GIG CYMRU NHS WALES

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

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	25 September 2025
Committee Meeting Date	05 August 2025
Chair	Bethan Evans

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. Following concerns raised at the last meeting, a refreshed **Putting Things Right & Legal Services Performance Organisational Recovery Plan** was developed collaboratively to address structural and staffing changes alongside system and process improvements aimed at restoring performance. Recent changes to the clinical model have increased the complexity of investigations and ongoing recruitment challenges have meant audit and investigation capacity has not increased as planned, further complicating the ability to manage complaints and coronial workloads effectively.

2. Some improvement actions have long lead in times and benefits are difficult to forecast, meaning timeliness related performance is expected to improve gradually over the coming year.

3. The Committee were not assured by the deliverability of the plan as outlined, not doubting the commitment or effort of staff, but expressing apprehension considering the pressures that the Trust is operating in, the complexity staff face, and the likelihood that complexity will increase with ongoing service diversification and transformation. Members emphasised the need to continually review staff support and training needs.

4. The Executive Director of Nursing & Quality noted that the Executive Leadership Team will closely monitor the plan over the coming months. – which was welcomed by Committee Members.

5. Members were assured that:

   - There is a prioritisation approach taken to actions based on what is achievable, with a focus on managing complexity from the Clinical Model Transformation and ensuring proportionate approaches to reported incidents.

- Workstreams are being managed across directorates, with audit and clinical capacity being built in relevant teams to support the process, such as audit and remote care.

ADVISE

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

6. Committee received a **Patient Story** from Sophie who is a Learning Disability Lived-Advisor with WAST and also has a mental health condition. She lives independently and sits on several groups and panels which represent and advocate for the learning disability community. Sophie is a regular user of the NHS 111 Wales Service, accessing by phone and online. She describes mostly favourable many experiences when contacting the 111 service but finds the frequent long waits for a return call frustrating at times. When she's been referred to hospital by 111 Wales, she finds it difficult as there is no direct transport and taxi costs are prohibitively high, and ambulances can take up to 12 hours to arrive. Sophie feels that the language used by 111 Wales is often complex and full of jargon and not learning disability friendly.

   Sophie describes a positive experience of using 111 Wales Press 2 during a mental health crisis episode; however, she finds the disjointed way in which mental health services work creates barriers to access, particularly for those with a learning disability.

   The Patient Experience & Community Involvement (PECI) team emphasised the importance of continued improvements such as the new learning disability register that can flag callers with learning disabilities to call takers and clinicians, regardless of self-identification and that ongoing staff training is focussed on making reasonable adjustments, especially regarding language, tone, and pace, acknowledging the challenges of telephony based communication. Ongoing and future developments, including integration with WhatsApp, expanding the virtual agent to ambulance care for appointment management, and exploring web chat capabilities, all aimed at providing more accessible care channels. QuEST noted that the first attempt at recruiting an LD Advanced Clinical Practitioner to support the Trust in this work had not been successful and that the team were confident more proactive market engagement undertaken would secure a successful candidate.

   The team highlighted the ongoing work to address transport challenges for individuals with learning disabilities with collaboration with third sector and community transport services to share available support with Learning Disability groups.

   The Committee extended their gratitude to Sophie for sharing her story so honesty, as this open feedback provides an opportunity to continue to drive forward service improvements.

7. The Committee received an update following the deeply moving **patient story from Mr and Mrs Cope concerning their son, Dylan,** which was received by the committee and Trust Board in May 2025. Lucie Jones, Head of Patient Safety, Concerns and Learning was commended by Members for the powerful and sensitive way she discussed Dylan's story at the WAST Q Event recently to ensure future improvements are made from such tragic circumstances. An All Wales sepsis safety netting leaflet has been developed by NHS Wales Shared Services through work with Dylan's family and Aneurin Bevan University Health Board.

8. The Committee received the **Operational Update for Q1 2025/26,** which members noted demonstrated a strong focus on quality and improving services for patients, and the level of change and transformation throughout. The report highlighted that handover delays are continuing a downward trend, which has resulted in reduced wait times for Amber response calls. Additionally, the Trust recently de-escalated to REAP level one, attributed in part to these improvements. related to investigations (concerns, coroner inquiries etc) include complexity in patient call flows involving multiple touchpoints has added significant lines of inquiry and investigation, making backlog resolution more challenging.

9. The **Annual Infection and Prevention Control Report 2024/25** was deferred.

10. Members' **reflections** included that the lighter agenda allowed for deeper focus on the Putting Things Right Report and the associated Recovery Plan, enabling more probing and challenging questions from Non-Executive Directors and robust scrutiny and assurance. Members praised the quality of reports, presentations and the strong Chairing was noted. Members' appreciated the transparency and early sight of strategic work, and acknowledged the significant risks being managed by the Trust.

11. The committee **met briefly in private** to approve the minutes of the May 2025 private session and receive a confidential risk report.

ASSURE

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

12. The **Monthly Integrated Performance Report (MIQPR)** was received, setting out the metrics for June 2025. Members noted that the board will receive and discuss the MIQPR at its meeting in September 2025. Performance related to Putting Things Right is reported separately below. Of note:
    - The Trust lost 15,278 hours to hospital handover delays in June 2025, one of the lowest levels in four years but still a significant operational challenge impacting response capacity and as such, inevitably leading to incidents of avoidable harm.
    - The Trust reported eight National Reportable Incidents in June 2025. Complaint response times against national definition improved to 88%, compared to a two-year average of 57%. Notwithstanding this, a PTR recovery plan has been received for the overdue open complaints.

13. The committee received an update on the revised **Ambulance Performance Framework**, highlighting the introduction of new outcome focused metrics for cardiac arrest and high-risk calls, with distinct clinical indicators and response targets. The committee welcomed the focus on clinical outcomes, robust data analysis, and alignment with national standards. Members were pleased to hear that the launch went well on 1 July 2025, which was supported by cross directorate working, and that there are no known patient safety incidents directly attributed to the changes in call categorisations known at this stage. Work is underway to prepare for the go-live of Phase II of the framework for what is currently the amber and green categories.

14. Members received an update on the **Ministerial Advisory Group Wait 45 Taskforce**, highlighting the focus on system improvement and pathway improvement, with workshops scheduled for each Health Board and a meeting with the Cabinet Secretary on 15th September 2025; the outcome of which will be

a focus of the next meeting. Members noted a significant cultural shift towards shared accountability and executive oversight, with improved collaboration between organisations. The Taskforce is also addressing direct admission pathways for key clinical conditions and emphasising the importance of whole system flow, including social care and community discharge. While there is optimism about the current momentum and leadership, the Committee acknowledged the need to ensure sustainability of improvements through winter and in the face of further operational pressures.

15. The **Putting Things Right (PTR) Report** for Q1 2025-26 was received. Members were assured on the learning, deep dives undertaken, the data driven insights and the intelligence being interpreted which are critical to assurance. Some of the areas of poor performance will be addressed in the PTR recovery plan above, but of note for the board:

    - The increase in concerns related to patient waits and the increase in Non-Emergency Patient Care Service cancellations. Renal and Oncology patients are not affected.
    - The performance challenges associated with delays in PTR responses and inquest statements have led to the Trust being issued with five Schedule 5 notices from a regional Coroner's office for the first time.
    - The external backdrop is concerning and the delay in providing statements and evidence to the Coroner's office risks financial and reputational penalties.
    - The distressing impact for all patients and families awaiting investigation findings or inquests is acknowledged and the Trust extends apologies to all affected.
    - The Trust has received a Section 27 Public Services Ombudsman report. All recommendations have been accepted and completed and, the actions taken by the Trust to enhance future safety are outlined in the learning section of this report on high risk overdoses.
    - The Chair will provide an assurance report to the Audit, Risk & Assurance Committee (ARAC) regarding low harm and near misses, noting that the focus is currently on the incidents that have taken place and that have been reported and that this type of proactive reporting is being built through the Clinical Model Transformation.

16. The **Annual Safeguarding Report 2024/25** was approved. The Committee praised the report's clarity and evidence of strong partnership working and noted the increase in internal safeguarding allegations being reported were indicative of a positive cultural shift within the organisation.

17. The **Clinical Audit Plan and Action Tracker update for Q1 2025/26** was received with no escalations.

18. Members received a presentation on the **Clinical Plan for 2025-2030** redevelopment which includes an innovative, interactive format to enhance user engagement. Next steps will be engagement with the ELT considering prioritisation of digital work, consideration of the Welsh Language and alignment with other Trust documents.

19. The **Internal audit on Start of Shift Procedure** was presented. The audit assessed the effectiveness of the procedure for preparing vehicles and ensuring availability of key equipment and medicines at shift start within Emergency Medical Services (EMS) and Ambulance Care. The audit rated two objectives as reasonable assurance, three as limited, and one as substantial, with several medium and high priority recommendations raised. The actions will be monitored by this committee.

20. The **Emergency Communication Nurse System Implementation Internal Audit Report** was received. The audit highlighting significant audit backlogs, with over 400 audits pending, and issues with monitoring and compliance. Members were assured of the plans to address these concerns with additional auditors and improved processes.

21. An update was received on the **Audit tracker** with 63% (40% last quarter) of committee related internal audit actions due in quarter were closed in quarter. The committee was assured that appropriate plans were in place to address those actions overdue. There were 30% of external audit recommendations closed in quarter. 17 of 32 Welsh Risk Pool open recommendations relating to the backlog of investigations and concerns have had revised dates during this period.

RISKS

Risks Discussed:

The Trust's two highest scoring **risks 223:** the Trust's inability to reach patients in the community causing patient harm and death and **risk 224:** significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service remain unchanged at a score of 25.

Members were appraised of the new approach to these risks, separating internal controls (what the Trust can manage) from external factors (what it can only monitor and influence), and aligning them to strategic objectives and draft risk appetite statements. Members welcomed the new format which maps controls to three lines of assurance lines and includes high level actions, with more detailed operational action plans monitored at a directorate level.

The risks reflect positive trends in the reduced handover delays, the new ambulance performance frameworks, the national Wait 45 Task Force, and phase 1 and 2 of the new clinical model. In addition to complaints, coroners' Schedule 5 notifications, recruitment and audit capacity issues all of which was discussed throughout the meeting.

New Risks Identified:

The significant risk related to the Trust's ability to manage the overdue investigations and audit processes and relating to the need to put more scrutiny on the Putting Things Right recovery plan and the wider organisational impacts was raised, and it was noted that the risk is currently being articulated and navigating governance.

COMMITTEE AGENDA FOR MEETING		
Operations Directorate Quarterly Report for Q1 2025-26	Patient story and Updates	Monthly Integrated Quality and Performance Report and annual review of metrics
Revised Performance Framework	Ministerial Advisory Group Wait 45 Taskforce	Putting Things Right Q1 2025-26 Report with Organisational Recovery Plan
Annual Safeguarding Report 2024-25	Annual Infection and Prevention Control Report 2024-25 *Deferred*	Clinical Audit Plan and Action Tracker Q1 2025-26
Clinical Audit Plan progress update	Risk management and BAF	Audit tracker Q1 2025-26
Internal Audit – Start of Shift Procedure	Internal Audit – Emergency	Audit Wales: Urgent and Emergency

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	Communication Nurse System Implementation	Care Report Arrangement for Managing Demand – WAST (consent item)

COMMITTEE ATTENDANCE					
NAME	**9 MAY 2025**	**13 JUN 2025**	**5 AUG 2025**	**4 NOV 2025**	**3 FEB 2026**
Bethan Evans (Chair)					
Ceri Jackson					
Rhiannon Beaumont-Woods					
Liam Williams					
Andy Swinburn			Jonathan Chippendale		
Lee Brooks	Peter Brown				
Rachel Marsh			Hugh Bennett		
Jonny Sammut	Keith Williams				
Trish Mills		Trish Mills			
Mark Marsden					
Hugh Parry					
Henry Garrard					

	Attended
	Deputy attended
	Apologies received
	No longer member