closely and comparing it with expectations. She also highlighted the need for the team to have time to embed the new approach, especially during the high-pressure Winter period.

Hugh Parry added it was natural to have initial concerns about potential risks, especially with such significant changes. However, as the project progressed, he became more confident that it would reduce patient harm. He also noted the excellent pace of the project's rollout and expressed hope that the wider transformation would improve conditions for both patients and staff.

RESOLVED: The Committee Noted the PowerPoint update for the introduction of Rapid Clinical Screening and took assurance from the position given, and the future approach for its implementation.

66/24 MONTHLY INTEGRATED QUALITY PERFORMANCE REPORT – SEPTEMBER 2024

Hugh Bennett highlighted the following points for the Committee's attention:

1. Immediate release requests by Health Board were reviewed, and the Committee noted that the two with the highest percentage of immediate release, for both Red and Amber 1, Cardiff and the Vale University Health Board (97.1%) and Cwm Taf Morgannwg University Health Board (86.5%), both have the lowest numbers of lost hours by health board over the quarter.

2. There was a continuing number of serious incidents shared with Health Board colleagues to investigate under the Joint Investigation Framework. For the second period in a row, none were directly related to immediate release requests.

3. The number of patient safety incidents received on Datix has reduced compared to the same time last year.

4. There was a sustained increase in the number of concerns received compared to the same period in 2023.

5. National Reportable Incidents had increased in the quarter.

6. A return to usual activity levels in respect of Coroner's requests for information was noted, however the ongoing impact of increased requests from last quarter was acknowledged.

7. The five-day complaint acknowledgement compliance met the 100% Welsh Government target in the quarter.

8. The 30-day response saw dips in the quarter from 70% (July), to 40% (August) and 46% (September). The drop in performance was because of the PTR and Legal Services Recovery Plan to reduce open complaints, which decreased from 197 in July to 106 in September. This approach aims to reduce overdue responses and set up consistent future performance, with rapid improvement expected now that complaint volumes are more manageable. Most complaints continued to relate to delayed response in the community following calls made to 999.

9. Organisational learning, particularly from nationally reportable incidents reviews, was reviewed, with clinical notices issued as a result on maternity action cards, Terrapace updates and ePCR nudge tool, and procedural changes for reviewing ECGs.

10. The experience for oncology and renal patients of the non-emergency patient care service remained above target which was positive, with advanced discharge and transfer performance improving, but remaining below target.

11. 111 NHS Wales call answering performance improved over recent weeks, with the call abandonment performance improving to 7% (was 11.9% in June) against a target of 5%. It is expected to improve further in October.

12. Return of Spontaneous Circulation (ROSC) rates deteriorated slightly in September to 19.4% (comparted to 22.7% in June) due to, however members noted that other clinical indicators are improving because of the clinical indicator improvement plans.

Jonny Sammut mentioned that the Digital Directorate was actively resolving data quality issues at the source. Additionally, there was ongoing recruitment for additional data quality resources, with the aim of bolstering the team with two additional Full Time Equivalents (FTE).

Andy Swinburn commented on the significant improvements in clinical indicators and the progress being made across various areas. The Stroke Bundle Compliance in reaching nearly 90% compliance in stroke bundle protocols was a significant achievement.

Ceri Jackson inquired whether the data quality issues undermined the integrity of the data that has been published for some time, and if any actions were needed to address this. Liam Williams explained there was a need to revisit the reporting of moderate harm numbers for the current financial year, explaining that there was a defined metric in the PTR report, which will be carried forward into the MIQPR.

The Committee inquired about the focus on immediate release, noting the high number of declined immediate releases for red and amber calls, and whether the new Cabinet Secretary's focus on handover delays included immediate release. Liam Williams referred to a letter published by NHS Wales Executive on handover delays and was made available for Committee Members to read.

Following a concern about the impact on Health Boards that were improving their handover delays but seeing their resources diverted to neighbouring Health Boards, and whether there was an overview of this impact from a commissioning perspective. Lee Brooks acknowledged that this posed challenges for commissioning, as Health Boards were concerned with activity within their geography, but the reality of resource flow and hospital locations meant that resources often crossed boundaries.

Following further conversation, it was mentioned by Jonathan Chippendale that there was a paper produced from some analysis completed several months ago that might be helpful. He offered to present this analysis, which talked about the flows and issues around patient cancellations at a future meeting. It was agreed that Jonathan Chippendale would provide an update at a future Committee meeting.

The Chair commented that the report demonstrated ongoing system pressures significantly impacting patients and the ability to reach them in a timely manner, leading to avoidable harm. She noted the ongoing actions to improve data integrity and noted a recruitment gap which was being mitigated. The Chair highlighted that while actions were being taken, the level of handover delays remained a significant challenge.

The Committee noted that a report on the Datix system and its use was due to be on the agenda but was delayed. This report will likely come to the January meeting, reflecting ongoing work to improve data quality and system use.

RESOLVED: The Committee received the Monthly Integrated Quality and Performance report for September 2024 and actions being taken and determined that the report provided sufficient assurance.

67/24 MENTAL HEALTH AND DEMENTIA ANNUAL REPORT 2023/24

Liam Wiliams presented the report drawing attention to the following areas:
He highlighted the international recognition received for the work done in support of people living with dementia, particularly in Reminiscence Interactive Therapy Activities (RITA) and the design of ambulance care vehicles.

The Team was commended for the partnerships they have fostered with organisations like Alzheimer's Society Cymru and received the Dementia Hero Award for Professional Excellence in 2023. The report also highlighted the challenges faced, such as under-resourcing and the need for greater strategic alignment and sets the strategic outlook for 2024/25.

Mental Health Response Vehicle (MHRV): This was having a positive impact with the imminent go-live of the MHRV covering the southeast of Wales, with plans to expand the service further.

Jonathan Turnbull-Ross added the following points: He emphasised the need for more integration, partnership, and clinical practice development in the upcoming year. He highlighted the importance of moving towards a 24/7 mental health practitioner model

and the significance of the MHRV. Furthermore, he noted the potential changes in Welsh Government funding and the need to work with Commissioners to understand the importance of investing in mental health practitioners.

The Chair expressed her concern that about the availability of resources to continue and expand the work, including the need for funding to support initiatives like the RITA specialist roles. Liam Williams gave assurance that many iPads were due for renewal, and as frontline devices were refreshed, older devices would be repurposed for use in RITA settings. There was support in principle from the Welsh Government's mental health team, and this will be further developed with the Joint Commissioning Committee (JCC).

Ceri Jackson advised the Committee of the strong collaborations with charities like Mind and the opportunity to Increase visibility and policy focus on these collaborations, especially in the context of dementia and mental health. She added that Vice Chairs of the Health Boards have a mandatory remit on mental health and primary care. She added that she will be facilitating a presentation from the Wales Council for Voluntary Action (WCVA) to mental health charities on the role of the third sector in mental health and suggested that colleagues from the Trust may want to link up with her and discuss offline to explore useful lessons and projects from the WCVA.

RESOLVED: The Committee endorsed the 2023/24 Mental Health and Dementia Annual Report and noted that it would be presented to the Trust Board for their information at its upcoming meeting in November.

68/24 PUTTING THINGS RIGHT REPORT QUARTER 2, JULY - SEPTEMBER 2024

Claire Appleton drew the Committee's attention to the following areas:

1. The ongoing continued high level of risk of harm caused by system pressures and hospital handover delays continued to be a familiar theme.

2. The implementation of options through Datix Cymru to enhance joint information sharing and building a learning repository for joint investigations was progressing.

3. There was a reduction in coroner approaches after a spike in July but highlighted that the impacts would continue as dates for statements and inquest attendances were set.

4. The five-day complaint acknowledgement was consistently achieving the 100% target.

5. The 30-Day Compliance had seen a drop in performance, however the overall number of open cases had reduced by 50%.

6. It was noted there had been no Prevention of Future Death Reports for this quarter.

The Committee acknowledged the work and effort the Team had undertaken to improve the PTR process and it was agreed, and following further discussion requested that a more streamlined report be presented at future meetings. Wendy Herbert added there was a meeting scheduled with Lee Brooks and Claire Appleton to review the PTR report. The goal was to ensure the report captured the key and salient points, as it had the potential to grow too detailed and lose focus on what was important.

RESOLVED: The Committee received the Putting Things Right (PTR) report for discussion and were satisfied with the assurance given regarding the Trust's PTR function.

69/24 DATIX RECOVERY AND IMPROVEMENT PLAN – ITEM DEFERRED

Liam Wiliams advised that this report was not able to go through the internal governance process and will be presented at the February meeting. Trish Mills confirmed that an offline discussion would be undertaken with Liam Williams to ascertain whether this report should be presented firstly to the Finance and Performance Committee (FPC) and then to QuEST, or whether taking it straight to QuEST was appropriate.

RESOLVED: The Committee noted that the Datix Recovery and Improvement Plan was deferred to the next meeting and that it would be ascertained whether the report should be presented in the first instance through FPC.

70/24 FOCUS ON CLINICAL INDICATORS - ST SEGMENT ELEVATION MYOCARDIAL INFARCTION (STEMI)

1. Jonathan Chippendale presented the Committee with a PowerPoint slide show which focused on the clinical indicator for STEMI (ST-Elevation Myocardial Infarction).
2. Measurement Criteria: The key elements measured included the administration of aspirin, GTN (glyceryl trinitrate), recording of at least two pain scores, and the administration of analgesia if indicated.
3. Data Quality: The data was drawn from the electronic patient care record (EPCR), and there was a noted variation between automated and manually audited data, indicating that care might be delivered but not always recorded accurately.
4. Several improvements had been made which included deep dives into data, user interface changes, collaborative work with EPCR users, and promotional activities like CEO roadshows.
5. The performance data showed an improvement from April 2023 onwards, with a step change in performance and an upward trajectory.
6. Further user interface changes were scheduled for November, including nudge tools to improve data recording and compliance.

The Committee found these updates valuable a In providing a deep dive and assurance on the quality of care. The extensive work ongoing in the Trust was noted, as was the positive impact on the culture around duty of quality, quality of care, ownership, and accountability.

RESOLVED: The Committee noted the update

71/24 CLINICAL AUDIT PLAN & ACTION TRACKER - Q2 (UPDATE) 2024/25

Jonathan Chippendale presented the update and drew the following points to the Committee's attention:

The Q2 2024-25 Clinical Audit Plan contained 13 audits covering a range of topics including clinical conditions, medicines, and compliance to documentation. This was a dynamic plan and since the Q1 update, the 'Newborn Normothermia' audit has been added. Of those indicated on the plan:

- 2 have been completed and approved at the Clinical Intelligence & Assurance Group (CIAG)
- 3 were progressing as planned.
- 2 were not progressing as planned as they were reliant on ePCR User Interface changes being implemented*. In addition, the Clinical Indicator Recovery Plan was currently a higher priority.
- 6 were yet to start, some were reliant on ePCR User Interface changes being implemented, some were not due to start until Q3/Q4.

Delays in implementing the required ePCR User Interface (UI) changes has impacted on the timely completion of actions. The Clinical Indicator Recovery Plan was a high priority and the timeframe for some of the clinical audits on the plan will need to be adjusted due to the required resources.

The Chair queried if the delay in ePCR UI changes would cause any detriment to the management of the clinical audit work and inquired about the expected duration of the delay. Andy Swinburn explained there has been some slippage in the current quarter, but ongoing discussions were taking place to address this. He expressed confidence that the necessary changes will be implemented, as they have been able to secure funding from other areas where there has been underspend.

RESOLVED: The Committee noted the Q2 2024-25 Clinical Audit Plan and Action Tracker update.

72/24 PATIENT EXPERIENCE AND COMMUNITY INVOLVEMENT BIANNUAL REPORT APRIL – SEPTEMBER

Leanne Hawker presented the Patient Experience and Community Involvement (PECI) biannual report. The report set out the team's focus on gathering feedback from the public and patients to improve the quality and experience of services She emphasised that the data demonstrated the emotional experiences of people using their services, identifying both positive and negative feelings. Leanne also noted the importance of acknowledging and responding to these emotions, and she pointed out specific information that highlighted feedback from frontline staff.

Key themes from feedback included response times for emergency services and access to care, and outlined plans for improving data collection methods and reviewing survey questions to ensure they adequately addressed the experiences of patients. Overcoming the challenges related to fully utilising the Civica system for patient experience feedback was key, including information governance concerns and the need to comply with the Information Commissioner Officer (ICO) requirements.

Liam Williams highlighted key points about the team's efforts and the importance of their work in evolving the clinical model to better understand and improve patient experiences.

Ceri Jackson commented that focusing on older people and their specific needs, especially considering protected characteristics, was very important. She asked how the Team could best gather and use this feedback to improve services for older people. Furthermore, the People's Experience Framework was a promising initiative as it aimed to gather comprehensive feedback from across the system, which can significantly enhance understanding of patient experiences. Ceri Jackson asked how optimistic was the Trust in the the people's experience framework to enable the Committee to hear about experiences across the system in the not too distant future. Leanne Hawker explained that the Team was collaborating closely with colleagues on the new framework and were optimistic about its potential. However, she noted that its effectiveness will depend on fully using all elements of the Civica system.

The Chair informed the Committee she had attended a learning disability conference facilitated by the PECI Team. She commented on the importance of broadening the engagement with individuals beyond the current groups, particularly those with more complex and profound learning disabilities and their families. She emphasised the need to engage with a broader representation to gather richer data and insights. Additionally, she mentioned the importance of understanding the impact of presenting to the Learning Disability Ministerial Advisory Group and suggested including the outcomes or changes resulting from such presentations in future reports.

RESOLVED: The Committee:

(1) Received the report and accepted the assurances that the Trust was meeting its statutory duties/responsibilities to consult' engage and involve the public/patients in its work; and

(2) Noted the activities to date and acknowledged that Patient Experience & Community Involvement Reports would be shared publicly through the Trust's People & Community Network.

73/24 LEARNING FROM DEATHS (MORTALITY REVIEWS) REPORT (Q1 - Q2)

Wendy Herbert provided an update on the learning from deaths report, highlighting the establishment of a new group to ensure the Trust captured learning from deaths, both internally and from external reviews.

She mentioned the significance of the Medical Examiner Service (MES), which was now fully functioning and included all community deaths. It was noted that 238 referrals have been received by the Trust from the MES in the first two quarters of 2024/25 with 44 cases requiring further review, either through the Serious Case Incident Forum (SCIF) process or additional investigation.

Members noted that themes and trends largely related to delays attending in the community and it was recognised that there was more to do to understand the differential impact of skill mix on patient outcomes.

Liam Williams added that the Trust was exploring new areas of learning from deaths including the use electronic patient records to identify patterns and conduct thematic analysis. The Trust was also learning from the Northwest Ambulance's data practices to help replicate successful strategies and improve overall data management.

Claire Appleton explained that the Trust was dealing with a significant volume of feedback and learning from the Medical Examiner Service, especially with the differences between how the service operated in Wales compared to England. The higher referral rate in Wales, with about 40% of cases being reviewed, compared to 10% in England. Receiving feedback on all cases, including those with compliments was valuable, however, managing this large volume of information and distinguishing between what was new learning and what was already understood was challenging.

RESOLVED: The Committee received the report for discussion.

74/24 IPC PREPAREDNESS & EMERGING HEALTH RISKS ASSOCIATED WITH MPOX AND OTHER HIGH CONSEQUENCE INFECTIOUS DISEASES

Members received assurance by Liam Williams on the work undertaken relating to Infection Prevention and Control (IPC) Preparedness and Emerging Health Risks with MPOX and the Trust's preparedness for an outbreak of a Highly Contagious Infectious Disease (HCID) as set out by NHS Wales Executive.

The Committee were asked to note the focus on efforts to respond effectively and that the Trust was actively enhancing its IPC Guidance, with a key focus on the rollout of Powered Air Purifying Respirators (PAPRs) to frontline staff. This initiative was aimed at strengthening protection against airborne pathogens, particularly during aerosol-generating procedures (AGPs).

Alongside this, the Trust was preparing for increasing seasonal pressures due to Winter respiratory infections (e.g. flu and RSV), while also remaining vigilant about emerging High Consequence Infectious Diseases (HCIDs) like Mpox, Marburg virus and Middle East Respiratory Syndrome (MERS-CoV). Furthermore, a member of the Resilience Team will be attending a WG meeting to provide additional assurance regarding the organisation's readiness for any outbreak.

RESOLVED: The Committee noted the update and confirmed their assurance that the Trust was taking all appropriate measures to prepare for a case of Mpox or other High Consequence Infectious Diseases.

75/24 MATERNITY AND NEONATAL SAFETY SUPPORT PROGRAMME UPDATE

Liam Williams presented the report which was a culmination of the work conducted by Bethan Jones (Local Safety Champion – Midwife) and Steve Magee (Regional Clinical Lead) in the Maternity and Neonatal Safety Programme. Key points of note for the Committee included:

1. The report highlighted significant improvements, including work on Neonatal thermoregulation, increasing normothermic admissions from 4% to 75%, and the adoption of the maternity early warning score (MEWS) consistent with England and Scotland.

2. The Team has been recognised for their contributions, for winning an award at the NHS Wales Awards recently for the Maternity and Neonatal Safety Support Programme.

3. A proposal for a national maternity advice line was being developed, expected to be commissioned through Welsh Government and NHS Wales executive, leveraging the 111 capability and collaborating with Health Board colleagues.

Bethan Jones joined the meeting and expressed gratitude for the support and noted the positive impact and influence of the programme across Wales.

RESOLVED: The Committee received the report and accepted the assurances that the Trust was meeting its statutory duties/responsibilities to consult; engage and involve the public/patients in its work.

76/24 NEAR MISS REPORTING AND LOW HARM INTELLIGENCE REPORT

Claire Appleton presented the report which updated the Committee on organisational low harm and near miss Concerns (Incidents, Complaints and Claims). Intelligence on near miss and low harm reporting was illustrated from the Datix Cymru Electronic Risk Management System covering the period September 2022 - September 2024.

This Report has addressed recommendations from the Audit Wales Quality Governance Review 2022 to ensure that intelligence from 'near misses' or minimal harm events was appropriately reported on and analysed.

The Health and Safety Executive defines a near miss as 'an event that, while not causing harm, has the potential to cause injury or ill health'. A hazard is defined as an unsafe situation or set of circumstances with 'the potential to cause harm'. For the purposes of this update, no distinction has been applied between hazards and near misses, as both represent valuable learning opportunities.

The Trust receives a large volume of No and Low Harm Incidents and Grade 1 and 2 Complaints, which after investigation, were assessed as not having resulted in harm and were near miss opportunities for learning. The report assures consistency in the assessment of harm and highlights those themes in lower harm incidents often reflected those in high harm incidents, particularly around delays and their impacts.

Deeper analysis was limited currently because of the classification system of reported incidents which catered largely to secondary care services. There was scope to improve the relevance and application of the code sets to Ambulance Services through the Trust's representation at national workstreams.

In terms of the additional waits from a patient safety perspective in relation to the consequences of delayed transfers into other facility transfers it would be useful to see that data and it was agreed this would be e mailed to Lee Brooks for his Team to analyse.

Following a discussion on future reporting it was the general consensus that going forward, the reporting and analysis of near misses and low harm would be helpful if included within the Putting Things Right report.

RESOLVED:

(1) Approved the future reporting of near misses being included in the quarterly Putting Things Right Report to Committee; and

(2) The Chair of Committee will provide assurance to the Audit, Risk and Assurance Committee on the future approach.

77/24 AUDIT TRACKER

An update was provided on the Audit Tracker by Trish Mills:

It was noted that 23% (39% last quarter) of Committee related internal audit actions (due in quarter) had been closed in quarter; with no (62% last quarter) external audit actions closed this period.

Trish Mills also noted that the external audits tab was not uploaded to the pack of papers but advised Members there were three external audits, including two from the 2022 quality governance recommendations around patient outcomes. The information would be circulated to Members after the meeting.

The Committee noted that there were two open actions from the previous Audit Wales Review of Quality Governance audit from 2022-23 which will be revisited in response to the recently completed Follow Up Review of Quality Governance audit, and new management actions will be developed for these outstanding actions.

The current version of the Tracker was now open for Directorate review for actions due in October, November, and December 2024. These updates will then be reported to the Committee at its meeting in February 2025. The Committee took assurance from the position given and did not have any concerns.

RESOLVED: The Committee:

(1) Received and reviewed any Internal Audits and Audit Wales reviews within their remit where relevant. There were none required for review at this meeting;

(2) Monitored management actions to address recommendations in the Tracker, noting any revised dates for actions (in blue).

78/24 RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK

Julie Boalch provided an overview of the two highest scoring risks 223 (*the Trust's inability to reach patients in the community causing patient harm and death*) and Risk 224 (*Significant handover of care delays outside accident and emergency departments impacts on access to definitive care being delayed and affects the Trust's ability to provide a safe & effective service for patients*) with the scoring of 25 remaining unchanged.

The Committee noted that the data presented was the same as that presented to the Audit Risk Assurance Committee and Trust Board in September 2024. Julie Boalch noted that the risks were being reviewed in line with their frequency review and will be presented to the Trust Board in November.

Additionally, she highlighted that workshops have been set up in December with key members of Lee Brooks and Liam Wiliam's teams, to finalise the work on reframing the controls for risks 223 and 224, with the results to be presented to the Board and Committees in early 2025.

RESOLVED: The Committee noted the contents of the report.

79/24 POLICIES FOR APPROVAL/NOTING

The following policies were presented the Committee:

Airway Policy, Liam Williams emphasised that the airway policy underscored its critical role in the Trust, and it was clear that a lot of effort has gone into developing this policy to ensure it met the needs of patients in cardiac and respiratory arrest situations. The policy was approved subject to a final read and final checks by Andy Swinburn in respect of correctness and consistency in terminology.

Management of Controlled Drugs Policy, Medicines Management policy and the Infection Prevention and Control - Sharps policy – All For noting

It was noted that the High Intensity Policy was not received and would be deferred to the next meeting.

RESOLVED: The Committee: Approved the Airway Policy subject to final checking, noted the Management of Controlled Drugs Policy, the Medicines Management Policy and the Infection Prevention Control – Sharps Policy. It was also noted that the High Intensity Policy was deferred.

80/24 COMMITTEE PRIORITIES AND CYCLE OF BUSINESS MONITORING REPORT

The Committee Priorities and Cycle of Business Monitoring Report was received.

RESOLVED: The Committee noted the update.

81/24 KEY MESSAGES FOR THE BOARD

These would be articulated on the Committee's Highlight report.

82/24 REFLECTIONS AND SUMMARY OF DECISIONS/ACTIONS

Ceri Jackson: Emphasised the balance between focusing on high-risk areas and celebrating successes. Appreciated the quality of presentations and acknowledged the extensive transformation and change within the Trust. Mentioned the challenge of lengthy papers and the need to keep this in mind.

Lee Brooks: Praised the chairing of the meeting for allowing sufficient airtime for important topics, even though it pushed the timeline. He appreciated the right level of challenge from Non-Executive colleagues, which added value to take back to their teams.

Trish Mills: Highlighted the challenge of having only two Non-Executive Directors for a lengthy and important meeting. Suggested focusing on what needs to come forward in meetings to help streamline the process and reduce the length of papers.

Liam Williams: Noted the need to balance giving assurance and having an audit trail for that assurance, ensuring good processes for internal and external requirements.

The Chair reflected on the importance of taking the necessary time for detailed reports, especially when they aligned with the Committee's terms of reference. She acknowledged the challenge of balancing detailed information with the need for concise reporting. The Chair also emphasised the significance of celebrating successes alongside addressing areas for improvement, highlighting the good work happening across the Trust.

83/24 ANY OTHER BUSINESS

None

Date of Next meeting: 4 February 2025

Meeting concluded at 14: 50.