



QUALITY, 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.

The papers for this meeting can be found by following this [link](#) to the Committee page on the Trust website.

Trust Board Meeting Date	29 May 2025
Committee Meeting Date	9 May 2025
Chair	Bethan Evans

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. **Handover delays continue to present patient safety risks and extended waits in the community** with red performance being outside of what is acceptable to deliver a safe emergency service. The Trust's focus is to implement a change in how it responds to patient demand through the Clinical Transformation Programme (CMT). The committee also received an update on the Ministerial Advisory Group regarding handover delays, which aims to move to a 45 minute position. There was optimism about the firm positioning of this initiative and a commitment to work with the system to achieve it, noting that the standard is 15 minutes.
2. The Trust has navigated a particularly challenging winter, with demand levels comparable to the exceptional pressures of 2022/23, including the impact of multiple community viral infections. In contrast to previous years, the 'no send' policy from the Clinical Safety Plan was not routinely applied, enabling the Trust to provide care to more patients with urgent needs. While this decision supported patients, it also meant that the Trust held more risk directly - risk that would ordinarily sit across the wider system - which contributed to an increase in incidents and complaints.
3. Although this impact was anticipated, it has nonetheless placed additional and increased pressure on our response times to complaints and investigations, particularly affecting the **30-day target for complaints, and the backlog of overdue investigations**. Against this backdrop - and in the context of the two recent Public Interest Reports from the Public Services Ombudsman for Wales and the annual Welsh Risk Pool Concerns Assessment - committee members sought assurance on progress toward recovery and on timely learning. They noted the following positive developments and mitigating actions:
 - The PTR and Datix recovery plans previously reviewed by the committee;



- Investment in the PTR team in 2024/25 to help manage the backlog of investigations, and now additional investment in audit capacity within operational and clinical teams, with recruitment underway and impact expected in Q2;
- Continued confidence in incident reporting systems, including enhancements to support earlier learning from complaints and incidents;
- A proactive approach to learning from the point of care, including through patient complaints and Medical Examiner processes;
- Organisational risks 223 and 224 continuing to inform our assurance arrangements and current response structures;
- A new, specific risk relating to audit processes and overdue investigations in development;
- Operational and QIA reporting refined to better capture demand pressures and the changes implemented in response.

There was a recognition that the key driver to making this required change is the ability of the system to reduce the significant impact experienced by people as a result of the breadth and depth of handover delays.

4. The committee will review progress against the recovery plans in August 2025 to gain further assurance.

ADVISE

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

5. Members expressed thanks to **Mr and Mrs Cope, parents of Dylan Cope**. Dylan's story, shared by his parents Corinne and Lawrence, detailed the tragic death of their nine-year-old son, Dylan from sepsis in December 2022. Dylan 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 but when his condition worsened, they contacted NHS 111 Wales (111) for advice. Whilst 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 tragically died several days later from a ruptured appendix and sepsis.

Members felt strongly that the board should also hear Dylan's story, and the video will be shared at the May board meeting. There were multiple failings and missed opportunities which 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 111, but also in the aftermath of tragedy, in details such as delivery of communication and the need for humanity and compassion to be at the forefront.

Members were told that changes to the Remote Clinical Service were implemented with Dylan in mind, including multiple safety nets for red flag sepsis symptoms. Additionally, an advanced clinical practitioner has been employed to improve paediatric care and support audits and learning opportunities. Improvements in the approach to correspondence have been made, with further adjustments sought through relevant Welsh Government regulations.



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, and likewise for the WAST staff who have been supporting Mr and Mrs Cope.

6. The Committee received **an update following the patient story from Gemma, which was received by the committee in February**. Gemma shared her experience as a profoundly deaf British Sign Language user in accessing healthcare.
7. **The Strategic Quality Plan 2025-27** was received and endorsed for approval by the board. The plan is attached at Annex A. Members acknowledged the need to prioritise the implementation of the plan, balancing its ambition with capacity and resource availability. Members were assured that quality is embedded into the CMT programme and noted the importance of educating and training staff to integrate the strategic levers into their roles.
8. The Committee received the **Operational Update for Q4 2024/25**, and of note highlighted scrutiny on the Manchester Arena inquiry, business continuity challenges, the CMT programme, end-of-shift pod implementation, ambulance care cancellations, integrated care planning, and ECNS audit. Discussions on the overdue investigations and bottlenecks from an audit perspective are noted in the alert section above.
9. The **Health Inspectorate Wales** report on the Emergency Department at the Grange University Hospital, and the **Llais** report entitled Getting Urgent and Emergency Healthcare in Welsh Hospitals were received.
10. Members' **reflections** on the meeting included:
 - The deeply moving story of Dylan and the need to keep the patient at the heart of what we do.
 - Robust discussions and good updates provided throughout the agenda.
 - Concerns regarding capacity challenges within the Trust, particularly regarding concerns and investigations progress.
 - 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.
 - 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.
11. The committee **met briefly in private** to approve the minutes of the February private session.

ASSURE

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

12. The **Monthly Integrated Performance Report (MIQPR)** was received, with members noting that the board will receive and discuss the MIQPR at its meeting in May. 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 are not being returned within the expected two and four-hour windows. This was the subject of discussion in Dylan's story also. The impact of handover delays was emphasised, with significant lost hours and long waits for red and amber calls. The importance of focusing on inequalities data and metrics, including geographic and protected characteristics, to better understand and address disparities in service delivery was raised, as were challenges in improving flow into SDEC pathways and the need for better collaboration with Health Boards to operationalise direct referrals.

13. The **Putting Things Right (PTR) Report** for Q4 2024-25 was received. The board will note the alert above regarding response times to complaints, but also of note was good work around compliance with the five working day target for issuing Duty of Candour initial letters.
14. The Public Service Ombudsman of Wales (PSOW) has published two **Section 23 Public Interest Reports** involving the Trust during March 2025 (one issued jointly to WAST and Swansea Bay University Health Board). The joint report detailed a missed opportunity for clinical review from CSD and a poor standard of complaint investigation. The second report identifies issues with clinical record-keeping and aspects of the complaints handling process; delays in information sharing and a lack of completeness within the investigation. The recommendations have largely already been undertaken, with evidence of completion being provided to the PSOW.
15. The **Annual Welsh Risk Pool (WRP) Concerns Assessment** has received an overall substantial rating, notwithstanding four areas of limited assurance regarding management of concerns, organisational learning and WRP reimbursement process. The Report highlights that processes for legal case management are considered to be an exemplar arrangement. Actions to address the issues will be monitored via the audit tracker
16. **The Learning from Deaths (mortality reviews) report Q3 and Q4** 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 are continued efforts to improve collaboration with primary care and community services to enhance advanced care planning and end-of-life care.
17. The **Quality Impact Assessment (QIA) for the Urgent Community Response** under the CMT programme was received. Members noted that this as a key component of the programme, and is 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.
18. The **Medicines Management Assurance Report** was received. The technical and detailed discussion highlighted the efforts to improve compliance, accuracy and monitoring within the Medicines Management system. The Advance Paramedic Practitioners are providing leadership and expertise, particularly in the use of antimicrobials, which is crucial for maintaining high standards of care. The transition to electronic systems improves accuracy and monitoring. Members were assured on the ongoing improvements despite the recognised challenges.



19. **Internal audit on Roll-out of Pentrox** was presented. 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, improved access to Omnicell cabinets and safes, better protocol compliance, and reporting on the benefits of Pentrox. Four medium-rated recommendations were made and accepted by management, and the actions will be monitored by this committee.
20. Committee received a presentation on the **clinical indicator related to Return of Spontaneous Circulation (ROSC)** which emphasised the continuous improvement in ROSC rates despite extended response times and the importance of measuring patient outcomes that matter most to them, such as survival to discharge without neurological deficits. The discussion 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.
21. The **Clinical Audit Plan and Action Tracker update for Q4 2024/25** was received with no escalations.
22. The **Patient Experience and Community Involvement (PECI) biannual report (October 2024 to March 2025)** was received. The report emphasised the importance of the patient experience as a critical dimension of quality within WAST. The report highlighted efforts to increase real-time feedback from service users and the focus on patient-reported outcome measures, versus experience measures. The significant work undertaken by the Peci team was noted, which included attendance at 96 events and engaging with over 5000 people.
23. Members received 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 board's endorsement of the population health principles, commitments, aims, and vision will continue to strengthen the approach and keep momentum. The plan supports delivery of the Trust's strategic objectives and compliance with the health and care quality standards, including equitable, timely and effective services.
24. An update was received on the **Audit tracker** with 40% (18% last quarter) of committee related internal audit actions due in quarter were closed in quarter. The committee was assured that appropriate plans were in place to address those actions overdue.
25. The outputs of the Committee's **annual effectiveness review** were discussed and the terms of reference and annual report that were approved by Chair's Action were ratified. The committee set its priorities for 2025/26 as:
 - Focus on the clinical model transformation, ensuring robust quality assurance and patient experience improvements.
 - Continued monitoring and reporting on performance against the duty of quality and duty of candour.
 - Prioritising the implementation of the new strategic quality plan to ensure tangible outcomes.

RISKS



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth Brifysgol GIG
Gwasanaethau Ambiwylans Cymru
Welsh Ambulance Services
University NHS Trust

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.

It's important to note 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.

It was noted that patient safety risks and learning opportunities may not be identified in a timely way if the number of open, uninvestigated incidents is not addressed.

New Risks Identified:

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.

COMMITTEE AGENDA FOR MEETING		
Operations Directorate Quarterly Report for Q4 2024/25	Patient story	Quality Plan 2025-27 and EqIA
Quality Impact Assessment (Urgent Care Response Service)	Putting Things Right Report with Annual WRP concerns assessment and section 23 Public Service Ombudsman for Wales reports	Monthly Integrated Quality and Performance Report and annual review of metrics
Medicines management assurance report	Internal audit – roll out of Pentrox	Learning from deaths (mortality reviews) report Q3 and Q4
PECI Biannual report	AACE benchmarking tool public health update	Focus on clinical indicator – ROSC
Clinical audit tracker	Audit tracker	Feedback from effectiveness review and setting of priorities
Risk management and BAF	Duty of quality implementation closure report (consent item)	HIW report (consent item)
Llais report – getting urgent and emergency healthcare in Welsh hospitals (consent item)		

COMMITTEE ATTENDANCE					
NAME	9 MAY 2025	13 JUN 2025	5 AUG 2025	4 NOV 2025	3 FEB 2026
Bethan Evans (Chair)					
Ceri Jackson					
Rhiannon Beaumont-Woods					
Liam Williams					
Andy Swinburn					



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth Brifysgol GIG
Gwasanaethau Ambiwylans Cymru
Welsh Ambulance Services
University NHS Trust

Lee Brooks	Peter Brown				
Rachel Marsh					
Jonny Sammut	Keith Williams				
Trish Mills					
Mark Marsden					
Hugh Parry					
Henry Garrard					

	Attended
	Deputy attended
	Apologies received
	No longer member