WELSH AMBULANCE SERVICES NHS TRUST

CONFIRMED MINUTES OF THE OPEN SESSION OF THE MEETING OF THE QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE HELD ON 31 OCTOBER 2023 VIA TEAMS

Meeting started at 09:30

PRESENT:

Bethan Evans	Non-Executive Director and Chair
Professor Kevin Davies	Vice Chair of the Board and Non-Executive Director (Chaired Meeting)
Paul Hollard	Non-Executive Director
Ceri Jackson	Non-Executive Director

IN ATTENDANCE:

Hugh Bennett	Assistant Director, Commissioning and Performance
Louise Colson	Head of Infection Prevention and Control
Leanne Hawker	Head of Patient Experience and Community Involvement
Wendy Herbert	Assistant Director of Quality and Nursing
Fflur Jones	Audit Wales
Alison Kelly	Business and Quality Manager
Mark Marsden	Trade Union Partner
Trish Mills	Board Secretary
Hugh Parry	Trade Union Partner (Left meeting during Item 55/23)
Steve Owen	Corporate Governance Officer
Alex Payne	Corporate Governance Manager
Felicity Quance	Deputy Head of Internal Audit, NWSSP
Duncan Robertson	Assistant Director of Clinical Development
Jonny Sammut	Director of Digital Services
Andy Swinburn	Director of Paramedicine
Sonia Thompson	Assistant Director of Operations EMS (Left meeting during Item 55/23)
Jonathan Turnbull-Ross	Assistant Director of Quality Governance
Liam Williams	Executive Director of Quality and Nursing

Apologies:

Kate Blackmore	Senior Quality Governance Lead
Lee Brooks	Executive Director of Operations

Julie Boalch	Head of Risk/Deputy Board Secretary
Ian James	Trade Union Partner
Mark Jones	Consultant Mental Health Nurse
Brendan Lloyd	Executive Medical Director Executive
Osian Lloyd	Head of Internal Audit
Rachel Marsh	Director of Strategy, Planning and Performance
Caroline Miftari	Head of Quality Assurance

49/23 PROCEDURAL MATTERS

The meeting was chaired by Professor Kevin Davies with Bethan Evans in attendance.

The Chair extended a warm welcome to everyone advising that the meeting was being recorded. Apologies were noted from Kate Blackmore, Lee Brooks, Julie Boalch, Ina James, Mark Jones, Brendan Lloyd, Osian Lloyd, Rachel Marsh, and Caroline Miftari.

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 10 August 2023 were confirmed as a correct record subject to amending the job title of Andrew Clement to Visual Design Specialist.

Action Log

The action log and the Committee Highlight AAA report from the last Quest meeting was considered:

Action 16/23: Agreed that a meeting be coordinated with the Quest Committee and the People and Culture Committee to discuss the situation regarding the challenges faced by the Putting Things Right (PTR) Team. Liam Williams advised, further to the update given at the last Quest Committee meeting that PTR investment had been approved by the Executive Leadership Team, also noting that the Organisational Change Process (OCP) was nearing completion. The Committee were assured that the risk of not currently having the full establishment in place was being managed. Action Closed.

Action 34/23: PTR reports, Future reports to indicate whether any external issues and factors that have contributed to delays. Liam Williams advised Members that the report on the agenda contained the relevant information. Going forward, there would be more thematic analysis with future reports continuing to develop. Action closed.

Action 34/23a: Spotlight on Clinical Indicators. As work developed beyond the five indicators currently reported on, ongoing updates would be provided. A presentation on Return of Spontaneous Circulation (ROSC) rates was on the agenda. Action closed.

Action 38/23: Internal Audit tracker, Update on how the Trust was dealing with historical actions. Details were included in the report on the agenda. Action closed.

Action 43/23: Policy report, Details of the current number of policies outside their review date be captured within the alert section of the AAA report. Information included in the report on the agenda. Action Closed.

Committee AAA report dated 10 August 2023

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 10 August 2023. Attention was drawn to the two items in the alert section: risks around patient safety and the PTR response times.

RESOLVED: That

(1) Apologies were recorded for Kate Blackmore, Lee Brooks, Julie Boalch, Mark Jones, Brendan Lloyd, Osian Lloyd, Rachel Marsh and Caroline Miftari.

(2) The Minutes of the Open meeting held on 10 August 2023 were confirmed as a correct record subject to amending the job title of Andrew Clement to Visual Design Specialist; and

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

50/23 OPERATIONS DIRECTORATE QUARTERLY REPORT – 2022-23 Q2

Sonia Thompson introduced the Operations Quarterly Report as read, and drew attention to the following pertinent elements within it:

Progress in completing the actions from the Manchester Arena Inquiry continued at pace. There were 71 recommendations which were relevant to the Trust; nine had been completed with 17 being assessed as they required national guidance. Monitoring and completing of the remaining actions were ongoing. Members noted that Commanders in the Trust were mandated to undertake Marauding Terrorist Attack (MTA) training.

The EMS Coordination (EMSC) Culture Programme has commenced with meetings chaired by the Director of People and Culture. Senior Leaders in the EMSC team have met with Trade Union Partners to discuss culture, behaviours, and concerns to design an action plan for improvement. This has been a great opportunity for staff to share their experiences of working in EMSC.

Following the Sexism and Sexual Safety at Work Survey and WAST Voices, action plans have been implemented across the four territories to raise awareness and to positively influence behaviour and culture within the Trust.

In terms of Ambulance Care, the system has been improved which now prioritises eligible patients over non-eligible patients transport requests.

A pilot in the Clinical Service Desk has been implemented to engage with South Wales Police looking to broaden the Remote Clinical Support to Police when they are waiting with patients for an ambulance response.

Comments:

Following a query in terms of the Trust's preparation for Winter regarding resources, Sonia Thompson explained that the Trust would be implementing a whole system escalation process which will include exercises with partners in November to test this, with any lessons learned being implemented. Members also acknowledged the ongoing work on the national whole system escalation framework, emphasising the importance of gaining a comprehensive system-level understanding of clinical risk and enhancing the management of the population's needs.

Members were keen to understand the EMS CSD reconfiguration following the outcome of the new Demand and Capacity review which was currently underway. It was understood the final draft would be ready for the Quest meeting in February 2024 and agreed that Hugh Bennett would arrange for it to be included at the meeting.

The Committee discussed and welcomed the MTA training being undertaken by Commanders.

In respect of the Non-Emergency Patient Transport Services (NEPTS) Eligibility matrix, the Committee requested an update to see if there had been any push back from Local authorities and Welsh Government in the way the matrix was being applied and whether people had been disadvantaged due to the adjusted service criteria. Liam Wiliams added that people would be disadvantaged if they did not meet the eligibility criteria.

RESOLVED: That the report was received.

51/23 EMS CLINICAL CONTACT CENTRE HEALTH INSPECTORATE WALES UPDATE

Sonia Thompson explained that the paper provided a summary and overview of the progress made on the actions agreed in response to the Health Inspectorate Wales (HIW) EMS Clinical Contact Centre (CCC) Patient Safety Review.

There were two actions which remained open, and progress was underway through workstreams that were incorporated in the IMTP. While there have been delays, the Committee can be assured that management remains focussed on full conclusion of all recommendations and continue to monitor progress. Details of the outstanding actions were given below:

Action 21.1: Complete the North Wales EMS CCC estate strategy and identify opportunities for improvements. A project board has been set up with project

support allocated with all interested parties including TU partners invited to the inaugural meeting with a view to develop the Organisational Change Process (OCP) of relocation staff from Bryn Tirion to alternative site(s). The ambition is to have the majority of this in place by the end of this financial year.

Action 12.1 Continue with the work of the Computer Aided Despatch (CAD) Phase 3 project to realign workloads within the EMSCCC for more efficient operation. As a result of securing updated data from ORH in relation to EMSC activity, it has been decided to reinvigorate and review the original EMT paper regarding resources and reconfiguration of work including boundaries and workloads. Initial conversations with TU partners have taken place and a proposed structure will go through operational governance processes over the forthcoming months.

RESOLVED: The Committee:

(1) Noted the update provided for the status update of the actions detailed in this paper and in the appended tracker;

(2) Confirmed its assurance that whilst actions 12.1 and 21.1 are overdue, progress is underway in structured workstreams; and

(3) Agreed that further update be provided to Committee either on completion, or if there are further impediments to completion.

52/23 PATIENT STORY

Prior to hearing the story Members were reminded of the distress and anxiety and the impact on families these patient stories caused. Liam Williams added that the narrative and context of the story was seen throughout the agenda.

Steven Parsons recounted his distressing experience of being unable to get an ambulance for his grandfather, who he thought was suffering a stroke. On this particular day, Steven's grandfather called him asked to come over the to the house as he wasn't feeling well. Initially Steven called 111 that night and was told by a Doctor that as long as his grandfather ok he could wait and see the GP in the morning. A short time later, Steven's grandfather collapsed, and he called 999 but was told there were no ambulances available at that time because of the system pressures. Believing it was a stroke, Steven decided to transport his grandfather to the hospital himself. Upon arrival Steven began to assist his grandfather and on arrival at reception his grandfather collapsed. His grandfather was rushed to A&E and Steven was advised that he was in cardiac arrest. Fortunately, he was resuscitated in the Emergency Department.

Whilst the Trust was operating under extremely high demand on the service at the time of Steven's call, the experience that Steven and his family had underlined the trauma families experience when there are no resources to send in response to their call. Steven raised a formal concern with the Trust with the incident being formally investigated and a written explanation of the findings was sent to Steven.

Whilst he understood that the NHS was understaffed and overworked, Steven emphasised that the ordeal his grandfather and his family endured should not have happened and expressed a desire to share his experience to help others understand that impact. The Patient Experience and Community Involvement (PECI) team were working with Steven and his family addressing some of the issues that arose, and Jason Killens has had an opportunity to meet with Steven and his sister as part of the Trust's duty of candour and putting things right process.

Comments

Leanne Hawker added that Patient Experience and Community Involvement (PECI) team were working with Steven and his family addressing some of the issues that arose, and Jason Killens has had an opportunity to meet with Steven and his sister as part of the Trust's Duty of Candour and Putting Things Right process. It was at this meeting that Steven expressed his desire to share this experience to highlight the effects of handover delays on patients and their families.

Leanne Hawker informed Members that this incident was a consistent theme emerging from the system pressures on Health Boards. Wendy Herbert added that Steven wanted the system to recognise the harm in the community because of the pressure. Of note and after this story, Steven's grandfather has required to access 999 on several occasions with more positive outcomes. It was also noted this story will be shared at Trust Board in November.

Liam Williams assured Members that managing the clinical risk was a key area of focus across all the health boards with a recognition that harm was occurring across the system. He added it was important to provide the necessary support to families following events of this nature when their needs have not been met.

Wendy Herbert raised the issue of families making the best decision under these circumstances, i.e. taking the patient to hospital or not. The emotional impact on families was extremely difficult to manage. She added that it was also very difficult and challenging to explain to loved ones that an ambulance was not available due to the pressures on the system.

Liam Williams advised the Committee that these stories were shared extensively with Health Boards who were able to use them as required.

Following a query as to why Steven was on the phone to 111 for three hours, Liam Williams informed Committee that this incident occurred when the 111 and 999 services were under a level of pressure hitherto not experienced. Call waits were extended beyond acceptable levels. He assured Members that the Trust's ability to escalate 111 calls to 999 calls was extremely effective.

With reference to the urgent and emergency care review in progress by Audit Wales (AW)it was asked whether AW received such stories to inform their work and understand the full impact of system pressures. Fflur Jones explained that stories like

this would be considered when completing part two of the review.

It was highlighted that the Operational Delivery Unit have informed the Stroke Association that they were conducting an Audit on self-presentation to emergency departments. Liam Williams agreed this would be reported through to Quest if there was a material consideration.

The Committee recognised that the issues raised in this story were constantly discussed at this meeting and the Board. Merged into these discussions was the constant reference to the Trust's two highest risks. Risk 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) both rated at 25. The Committee also acknowledged the avoidable harm to patients that continued as a result of the system pressures.

Members, whilst acknowledging that everything possible was being done to improve the system suggested if anything different could be done, for example implement something jointly with health boards.

RESOLVED: That the Patient story was noted.

53/23 PUTTING THINGS RIGHT (PTR) REPORT QUARTER 2, JULY – SEPTEMBER 2023

Wendy Herbert presented the report and drew the Committee's attention the following areas:

There continued to be a high level of risk of harm to our patients in the community and patients delayed outside of emergency departments.

There was a sustained increase in the number of concerns, and a backlog remains at the processing stage for September 2023.

A continuing high volume of incidents were being reviewed at the Serious Case Incident Forum (SCIF). During this reporting period there were 16 SCIF meetings held, with 73 incidents discussed. 10 incidents have been reported as Nationally Reportable Incidents (NRIs) to the NHS Wales Executive, and 39 incidents were referred under the Joint Investigation Framework to the respective Health Boards. It was noted that no incidents linked directly to the refusal of immediate release requests were identified.

The Trust received three Regulation 28 reports (reports to prevent future deaths) during this period. The number of approaches received from Coroners has increased during the reporting period. The complexity of the requests being received continues to be high, resulting in more statements per approach, together with increased legal complexity, requiring extensive disclosure, attendance at Pre-Inquest Hearings and multiple witnesses, Interested Parties and day inquest hearings

The Trust continued to receive a constant number of concerns with 253 received during this reporting period. The PTR Organisational Change Process (OCP) commenced on 25 September 2023 with the aim of increasing staff resource to improve compliance and meet the current demand.

During this period a total of 1,000 patient safety incidents were reported; 386 in July, 329 in August, and 285 in September. It must be noted that the harm grading may change subject to the outcome of any investigation.

In terms of long waits, 186 of the patients waiting over 12 hours had experienced a fall, with the longest waiting patient being 39 hours and 59 minutes.

The Patient Safety Team were working with tissue viability colleagues nationally to explore the contribution from the Trust in providing data and information to inform investigations of patients who have developed pressure damage in the back of ambulances.

There has been an increase in concerns regarding NEPTS activity regarding cancellation of some transport due to a change in the transport eligibility criteria, particularly in the Aneurin Bevan University Health Board area.

The Trust continues to learn lessons from the investigations it conducts and details of these were shared through informative notices across the organisation for the benefit of colleagues.

Comments:

Liam Williams referred to the compliance table within the report which illustrated that the Trust, whilst not fully compliant with the timelines in responding to families, was complying with the Duty of Candour.

Members expressed their concern with the increase in the number of concerns regarding NEPTS, particularly in the South East. Wendy Herbert advised that the Trust was monitoring activity in the North and Central and West, as there were fewer concerns in those areas, and to see what could be done differently to improve the situation.

The Committee raised concern in respect of the upward trend in the number of coroner's requests for information particularly in the North Wall area. Wendy Herbert assured Members that the Trust was engaging with the coroner on initiatives in place to address this trend.

The Committee wished to understand the detail behind one particular patient who had waited almost 40 hours for an ambulance response. It was agreed that context around this would be provided in the next update report.

Members discussed the levels of harm to patients, and it was noted that following investigation into a particular case the level of harm may be readjusted from its initial

assessment. Liam Williams informed Members that the SCIF process initially identified the severity of harm.

The Committee sought clarity on when the timelines to responding to concerns would start to improve. Wendy Herbert advised that part of the OCP would see the additional appointments of senior clinical leadership and administrators, and it was anticipated by January 2024 these posts would be filled. Liam Williams added that once these were in place it would be possible to consider a performance improvement plan, and the associated activity would be fed back to the Committee. . He added that further efficiencies will be made through the appropriate digitisation of administration.

The Committee expressed concern in terms of the risk to patients with pressure relieving devices in temporary environments and were keen to see evidence going forward. Liam Williams explained that when any deterioration occurs while the patient was awaiting hospital transfer, it was the Health Board's responsibility.

Andy Swinburn assured the Committee that the pressure relieving mattresses were being considered as a wider means to support older more frail patients, and not as a means to normalise handover. If the Trust went ahead with this mitigation, roll out would be part of a package of learning and not just a simple 'issue and forget' approach.

RESOLVED: The Committee received the report.

53/23 QUALITY IMPACT ASESSMENTS

Liam Williams explained that Quality Impact Assessments (QIA) have been developed as part of a revised process to ensure that the Trust was able to meet the Welsh Government requirement to maximise financial efficiency opportunities. He then gave an overview of the governance route the QIA's took in order to guarantee the correct scrutiny and monitoring. During the scrutiny process, if there was a need the QIA would be escalated to the Board, especially if there was any reputational impact.

The following QIAs were presented to the Committee who noted that the Executive Leadership Team (ELT) would be reviewing them at its next meeting.

Financial Savings – Non-Emergency Patient Transport Service (NEPTS) Capacity Management Plan

This QIA was undertaken to implement a revised approach to the application of the Non-Emergency Patient Transport Service (NEPTS) eligibility criteria and a revised Capacity Management Plan.

Financial Savings – Mid and West Wales Fire and Rescue Services

This QIA was undertaken for the decommissioning of Mid and West Wales Fire and Rescue Services (M&WWF&RS) support to the Welsh Ambulance Services NHS Trust (WAST) emergency responses.

Comments:

Clarity was sought on the actual financial savings compared to the level of risk. Liam Williams explained the report to Committee focused on the quality and clinical risk while the report to ELT contained the financial detail. Going forward this detail would be included in future QIA reports for the Committee.

Members queried that if there was a reputational risk whether the Board would be made aware, particularly with the Mid and West Wales Fire and Rescue service. Liam Wiliams advised that any high level of reputational risk, would be escalated to the Board if identified at ELT.

Members sought assurance that the ELT considered the Service change in respect of the changes to the eligibility criteria particularly from a disability perspective which would affect patient mobility. Liam Williams assured the Committee that dependant on the person's disability, it was likely to be under the eligibility criteria. However, in cases where the patient is not eligible, the Commissioners would need to be advised as the Trust was servicing a contracted requirement.

Trish Mills advised that work was ongoing to develop an integrated assessment signposting document which will go to the Audit Committee when it's finalised, which will bring together all the EQIA and QIA's in one place.

RESOLVED: That the Committee:

(1) Noted the Non-Emergency Patient Transport Service (NEPTS) Capacity Management Plan QIA and the approval by WAST Executive Leadership Team to implement the commissioned NEPTS eligibility criteria; and

(2) Noted the contents of the Mid and West Wales Fire and Rescue Services (M&WWF&RS) QIA and the Executive Leadership Team decision to approve the decommissioning of M&WWF&RS.

54/23 SPOTLIGHT ON CLINICAL INDICATORS - RETURN OF SPONTANEOUS CIRCULATION (ROSC) RATES

Duncan Robertson gave a presentation on the Return of Spontaneous Circulation in which he pointed out the following details:

The Trust measures the numbers of cardiac arrest cases which include a documented resuscitation attempt and that includes relevant sections completed on the ePCR or where the diagnostic code for Cardiac Arrest is used. These cases were measured at hospital, not in the community.

A deep dive audit was carried out last year as with all the clinical indicators and the ePCR narrative was reviewed where the cardiac arrest was documented but not complete enough for the relevant sections. Following this review a clinical indicator dashboard was introduced and the ROSC rate trend was starting to move upwards. There were roughly 250 to 300 attempted resuscitations per month.

Notable improvements included the implementation of CHARU (Cymru High Acuity Response Unit), the introduction and ongoing enhancements of ePCR, increased participation in Good Sam (with a record of over 10,000 sign-ins across Wales in a single Friday evening), Mandatory in Service Training (MIST), an expanded deployment of public access defibrillators (now exceeding 8,000), and a series of public messaging and events.

Comments:

Following a query in terms of how data was produced, Duncan explained that there several methods used and these were reviewed through the clinical intelligence and assurance group. The Trust, going forward will be able to capture data on the patients who leave hospital following a ROSC, which will enable positive feedback to be shared with all those involved in the ROSC.

Duncan Robertson commented that whilst the data did not explicitly indicate that CHARU was directly involved in the increase of ROSC rates, however it has played a key part in managing cardiac arrests. Andy Swinburn added that work was underway to look at the utilisation of CHARU against the code set determined.

RESOLVED: The Committee noted the update.

55/23 MONTHLY INTEGRATED QUALITY PERFORMANCE REPORT

Hugh Bennett updated the Committee on the MIQPR and drew their attention to the following points:

In terms of system pressure, this continued to be on the rise, hours lost to handover at hospitals was just under 20,000 in September with December likely to be in the region of 25,000.

Continued achievement of the clinical call back time target for the highest priority 111 Wales calls, while the priority 2 and 3 call back times also achieved the 90% performance target in July.

999 call answering continued to be challenging, in the second half of the calendar year the 95th percentile has began to worsen; in August 2023 it was 31 seconds with a small improvement to 28 seconds in September 2023.

The increase in Clinical Support Desk capacity has meant that the Trust was able to increase its consult and close rate through last year, however, it has declined in recent months, achieving 12.6% in September 2023, with an increased ambition of 17% in

2023/24 (quarter 4). Action plans were in place within the service, but there were some risks emerging in terms of delivery.

The Wales Immediate Release figures for September 2023 were: Red 156 accepted and 5 declined; and Amber 1, 156 accepted and 291 declined.

The return to spontaneous circulation (ROSC) rate dropped to 22.1% in September 2023 compared to 23.8% in August 2023.

Response Abstractions: EMS abstraction levels decreased to 33.59% in September 2023, but remained above the 30% benchmark. EMS Response sickness abstractions stood at 9.5% (benchmark 5.99%).

Trust sickness absence: the Trust's overall sickness percentage was 9.22% in August 2023, a deterioration from the 8.23% recorded in July 2023. Actions within the Integrated Medium Term Plan (IMTP) concentrate on staff well-being with an aim to start to reduce this level.

Staff training and PADRs: PADR rates did not achieve the 85% target in September 2023 (70%), while compliance for Statutory and Mandatory training increased slightly to 76.21%.

Comments:

The Committee queried if there was any data regarding call to door times for strokes. Andy Swinburn informed Members that the information would be in the MIQPR going to Trust Board in November.

Following a query into the outcomes of patients with strokes or acute coronary syndrome, Andy Swinburn advised that the data collection had moved from paper to ePCR. The ePCR now allows users to identify any areas where there is missing information in the respective care bundle. Further information regarding this was contained in the update on Clinical Indicators item.

RESOLVED: To Consider the August/September 2023 Integrated Quality and Performance Report was considered which provided sufficient assurance for the Committee.

56/23 LEARNING FROM MORTALITY REVIEWS UPDATE

Wendy Herbert presented the report to the Committee and highlighted several areas:

The Trust has adopted the NHS Wales Learning from Mortality Reviews Framework (the Framework) (2022) which outlines the new approach in NHS Wales to undertaking Mortality Reviews.

The Government in England confirmed in September 2023 that it was launching a statutory inquiry into the Countess of Chester Hospitals NHS Foundation Trust, with the Health Secretary stating that the inquiry will 'examine the cases' wider circumstances', including 'the conduct of the wider NHS and its regulators'.

The Medical Examiner Service is hosted by NHS Wales Shared Services Partnership and will provide independent scrutiny of all deaths in Wales that are not investigated by the Coroner. One of the key functions carried out by the Medical Examiner was to provide bereaved families with greater transparency and opportunities to raise concerns. The Medical Examiner Service will be a statutory function by April 2024. Currently the focus was on secondary care and the Trust was working with the Medical Examiner to bring this service into Communities. The concerns raised by families to the Medical Examiner included; enhanced waiting times for an ambulance and handover of care delays and poignantly following today's patient story, families taking sick relatives to hospital by car.

The Trust is part of the National Mortality review Group which is hosted by NHS Wales Executive. One of the group's responsibilities is the development and updating of the Duty of Candour arrangements.

Members were advised of the next steps in terms of the Trust's learning from deaths which included the establishment of a learning from deaths forum. Part of the learning will also look at Speaking up Safely reporting,

Comments:

Liam Williams informed the Committee that as part of the CEO roadshows next week, there will be a presentation that will be highlighting the Trust's desire to create a culture in an environment where people always feel able to raise concerns.

It was queried the how the Medical Examiner became involved. Wendy Herbert advised that when the Medical Examiner Service was fully functional it will review every single death apart from those being considered by the Coroner.

Duncan Robertson explained that the Medical Examiners will, through ePCRs be able to extract the necessary clinical data; however, it may not necessarily prevent requests for additional data. The Trust can work with them to make access more self-serve rather than the Trust providing them with the data.

The Committee raised their concerns that the workload for staff from the Trust required to assist the Medical Examiner could be significant going forward.

RESOLVED: The Committee discussed the Forward Plan for Mortality Reviews and outputs from the Medical Examiner Service and highlighted any further assurance requirements.

57/23 DUTY OF QUALITY/DUTY OF CANDOUR IMPLEMENTATION

Liam Williams updated the Committee on progress.

The appointment of the Senior Quality Governance Lead and bespoke implementation plan has increased capability and capacity to support full implementation. The current impact of this has been a review of arrangements which has led to some previously reported good progress being revised on the current WG report.

A Highlight Report is submitted monthly by WAST to Welsh Government using a centralised 'Road Map' to track progress against deliverables. The Highlight Report for August 2023 (submitted in September 2023) RAG rated progress as Yellow; this is defined as 'organisation has identified that delivery is at risk but manageable or behind schedule but within tolerance'. The Road Map includes detailed requirements of the legislation, and it is to be expected that the Highlight Report will continue to be expanded as additional deliverables approach milestones.

RESOLVED: The Committee noted the report and took assurance on the progress made to deliver the Duty of Quality and Duty of Candour.

58/23 MENTAL HEALTH AND DEMENTIA ANNUAL REPORT

Wendy Herbert asked the Committee to note the commendable efforts of the Mental Health and Dementia Teams, highlighting their significant and diverse contributions to the well-being of our service users, as highlighted in the comprehensive and impactful annual report.

It was emphasised that both teams received separate funding from the Welsh Government, underlining the importance of securing this funding for the 2024/25 period, given the significant positive impact they have on patients.

The education and training packages that the team have provided has been delivered on a national basis and a number of different platforms. The training has been tailored to respond to any cultural changes and meet the needs of patients. This training was key in delivering an excellent service for patients.

It was interesting to see the changing and emerging themes and trends post pandemic and what the team were responding to and/or experiencing.

It was clearly evidenced throughout the annual report, the importance of working with stakeholders such as Welsh Government and Health Boards, and more importantly service users.

There were several quality improvement initiatives the teams were considering which will form part of the three year Dementia Plan.

The Committee should acknowledge the significant amount of work undertaken by the team and the considerable positive impact in the more vulnerable parts of the population. This work was endorsed by Liam Williams who added that the Trust was not a mental health provider but a good interface for those people in a mental health crisis. In terms of the 111, press 2 service (callers are transferred to a dedicated member of the mental health team), he added that work was ongoing to maintain this health service provision.

Comments

The Committee acknowledged the comprehensive report and commended the team for their continued value in the work they do, albeit under challenging circumstances. It was noted that the report would be presented to the Board appended to the Committee highlight report for their information.

The Committee discussed the sustainability of funding for these two teams underlying the importance of securing funding for 2024/25, given the positive impact they have on patients. It was further discussed whether funding could be sourced from the Trust's Charity, should public sector funding not be given.

RESOLVED: The Committee noted developments of the Mental Health & Dementia Team and progress to date.

59/23 PATIENT EXPERIENCE AND COMMUNITY INVOLVEMENT (PECI) BI- ANNUAL (APRIL – SEPTEMBER 2023) REPORT

Leanne Hawker presented the report which illustrated the engagement with the public noting that the report focused on the experience of patients. In terms of key points from the report they were highlighted as follows:

There was a need to increase the volume of patient experience returns and work to improve this included improved integration through the Civica (a company that provides public sector software) patient experience system. This would enable patients to receive surveys as opposed to patients looking for them through SMS text messaging. Another key feature allows for patients to directly record and upload stories themselves onto the system

The Learning Disabilities Ministerial Advisory Group continues to make key progress to meet the needs of people with learning disabilities.

The overall experience of Ambulance Care (formerly NEPTS) from patients was reported as very good.

The PECI team continued to work with Llais (Citizens Voice Body), and share good practice across the sector and grow the people and community network, who will be involved in the refresh of the national Patient Reported Experience Measures (PREM).

Since the introduction of the Civica patient experience system, there have been some

information governance issues in relation to surveying patients who call 999. Further information and feedback is awaited from the Director of Legal and Risk. The Trust's information governance team have also escalated the issues. Formal guidance from the ambulance information governance group has advised the Trust to cease surveys until such time their guidance has been issued. The Trust continues to seek a viable solution to this complex issue.

Comments:

The Committee welcomed the report and queried if there were further opportunities the team could engage in to acquire further feedback from patients. Leanne explained that the Bevan Commission has commenced activities to gather insight form the public by hosting workshops which has been fully supported by the PECI team. The feedback has been very interesting with the public desire for radical changes in the NHS. Liam Williams added there was a need, as the proportion of feedback was relatively small, to establish a greater understanding of people's experiences by opening up the gateway to a broader population and getting a greater understanding of their experiences particularly when experiences were poor.

In terms of Information Governance, the Committee noted the significant challenges and safeguarding issues since the introduction of the Civica patient experience system. Leanne Hawker explained that the issues concerned the surveying of 999 calls being made by patients. The Trust's Information Governance Team was awaiting further clarification from the Director of Legal and Risk at the Welsh Risk Pool. She added that the Trust was aware of an England NE Ambulance service who were surveying patients through the use of Data Protection Impact Assessments and have since been strongly advised by the Ambulance Information Governance Group to cease this process. The Trust have also been advised to stop these surveys until formal guidance on how to conduct them has been received. There were some sensitivities around who was actually being surveyed and once the issue has been resolved, the Trust can continue to survey patients ensuring that all safeguarding procedures would be adhered to. It was agreed that the Committee would be updated once further clarity on the implications for the Trust was known.

RESOLVED: The Committee

(1) Noted the activities to date and acknowledged that PECI Reports will be shared publicly through the Trust's People & Community Network; and

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

60/23 CLINICAL AUDIT PLAN 2023-2024 MONITORING REPORT - QUARTER 2

Duncan Robertson gave an update on the clinical audit plan advising there were no issues to report to Committee.

RESOLVED: The update was noted.

61/23 INFORMATION GOVERNANCE REPORT

Jonny Sammut in presenting the report drew out the following highlights for the Committee's attention:

Data Protection breaches, there had been 28 Datix incidents recorded in August, and this has been reduced in September and October

An analysis had recently been conducted on password which has revealed that around 1,000 were considered to be fairly weak, work was ongoing to improve this.

Compliance with the Freedom of Information Act remains challenging, recording rates of 41% in August and 45% in September against a target of 90%. However, a review of the process and digital support was expected to lead to improvements in compliance. It should also be noted that some of the requests were becoming more complex in nature.

In terms of mandatory training, this was falling short of compliance on Data Protection and Information Governance. Work was ongoing in the background to communicate to staff that this training where applicable required completion.

A simulated phishing attack had recently been carried out in the Trust. The results, having being reviewed, illustrated there were some users who required further education in this area to avoid answering phishing e mails.

Comments:

Trish Mills commented that as mentioned in the update the Trust was looking to automate the FOI process to increase efficiency.

RESOLVED: The update was noted.

62/23 RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK REPORT

Trish Mills reminded the Committee of the two highest scoring risks- 223 (the Trust's inability to reach patients in the community causing patient harm and death) and 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).

Having listened to the patient experience, the report from the PTR team and the information in the MIQPR, these risks clearly were to remain at a score of 25.

The Trust Board, at its meeting in November will be receiving a revised paper around the actions to mitigate avoidable harm with a refresh on some of the narrative in these two highest scoring risks particularly around the context elements.

Members were assured that the two risks, whilst not moving in score, were reviewed regularly and discussed at many of the Board's Committees.

Comments

Liam Williams commented that these two risks were dynamically updated through several Committees and through to the Board following a robust governance process. He added that the risks had and continue to be escalated to Welsh Government.

RESOLVED: The contents of the report were noted.

63/23 POLICIES FOR APPROVAL/ADOPTION

The following policies were presented to the Committee for their adoption/approval:

The All-Wales Aseptic Non-Touch Technique Policy was adopted.

Trish Mills added there will be a chairs action to approve the Infection Prevention and Control policy plus another policy.

Medicines Management Policy – Andy Swinburn advised there was nothing specific to draw out and it was approved.

Information Security Policy - Jonny Sammut explained there was nothing of substantial note to be drawn out, subject to clarification on the hyperlinks at paragraph 7.10 the policy was approved.

RESOLVED:

(1) The Aseptic Non-Touch Technique Policy was adopted; and

(2) The Medicines Management Policy and Information Governance Policy (subject to the clarification stated) were approved.

64/23 AUDIT TRACKER UPDATE

Trish Mills gave an update on the revised Audit tracker explaining there had been some good engagement with Internal Audit and Audit Wales, advising the Committee that an audit process handbook had been presented at the last Audit Committee meeting.

Overall, of all the audit recommendations about 30% in this cycle have been closed, with a higher proportion of closed items for this Committee.

The report was continually maturing and the Committee were advised that work was underway with Digital Health and Care Wales (DHCW) to find a SharePoint solution to improve overall reporting.

There was also a focus now to close off the more historical audit actions particularly those from 2021/22, with two which require further work to be closed off.

An update was also given on the Audit Wales actions which included the Quality Governance review and the Structured Assessment with four of the actions closed.

RESOLVED: The Committee:

(1) Noted the management actions to address recommendations in the Tracker, noting any revised dates for actions (in blue);

(2) Noted the proposal for closer scrutiny of the impact of actions in response to audit recommendations; and

(3) Noted that the Records Management and Senior Paramedic internal audits are nearing completion and will be presented to the next meeting.

65/23 COMMITTEE PRIORITIES AND CYCLE OF BUSINESS MONITORING REPORT

The report was presented for information.

RESOLVED: The Committee noted the report.

66/23 PATIENT STORY UPDATES

The report was presented for noting.

RESOLVED: The update was noted.

67/23 KEY MESSAGES FOR BOARD

Trish Mills would draft the update which will be presented to the Board via the Committee's AAA highlight report.

68/23 REFLECTIONS & SUMMARY OF DECISIONS & ACTIONS

The Chair reflected it was quite remarkable with the size of the agenda that the meeting only ran over by 23 Minutes.

69/23 ANY OTHER BUSINESS

There was no other business.

Date of Next meeting: 8 February 2024

Meeting concluded at 13:23