

WELSH AMBULANCE SERVICES NHS TRUST

MINUTES OF THE OPEN SESSION OF THE MEETING OF THE QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE HELD ON 9 MAY 2025 VIA TEAMS

Meeting started at 09:30

PRESENT:

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

IN ATTENDANCE:

Claire Appleton	Assistant Director of Putting Things Right
Jayne Beeslee	Non-Executive Director
Kate Blackmore	Assistant Director of Quality Governance
Julie Boalch	Assistant Director of Corporate Governance and Risk
Peter Brown	Assistant Director of Operations
Jonathan Chippendale	Consultant Paramedic
Louise Colson	Head of Infection, Prevention and Control
Dr. Penelope Cresswell-Jones	Specialty Registrar in Public Health (Item 15 only)
Penny Durrant	Deputy Director of Nursing, Quality and Governance
Leanne Hawker	Head of Patient Experience & Community Involvement
Wendy Herbert	Deputy Director of Quality and Nursing
Fflur Jones	Performance Auditor, Audit Wales (Left during item 34/25)
Mark Marsden	Trade Union Partner
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Trish Mills	Director of Corporate Governance/ Board Secretary
Steve Owen	Corporate Governance Officer
Hugh Parry	Trade Union Partner
Alex Payne	Corporate Governance Manager
Felicity Quance	Deputy Head of Internal Audit
Andy Swinburn	Executive Director of Paramedicine
Liam Williams	Executive Director of Quality and Nursing
Keith Williams	(Left during item 26/25 and returned during 28/25)

OBSERVERS:

Skye Banks	Compliance Administrator
Sian Lane	Joint Commissioning Committee
Angela Mutlow	Llais
Claire Muxworthy	Clinical Intelligence and Assurance Co-ordinator

APOLOGIES:

Lee Brooks	Executive Director of Operations
Alison Kelly	Business and Quality Manager
Osian Lloyd	Head of Internal Audit
Henry Garrard	Director of Digital Services
Jonny Sammut	Trade Union Partner

22/25 PROCEDURAL MATTERS

The Chair extended a warm welcome to everyone advising that the meeting was being recorded. Apologies were noted from Lee Brooks, Alison Kelly, Osian Lloyd, Henry Garrard and Jonny Sammut.

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 4 February 2025 were received and confirmed as a correct record.

Committee Highlight Report – 4 February 2025

The committee highlight report dated 4 February 2025 was received. The attendance box at the end of the report was to be amended to include Rhiannon Beaumont-Wood as having attended the meeting.

Chair's Action

The ratification of the Chair's action to approve the Committee Annual Report, Terms of Reference and Cycle of Business was noted.

Action Log

The action log was considered:

Action Number 03/25: Committee Effectiveness review. *As a committee it was agreed that Comments on the Draft Annual Report should be forwarded via email for consideration. For the Priorities for 2025/26: It was requested that any ideas around priorities should be sent through by e mail. Terms of Reference: The Committee noted any amendments will be made before finalising and issued via Chair's Action to the committee for endorsement.* This work was now complete, and it was agreed to close the action.

Action Number 04/25 – Patient Story - *It was agreed that Jonny Sammut would look at what the Trust had in place from a digital perspective, website etc. in terms of accessibility and how to develop this further and improve accessibility for patients who faced barriers in accessing the service.* Jonny Sammut has considered this and the Trust does not currently have approved software in place - we have engaged with our partners at Microsoft and Apple to start conversations on what technologies may be available and these will be explored (with relevant business cases presented). It was agreed to close the action.

Action Number 04/25a: patient Story - *The Chair asked that the People and Culture Committee (PCC) monitor the progress of the wider accessibility initiative, focusing on supporting deaf individuals and others facing barriers to accessing services and engaging with the Trust.* It was agreed that as Chair of the PCC, Ceri Jackson, would take this action forward which has now been transferred to the PCC. It was agreed to close the action.

Action Number – 06/25: *The Duty of Quality Implementation Plan - Closure Report.* It was agreed that the Duty of Quality Implementation Plan closure report be added as a Consent Item section at the next meeting. Added to the Consent Item section for 9 May 2025 meeting. It was agreed to close the action.

Action Number 08/25- *Datix Recovery and Implementation Plan,* It was agreed that Jonny Sammut would update Jayne Beeslee, the Non-Executive Director (NED), who is the NED Trust Board Digital Champion), with regards to her involvement in the All Wales Digital Network and the issues which are being address through this Improvement Plan. A meeting with the Chair of FPC and the Director of Digital has been arranged in May to discuss this. It was agreed to close the action.

Action Number 13/25 - *Cancelled Calls Potential Impact Analysis.* The information contained in the presentation was comprehensive and detailed, Jonathan Chippendale explained that approximately 50% of these cancelled calls likely resulted in patients who then self-presented at the Emergency Department. It was suggested by Liam Williams it would be beneficial for a more comprehensive evaluation and benefits realisation report be presented to the Committee. It was therefore agreed that Liam Williams would liaise with Rachel Marsh and Andy Swinburn to undertake this task. Liam Williams advised that legally privileged advice had been sought and gained to confirm the opportunity for data linkage. The current advice prohibited the Trust from explicitly linking data in the national data repository for this purpose. A submission to Commissioners and Policy advisors to request Cabinet Secretary authority to work consistently with PHW and Digital Health and Care Wales has been made. It was agreed to close the action.

Committee AAA report dated

The Chair drew the Committee's attention to the contents of the AAA report for their information; this highlighted the key points from the meeting on 4 February 2025.

RESOLVED: That

- (1) Apologies were recorded for Lee Brooks, Alison Kelly, Osian Lloyd, Henry Garrard and Jonny Sammut**
- (2) The Minutes of the Open meeting held on 4 February 2025 were confirmed as a correct record.**
- (3) The Committee ratified the decision made by Chair's Action to approve the Committee Annual Report, Terms of Reference and Cycle of Business.**
- (4) Consideration was given to the Action Log and the AAA report as described above.**

Peter Brown presented the Operations Report for quarter four, highlighting key issues such as the scrutiny on the Manchester Arena inquiry submission, the LIFE X and control room outage, the Clinical Model Transformation, the end of shift pod implementation at Glangwilli, ambulance care cancellations, integrated care updates and the Emergency Communication Nurse System (ECNS) audit. Further detailed information was contained in the update report.

Following a query on the increased volume of incidents requiring audit and investigation within integrated care, Peter Brown commented that there had been a significant increase compared to previous levels, which has posed some challenges in the short term with respect to auditing processes. He highlighted that the focus has shifted from routine and random audits to more targeted audits of specific cases. However, due to the increased audit activity during this period, some audits have not been completed as promptly as would be ideal, which was reflected in the challenges mentioned in the Putting Things Right (PTR) paper.

Liam Williams noted that while this impact was expected, it has still increased pressure on the response times to complaints and investigations, particularly affecting the 30-day target for complaints and the backlog of overdue investigations.

The Chair acknowledged that the Trust was taking all possible measures. Nevertheless, the situation remained extremely challenging. It was crucial to discuss this matter openly, as there were associated risk factors.

Ceri Jackson asked about the level of optimism in terms of reducing the handover delays and the impact these have on patients. Peter Brown referred to the Ministerial Advisory Group which announced a goal to reduce handover delays to 45 minutes, which was welcomed. However, the standard was 15 minutes, so this target should be seen as an improvement, not the final goal. To deliver the expected care for patients and improve staff work experience, the Trust needs to reduce handover delays to 15 minutes.

Ceri Jackson asked about the risk regarding the volume of concerns investigations and audits outstanding. Liam Williams commented that the Trust was developing a risk which would formally enter the Trust's governance processes in due course.

Rhiannon Beaumont-Wood sought confirmation that the audits were adapting promptly to various pathways to provide timely learning and improvement. Liam Williams gave assurance this was being managed through two main routes at an organisational level: the Technical Advisory Group and the Clinical Advisory Group, established in Q3 last year.

Following a request from Rhiannon Beaumont-Wood regarding the move to Ty Elwy. Peter Brown advised the committee that the team has successfully transitioned to Ty Elwy from 8 May 2025. The transition has been operationally smooth and effective in terms of service delivery.

RESOLVED: The Operations Report was received and noted.

24/25 PATIENT STORY

Lucie Jones presented the distressing experience narrated by Dylan's parents, Mr and Mrs Cope. Dylan was a nine-year-old boy who tragically died in December 2022 from sepsis. An investigation led by Aneurin Bevan University Health Board examined Dylan's care leading up to his death, involving NHS 111Wales. In December 2022, Mr Cope contacted 111Wales when call volumes were at their highest recorded level. Dylan had experienced severe abdominal pain, initially suspected to be appendicitis, but later diagnosed as having flu, following a hospital assessment. Dylan was subsequently discharged from hospital and when his condition worsened, his parents contacted NHS 111Wales for advice. While waiting for a call back from a clinician, Dylan's condition rapidly deteriorated. Dylan became critically unwell and following emergency surgery at the University Hospital of Wales in Cardiff, Dylan very sadly died several days later from a ruptured appendix and sepsis.

There were multiple failings and missed opportunities that may have prevented Dylan's death, and members were moved both by the circumstances that led to his death, and the drive that Mr and Mrs Cope have to ensure that his legacy is meaningful change at all levels. This includes to the delivery of services in 111Wales, and in the aftermath of tragedy, in details such as delivery of communication and the need for humanity and compassion to be at the forefront.

Lucie has been the family liaison since January 2023, meeting with Mr and Mrs Cope along with a colleague from the Sepsis Trust.

Liam Williams noted that the new Call Prioritisation Streaming Service (CPSS) used in NHs 111Wales and the Emergency Communication Nurse System used in Remote Integrated Care Service (RICS) were both implemented with Dylan in mind. Specifically, assurance was given that CPSS contained multiple red flags for sepsis symptoms which were not present in the previous system. Additionally, as part of the increased specialist knowledge and leadership being developed for RICS, an advanced clinical practitioner has been employed to improve paediatric care and support audits and learning opportunities. It was also noted that improvements in the approach to correspondence have been made by the Trust, with further adjustments sought through recent consultations on changes to the Welsh Government Putting Things Right regulations and guidance.

The committee acknowledged the ongoing efforts to ensure Dylan's legacy leads to meaningful change, and thanked Mr and Mrs Cope for their candour and their courage in sharing Dylan's story.

Peter Brown advised the committee he has had numerous interactions with Mr and Mrs Cope and acknowledged the incredible bravery of the family. Dylan's legacy continues to be a focal point of discussions and underscores the importance of quick response times, high-quality assessments, continuous education, and practice enhancement within the Trust.

Wendy Herbert, advised committee that Mrs Cope's goal and passion was to create a legacy for her son Dylan, ensuring he did not die in vain by raising awareness about sepsis. One of the Trust's aims was to educate both the public and clinicians on identifying sepsis

symptoms, which vary among individuals. The Putting Things Right (PTR) team has worked diligently under regulatory frameworks, making subtle but impactful changes to communication that could help other grieving parents.

Rhiannon Beaumont-Wood was reassured to hear that the new system addressed and responded to some of the issues raised and was pleased to hear of the early involvement of the third sector in the process. Their expertise was invaluable, and utilising their knowledge appropriately was beneficial. She queried about the support provided to staff who have been involved in supporting Mr and Mrs Cope.

Peter Brown commented that many colleagues were affected by this incident, notably PTR colleagues. The call handler involved decided not to return to work after the experience, despite being offered full support. The clinician received significant well-being support and has continued in their role. Those involved in investigations also sought and received well-being support.

Rachel Marsh discussed the 111Wales service as a gateway for individuals with urgent care needs. As an organisation, there was a need to focus on various performance and quality aspects of the service, such as response time and follow-up call speed. These elements were becoming increasingly important for the healthcare service provided to patients, similarly to those who call 999.

Members felt strongly that the board should also hear Dylan's story, and the video will be shared at the 29 May 2025 meeting.

The Chair expressed confidence in the actions that have already been taken and that the Trust remains committed to doing its utmost to continuously learn from these experiences which was part of Dylan's legacy. She extended her gratitude to Lucie, Leanne, and others involved, not only for sharing the story with committee today but also for the work they have done supporting Dylan's parents. Additionally, the Chair extended an appreciation to the wider team for thoroughly analysing what went wrong and identifying areas for improvement.

RESOLVED: The Committee received the Patient Story via a video.

25/25 STRATEGIC QUALITY PLAN 2025-28 [TO INCLUDE EQUALITY IMPACT ASSESSMENT]

Kate Blackmore presented the report acknowledging that the plan recognised the financial challenge faced by the Trust and across the NHS in Wales and subsequently had adopted a pragmatic approach. While the aim of the plan was to be more ambitious and extend efforts further, it was essential to be realistic about the capacity and resources, especially considering significant transformation programmes already underway within the Trust.

Kate Blackmore further stated that the plan aimed to be delivered using a co-production approach, seeking input from service users, staff, and the broader organisation to understand what quality meant to them. The team preparing the plan responded to committee feedback by including a draft Equality Impact assessment (EqIA). Contributions

were also received from the Welsh language lead and Trade Union partners. Kate added that further amendments may follow based on ongoing consultations with executive leads and, she was working on final formatting tweaks, before publication and onward transmission to Trust Board for approval.

Ceri Jackson welcomed the level of ambition in the plan. However, she raised concerns about resourcing and capacity to drive this work, given the level of change in the Trust and asked for reassurance on this point.

Liam Williams confirmed that the Trust was focusing on maturity, dedicated resources, and prioritising efforts. At the executive level, the Trust was balancing these priorities, aiming to embed strategic levers into the clinical model for improvement.

Rhiannon Beaumont-Wood welcomed the plan, appreciating the ambition shown in addressing inequalities and aiming to have a significant impact on population health. She was curious about the strong emphasis on the Corporate Parenting role. While it was important to address the needs of children in care, there should also be a broader focus on children and young people, particularly if the Trust aimed for substantial gains in population health through initiatives for unborn and young individuals.

Kate Blackmore responded in relation to Corporate Parenting in that the Trust focused on this area specifically because it represented a new commitment for the organisation. The objective through the strategic quality plan was to position the Trust for readiness as it developed its next long-term strategy.

The Chair sought clarity on the alignment with the clinical plan and whether any substantive changes were anticipated once full alignment was achieved. Kate Blackmore anticipated no major changes once the plan was finalised.

The Chair, on behalf of the committee thanked Kate Blackmore for her work on the plan.

The committee endorsed **the Strategic Quality Plan 2025-27** for approval by the Board.

At this stage of the meeting the Duty of Quality Implementation Plan Closure Report (brought forward from consent items) was presented to the committee and approved.

RESOLVED: That

- 1. The committee endorsed the Strategic Quality Plan 2025-27 for Board approval.**
- 2. Approved the Duty of Quality Implementation Plan Closure Report.**

26/25 QUALITY IMPACT ASSESSMENT - URGENT CARE RESPONSE SERVICE

The Quality Impact Assessment (QIA) for the Urgent Community Response under the Clinical Model Transformation (CMT) programme was received for assurance.

Ceri Jackson referred to the definition of urgent and emergency care and questioned whether this definition remained static from a policy perspective. She added that the

discussion among Vice Chairs of other Trusts suggested that a review was important for the Trust. Rachel Marsh commented that the definition being developed may differ slightly from the current understanding and could also vary from definitions used in other parts of the UK. It was anticipated that within the next few months, Welsh Government will issue a policy statement that clarifies how urgent care will be defined in Wales.

Members noted that the QIA was a key component of the programme, and was crucial for improving outcomes, preventing unnecessary hospital admissions, and aligning to the strategic priorities within NHS Wales. The QIA was comprehensive, and members took assurance on the approach and outcomes.

RESOLVED: The Quality Impact Assessment (QIA): Clinical Model Transformation: Urgent Community Response was received for assurance.

27/25 PUTTING THINGS RIGHT REPORT - Q4 2024/25

Claire Appleton presented the report and drew attention to the following areas:

The impact of high demand across Trust Emergency and Non-Emergency Services has resulted in several significant issues:

- Harm due to extensive response times in the community for emergency care
- Distress caused by cancellations of pre-booked transport
- Large volume of high harm cases shared with Health Boards for joint investigation.
- Increase in Nationally Reportable Incident (NRI) reporting and Duty of Candour cases

There have been challenges in providing timely complaint responses; (reducing percentage of complaints responded to in 30 working days and high number of open, overdue responses.

There were two Public Interest Reports published by the Public Service Ombudsman for Wales and the findings of the Annual Welsh Risk Pool Concerns Assessment were included.

Liam Williams added that the report highlighted a high volume of activity across the Trust. Notably, this winter the Trust restricted its use of the no-send policy, which in previous years resulted in patients with lower acuity needs seeking care by alternative means, often through self-presentation at Emergency Departments. This change has allowed the Trust to support more patients with urgent care needs, although it has increased risk exposure and incident reporting. The Trust was still assessing the impact of this policy shift on system risk and patient outcomes.

Rhiannon Baumont-Wood, commented regarding the Welsh Risk pool report, and noted the overall rating of substantial despite having three substantive and four limited recommendations. The report mentioned differing opinions on the importance of coding, which seemed more applicable for the Trust and sought clarity on whether these differences have been resolved or if there were opportunities to influence this aspect more effectively.

Claire Appleton explained that the assessment covered records from January to March last year, focusing on case management and data input into the Datix system. While the processes were found to be robust, some quick fixes in data input could improve accuracy.

The overall assurance was strong, but the data did not fully reflect this, which impacted the rating. The Datix system setup, influenced by Health Boards, led to some user engagement issues. A recovery and improvement plan has been implemented to address these challenges.

Ceri Jackson expressed her concerns with some of the indicators in the report regarding resources, winter pressures, handover delays, and the lack of assurance these factors brought. Furthermore, the Ombudsman reports highlighted delayed responses, deficiencies in the complaints investigation process, and concerns about the robustness of Trust investigations. She questioned, considering the upcoming challenges in the next few months, whether the Trust was at risk of completing the quantity of Ombudsman investigations.

Liam Williams advised that the primary measure of assurance was ensuring thorough incident reporting and review processes to facilitate learning and improvement. He added there was a recognised need for enhanced scrutiny on audit processes linked to the PTR recovery plan. He added that the demand during the winter season was consistent with high levels from previous years, compounded by multiple viral infections impacting the NHS significantly. This demand influenced the quality and operations reports, highlighting the pressures faced. There were two Public Service Ombudsman reports which have been closely managed in collaboration with the Ombudsman's office. Gaps have been identified in systems and processes, which have since been addressed to ensure more effective operation.

The Committee asked for an update on the progress with the PTR recovery plan which Wendy Herbert agreed to provide at the next meeting.

RESOLVED: The Quality, Patient Experience & Safety Committee received the report for discussion and identifies any additional assurance requirements.

28/25 MONTHLY INTEGRATED QUALITY PERFORMANCE REPORT

Prior to the update, Rachel Marsh updated members regarding MIQPR metrics for the committee, advising that at a recent board development discussion, it was agreed not to change the board level metrics, though new metrics from the new performance framework starting 01 July 2025 will be included, along with adjustments from ongoing work on Amber and Green metrics.

Rachel Marsh presented the report, with members noting that the board will receive and discuss the MIQPR at its meeting in May 2025. The report highlighted high levels of call abandonment in the 111 service and the need for improved call answering performance.

Clinical response times for P2 and P3 categories were discussed, noting that many calls were not being returned within the expected two and four hour windows. The impact of handover delays was emphasised, with significant lost hours and long waits for red and amber calls.

Rhianon Beaumont-Wood raised a point about the inequalities data, concern over sickness levels, and queried how the Trust could improve the flow of patients into Same Day Emergency Care (SDEC).

Rachel Marsh advised there was a metric for staff inequalities in the data. However, they will not be changed this year, but they remained a focus for the long term. Members recognised that SDEC has been a challenging issue. It was frequently addressed in meetings with the Welsh Government and Joint Commissioning Committee (JCC).

In terms of sickness rates, Peter Brown advised that levels have decreased in the last two months and were now just below 7% for call handlers. While this level was not optimal within the organisation, it compared positively to other 111 contact centre environments.

Ceri Jackson raised the point that at Emergency Departments there was a noticeable impact on older people.

Liam Williams mentioned that the Welsh Government was working on frailty and deconditioning, with policy leads reporting to the Cabinet Secretary. This work was driving the workflow within the Six Goals Programme focused on building neighbourhood capacity and capability. There was significant pressure on improving care transfers, building community capacity to prevent hospital admissions, with the focus primarily to addresses older people, frailty, and avoiding deconditioning.

It was agreed that Rachel Marsh would conduct a deep dive analysis on the disproportionate impact of handover delays on older people and provide that information at the next meeting in November 2025.

An error was pointed out in paragraph 19 of the report regarding response abstractions. It stated that EMS abstraction levels decreased to 33.86% on March 25, below the 30% benchmark figure. This should read as above the 30% benchmark.

RESOLVED: The Committee: considered the Monthly Integrated Quality & Performance Report and actions being taken and acknowledged that it provided sufficient assurance.

29/25 MEDICINES MANAGEMENT ASSURANCE REPORT (INCLUDING AUDIT COMPLIANCE REPORT)

Jonathan Chippendale presented the Medicines Management Assurance Report. The technical details outlined in the report highlighted the efforts to improve compliance, accuracy and monitoring within the Medicines Management system. The areas covered in the report included:

1. Vehicle medicines Audit
2. Omnicell Monthly Cycle Count
3. Unresolved Controlled Drug Discrepancies on the Omnicell System
4. Patient Group Directions (PGD) – Evidence of Signed Authorisations
5. Expired PGDs
6. Abloy System

7. Notification Alerts
8. Controlled Drug Quarterly Occurrence Reports
9. Medication Errors
10. Pentrox (Ref audit report)
11. Antimicrobial report

Jonathan Chippendale added that the Advance Paramedic Practitioners were providing leadership and expertise, particularly in the use of antimicrobials, which was crucial for maintaining high standards of care. Furthermore, the transition to electronic systems had improved accuracy and monitoring.

Andy Swinburn discussed how the Trust's electronic systems offered superior insight into medicine use compared to other ambulance services. The implementation of more prescribers for antimicrobials enhanced decision-making on appropriate use.

The committee recognised the plans in place to improve overall compliance levels in medicines management.

RESOLVED: The Committee noted the contents of the report.

30/25 INTERNAL AUDIT REPORT: ROLL OUT OF PENTHROX

Jonathan Chippendale advised the committee that the audit assessed the impact of the rollout of Pentrox on patients and staff and highlighted the need for updated training modules for Community First Responders (CFR), improved access to Omnicell cabinets and safes, better protocol compliance, and reporting on the benefits of Pentrox.

Members noted that four medium-rated recommendations were made and accepted by management, and the actions will be monitored by this committee.

The Internal Audit report was erroneously omitted from the papers and the committee noted it would be uploaded following the meeting.

RESOLVED: The Committee noted the discussion at the meeting of the ARAC on the 06 March 2025, and the assurance that was received following receipt of the audit report and agreed management actions.

31/25 LEARNING FROM DEATHS (MORTALITY REVIEWS) REPORT - QUARTERS 3 AND 4 OCTOBER 2024 - MARCH 2025

The report detailed the operationalisation of the National Mortality Review Framework, including case volumes, triage, and learning elements. The disproportionate impact on older people was highlighted, with concerns about the provision in the system of equitable services to all communities. The thematic learning from Medical Examiner referrals indicated areas for improvement in end-of-life care and advanced care planning. There were continued efforts to improve collaboration with primary care and community services to enhance advanced care planning and end-of-life care.

Ceri Jackson raised concerns about whether the NHS was genuinely providing equitable services to communities.

Following a query, Wendy Herbert stated that as an organisation, the Trust does exceptionally well in end-of-life care. However, there was a lack of key partners for advanced care planning within the community, which was typically managed by primary or secondary care.

Rhiannon Beaumont -Wood sought to understand more around the cohort of patients that were self-conveying asking if it was possible to extrapolate any direct learning from any system. Furthermore, she asked if there was anything the Trust could do about the limitations of the Medical Priority Dispatch System (MPDS) categorisation.

Andy Swinburn explained that regarding the tracking of individual patients and their subsequent appearances elsewhere in the system, this data was not currently captured.

Andy Swinburn stated that the Trust will soon be the only UK ambulance service using MPDS as England was switching to NHS pathways. Although MPDS has strong evidence for identifying sick patients, it lacked specificity and often grouped many people together. While MPDS was effective in finding and categorising sick people, it also included many others who may not need urgent care.

Peter Brown noted that emerging evidence indicated that a significant number of patients were cancelling appointments following a remote clinical assessment. The ongoing work aims to understand the reasons behind these cancellations.

RESOLVED: The Committee received the report for discussion and identified any additional assurance requirements.

32/25 PATIENT EXPERIENCE AND COMMUNITY INVOLVEMENT BIENNIAL REPORT (OCTOBER 2024 - MARCH 2025)

The Patient Experience and Community Involvement (PECI) biennial report (October 2024 to March 2025) was received. The report emphasised the importance of the patient experience as a critical dimension of quality within the Trust. It highlighted efforts to increase real-time feedback from service users and the focus on patient-reported outcome measures, versus experience measures.

Leanne Hawker, following a question regarding the determination of priorities, explained that they were based on what was being emphasised at a national level in NHS Wales. There was a significant focus on national experiences, such as the maternity initiative and the upcoming survey for children and young people later this summer. Many of these priorities were being guided by national directives in Wales. There was also a substantial effort to increase survey returns and improve learning outcomes, supported by the Data Protection Impact Assessment (DPIA) currently with the Information Commissioner's Office for approval.

RESOLVED: The Committee noted the contents of the report.

33/25 UPDATE ON HEALTH INEQUALITIES MATURITY MATRIX AND POPULATION HEALTH PLAN

Liam Williams introduced the work undertaken by Dr Penelope Creswell-Jones, a specialist registrar from Public Health Wales during their six-month rotation with the Trust.

Dr. Penelope Creswell-Jones provided a presentation on the health inequalities maturity matrix and population health plan which described the progress made, its ambition and recognised the benefits of multidisciplinary collaboration to reduce and address health inequalities. The plan supported delivery of the Trust's strategic objectives and compliance with the health and care quality standards, including equitable, timely and effective services. Members were advised of the numerous opportunities related to data and intelligence, both at the level of individual patient care and improving quality through various risk assessments and tools. She added that investment in time and resources was necessary to achieve these goals, along with the Trust's commitment and accountability related to population health. Furthermore, future registrar placements may also contribute to this progress.

Ceri Jackson suggested exploring funding opportunities through the Charity for potential trust and foundations to support innovation and pilot projects in the public health space. This approach could help seize opportunities and drive forward initiatives related to population health and tackling inequalities.

RESOLVED: The Committee noted the report and received the presentation.

34/25 FOCUS ON CLINICAL INDICATOR - RETURN OF SPONTANEOUS CIRCULATION

The committee received a presentation on the clinical indicator related to Return of Spontaneous Circulation (ROSC) which emphasised the continuous improvement in ROSC rates.

Members held a discussion which highlighted the importance of evolving metrics to better reflect patient outcomes and the need for system-wide measures to improve care pathways and patient experiences.

Andy Swinburn offered to consider pausing clinical indicator presentations to committee, suggesting that it might be more beneficial to wait until new clinical indicators were developed as part of the clinical model change. This approach would avoid repeating information and provide updated and relevant insights once the new indicators are established. It was agreed this proposal would be further discussed outside of the meeting.

Jonathan Chippendale mentioned, following a question by the Chair, that other ambulance services such as East Midlands has a ROSC performance of around 23%, while London, considered an outlier, has a higher performance of approximately 29-30%.

RESOLVED: The Committee received the presentation on the clinical indicator related to the Return of Spontaneous Circulation (ROSC)

35/25 CLINICAL AUDIT PLAN AND ACTION TRACKER Q4 (UPDATE) 2024/25

The Clinical Audit Plan and Action Tracker update for Q4 2024/25 was received with no escalations.

Rhiannon Beaumont–Wood asked for an update on the safeguarding referrals audit. Jonathan Chippendale commented that he would collaborate with safeguarding colleagues to clarify the requirements of the audit. Furthermore, flexibility will be maintained to incorporate additional assurance needs as they arise, whether from patterns of events or specific requests.

RESOLVED: The committee noted the Q4 2024-25 Clinical Audit Plan and Action Tracker update.

36/25 AUDIT TRACKER Q4 2024/25

Trish Mills provided an update on the audit tracker, noting a correction in the report that six out of fourteen audit recommendations due for closure in the quarter were closed, which was a 40% closure rate, doubling the previous quarter's performance. There were no other escalations mentioned.

RESOLVED: The Committee

- (1) Received assurance on the monitoring of management actions to address recommendations in the Tracker, noting any revised dates for actions.**
- (2) Supported the proposed approach to review the outstanding Electronic Patient Clinical Records (ePCR) audit recommendations.**

37/25 FEEDBACK FROM EFFECTIVENESS REVIEW, COMMITTEE CYCLE OF BUSINESS MONITORING REPORT AND 2025/26 PRIORITIES

Trish Mills discussed feedback related to the effectiveness review, committee cycle of business, and monitoring report. The Chair's action for the approval of the Annual Report and Terms of Reference was ratified. Additionally, she proposed focusing on no more than three priorities for the year, emphasising that these should align with existing work rather than adding new tasks.

The three priorities discussed were:

1. Focus on the Clinical Model Transformation (CMT), ensuring robust quality assurance and patient experience improvements.
2. Continued monitoring and reporting on performance against the duty of quality and duty of candour.
3. Prioritising the implementation of the new strategic quality plan to ensure tangible outcomes.

Ceri Jackson advocated the importance of focusing on the CMT. She also suggested continuing the focus on the Duty of Candour and considering the progress around the implementation plan of the strategic quality plan.

Rhiannon Beaumont-Wood supported the idea of focusing on the CMT as a priority. She also suggested conducting deep dives on specific areas such as the 111 service to better understand quality assessment and the experiences of Community First Responders.

Andy Swinburn emphasised the importance of considering the absence of baselines for many of the elements being reviewed in the CMT. He cautioned that while reviewing these elements, it might illustrate harm or deterioration in patients' conditions, which previously might not have been quantified.

Bethan Evans highlighted three key areas of focus: the continuous measurement of performance against the Duty of Quality and Candour; the CMT, and the implementation of the quality strategy.

Bethan Evans suggested considering an email poll to gather feedback from members on the frequency and duration of meetings aimed to address the recurring theme in feedback about the length of agendas and meetings, and whether more frequent, shorter meetings might be more effective than less frequent, longer ones.

Trish Mills mentioned that the Audit, Risk and Assurance Committee (ARAC) was considering the frequency and structure of meetings, including the Academic Partnership Committee (APC), within Q1 and Q2. This review will consider quorum requirements, frequency, and the natural crossroads of the APC.

Bethan Evans suggested that committee members be mindful of the ongoing work to address the feedback received about meeting frequency and duration.

RESOLVED: The Committee

- (1) Ratified the decisions made by Chair's Action effective the 24 April 2025 in relation to the outputs of the annual committee effectiveness review.**
- (2) Noted the output of the Mentimeter survey held on the 04 February.**
- (3) Noted note the proposed changes to operating arrangements for 2024/25 and the outcome of the meeting of the ARAC on the 01 May 2025.**
- (4) Discussed and agree its priorities for the 2025/26.**
- (5) Noted the cycle of business monitoring report for quarter one of 2025/26.**

38/25 RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK

Julie Boalch presented the report advising that this was the same data that was presented to Trust Board in March 2025 acknowledging that the risks have all been updated in readiness for the next round of governance.

Liam Williams highlighted that the focus of the committee agenda remains on the system pressures and the impact this has on people which is discussed and highlighted

throughout the meeting. The discussions are directly related to managing and assuring members against the risks identified, particularly those associated with the clinical model transformation and patient care.

A risk relating to concerns in relation to the overdue investigations and audit processes and the need to put more scrutiny on the Putting Things Right recovery plan and the wider organisational impacts is in development.

RESOLVED: The Committee considered the contents of the report.

39/25 CONSENT ITEMS

The following two reports were received for information:

Health Inspectorate Wales Report

Llais Report - Getting Urgent and Emergency Healthcare in Welsh Hospital

RESOLVED: The Health Inspectorate Wales Report and Llais Report - Getting Urgent and Emergency Healthcare in Welsh Hospital were received.

40/25 KEY MESSAGES FOR THE BOARD

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

RESOLVED: The Committee noted that the key messages for the Board would be articulated through the Committee highlight report

41/25 REFLECTIONS AND SUMMARY OF DECISIONS/ACTIONS

Members' reflections on the meeting included:

1. The deeply moving story of Dylan and the need to keep the patient at the heart of what we do.
2. Robust discussions and good updates provided throughout the agenda.
3. Concerns regarding capacity challenges within the Trust, particularly regarding concerns and investigations progress.
4. The need for balance throughout the agenda regarding presentations and discussion was acknowledged, given the extensive business for the committee and the length of the meetings.
5. The committee welcomed Jayne Beeslee, Non-Executive Director, who observed as part of her ongoing induction. Additionally, Sian Lane, a colleague from the Joint Commissioning Committee, observed the meeting.

Date of Next meeting: 13 June 2025

Meeting concluded at 15:20