CONFIRMED MINUTES OF THE CLOSED MEETING OF THE WELSH AMBULANCE SERVICES NHS TRUST BOARD, HELD onTHURSDAY 24 MARCH 2016, atDYFED-POWYS POLICE HEADQUARTERS, LLANGUNNOR, CARMARTHEN, SA31 2PF

BOARD MEMBERS PRESENT:

Mick Giannasi	Chairman of the Board
Tracy Myhill	Chief Executive
Claire Bevan	Director of Quality, Safety and Patient Experience
Emrys Davies	Non Executive Director (part)
Hannah Evans	Director of Planning and Performance (Interim)
Pam Hall	Non Executive Director (Via Webex)
Estelle Hitchon	Director of Partnerships and Engagement
Richard Lee	Director of Operations (Interim)
Dr Brendan Lloyd	Medical Director
James Mycroft	Non Executive Director
Patsy Roseblade	Director of Finance and ICT
David Scott	Non Executive Director
Claire Vaughan	Director of Workforce and Organisational Development (OD)
Martin Woodford	Non Executive Director and Vice Chair

TRUST BOARD REPRESENTATIVES:

Trish Gaskell	Claims Manager/Solicitor (Via Webex)
Bleddyn Roberts	Staff Side Representative (Via Webex)
Steve Owen	Corporate Governance Officer

APOLOGIES

Keith Cox	Board Secretary
Professor Kevin Davies	Non Executive Director

OBSERVER

Paul Hollard	WAST Non Executive Director designate

10/16 RESOLUTION TO MEET IN CLOSED SESSION

Representatives of the press and other members of the public were excluded from the meeting having regard to the confidential nature of the business to be transacted in accordance with the requirements of Section 1(2) of the Public Bodies (Admissions to Meetings) Act 1960.

11/16 PROCEDURAL MATTERS

The Chairman welcomed all to the meeting and reminded Members that the meeting was being audio recorded.

RESOLVED: That the standing declaration of Mr Emrys Davies being a retired member of UNITE be noted.

12/16 QUALITY REPORT - NHS WALES WELSH AMBULANCE SERVICES NHS TRUST PRE HOSPITAL CARE

The Director of Quality, Safety and Patient Experience presented the report as read advising Members that the report related to the six strategic aims of the Trust, with a key focus on delivering the best possible patient outcomes and experiences.

Members' attention was drawn to the correlation between the increased surge on the number of Serious Adverse Incidents (SAI) being reported and the significant increase in escalation levels across all the Health Boards. The Director of Quality, Safety and Patient Experience highlighted the following areas within the report for the Board's attention:

1) Handover delays at hospitals
2) SAI related to handover delays
3) Patient and staff experience and dignity related issues

The Director of Quality, Safety and Patient Experience reported that the month of February 2016 had seen an increase, from the same reporting period of last year,in the number of SAI being reported. Furthermore, the Trust recognised the challenges being faced by the Trust in responding to patients in the community with special regard to those who had fallen and in particular the elderly frail.

The Chairman asked the Board to acknowledge the quality of work undertaken by the Director of Quality, Safety and Patient Experience and her team in producing the report and asked for Members comments in relation to it:

1) An accuracy issue was raised in relation to the table on page eight and the Director of Quality, Safety and Patient Experience confirmed this would be rectified following the meeting
2) It was reported by the Medical Director that following detailed scrutiny, there was no evidence that suggested a correlation between the increase in SAI and the new clinical response model
3) The Director of Quality, Safety and Patient Experience commented that there was a real opportunity for the Trust to combine its learning with other Health Boards in collectively resolving the issues being faced on an NHS wide basis

The Chief Executive advised the Board that the Chief Executive NHS Wales had written to all the Health Boards in relation to the growing concerns in terms of the pressures across the system and the impact this was having upon the Trust.

Furthermore, the Chief Executive provided the Board with the rationale ofthe report being issued; a summary of which had been submitted to EASC for consideration at its meeting.

The EASC meeting, attended by the Chief Executive, the Director of Operations (Interim) and the Director of Quality, Safety and Patient Experience had referred to the pressures in the system and impact on quality, safety and dignified care. Following that meeting, the

Trust must now agree with the Commissioner what the next steps were in order to provide a satisfactory resolution collectively with the Health Boards.

The Board were briefed by the Chairman that the quality and safety report had been received by the Commissioner but had not been fully considered by EASC. The Chairman suggested that, with the support and on behalf of the Board, he and the Chief Executive write to the Chair of EASC expressing its disappointment and concern with regard to the manner in which the submitted report was treated. It was the Trust's expectation that the full report would have been shared with those that commission the services the Trust provided. The letter would alsorequest thatEASC send the report to Health Board Chief Executives for it to be fully considered.

Following a detailed discussion, Members agreed with the recommended course of action and suggested that the report also be escalated through the clinical executives. In addition, assurancewas required that future reports submitted of a similar nature be acknowledged by EASC.

RESOLVED: Thatthe Chairman and Chief Executive write to the Chair of EASC expressing the Board's concern and disappointment in terms of how the report was handled with a request that the full report be forwarded to all Health Board Chief Executives in order for it to be properly and fully considered.

13/16 LEGAL CASES UPDATE

The Claims Manager/Solicitor presented an overview of the report drawing the Board's attention to the significant issues with regard to inquests and claims being managed by the Trust.

RESOLVED: That

(1) there were five inquest hearings planned with a potential media interest be noted; and

(2) an integrated report which focused on the analysis surrounding the impact of inquests and claims be provided at the next meeting.

14/16 SERIOUS ADVERSE INCIDENTS (SAI) AND PROCEDURAL RESPONSE TO UNEXPECTED DEATHS IN CHILDREN (PRUDIC)

The Director of Quality, Safety and Patient Experience provided the Board with an updated summary with regard to SAI reporting following the last meeting and advised that the number of SAI reported in February 2016 had been the highest since 2008. Members were assured that the Patient Safety Team had actively been working with the corresponding teams in Health Boards to investigate all of the reported SAI.

In terms of PRUDIC, the Board were provided with the number of reported child deaths since the last reporting period; seven in January 2016 and four in February 2016 and asked the Board to acknowledge the work of those staff involved supporting staff and partnership working with other agencies.

The Director of Quality, Safety and Patient Experience predicted that a heightened number of concerns would be received following the increased number of SAI and stressed that the diligence and timely completion of investigations was paramount.

Members discussed the way forward in terms of how the lessons learned from SAI were managed, monitored and escalated. In addition they discussed in detail the role of the Organisational Learning Group with the overall SAI learning process.

RESOLVED: That

(1) the content of the report be noted;

(2) the recognition of the link to Quality and Safety in reflecting the issues raised to EASC be noted; and

(3) the Chairs' Working Group consider how the lessons learned from SAI were progressed and how the Trust managed them.