QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE
HIGHLIGHT REPORT TO BOARD

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

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

Trust Board Meeting Date	28 May 2026
Committee Meeting Date	7 May 2026
Chair	Bethan Evans

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. The Committee discussed a significant and emerging **patient safety risk relating to delays in gaining access to properties**, noting the Trust lacks statutory powers to force entry and is reliant on Police and Fire and Rescue Services, whose roles are critical but have been inconsistent in practice. Instances of non-attendance have contributed to serious patient safety consequences. An interim joint operating model in place from 1 April 2026 for a pilot period of six months will continue to be closely monitored, with recognition that ambulance services must not be left unable to act when patients are at risk.

2. The Committee noted that delivery of the **Strategic Quality Plan** is off track against original timelines due to capacity constraints, system dependencies and wider organisational pressures. A formal review has been built into the IMTP to reset expectations, with executive engagement planned in June to support reprioritisation and ensure focus on deliverable, high impact actions. The Committee welcomed the shift towards a more realistic and prioritised approach, while acknowledging ongoing challenges, particularly in relation to data and digital dependencies and programme governance. It was agreed that future reporting should provide clarity on revised priorities, timelines and any areas for de-prioritisation, with assurance that credible delivery will depend on alignment with organisational capacity.

ADVISE

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

3. Committee heard from **Community First Responder, Mike Senior,** who highlighted the use of video triage during a call involving a young child with acute symptoms. Mike described how real-time video

consultation enabled a clinician to visually assess the patient, gather additional information from the parent, and determine the most appropriate course of action, providing reassurance to both the responder and the family and resulting in a positive outcome. Members recognised the potential benefits of video-enabled clinical support, including enhanced patient reassurance, improved clinical decision-making through visual assessment, and a more collaborative approach between clinicians and responders. It was noted that video consultations are already in use within the service but remain relatively low in overall utilisation, with variability in uptake across clinical teams. Members discussed the balance between clinical value and operational efficiency, noting that while video can enhance patient experience and support certain clinical scenarios (e.g. paediatric, stroke, and mental health presentations), it may also extend call handling times and therefore requires considered application. The importance of identifying where video adds the greatest value, rather than adopting a universal approach, was emphasised and the Executive Leadership Team were requested to discuss the approach further.

4. NHS Wales Performance and Improvement has been commissioned by Welsh Government to support rapid implementation of the **45-minute handover** protocol across Wales, taking an active facilitation and assurance role with health boards during May to assess readiness, refine timelines and agree standard operating procedures. Initial engagement will focus on the most challenged systems, including Betsi Cadwaladr, Aneurin Bevan and Swansea Bay, which is a positive development. However, a degree of caution remains, as delivery continues to rely heavily on local ownership and similar approaches have not previously achieved sustained improvement.

5. The committee noted the significant breadth and scale of **operational delivery in Q4**, achieved despite sustained leadership capacity pressures, with progress recognised across key areas including remote clinical care, Datix backlog reduction, quality and support days, and the remote integrated care service (RICS) developments following the single CAD queue go-live. The falls desk was highlighted as delivering clear patient and system benefits, supported by robust evaluation, although concerns remain regarding sustainability due to short term funding arrangements and the need to strengthen the evidence base. The committee also recognised the substantial challenge of delivering over £4m of savings within the operations directorate, commending the careful and balanced approach taken to protect frontline care, patient safety and workforce impact in what was the first year requiring service reductions at this scale.

6. Members welcomed Dr Umar Ahmad, Non-Executive Director to his first meeting of this committee. **Reflections** included a sense of strong assurance across a wide range of areas, with evidence of increasingly mature. Members noted the positive impact of cross-directorate working, which is helping to embed quality across the organisation. Overall, the committee reflected a positive trajectory, with clear progress evident alongside an ongoing commitment to maintaining focus on key risks and areas for improvement.

ASSURE

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

7. The board will recall that during 2025/26 this committee escalated the issues of performance and backlogs with respect to **Putting Things Right and concerns management.** This meeting

recognised clear and tangible improvement in performance, following a period of recovery activity. Members acknowledged the significant organisational effort involved, with improvement achieved against a backdrop of sustained operational pressure and staffing constraints. Strengthened governance arrangements were welcomed, including programme oversight, with regular executive leadership scrutiny.

However, members were equally clear that, while progress is evident, assurance on sustainability cannot yet be fully provided. Concerns remain about whether current performance can be maintained now that recovery resources have stepped down and activity has moved into business as usual. It was acknowledged that the introduction of the new Listening to People regulations from 1 April presents additional uncertainty, with limited national guidance and KPIs available at the point of implementation. In particular, early experience suggests higher than anticipated demand for face to face resolution meetings, with implications for future capacity.

There was agreement that clear trajectories are now required, even if assumption based, to support ongoing monitoring and to demonstrate what sustained improvement should reasonably look like over time. This was seen as critical for assurance at committee and board level.

8. The **Monthly Integrated Performance Report (MIQPR)** was received, setting out the metrics for March 2026. Performance against high acuity measures remains under pressure, with limited improvement in emergency response times, with work underway through clinical model transformation programme to better manage demand and categorisation. It was recognised that delivery against the new ambulance performance framework targets is fundamentally dependent on reducing ambulance handover delays, which currently represent activity loss significantly beyond planned assumptions and cannot be mitigated by ambulance service actions alone. As above, while recent national direction on the 45 minute handover standard is encouraging, a degree of caution remains given reliance on local health board ownership and the lack of sustained improvement from previous initiatives. Any future performance trajectories will therefore be dependent on wider system change, particularly improvements in hospital flow.

9. The committee focused on **Return of Spontaneous Circulation (ROSC) as a key clinical indicator**. Members heard that while direct linkage to survival to discharge remains limited, ROSC represents a critical early outcome. Data shows a gradual improvement in performance over time, with trends broadly consistent with international comparators. Improvements in this area are typically incremental and achieved over a sustained period and should therefore be viewed as part of a longer-term trajectory of continuous improvement. The relevant measure in the MIQPR is the metric on response to Purple Arrest calls for which the ROSC rate for March 2026 was 22.5%, which is an improvement on 19.8% recorded in March 2025.

10. Internal audit on Cymru High Acuity Response Unit (CHARU) – confident to keep to timelines.

11. The **Annual Duty of Quality Report 2025/26** was endorsed and will be presented to the board for approval in June. The committee welcomed the report as a strong and improved iteration, particularly recognising its streamlined, integrated approach and enhanced accessibility. Feedback focused on refining structure and strengthening context for an external audience, including giving greater prominence to patient safety and clearer articulation of governance and oversight arrangements.

12. The biannual **patient experience and community involvement (PECI) report** from October 2025 to March 2026 provided triangulated insight into patient experience, safety and person-centred care alongside operational performance data. Members noted that:

    - the report continues to show strong and consistent positive feedback on the care, professionalism and compassion of frontline staff, with patients clearly differentiating between individual care experiences and wider system pressures
    - compliments featured prominently and were welcomed as an important source of staff recognition
    - conversely, negative experience feedback remains system-driven and consistent, focused primarily on access delays, callback reliability and long waits – these that were not unexpected and reinforce existing organisational risk understanding rather than identifying new concerns
    - sample sizes remain relatively small, particularly for EMS and 111 feedback, and should therefore be interpreted as experience intelligence rather than statistically representative data, with increasing feedback volumes, including through SMS and digital routes, recognised as a key next step to strengthen assurance
    - patient experience intelligence is embedded within governance arrangements and linked to improvement activity: the value of PECI was seen as its ability to inform learning and improvement, not monitoring alone
    - progress was welcomed on digital engagement and co-production, including one-to-one web chat development and work with seldom-heard groups, describing this as a meaningful shift towards human-centred design

    Overall, the Committee agreed that the PECI report now clearly articulates the 'so what', providing assurance on the quality of care delivered while reinforcing the impact of wider system pressures on patient experience that continue to require system-level action.

13. The Committee received assurance from the **learning from deaths (mortality) report**, covering the period October 2025 to March 2026. Seasonal increases in Medical Examiner referrals were noted, alongside continued operation of the two-tier triage process for review of deaths. Members discussed the backlog of Level 2 multidisciplinary reviews, acknowledging this reflects capacity pressures during PTR recovery and incident management activity, but were assured that learning continues to be identified and that plans are in place to reduce the position. Recurring themes remain consistent and system-driven, including prolonged waits for ambulance response, patient deconditioning, limitations in community and end-of-life care, and outcomes in time-critical conditions such as stroke and sepsis. Two Regulation 28 Prevention of Future Death reports were received and responded to within required timescales, with themes aligning to known organisational risks. The committee welcomed recent digital safety improvements to the ePCR system, strengthening NEWS2 controls, but emphasised the need for continued focus on timeliness and sustainability, with clearer indicative timeframes requested in future reporting.

14. The committee were assured that **medicines management arrangements** are strong with continual improvements, with high compliance across key controls including audits, controlled drugs management and patient group direction use, supported by strengthened governance arrangements. No significant risks were identified, and the position reflects a robust, safe and effective medicines management system.

15. Following an action from the last meeting where the annual infection prevention and control report was presented, the committee were assured regarding the Trust's **current respiratory protective equipment arrangements** following the organisational transition from Filtering Facepiece 3 respirators to Powered Air-Purifying Respirators. The report provided moderate assurance on these arrangements, with a clinically robust and embedded model in place and no evidence of systemic safety risk.

16. The **Q4 Audit Tracker** report focused on high priority actions or actions from limited assurance audits that were on their final revised date. No escalations are required to the board.

RISKS

Risks Discussed:

The committee reviewed the most recent risk report on **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).

The scoring on risk 223 is set to increase from 20 to 25 following three consecutive months of deteriorating handover performance. As noted above, Welsh Government has directed rapid implementation of the 45 minute handover protocol, with NHS Performance and Improvement providing national facilitation and assurance. New actions on logistics for the release to respond approach have been introduced to the risk.

Risk 224 has not changed in score and remains at 25. The great majority of mitigations for these two risks remain outside of the Trust's control, however the committee continues to focus on actions for those areas the Trust can 'manage', and the ways in which it can influence those which it 'monitors'.

New Risks Identified: no new risks identified to be added to the register from this meeting.

COMMITTEE AGENDA FOR MEETING		
Staff experience of community first responder	Operations directorate Q4 report	PTR Q4 report and update on PTR concerns management programme
MIQPR	Spotlight on ROSC	Internal audit: CHARU
Duty of Quality Annual Report	Strategic quality plan implementation update	RPE report
PECI report	Mortality report	Medicines management report
Risk management and BAF	Audit tracker	Cycle of business monitoring report

COMMITTEE ATTENDANCE				
NAME				
Bethan Evans (Chair)				
Ceri Jackson				
Dr Umar Ahmad				
Liam Williams	Penny Durrant			
Andy Swinburn				

Lee Brooks				
Rachel Marsh				
Trish Mills				
Mark Marsden				
Hugh Parry				
Henry Garrard				

	Attended
	Deputy attended
	Apologies received
	No longer member