2QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE
HIGHLIGHT REPORT TO BOARD

This report provides the Board with key escalation and discussion points at the last Committee meeting. A full list of items discussed appears at the end of the report to enable members to raise any questions to the Chair which have not been drawn out in the report.

Trust Board Meeting Date	26 September 2024
Committee Meeting Date	13 August 2024
Chair	Bethan Evans

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. Lost hours due to handover delays remained significant in May and June 2024 (24,762 and 22,230 hours lost respectively) with a slightly improving picture in July 2024 of 19,596 hours. **Handover delays continue to present patient safety risks and extended waits in the community** with a deteriorating Red performance being outside of what is acceptable to deliver a safe emergency service.

2. 2,159 patients (2,137 in the previous quarter) waited over 12 hours to receive a response in Quarter 1, with one patient waiting 50 hours and 20 minutes (that patient was mobilised following a fall and welfare calls were carried out). 279 of the 2,159 patients had experienced a fall and it is well documented that this cohort of patients, who are frequently older people with high levels of frailty, will experience additional harm due to the protracted delays including pressure damage, acute kidney injury, deconditioning and poorer outcomes. The Trust continues to work across the system with partners to influence system change. The Trust's main focus in the first half of 2024/25 is to implement a material change in how it responds to patient demand by **evolving its clinical model**, and it is expected that the changes will see a reduction in the patients who have fallen waiting so long.

ADVISE

(Detail any areas of on-going monitoring, approvals, or new developments to be communicated)

3. **Linda Erro Castillo** shared the experience of her family after calling an ambulance for her son Guy who was in distress and pain and unable to breath. Guy has learning difficulties and Linda's concern included the need to ensure that call handlers bear in mind the experience of vulnerable persons who may not be able to answer questions clearly after calling 999. In this case, Guy was not in a position to speak to the call handler other than to confirm his name, and Linda liaised with two of the Trust's call handlers after the first provided an ETA of 3-5 hours and a second when Guy's situation worsened. Linda's frustration and distress was clear to the Committee, noting that she thought Guy was going to die and the suggestion that they take him to a hospital himself – the closest being on hour away –

increased this distress significantly. Her comments such as being fearful that no-one would come, that it was the most terrifying experience, and that not everyone fits into the same mould were impactful.

Members sought to understand the pace of the work being done to improve the experiences of patients with learning difficulties and their families given similar issues have been raised in patient stories. The targeted engagement with learning difficulty groups and the Ministerial Advisory Committee on Learning Disabilities was noted and appreciated, as was the work with Ambulance Trusts in the UK looking at best practice. What is key however is the change that will come with our evolving clinical model and the ability to screen patients with complex needs earlier, noting that the MPDS system is heavily scripted with limited room for movement on this. The new model will identify patients with complex needs earlier through clinical screening undertaken by a clinician and as part of a holistic review of the patient.

Members also reflected there is more we can do to support families as they wait for a resource e.g. Community Welfare Responders (CWR) and Community First Responders as we continue to have inevitable delays.

The Chair thanked Linda for her frankness and for bringing her experience to the Trust.

4. The Committee received **an update following the staff story from Fiona Maclean** at the last meeting and noting that the 'support after cardiac arrest page' is now live on the Resus Council UK website: https://www.resus.org.uk/public-resource/support-after-cardiac-arrest.

5. The **Annual Safeguarding Report 2023/24** was approved and is attached at Annex 1. The report builds on the strengthened relationship with Public Health Wales and emphasises the Trust's role in the Chief Nursing Officer's review of the Safeguarding Policy construct in Wales. Members welcomed the progress and high level priorities outlined in the report including the roll out of the Home Office PREVENT training and the development of a new PREVENT Policy. The work plan reflects the Trust's ongoing commitment to safeguarding, the proactive measures being taken to enhance staff training and reporting and addresses the challenges faced by the team due to increased workload.

6. An update was received on the **Quality Strategy 2021-2024 implementation plan**, as well as the development of its successor, the Quality Plan 2025-2028. Whilst there are some challenges to the implementation plan there is nothing for escalation and a number of key successes and progress, including the first WAST Quality Event which was held in July. A key focus for the **Quality Plan 2025-2028** is co-production include understanding the voices of our citizens and service users as well as those of our people. The Committee approved the approach to the plan and an extension of the current strategy to 1 April 2025 to allow for its development.

7. The Committee received the **Operational Update for Q1 2024/25** and relevant updates. It was noted in the May meeting that the Trust's accredited centre of excellence standard for MPDS (999 call handling) has fallen below the required standards set by the International Academy of Emergency Dispatch in the last quarter; however, demonstrable improvements have already been made to return to compliance in April. Prolonged test of change for CWRs was discussed and welcomed.

8. The **Management of Medical Devices Policy was approved**. An Equality Impact Assessment has been undertaken for this policy and there were no issues to escalate.

9. Members' **reflections** on the meeting included:

- The quality of papers were very good as were the presentations. Additionally, the papers demonstrated the governance flow through the relevant directorates and internal governance forums.
- Wider contributions from those in the meeting was welcomed.
- Although there are challenges across the system in terms of patient journey and patient outcome, WAST is involved in the discussions about pathways and outcomes as a key partner.
- New observers and contributors were welcomed to the meeting and offers of induction extended.
- It was the last meeting for Duncan Robertson, Assistant Director of Clinical Development, and he was thanked for bringing his expertise and focus on the clinical indicator spotlights to the meeting recently.
- It was also the last meeting for Kevin Davies, Non-Executive Director, who was thanked for his knowledge, calm sense of reasoning and drive for improvements.

ASSURE

(Detail here any areas of assurance the Committee has received)

10. The Committee received assurance by way of the **Monthly Integrated Performance Report** (MIQPR (Monthly Integrated Quality and Performance Report)) for June and July 2024 along with the **Quarter 1 2024-25 Putting Things Right (PTR) Report**. The Committee noted that:

- A sustained increase in the number of concerns received;
- A continuing number of serious incidents shared with Health Boards colleagues to investigate under the Joint Investigation Framework, but this is on a reducing trend. None were directly related to immediate release requests;
- A continued upward trend in Coroner's requests for information;
- The Trust received one Report to Prevent Future Deaths (Regulation 28);
- The PTR Recovery Plan is on track for delivery;
- The five-day complaint compliance remains lower than the 100% Welsh Government target at 98% in June 2024 but there is a positive movement in responding to a concerns within 30 days. The majority of complaints continue to relate to delayed response in the community following calls made to 999;
- The number of patient safety incident received on Datix has reduced compared to the same time last year;
- Organisational learning, particularly from clinical reviews, was reviewed. Transition to a new thematic PTR report showing trends continues to be a work in progress working with both WAST and national Datix Cymru teams;
- Members raised the need to include public health data related to population weighting (particularly with respect to long Amber 2 waiting times). Data flows are not yet in a position to support this, but workshops are planned to look at some of these issues through including ethnicity and race;
- 111Wales call answering performance improved over recent weeks, however the call abandonment

performance is at 11.9% in June (target 5%). It is expected to pick up over the coming months when new call handlers are in place following the CAS implementation, however it was noted that demand is 4.76% higher than June 2023;
- ROSC rate deteriorated in June 14.1% to however have picked up in July at 22.7% and August early data is looking to be 28.8%.

11. The Committee focused on the **clinical indicators related to hypoglycaemia** including a presentation on the care bundle criterion which is completed on the electronic patient clinical record (ePCR). The board will note from the MIQPR that whilst there has been a steady increase in performance of the care bundle there is a way to go for full compliance. It was anticipated that unfamiliarity with the new ePCR would reduce clinical indicator compliance as it had in other UK Trusts, however the committee was assured the recovery plan being implemented includes ePCR user interface changes, focussed communication, clinical workshops, implementing the clinical supervision policy, and reviewing the scripting for clinical indicator reports.

12. The **Learning From Deaths (Mortality) bi-annual update** was received. The Medical Examiner Service (MES) provide independent scrutiny of deaths not taken for investigation by a Coroner and feedback from families, with such scrutiny following recommendations from a number of high-profile NHS inquiries. 1,154 referrals have been received by the Trust from the MES with all undergoing initial screening and with escalations as required. Themes and trends are being identified following these reviews and a number of improvements are being made as a result of learning from reviews which was reassuring to the Committee.

13. The final **Annual Quality Report 2023/24** was received for information after a draft was discussed at the May meeting. The report was approved by the board on 12 July and has now been published. Included in the report was the first self-assessment against the revised Health and Care Quality Standards, which was welcomed.

14. The **Clinical Audit Plan and Action Tracker update for Q1 2024/25** was received with no escalations. 12 audits are included in the plan for 2024/25 and those completed during the period covering a range of topics including clinical conditions, medicines, and compliance to documentation.

15. The **Clinical Audit Internal Audit** was received with a rating of reasonable assurance, noting that the matters requiring management attention include (a) the Clinical Strategy lacks sufficient reference to clinical audit and its role within the Trust; and (b) the Clinical Audit Plan could be strengthened to demonstrate alignment between individual audits and the Trust risk register and priorities. Management action plans are in place which this committee will monitor, but of note is a substantial assurance rating on benefits realisation and lessons learned which was commended. Osian Lloyd, Head of Internal Audit noted that the report benchmarked well against other Health Bodies and as compared to the last limited assurance audit at WAST on clinical audit.

16. The meeting in May 2024 focused on the **changes to the stroke categorisation** and assurance was provided noting that there is no evidence to suggest the changes have impacted on the Amber 1 response times. The Trust continues to work with the Welsh Stroke Network in line with the UK guidelines and recommendations made by Health Inspectorate Wales. Placement of the specialist hyper acute stroke units is still being determined which will influence the Trust's modelling in the future.

17. In closed session an update on the **111 CAS (Clinical Assessment Software) Replacement Project** which went live on 30th April 2024 was provided and assurance provided that there have been no reported clinical incidents, no serious adverse incidence and no patient experience complaints related to the use of the system. The committee heard that whilst it was introduced as a replacement to the former system, however within the emerging Trust Clinical Model Transformation Programme there are significant opportunities for enhancing patient experience, reducing inequity in patients accessing services, and build more efficient Trust services and processes. Members thanked all those that worked on this significant programme at pace.

18. An update was received on the **Audit tracker** with 39% (76% last quarter) of committee related internal audit actions (due in quarter) closed in quarter, with 62% (33% last quarter) of external audit actions closed this period.

19. Members received the Committee **Cycle of Business Monitoring Report** and progress against the **Committee's priorities** for 2024/25 with no escalations.

RISKS

Risks Discussed: The Trust's 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 delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service remain unchanged at a score of 25.

Committee received assurance that the risks continue to be monitored closely in the relevant governance forums. Early indications are that the scores will remain unchanged in the next reporting cycle; however, Members acknowledged the discussion on these items throughout the whole agenda and that the controls, assurances and mitigating actions are reviewed regularly.

New Risks Identified: No new risks were identified.

The papers for this meeting can be found by following this link to the Committee page on our website.

COMMITTEE AGENDA FOR MEETING		
Operations Directorate Quarterly Report for Q1 2024/25	Patient story – Linda Erro Castillo	Putting Things Right Report Q1 2024/25
Monthly Integrated Quality and Performance Report	Revised approach to clinical screening (deferred)	Annual Safeguarding Report 2023/24
Quality Strategy Implementation Plan Update 2021-2024	Quality Plan Development and Implementation 2025-2028	Learning from deaths (mortality reviews) update
Clinical audit plan and action tracker Q1 2024/25	Spotlight on clinical indicators: Hypoglycaemia	Impact of the changes to stroke categorisation
Internal audit: - Audit Tracker - Clinical Audit Internal Audit	Risk Management and Board Assurance Framework Report	Management of Medical Devices Policy
Committee cycle of business monitoring	Annual Quality Report 2023/24 and Duty	111 CAS Replacement Summary (in

report and priorities update (consent item)	of Quality Standards Self-Assessment (consent item)	closed session)

COMMITTEE ATTENDANCE				
NAME	**07 MAY 2024**	**13 AUGUST 2024**	**05 NOVEMBER 2024**	**04 FEBRUARY 2024**
Bethan Evans (Chair)				
Kevin Davies				
Ceri Jackson	Chair			
Liam Williams				
Andy Swinburn		From 1100[1]		
Lee Brooks	Jonathan Edwards	Pete Brown (open)		
Rachel Marsh	Hugh Bennett	From 1120[2]		
Jonny Sammut				
Trish Mills	Julie Boalch			
Mark Marsden				
Hugh Parry				
Henry Garrard				

	Attended
	Deputy attended
	Apologies received
	No longer member

[1] Duncan Robertson in attendance from 0930
[2] Alex Crawford in attendance from 0930