WELSH AMBULANCE SERVICES NHS TRUST

MINUTES OF THE OPEN SESSION OF THE MEETING OF THE QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE HELD ON 13 AUGUST 2024 VIA TEAMS

Meeting started at 09:30

PRESENT:

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

IN ATTENDANCE:

Claire Appleton	Head of Putting Things Right
Kate Blackmore	Head of Quality
Julie Boalch	Head of Risk/Deputy Board Secretary
Peter Brown	Assistant Director of Operations, Operations Transformation
Jonathan Chippendale	Consultant Paramedic
Alex Crawford	Assistant Director of Planning and Transformation (Left meeting at 11:05)
Penny Durrant	Deputy Director, Nursing Quality and Governance
Leanne Hawker	Head of Patient Experience & Community Involvement
Alison Kelly	Business and Quality Manager
Osian Lloyd	Head of Internal Audit, NWSSP
Mark Marsden	Trade Union Partner
Rachel Marsh	Executive Director of Strategy, Planning and Performance (Joined meeting at 11:25)
Vicky Maxwell	Head of Safeguarding
Trish Mills	Director of Corporate Governance/ Board Secretary
Steve Owen	Corporate Governance Officer
Hugh Parry	Trade Union Partner
Alex Payne	Corporate Governance Manager
Duncan Robertson	Assistant Director of Clinical Development (Left meeting at 12:08)
Jonny Sammut	Director of Digital Services (Left meeting at 09:45 and rejoined at 11:00)
Andy Swinburn	Executive Director of Paramedicine (joined meeting at 11:00)
Liam Williams	Executive Director of Quality and Nursing

Apologies:

Lee Brooks	Executive Director of Operations
Henry Garrard	Trade Union Partner
Fflur Jones	External Audit

40/24 PROCEDURAL MATTERS

The Chair extended a warm welcome to everyone advising that the meeting was being recorded. Apologies were noted from Lee Brooks, Henry Garrard and Fflur Jones.

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 7 May 2024 were confirmed as a correct record.

Matters Arising
The following update on the previous staff story which was a presentation by Fionna Maclean was provided to the Committee. The 'Support after cardiac arrest page' was now live on the Resus Council UK website: Support after cardiac arrest | Resuscitation Council UK. Support cards, designed by the Patient Experience Community Involvement (PECI) Team with input from the People & Community Network, were awaiting the addition of a Quick Response (QR) code.

Action Log
The action log and the Committee Highlight AAA report from the last Quest meeting were considered:

Minute: 07/24 - *The Committee asked that a timeline/timetable of how the revised Quality Strategy would be delivered be provided to the Committee.* Details of the timeline are included in the QSIP 2021 -2024 update paper - propose that this action be closed. Agreed – Action Closed.

Minute: *The Chair advised there had been an increase in the number of safeguarding alerts raised, whilst the report states a significant drop, Liam Williams explained that some of the alerts are coded to the Health Boards and were picked up at Local Authority level. Liam Williams agreed to clarify this point.* Further to investigation of the data, the Trust have no formal reporting mechanism or requirement to share Safeguarding alerts with HIW. HIW are only informed of significant safeguarding concerns that we believe warrant their attention and the attention of their inspectors. Our formal reporting mechanism and legal duty is to send safeguarding reports directly to the relevant Local Authority as the statutory responsible body. As reported at the meeting, the Trust safeguarding reports submitted to Local Authorities have increased annually in recent years. Action Closed.

Committee AAA report dated 7 May 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 7 May 2024.

RESOLVED: That

(1) Apologies were recorded for Lee Brooks, Henry Garrard and Fflur Jones.

(2) The Minutes of the Open meeting held on 7 May 2024 were confirmed as a correct record.

(3) An update on the previous staff story was given which concerned Fionna Maclean and an update on providing support following a cardiac arrest.

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

41/24 OPERATIONS DIRECTORATE QUARTERLY REPORT – 2024/25 Q1

Peter Brown presented the report and drew the Committee's attention to the following headlines:

Since the start of the financial year, Community Welfare Responders (CWR) support officers have recruited and trained 20 CWR volunteers working across 14 active teams. CWRs have attended 68 patients in April & May with a hear and treat rate of 43.5%. The Trust was preparing to extend the test of change for CWRs over the coming winter, with plans to start in November. This longer trial aims to better understand how CWRs can be effectively utilised in the community, especially with dedicated clinical support.

The Trust went into remediation with the International Academies of Emergency Dispatch (IAED) for the Medical Protity Dispatch System (MPDS) following Q4. An action plan was approved and was submitted to the IAED as per its Remediation Policy.

In terms of the Medical Transfer Protocol Suite (MTPS), Operations Quality has begun training EMS Coordination staff on MTPS which were the new interfacility transfer protocols within MPDS.

Delayed transfer of care at Emergency Departments across Wales remained a significant challenge in being able to provide a safe level of emergency service with timely response to calls. The total amount of lost hours during Q1 was 5% lower than the hours lost during previous quarter. In April 2024 the total lost hours were 23,616, May 2024 at 24,762 and June 2024 at 22,230.

There were ongoing issues with Red and Amber performance metrics, which were closely tied to the increasing handover hours lost at Emergency Departments. This loss of resources was a significant factor affecting performance in these areas.

While it was noted that the level 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 overruns, work progresses on several initiatives to further reduce end of shift overruns to support the wellbeing of staff.

Quality and Support days continued to provide invaluable support to operational staff in the promotion of key indicators and expectations relating to many elements of quality behaviour within Trust premises, on ambulance vehicles, and relating to the member of staff personally.

Comments:

Kevin Davies pointed out that it would be wise to review the terminology used, as a recent questionnaire he received 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 general public. Peter Brown agreed to action. Ceri Jackson raised three points:

1. Ceri Jackson sought further information on the alignment of the CWR role with Health Boards. It was agreed that Peter Brown would take this offline and update Ceri Jackson accordingly.

2. Amber Performance Forecast: the recent deterioration in amber performance was noted understanding this has been a longstanding challenge, and it was asked if there was anything that could be shared about the forecast for the next three months. Peter Brown added that if handover delays continued to be as persistently difficult as they were, the Trust was not anticipating a recovery in performance at this stage.

3. Thanet House Lease Expiry: It was recognised that the lease was due to expire, and assurance was sought on how this was being managed; particularly given the potential disruption to the teams based there - especially the 111 service. Peter Brown assured the Committee that good progress in the plan to replace Thanet House was being made.

RESOLVED: That the report was received.

42/24 PATIENT STORY – LINDA (VIDEO)

Leanne Hawker explained that the story involved Linda, who was the primary caregiver for her adult son, Guy. Guy has a learning disability and other complex needs. When she called 999, Guy was vomiting and struggling to breathe, which caused significant concern. At the time of the call, Guy was in considerable pain and distress, heightening the family’s anxiety.

Despite the urgency of their situation, they were provided with an estimated arrival time of three to eight hours. This prolonged wait caused immense anxiety for Linda and her family, as they felt helpless and unable to secure timely assistance for Guy. As his symptoms seemed to worsen, they called again and were frustrated by the need to answer the same questions repeatedly.

On the evening in question, Guy had been sent home from work after being sick. Later, Linda found him in his bedroom standing rigid, racked with pain, grey in colour, and gasping for breath. His torso was as hard as concrete, and he was clearly in severe distress. Despite never having called an ambulance before in her 63 years, Linda knew she had to act quickly.

She called 999, and while trying to remain calm, answered numerous questions from the call handler. Feeling utterly helpless, she watched as her son's condition worsened, prompting her to call 999 again. To her dismay, she had to repeat the same questions and was told that due to the General Data Protection Regulations (GDPR), the previous information could not be used.

Linda later discovered that Guy's case had been downgraded from a Red to an Amber priority because the report inaccurately stated that he was speaking in full sentences, which was not the case. The call handler suggested that they drive Guy to the hospital themselves, but Linda found this suggestion unrealistic.

The experience has left Linda and her family traumatised, particularly because they were working to ensure Guy can live independently. Linda emphasised the need for call handlers to be more sensitive and responsive to the needs of vulnerable individuals, including those with learning difficulties, the elderly, and people with conditions like dementia. For Linda, the expectation was not just transportation to the hospital but immediate medical assistance, but to have aid from someone with oxygen who could assess and stabilise her son.

Leanne Hawker added that the Patient Experience and Community Involvement (PECI) Team has been actively working with Linda and her family to keep them informed about the ongoing internal initiatives aimed at improving patient care. A significant focus has been on ensuring the Team were aware of and responsive to any additional needs that callers may have, especially those that go beyond the immediate clinical presenting problem when contacting 999.

To address this, the Trust has been enhancing the electronic Patient Care Record (ePCR) system to capture more accurate data regarding patients' broader needs. Additionally, the Trust has extended these discussions to include emerging developments within the organisation, particularly how non-clinical needs during phone interactions can be identified.

A key concern has been whether extended processes might inadvertently increase risks for individuals with Learning Difficulties (LD), and how the Trust can ensure more equitable care for the LD community.

The PECI Team has also been promoting training modules to raise staff awareness about the specific needs and impacts on people with learning disabilities. As the Trust prepared for the winter, the Team has been discussing potential adjustments and necessary scripting changes to better support this community.

The Team was also exploring digital developments, such as video or face-to-face triage, to provide a sense of connection while patients were waiting.

Ceri Jackson added it was clear that this was a challenging area, particularly when it came to serving individuals with learning disabilities. The fact that the call handler logged that the patient was speaking in full sentences, has raised important questions about training and communication.

Kevin Davies expressed frustration, noting that the issues mentioned, such as repetitive questioning and the need for a higher index of suspicion for patients with learning disabilities, have been discussed before. He emphasised the importance of addressing these issues to prevent similar stories in the future and questioned when improvements would be visible.

The Chair, Bethan Evans, commented that listening to Linda's story was truly heart-wrenching. Her phrases, like "no one will come," captured the deep fear and helplessness she felt, making it clear that it was a terrifying experience for her. Her comment, "we don't all fit into the same mould," resonated strongly and highlighted the need for a more tailored approach to care.

Leanne Hawker added that while there was still work to be done, the Trust has made significant strides in raising awareness, building expertise, and establishing important partnerships. The implementation of the ePCR changes and continued collaboration with external groups were expected to yield positive outcomes soon. The focus now will be on ensuring that these efforts translate into tangible improvements in the experiences and outcomes for people with learning disabilities.

Liam Williams provided a comprehensive overview of the ongoing efforts and challenges in adapting the Trust's operating model to better serve patients with learning disabilities. He emphasised that while significant changes were being made, especially with the new clinical transformation model, there were inherent limitations in altering the current approach for 999 call handlers, particularly given the international standards and the heavily clinically scripted protocols they must follow.

Liam Williams added that the Committee should recognise the outstanding work that the Patient Experience and Community Involvement (PECI) Team has been doing. He expressed recognition that the Team were finalists in the UK Patient Experience Network National Awards.

RESOLVED: The Committee received the patient story.

43/24 PUTTING THINGS RIGHT (PTR) REPORT

Claire Appleton presented the Putting Things Right Report, highlighting the challenges and progress within the Patient Family Relations, Mortality, and Legal Services teams. She mentioned increased compliance with the 30 day response timeframe for formal complaints and the implementation of a recovery plan. Claire also noted the upcoming legislative changes affecting the landscape and the team's efforts to navigate these changes. Additionally, she mentioned the increasing trends in complaints, patient safety incidents, mortality review work, and coroner's inquests approaches.

Claire Appleton noted there were changes in the reporting profile around Serious Case Incident Forum (SCIF) cases, influenced by both the easing of winter pressures and internal process improvements. She highlighted the need to monitor these changes to ensure they reflected genuine shifts in harm levels or operational circumstances rather than internal leadership changes.

Kevin Davies raised concerns about the way data was reported, specifically the dangers of focusing solely on Health Board data rather than considering population type data. He highlighted that while Betsi Cadwaladr University Health Board (BCUHB) served approximately a million people, the other five Health Boards and one Trust covered around 2 million people combined. This discrepancy posed challenges in how the data was reported and interpreted.

Liam Williams added that the Trust was addressing the challenge of improving how data was reported and analysed, particularly concerning weighted population metrics. The aim was to shift the reporting to focus more on weighted population metrics.

Ceri Jackson raised a query about Table One in the report regarding the classification of harm levels in patient complaints. It was noticed there had been a significant increase in reported moderate harm compared to the previous year, while reports of low harm had decreased.

Claire Appleton explained that the reported moderate harm incidents have remained broadly similar across quarters, indicating a stable trend in this category. There has been a notable decrease in the number of low and no harm incidents reported. This shift may be linked to changes in how incidents were categorised and recorded in the Datix system.

Alex Crawford sought an update to determine if the Never Events Framework was an effective mechanism to drive patient safety improvement with one of the options being to abolish the Never Events Framework and list. Claire Appleton advised the Committee that this was still an option being considered.

Bethan Evans was keen to understand whether the full structure was now in place for the PTR Team. Claire Appleton advised the Committee that all the necessary roles have been filled according to the recruitment plan. There has been some absenteeism due to sickness, but it was expected this would improve starting in September.

Bethan Evans questioned, how the work on developing the report so that it focused more on thematic reviews and trends was progressing. Claire Appleton explained there was work to improve how thematic learning was captured through the Datix system.

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

44/24 MONTHLY INTEGRATED QUALITY PERFORMANCE REPORT – JUNE/JULY 2024

Alex Crawford highlighted the following points for the Committee's attention:

The response times to 999 callers remained a concern with red 8-minute performance at 48.2% in July 2024 and Amber 1 median at 1 hour and 26 minutes.

The Trust lost 19,596 hours to handover in July 2024 (marginally higher than July 2023), and this level of lost capacity was difficult to compensate for, despite all the actions being taken.

Ambulance Care performance has been stable, with oncology remaining above target and renal performance achieving its target.

111 call answering performance has improved over recent weeks, however the call abandonment performance was at 11.9% in June (target 5%). It was expected to improve over the coming months when new call handlers were in place.

Alex Crawford explained that in terms of the falls response, there was coverage for falls response services across Wales, with expansion plans outlined in the Integrated Medium Term Plan (IMTP). The goal was to enhance service levels and pathways, particularly working with Health Boards to improve response.

Alex Crawford advised that with respect to the recruitment challenges within the Cymru High Acuity Response (CHARU) units Assessment and Referral Unit) recruitment within CHARU was showing improvement overall, but rural areas presented significant challenges.

Peter Brown advised the Committee that the sickness rates among call handlers in the 111 service were trending back in the right direction. Sickness rates have recently halved compared to the peak levels seen four weeks ago.

Members noted there had been a recent reduction in the Return of Spontaneous Circulation (ROSC) in patients following a period of improvement. Duncan Roberston explained that adjustments have been made to the scripting behind case selection to exclude cases that might have been counted incorrectly or were not relevant.

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

45/24 ANNUAL SAFEGUARDING REPORT 2023/24

Vicky Maxwell explained that the report had been developed on the strengthened relationship with Public Health Wales and emphasised the Trust's role in the Chief Nursing Officer's review of the Safeguarding Policy construct in Wales.

There had been an increase in safeguarding reporting which could be attributed to several factors. The most significant reason was the enhanced ability of staff to recognise and respond to safeguarding concerns.

Vicky Maxwell highlighted the leadership role of the Trust in rolling out the Home Office prevent training across the workforce. This training was well received and has enhanced the ability to recognise and escalate concerns appropriately. Furthermore, the safeguarding maturity matrix to public health colleagues has been submitted which will be a self-assessment tool for safeguarding practices, and this will inform the safeguarding work plan for the coming year.

Ceri Jackson commented that the report offered a great deal of assurance, showing that not only was the Trust meeting its mandated responsibilities, but also exceeding them. The emphasis on collaboration across the system was particularly appreciated. However, she expressed a few small concerns about the language used in the report. For instance, in the Executive Summary, the word 'celebrating' in the first line does not seem entirely appropriate for this context. Similarly, the phrase 'we look forward to the challenges around safeguarding' at the end could be reframed.

Vicky Maxwell noted the feedback, noting the importance of balancing the report's content to avoid focusing solely on negative aspects. Bethan Evans noted that the Annual Report was pivotal for the Trust. It underpinned the work and the Trust's commitment to keeping people safe in the community.

Liam Williams added that the Trust was aligning the work of various teams, including safeguarding, mental health services, and frequent caller teams, which will lead to more cohesive and efficient operations. He agreed prior to publication that the comments in respect of the type of language used as described above by Ceri Jackson would be reviewed.

RESOLVED: The Committee

(1) Approved the Safeguarding Annual report 2023/24 pending any minor adjustments prior to its submission to the Trust Board for information; and

(2) Noted and considered the sustained increase in demand and the cumulative impact on the Safeguarding Team.

46/24 QUALITY STRATEGY IMPLEMENTATION PLAN UPDATE 2021-2024

Kate Blackmore provided an update on the progress of ongoing actions, particularly in relation to Quality Improvement (QI) initiatives. The report highlighted that 15 actions have been completed out of a total of 25. This indicated steady progress, but there were still 10 actions that required further attention.

The plan included a timeline for QI training, with a rollout expected by the end of September and full completion by the end of Q3. The first annual Welsh Ambulance Services University NHS Trust Quality roadshow took place on 2 July 2024, focussed on education and practical examples of the Quality Management System and the importance of continued engagement with service users.

The Duty of Candour training has been completed by several individuals, but there were still challenges with recording this through the Electronic Staff Register (ESR). Education and Development colleagues were working to embed the training records into LMS365.

Following a question regarding the expectation in closing the remaining actions in the outgoing strategy by December 2024 Kate Blackmore stated that she was confident that the remaining actions would be completed by the end of Quarter 3 2024/25 - December 2024.

The Chair asked whether there were any specific themes or challenges emerging from the service experience surveys currently operating within Civica. Kate Blackmore noted that steps are being taken to address challenges and improve feedback collection.

The Quality Management Group has been working on refining the wording and answer options in the Civica surveys to better capture detailed feedback from service users. Currently, the surveys were mostly completed in the context of ambulance care. As an interim solution, efforts were underway to promote Civica surveys more actively.

RESOLVED: The Committee noted the progress on the Quality Strategy Implementation Plan for 2021-2024.

47/24 QUALITY PLAN DEVELOPMENT AND IMPLEMENTATION PLAN 2025-2028

The current Quality Strategy is due to be reviewed and Kate Blackmore provided an overview of the Trust's approach to developing the new 'Plan' which aligns with the Trust's long-term strategy. She highlighted the following key points:

1. This plan will need to integrate various guidance and legislation, including:

    - The Health and Social Care Quality and Engagement (Wales) Act 2020;
    - The Well-Being of Future Generations Act 2015;
    - The six goals work for urgent and emergency care.

2. The plan will consider the Trust's role in population health, including the value-based healthcare framework. It will also consider social deprivation, ethnicity, and

other protected characteristics, addressing issues such as learning disabilities and sensory loss.

3. In terms of the process in developing the plan:

    - A Task and Finish group will be established in September, following the completion of patient engagement activities.
    - Workshops will be conducted across the Trust to gather feedback from teams and leaders about the plan's content.
    - The first draft of the plan will be prepared and reviewed through appropriate forums for feedback in October and November, with the goal of obtaining approval in December.
    - An implementation plan will be rolled out for Quarter 1 of the next year.

4. The paper includes a request to approve an extension of the current strategy through to April 1, 2025. This request was based on feedback from auditors conducting the quality governance review, who inquired about the extension of the existing strategy.

Ceri Jackon asked of the quality strategies of key stakeholders and the appetite for collaborative work to reduce harm and improve quality and outcomes for patients. Liam Williams provided reassurance about the commitment from system partners to reduce harm, emphasising that their challenges were as significant as the Trust's, though they may face different aspects of it. System partners were eager to work collaboratively to reduce harm and this collaboration extended beyond emergency care to encompass various aspects of healthcare.

Liam Wiliams noted that the Quality Plan for 2025-2028 aims to shift towards targeted improvement to achieve the best outcome improvements for populations, particularly focusing on reducing inequality and improving outcomes. This involves considering where quality impact could be most targeted and is part of the broader transformation and quality improvement journey across the organisation.

Rachel Marsh highlighted the important role of quality from the commissioning perspective, adding that the Joint Commissioning Committee (JCC) was actively working on refining their substructures and enhancing their approach to quality.

RESOLVED: The Committee

(1) Approved the proposed approach to the development of the Quality Plan 2025-2028, and;

(2) Approved an extension of the current Strategy until 1 April 2025 to allow the development of a robust Quality Strategic Plan for the following 3 years.

48/24 LEARNING FROM DEATHS (MORTALITY REVIEWS) UPDATE REPORT

Claire Appleton introduced the report which set out the current position and progress since October 2023, and drew the Committee's attention to the following areas:
The Medical Examiner (Wales) Regulations 2024 were established on 15 April 2024 as part of the wider death certification reforms being introduced in England and Wales through Regulations being laid by the UK Government's Department of Health and Social Care.

The Medical Examiner Service (MES) will be reviewing all deaths not taken for investigation by a Coroner from 9 September 2024. As part of the Learning from Deaths Forum Programme of Work a look back of all MES Referrals from September 2020 to March 2024 has been undertaken to provide assurances in respect of screening, appropriate escalation and the improvement actions undertaken.

Since the establishment of the MES the Trust has received 1154 Referrals (as of 19 June 2024). All Referrals have undergone an initial screen, with cases escalated to the Serious Case Incident Forum (SCIF) as appropriate. Four hundred and seventy-one Referrals have been forwarded to relevant teams for review and appropriate action and have subsequently been closed.

The Trust's Learning from Deaths Forum was established in October 2023 and met on a quarterly basis. The remit of the Forum includes oversight of the Trust's Learning from Deaths Framework, MES Referrals, Prevention of Future Deaths Reports (Regulation 28), bereavement care and scoping out opportunities for the use of collective analysis of information and data to inform Mortality Reviews to provide early warning mechanisms.

From May 2022 a dedicated module has been in place on the All Wales Datix Cymru system. The module was currently populated manually by the Patient Safety Team following receipt of the MES letter.

Claire Appleton added that progress was being made incrementally in respect of learning from deaths, with several externally driven dependencies. There were several next steps being implemented which were comprehensively listed in the report.

Ceri Jackson raised a significant point regarding the potential presence of a high number of protected characteristics within the data on these deaths. Understanding the demographics and characteristics of those involved could offer crucial insights.

Claire Appleton highlighted a significant challenge in accurately capturing and analysing data related to protected characteristics within the current systems, particularly in the context of referrals from Medical Examiners.

Liam Williams highlighted the ongoing developments within the electronic Patient Care Record (EPCR) system, which offered promising advancements in capturing some protected characteristics data. Although the EPCR will not capture all protected characteristics, it represented a significant step forward from the current capabilities.

RESOLVED: The Committee discussed and approved the report and next steps as detailed in paragraph 34, highlighting any further assurance requirements.

49/24 CLINICAL AUDIT PLAN & ACTION TRACKER - Q1 (UPDATE) 2024/25

Duncan Roberston provided the Committee with an update and drew their attention to the following areas: The 2024-25 Clinical Audit Plan contained 12 audits covering a range of topics including clinical conditions, medicines, and compliance to documentation.

1. One has been completed and approved at the Clinical Intelligence and Assurance Group (CIAG).
2. Two were progressing as planned (one since been approved at the July CIAG)
3. Two 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.
4. Seven were yet to start, some were reliant on ePCR user interface changes being implemented, some were not due to start until Q2/Q3/Q4.

For the audit approved during Q1 (Clinical Frailty Scale Follow Up Audit) there were seven actions:

1. Five have been completed.

2. Two were off track and recovery action taken.

There were no specific comments related to the above topic. As this was Duncan's final QuEST Committee meeting, the Chair expressed gratitude for his contributions. Duncan Robertson appreciated the recognition, but it was important to note that his contributions represented the hard work of a larger team.

RESOLVED: The Committee noted the Q1 2024-25 Clinical Audit Plan and Action Tracker update.

50/24 SPOTLIGHT ON CLINICAL INDICATORS: HYPOGLYCAEMIA

Duncan Robertson provided an in depth update on the focus on hypoglycaemia as a Clinical Indicator (CI) for the Trust, highlighting the challenges and ongoing efforts to improve data accuracy and compliance with the care bundle. The key points were:

What we measure (criteria): The number of patients with a working diagnosis of Hypoglycaemia (Diabetic – low blood sugar) (*denominator).*

Data quality and reporting: An ePCR technical specification was created to enable reporting. Since the implementation of ePCR all CIs were reported on using 'raw' data inputted by clinicians (*no manual auditing prior to reporting*).

Improvements to date: A more accurate clinical picture of the care delivered, highlighted the variation between automated and audited data, helps inform future reporting and caveats and informs an improvement plan and changes to the ePCR User Interface.

Next steps to improvement:

1. A recent User Interface change included a 'nudge tool' to improve ePCR compliance for specific fields at point of ePCR closure.

2. Enable message prompts and quick access to non-compliant fields prior to closing ePCRs.

3. Continued engagement with Senior Paramedics to influence more direct clinical supervision during ride outs.

4. Complete the development of a 'Tenant Structure' to enable CIs to be reported at a range of levels (Trust wide, Health Board area, Locality, Team, Individual).

5. Clinical Improvement & Clinical Intelligence and Assurance teams meeting with Senior Paramedics to provide support, guidance and data to promote CI compliance.

6. A CI Performance Group has been established maintaining a focus on improvements and sharing best practice

Clinical Indicator Recovery Plan: Following the switch to ePCR, the way data is collected when with the patient has changed. There are theoretical advantages to the new process, however this has not yet been realised with the monthly results.

The Trust aims were to provide an efficient structure that enables 'always on' automatic reporting, enabling accurate and almost live data to be used for reporting at a variety of levels for all appropriate records.

Andy Swinburn highlighted the complexity of the challenges and the nuanced approach required to drive meaningful change. The complexity involved multiple factors, including human behaviour, data entry habits, and systemic challenges.

Following a query in terms of empowering clinicians, Duncan Robertson stressed the importance of empowering senior Paramedics by providing them with improved data and feedback mechanisms, with the goal of enabling individual clinicians to take ownership of their own data. A key focus was ensuring that all clinicians had access to relevant data.

The Committee noted it was clear there was a significant amount of work being undertaken, not just with this CI on hypoglycaemia, but across the other indicators that have been reviewed over the past several months in this Committee.

RESOLVED: The Committee noted the PowerPoint update for the Hypoglycaemia (Diabetic – low blood sugar) Clinical Indicator.

51/24 IMPACT OF THE CHANGES TO STROKE CATEGORISATION

Andy Swinburn presented the report explaining that in April 2023, the National Stroke guidelines were updated, and in December 2023 Health Inspectorate Wales (HIW) released its findings in relation to the review undertaken in relation to 'Patient flow, a journey through the stroke pathway'.

He explained that the recent change in clinical guidance regarding stroke treatment had been a significant development. The window of opportunity for administering thrombolysis, a critical treatment for stroke patients, had been extended from 4.5 hours to 12 hours, provided there was still clinical benefit in doing so. This change has had substantial implications for how stroke cases were categorised and responded to.

Previously, many stroke cases were categorised as Amber 2, often due to being outside the initial 4.5-hour window or because the onset time of stroke symptoms was unclear. However, with the extended window, almost all stroke cases now fell under the Amber 1 category, which prioritises them more highly for response. This reclassification represented a significant shift in the number of cases classified as Amber 1.

Modelling the impact of this change was challenging, particularly because the exact time of stroke onset was not consistently captured in the past. Despite these challenges, the implementation has gone well, supported by the stroke network, and was now in place across most regions, with one Health Board area still working to increase the availability of stroke physicians. There has been no significant decline in response times despite the increase in the number of cases classified as Amber 1.

Ceri Jackson queried if there was any update as to where the specialist stroke units would be located. Andy Swinburn commented that the exact locations of the future hyper-acute stroke units were still under discussion, with only one emergency department (ED) not yet accepting stroke patients. Despite this, all other receiving departments were currently equipped to handle stroke cases.

Andy Swinburn assured the Committee that the Trust was well prepared to adapt to the changes once the locations of the hyper-acute stroke units were finalised, ensuring that the transition was as smooth as possible for all involved. The Committee agreed it would be useful to receive an update at the Committee once the locations of the hyper-acute stroke units were finalised.

RESOLVED: The contents of this executive summary were accepted, and that assurance was gained that the Trust continued to work with the Welsh stroke networks in relation to the care provided to patients presenting with a potential stroke following the agreed UK guidelines and recommendations made by HIW.

52/24 AUDIT TRACKER 2.0 JUNE 2024 (Q1)

An update was received from Trish Mills 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. The number of external audit actions closed has nearly doubled, reflecting significant progress. Trish Mills acknowledged and thanked everyone involved for their hard work and support in maintaining the positive status of the audit tracker.

Clinical Audit (Internal Audit)

The Committee received the Clinical Audit Internal Audit Report, which gave a reasonable assurance opinion. Duncan Robertson explained that the Clinical Audit internal audit findings have provided the Trust with key insights that will help shape the detailed work needed to move forward. Osian Lloyd, Head of Internal Audit noted that the report benchmarked well against other Health Bodies and was a positive report.

Two actions were due to be closed in September, while three minor issues have already been resolved. The final action, which was tied to the development of a clinical plan as part of the broader Trust strategy, was targeted for completion by 31 March 2025. A workshop has already been conducted and will incorporate the importance of clinical audit into the overall clinical plan.

RESOLVED: The Committee

(1) Received and reviewed the Clinical Audit (Internal Audit) Report;

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

53/24 RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK (BAF)

Julie Boalch explained that the purpose of the report was to provide assurance in respect of the management of the Trust's principal risks, specifically the two risks that were relevant to Committee's remit for oversight.
Risks **223** (*the Trust's inability to reach patients in the community causing patient harm and death*) and **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*) scoring 25 remain unchanged because of sustained and extreme pressure across the Welsh NHS urgent and emergency care.

The risks were reviewed monthly and have already been updated for the next reporting cycle. These updated risks will be presented to the Audit and Risk Assurance Committee (ARAC) in September, followed by the Trust Board, and finally to this Committee in November with the most up to date position. However, as noted in the paper, early indications suggested that the risk scores were likely to remain unchanged.

The key point to note was that the risks presented in the BAF section remain unchanged from those shared at the May Board and the June ARAC meetings. This consistency was due to the scheduling and timing of the meetings, which has not allowed for any updates or changes to be reflected in the current documentation.

RESOLVED: The Committee noted the contents of the report.

54/24 POLICIES FOR APPROVAL/ADOPTION

The Management of Medical Devices Policy was presented by Julie Boalch for approval. The Committee were assured that an Equality Impact Assessment (EQIA) was conducted with no issues raised, and the policy has undergone Trust wide consultation.

RESOLVED: The Management of Medical Devices Policy was approved.

55/24 COMMITTEE TERMS OF REFERENCE AND ANNUAL REPORT 2023/24

The Committee Terms of References and Annual Report 2023/24 were received.

RESOLVED: The Committee Terms of Reference and the Annual Report 2023/24 were received.

56/24 COMMITTEE PRIORTIES AND CYCLE OF BUSINESS (CoB) MONITORING REPORT

An update on progress against the agreed CoB for was received. Trish Mills highlighted several key points from the report, focusing on how the cycle of business was managed.

On the Monitoring Report, the Committee's attention was drawn to the Annual Putting Things Right Report and the Annual Infection, Prevention and Control Reports which have been deferred to the Q3 meeting of the Committee.

RESOLVED: The Committee noted the update.

57/24 ANNUAL QUALITY REPORT 2023/24 AND DUTY OF QUALITY STANDARDS SELF-ASSESSMENT

Liam Williams acknowledged this was a consent item that has already been presented to the Trust Board. However, he formally acknowledged the excellent work done by the team in creating this report.

Bethan Evans added that it was clear an immense amount of work has been put into this report, especially given that it was the first time the Trust has produced one.

58/24 KEY MESSAGES FOR BOARD

The ongoing system pressures were having a significant impact on both patients in the community and those awaiting handover in ambulances. Today's discussions highlighted some stark performance data, underscoring that these challenges persisted.

The key message from this Committee remained clear: the system pressures were creating substantial difficulties for patient care and impacting staff well being.

59/24 REFLECTIONS & SUMMARY OF DECISIONS & ACTIONS

The quality of papers was 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 and new observers and contributors were welcomed to the meeting and offers of induction extended.

Although there were challenges across the system in terms of patient journey and patient outcome, the Trust was involved in the discussions about pathways and outcomes as a key partner.

Operations Report: Agreed to continue discussions offline about aligning with HB's.
Patient Story: This provided valuable insights, although it highlighted recurring issues.
Annual Safeguarding Report: for 2023/24 was approved.
Quality Strategy Implementation Plan: approved the development of the quality plan for 2025 to 2028 agreeing to extend the current quality strategy until April 2025.
Impact of Changes to Stroke Categorisation: noted that updates on the location of stroke units will be provided in due course.
Medical Devices Policy: The policy was approved without any further issues.

60/24 ANY OTHER BUSINESS

The Committee acknowledged this would be the last meeting of the Committee that Kevin Davies would attend, and he was thanked for his contributions over the years.

Date of Next meeting: 5 November 2024

Meeting concluded at 13:45