

Bundle Quality, Patient Experience and Safety Committee 10 October 2025

Agenda attachments

- 00 Quest Agenda – 10 October 2025 – Extraordinary Open Meeting
- 0 16:00 – OPENING ITEMS
- 1 Chair's Welcome, Apologies and Quorum
- 2 Declarations of Interest
 - Item 02 Board Member Register of Interests – Updated 01 October 2025
- 3 Minutes of the open meeting held on 5 August 2025
 - Item 03 2025-08-05 unconfirmed QUEST Open Minutes
- 3.1 FOR APPROVAL, ASSURANCE AND DISCUSSION
- 4 16:05 – Call Categorisation: Phase Two Incident Coding (Orange/Yellow/Green) Assurance Pack *Endorse and recommend for approval the Quality Impact Assessment and Equality Impact Assessments by the Trust Board on 23 October 2025*
 - Item 04 Ambulance Performance Framework Phase Two QIAV1.2 QuEST Cover Paper
 - Item 04 Annex 1 Ambulance Performance Framework Phase Two QIA V1.0 CQGG Approved 290925
 - Item 04 Annex 2 Integrated Equality Impact Assessment ERS Workstream
 - Item 04 Annex 3 OrangeYellowGreen Monitoring and Assurance Action Plan
 - Item 04 Annex 4 Ambulance Performance Framework Explainer V2 (CAG)
 - Item 04 Annex 5 Ambulance Performance Framework Phase 2 Assurance Report V0.9
- 4.1 CONSENT ITEMS
- 4.2 16:55 – CLOSING ITEMS
- 5 Key Messages for the Board
- 6 Reflections and Summary of Decisions/Actions
- 7 Any Other Business
- 8 Date and Time of the next meeting: 4 November 2025

Length of Meeting: 01:00		Agenda Status: [OPEN] QUEST COMMITTEE - 10 October 2025		Deadline for Papers: 1 October 2025					
Time	Mins allotted	Agendum	Title	Format	Item for	Item requested by	Paper prepared by	Item presented by	Colleagues to cc
OPENING ITEMS									
16:00	00:05	1	Chair's Welcome, Apologues and Quorum	Verbal	Information	Standing	n/a	Chair	n/a
		2	Declarations of Interest	Verbal	To State Conflicts	Standing	n/a	Chair	n/a
		3	Minutes of the open meeting held on 5 August 2025	Paper	Approval	Standing	n/a	Chair	n/a
FOR APPROVAL, ASSURANCE AND DISCUSSION									
16:05	00:50	4	Call Categorisation: Phase Two Incident Coding (Orange/Yellow/Green) Assurance Pack Quality Impact Assessment and Equality Impact Assessment	Paper	Endorsement	CoB	Quality	Liam Williams/Rachel Marsh	Alison Kelly, James Houston
CONSENT ITEMS The items that follow are for information only. Should a member wish to discuss any of these items they are requested to notify the Chair so that time may be allocated to do so.									
CLOSING ITEMS									
16:55	00:05	5	Key Messages for the Board	Verbal	Discussion	Standing	n/a	Chair	n/a
		6	Reflections and Summary of Decisions/Actions	Verbal	Discussion	Standing	n/a	Chair	n/a
		7	Any Other Business	Verbal	Discussion	Standing	n/a	Chair	n/a
		8	Date and time of the next meeting: 4 November 2025	Verbal	Information	Standing	n/a	Chair	n/a
17:00	01:00	CLOSE							

LEAD PRESENTERS

Name	Position
Bethan Evans	Chair and Non-Executive Director
Rachel Marsh	Executive Director of Strategy, Planning & Performance
Liam Williams	Executive Director of Quality and Nursing

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Left Trust
BEAUMONT-WOOD, Rhiannon	Non-Executive Director * Member of the Remuneration Committee * Member of the the Audit, Risk and Assurance Committee * Member of the Quality, Patient Experience and Safety Committee	Dorset Integrated Care Board (NHS Dorset), Non-Executive Director	Financial Interest	May 2023		
		Nursing and Midwifery Council (NMC), Designated Council Member for Wales	Financial Interest	June 2024		
		RBW Executive and Professional Coaching Ltd, Company Director (Company No 14938585) and Shareholder	Financial Interest	June 2023		
		Currently on coaching framework with Health Education and Improvement Wales	Financial Interest	June 2024		
		Registered Nurse (NMC)	Non-Financial Professional	January 1985		
		Registered Specialist Community Public Health Nurse	Non-Financial Professional	September 1996		
BEESLEE, Jayne	Non-Executive Director * Chair of the Finance and Performance Committee * Member of the Remuneration Committee * Member of the Academic Partnership Committee	Member of the Royal College of Nursing	Non-Financial Professional	2007		
		Employment for interim assignments via Public Sector Resourcing (an agency) regarding the review of major UK government programmes (remunerated net of tax via an Umbrella Company - Danbro Employment Umbrella Ltd)	Financial Interest	01 October 2023		
		Member Representative on the UK Civil Service Pension Board	Non-Financial Personal	01 October 2019		
		Governor on the Finance & General Purposes Committee of Cardiff and Vale Further Education College	Non-Financial Personal	01 February 2024		
BROOKS, Lee	Executive Director of Operations	Fellow Chartered Institute of Personnel & Development	Non-Financial Personal	01 April 2006		
		Partner employed by Welsh Ambulance Services NHS Trust	Any Other Interest	July 2019		
		Member of the Order of St John	Any Other Interest	01 March 2023		
		Volunteer – St John's Ambulance Cymru	Any Other Interest	06 April 2023		
		Council Member – St John's Ambulance Cymru Gwent Council	Any Other Interest	06 April 2023		
		Trustee of Action for Children [1097940]	Position in Charity or Voluntary Organisation	01 February 2021		
CURRAN, Peter	Non-Executive Director * Chair of the Audit, Risk and Assurance Committee * Chair of the Charity Committee * Member of the Finance and Performance Committee * Member of the Remuneration Committee	Company Director - Action for Children [04764232]	Directorships	01 February 2021		
		Company Director - Action for Children (Wales) Ltd [10011497]	Directorships	05 April 2022		
		Trustee of National Youth Arts Wales [1170643]	Position in Charity or Voluntary Organisation	06 May 2021		
		Company Director - National Youth Arts Wales [10449512]	Directorships	06 May 2021		
		Non-Executive Director for Taff Housing	Position in Charity or Voluntary Organisation	01 May 2022	17 July 2025	
		Chair - Taff Housing Association	Any Other Interest	17 July 2025		
		Company Director - Team Police Ltd [12518812]	Directorships	01 January 2022	31 October 2024	
		Independent Board Member of the Project Board - National Contemporary Art Gallery for Wales	Any Other Interest	01 January 2024	30 September 2025	
		Interim Finance Director for Torfaen Leisure Trust	Directorships	01 September 2023	29 February 2024	
		Member of Governing Body / Independent Member – Kaplan International Colleges UK Ltd [05268303]	Directorships	01 March 2024		
		Independent Member - Kaplan Open Learning (inc member of the Audit & Risk Committee)	Directorships	21 March 2024		
		DENNIS, Colin	Chair of Trust Board and Non-Executive Director * Chair of Remuneration Committee	Chair - Citizen Housing [Charity] (previously WM Housing Group)	Position in Charity or Voluntary Organisation	01 January 2015
Company Director - Citizen Treasury PLC (previously WM Housing Treasury Ltd)	Directorships			29 August 2017		
Company Director - Citizen Treasury Vehicle Ltd	Directorships			04 September 2017		
Chair - North Devon Homes	Position in Charity or Voluntary Organisation			01 October 2021	January 2025	
Company Director - North Devon Homes	Directorships			01 April 2022		
Chair - Green Square Accord (Housing Association)	Position in Charity or Voluntary Organisation			26 March 2024		
Company Director - LowCarbonLiving Homes Ltd [04207671]	Directorships			26 March 2024		
Company Director - Green Square Estates Ltd [8719365]	Directorships			26 March 2024		
EVANS, Bethan	Non-Executive Director * Chair of Quality, Patient Experience & Safety Committee * Member of Finance & Performance Committee * Member of People & Culture Committee * Member of Remuneration Committee	Chief Executive Officer (Employed) at My Choice Healthcare Limited.	Any Other Interest	01 June 2019		
		Non-Executive Board Member at Beacon Housing (Social Housing Organisation - Community Benefit Society)	Position in Charity or Voluntary Organisation	01 November 2019		
		Company Director - My Choice Healthcare South Wales Limited	Directorships	11 March 2020		
		Company Director - Moorlands Rehabilitation (Staffordshire) Limited.	Directorships	20 December 2019		
		Company Director - Moorlands Property Ltd	Directorships	16 August 2022		
		Company Director - Springfield (Bargoed) Limited.	Directorships	12 March 2020		
		Company Director - Springfield Property Lettings Ltd	Directorships	16 August 2022		
		Company Director - Homes of Excellence Limited	Directorships	19 March 2021		
		Company Director - Victoria House Care Property Limited	Directorships	05 March 2020		
		Company Director - My Choice Healthcare (Four) Limited	Directorships	27 April 2022		
		Company Director - Luk Ros Property Limited	Directorships	12 March 2020		
		<i>[Previously called Homes of Excellence Healthcare Limited, Company name changed 12.08.2022 - #12513139]</i>	Directorships	12 March 2020		

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Left Trust
EVANS, Bethan [continued]	Non-Executive Director * Chair of Quality, Patient Experience & Safety Committee * Member of Finance & Performance Committee * Member of People & Culture Committee * Member of Remuneration Committee	Company Director - Hawthorn Court Property Limited	Directorships	27 April 2022		
		[Previously called My Choice Healthcare (Three) Limited, Company name changed 12.08.2022 - #13371375]	Directorships	27 April 2022		
		Company Director - Ocean Living Property Limited	Directorships	22 July 2022		
		Company Director - Hawthorn Court Care Limited	Directorships	22 July 2022		
		Company Director - Glynconel Property Limited	Directorships	01 July 2022		
		Company Director - My Choice Healthcare (Two) Limited	Directorships	01 July 2022		
		Company Director - Carmarthen Care Limited	Directorships	02 January 2024		
		Company Director - Towy Castle Property Limited	Directorships	01 September 2023		
		Company Director - Glamorgan Care Ltd	Directorships	25 October 2024		
		Company Director - The Mountains Care Ltd	Directorships	09 December 2024		
		Company Director - Alexandra House Care Ltd	Directorships	24 June 2024		
		Company Director - Alexandra House Property Ltd	Directorships	24 June 2024		
		Company Director - My Choice Healthcare Seven Ltd	Directorships	22 October 2024		
		Company Director - Danygraig Property Ltd	Directorships	10 December 2024		
Company Director - The Mountains Property Ltd	Directorships	09 December 2024				
HITCHON, Estelle	Director of Partnerships and Engagement	Member of Academi Wales Expert Panel	Position in Charity or Voluntary Organisation	15 July 2024		
		Independent Governor (Non-Executive Director), Coleg Sir Gar/Coleg Ceredigion	Non-Financial Personal	01 January 2025		
HUTCHINGS, Hayley	Non-Executive Director * Member of the Remuneration Committee * Member of the Academic Partnership Committee * Member of the People and Culture Committee	Employed at Swansea University, Professor of Health Services Research	Financial Interest	17 June 1995	31 May 2025	
JACKSON, Ceri	Non-Executive Director & Vice Chair of the Trust Board * Chair of the People and Culture Committee * Member of the Charity Committee * Member of Audit Committee * Member of Quality, Patient Experience & Safety Committee * Member of Remuneration Committee	Management Consultant primarily working in third sector	Interest in Companies and Securities	01 May 2019		
		Associate Director of SamKat Consulting Ltd in my capacity as self-employed management consultant	Directorships	01 June 2021		
		Charity Trustee - Stroke Association Trustee, Chair Wales Advisory Group.	Position in Charity or Voluntary Organisation	08 October 2020		
		Charitable Company - Stroke Association - Company Director	Directorships	08 October 2020		
KNEESHAW, Carl	Director of People	Chartered Fellow of Chartered Institute of Personnel and Development	Personal or Departmental Sponsorship	April 2020		
		Fellow of Institute of Leadership	Personal or Departmental Sponsorship	October 2020		
		Safeguarding Lead for local outreach charity, Brunstad Christian Church – Huntworth, Bridgwater, Somerset	Position in Charity or Voluntary Organisation	September 2018		
LEWIS, Angela	Director of Culture Change	Nil Declaration				
MARSH, Rachel	Executive Director of Strategy, Planning and Performance	Nil Declaration				
MILLS, Patricia (Trish)	Director of Corporate Governance/ Board Secretary	Nil Declaration				
PARRY, Hugh	Trade Union Partner	Nil Declaration				
ROBERTS, Edward	Interim Finance Director (from 09 September 2025)	Nil Declaration				
ROWAN, Hannah	Non-Executive Director * Chair of Academic Partnership Committee * Member of Charity Committee * Member of People & Culture Committee * Member of Remuneration Committee	Director, St Martin's Associates (Business consulting and coaching)	Directorships	04 April 2022		
		Non -Executive Director Qualifications Wales (regulator for all non degree qualifications in Wales)	Any Other Interest	01 April 2021		
		Trustee MAE Cymru (Christian charity which champions gender equality in church of Wales)	Position in Charity or Voluntary Organisation	13 November 2021	November 2023	
		Elected member, The governing body of the church in Wales (Parliament of church in Wales - voting member)	Any Other Interest	01 April 2021		
		Relative (Parent) is a Non-Executive Director for Social Care Wales	Any Other Interest	01 April 2017		
SAMMUT, Jonathan (Jonny)	Director of Digital Services [appointed 26.09.2023]	Fellow of the British Computer Society – FBCS	Any Other Interest	04 March 2024		
		Panel Member of the UK CIO Advisory Panel – Digital Health	Any Other Interest	05 July 2023	2 June 2025	
		Federation of Informatics Professionals - Leading Practitioner	Any Other Interest	25 April 2024		
		Chair of BCS Hub Wales	Any Other Interest	20 June 2025		
		Strategic Advisor to College of Paramedics	Any Other Interest	01 January 2020		
TURLEY, Christopher	Executive Director of Finance and Corporate Resources	Treasurer of Royal Gwent Hospital League of Friends.	Position in Charity or Voluntary Organisation	01 February 2022	05 November 2024	
TURNER, Damon	Trade Union Partner	Nil Declaration				

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Left Trust
WILLIAMS, Liam	Executive Director of Quality and Nursing [from 01 August 2022]	Chair/Director - Thornbury Carnival Community Interest Company Voluntary	Position in Charity or Voluntary Organisation	01 August 2019		
		Member Royal College Nursing	Any Other Interest	01 August 2022		
		Committee member - Royal College Nursing, Nurses in Management and Leadership Forum Steering Committee	Position in Charity or Voluntary Organisation	01 August 2022		
		Vice Chair - Royal College of Nursing, Nurses in Management and Leadership Forum Steering Committee	Position in Charity or Voluntary Organisation	03 February 2025		
WOOD, Emma	Chief Executive (from 01 October 2025)	Chartered Fellow of CIPD (Chartered Institute of Personnel and Development)	Non-Financial Professional	2000		
		External Moderator for HR Masters modules for University West of England	Financial Interest	September 2024		
		Member of Yoga Professional Alliance	Non-Financial Personal	TBC		
		Sub-Yoga Teacher - Burnham Swim and Leisure Centre	Financial Interest	TBC		



GIG
CYMRU
NHS
WALES

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

**WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST
UNCONFIRMED MINUTES OF THE OPEN SESSION OF THE MEETING OF
THE QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE
HELD ON 5 AUGUST 2025 VIA TEAMS**

MEMBERS PRESENT:

Bethan Evans	Non-Executive Director and Chair
Ceri Jackson	Non-Executive Director and Vice Chair of the Board
Rhiannon Beaumont-Wood	Non-Executive Director

IN ATTENDANCE:

Julie Boalch	Assistant Director of Corporate Governance and Risk
Hugh Bennett	Assistant Director of Commissioning and Performance
Lee Brooks	Executive Director of Operations
Jonathan Chippendale	Assistant Director of Clinical Development
Penny Durrant	Deputy Director of Nursing, Quality and Governance
Henry Garrard	Trade Union Partner
Sarah Harland	Corporate Governance Officer
Leanne Hawker	Head of Patient Experience and Community Involvement
Wendy Herbert	Deputy Director of Quality and Putting Things Right
Lucie Jones	Head of Patient Safety, Concerns and Learning
Alison Kelly	Business and Quality Manager
Osian Lloyd	Head of Internal Audit
Vicky Maxwell	Head of Safeguarding (Joined at item 8)
Trish Mills	Director of Corporate Governance/Board Secretary
Alex Payne	Corporate Governance Manager
Jonny Sammut	Director of Digital Services
Liam Williams	Executive Director of Quality and Nursing

OBSERVERS:

Ela Lewis	Senior Project Manager
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APOLOGIES:

Claire Appleton	Assistant Director of Putting Things Right
Kate Blackmore	Assistant Director of Quality Governance
Estelle Hitchon	Interim Executive Director of Strategy, Planning and Performance/Director of Partnerships and Engagement
Fflur Jones	Performance Auditor, Audit Wales
Mark Marsden	Trade Union Partner
Rachel Marsh	Interim CEO
Andy Swinburn	Executive Director of Paramedicine
Angela Mutlow	Director of Operations, Llais

1. WELCOME AND APOLOGIES

- 1.1 The Chair extended a warm welcome to everyone, and informing members that the meeting was being recorded. Apologies were noted from Claire Appleton, Kate Blackmore, Estelle Hitchon, Fflur Jones, Mark Marsden, Rachel Marsh, Andy Swinburn and Angela Mutlow.

The Committee RESOLVED to: Apologies were recorded for Claire Appleton, Kate Blackmore, Estelle Hitchon, Fflur Jones, Mark Marsden, Rachel Marsh, Andy Swinburn and Angela Mutlow.

2. DECLARATIONS OF INTEREST

- 2.1 There were no further declarations of interest to those already listed in the Register.

3. MINUTES AND HIGHLIGHT REPORTS

3.1 MINUTES FROM THE OPEN MEETING 9 MAY 2025

The Minutes from the meeting held on 9 May 2025 were received and confirmed as a correct record and with no amendments requested.

The Committee RESOLVED to: The Minutes of the Open meeting held on 9 May 2025 were confirmed as correct record.

3.2 COMMITTEE HIGHLIGHT REPORT 9 MAY 2025

The Chair drew the Committee's attention to the contents of the AAA report for their information; this highlighted the key points from the meeting on 9 May 2025.

3.3 MINUTES OF THE EXTRAORDINARY MEETING 13 JUNE 2025

The Minutes of the extraordinary meeting held on 13 June 2025 were received and confirmed as a correct record.

The Committee RESOLVED to: The Minutes of the Open meeting held on 13 June 2025, were confirmed as correct record.

3.4 COMMITTEE HIGHLIGHT REPORT EXTRAORDINARY MEETING 13 JUNE 2025

The Chair drew the Committee's attention to the contents of the AAA report for their information; this highlighted the key points from the meeting on 13 June 2025.

4. ACTION LOG AND MATTERS ARISING

- 4.1 *27/25 9 May 2025, Putting Things Right Report – An update was requested on the progress of the Putting Things Right Recovery Plan, it was agreed this would be provided at the next meeting. Update 28 July 2025 The Putting Things Right Recovery Plan was presented at the meeting of the Executive Leadership Team on 30 July 2025 for further consideration and next steps ahead of the meeting of the QuEST Committee on 5 August 2025. Liam Williams delivered a verbal update to this effect, *Agenda Item 10*. The Committee were satisfied with the update; item proposed for closure.*
- 4.2 *28/25 9 May 2025, Monthly Integrated Performance Report – To conduct a deep dive analysis on the disproportionate impact of handover delays on older people and provide that information for the November meeting.*
- 4.3 *33/25 9 May 2025, Update on Health Inequalities Maturity Matrix and Population Health Plan – Ceri Jackson suggested exploring funding opportunities through the Charity for potential to support innovation and pilot projects in the public health space. Update 29 July 2025 A meeting has been arranged on 4 September 2025 with Liam Williams, Ceri Jackson and David Hopkins to explore funding opportunities through the Charity.*

The Committee RESOLVED to: Consideration was given to the AAA Reports and Action Log

5. OPERATIONS DIRECTORATE QUARTERLY REPORT Q1 2025/26

- 5.1 Lee Brooks presented an overview of the Quarterly Operations Report Q1 25/26. The Chair responded positively to Lee's summary, highlighting the many positives in his report and expressing pleasure at starting the meeting on such a positive note. The Chair also congratulated Laura Charles for receiving the King's Ambulance medal.
- 5.2 Ceri Jackson emphasised the significant change and transformation focused on quality and patient service in Lee's report, acknowledging that some improvements, such as reduced handover delays, will take time to fully realise. Ceri also highlighted positive staff feedback from a recent visit and acknowledged the large volume of work involved.
- 5.3 Rhiannon Beaumont-Wood echoed the positive perspective on Lee's report, especially the achievement of Resource Escalation Action Plan (REAP) level one and the opportunities for staff in Urgent Care Services. Rhiannon asked about the anticipated impact and timeline of ongoing recruitment on reducing backlogs and the expected benefits of the upcoming team-based working workshop. Lee explained that the backlog reasons vary, with a key focus on improving audit processes, which will take several months due to recruitment, training and onboarding. Lee emphasised increased complexity

in investigations due to more clinical touchpoints but hopes that overall harm and incidents will decrease as improvements take effect. Regarding team-based working, Lee described a pilot in integrated care aiming to improve belonging, attendance and communication, but acknowledged differences in structure and geography.

- 5.4 Liam Williams supported Lee's focus on the W45 initiative, adding that touch point meetings are scheduled for each Health Board. Liam highlighted growing momentum behind both local and national improvement work, with an emphasis on tracking not just operational process measures but also clinical outcomes, particularly for ST-Elevation Myocardial Infarction (STEMI) heart attack and stroke. Liam reported national efforts are gaining traction, with workshops being set up and a clear focus on both operational and clinical improvement areas.
- 5.5 The Chair acknowledged the positive changes observed in emergency departments, adding they look different compared to the past due to recent improvements. The Chair thanked Lee for the comprehensive report, stating that many discussed topics would reappear later in the agenda, and emphasised the rarity and significance of being at REAP level one. The Chair also highlighted the value of Health Board partners trialling new approaches to reduce handover delays and expressed hope that these improvements would continue.

The Committee RESOLVED to: The Operations Directorate Quarterly Report Q1 2025/26 was received and noted.

6. PATIENT STORY

- 6.1 Leanne Hawker introduced Sophie's Story. Sophie is a learning disability lived advisor with the Trust, who shared her experiences with the 111 service through the Trust's engagement model, highlighting both positives and areas for improvement. When Sophie has been referred to hospital by 111, she finds it difficult as taxi costs are prohibitively high, and ambulances can take up to 12 hours to arrive. Sophie feels that the language used by 111 is often complex and full of jargon and not learning disability friendly.
- 6.2 Liam Williams emphasised focusing on aspects of the service within their control, particularly the 111 press 2 mental health support, and the need for accessible language in digital tools and clinician interactions. Liam also reported efforts to recruit a clinical expert in learning disability.
- 6.3 Jonny Sammut acknowledged Sophie's openness and discussed recent innovations such as the virtual agent on 111, integration with WhatsApp and expanding virtual agent capabilities to ambulance care; these efforts aim to

provide more choices and improve accessibility. An action was raised to explore a co-production approach on future digital resources to enable improved engagement and experiences of those with learning disabilities.

- 6.4 Rhiannon Beaumont-Wood acknowledged the value of the learning disability register and enquired about its accuracy and update process and the user-friendliness of the symptom checker, and whether there had been updates or support for the learning disability community on timeliness and transport challenges raised by Sophie. Leanne Hawker advised that the learning disability community prefers simple language and fewer questions due to concerns about complex questioning and diagnostic overshadowing. While some, like Sophie, can use the symptom checker independently, others need assistance. Ongoing work includes monitoring, workshops, and collaboration with Health Boards and third-sector organisations to provide up-to-date and accessible information about community transport options.
- 6.5 The Chair stressed the need for continuous improvements in accessibility and support for people with learning disabilities and praised Sophie for her advocacy and valuable feedback. Ceri Jackson emphasised the importance of patient feedback and improving the language used by the service. Liam Williams highlighted the ongoing transformation within clinical contact centres, focusing on clinical workforce training and education to improve remote consultations. Liam also reported the potential of virtual agents and symptom checker updates to enhance sensitivity for patients with learning disabilities. The Chair concluded by emphasising the significance and impact of patient stories in guiding service development improvement.

The Committee RESOLVED to: The Committee received Sophie's story.

6.1 PATIENT STORY UPDATES

- 6.1.1 The Chair expressed her gratitude to Lucie Jones for presenting Dylan's impactful story at the previous meeting, it was presented powerfully and sensitively; emphasising the positive impact of Lucie's relationship with Dylan's parents and their wish for Dylan's story to be used for ongoing learning and improvement.
- 6.1.2 Wendy Herbert echoed Bethan's comments, acknowledging the strong relationship Lucie has built with this family who are experiencing loss and grief. Liam Williams reported on the development of an all-Wales Sepsis leaflet, resulting from work with Dylan's family, which is expected to become a standard product.

The Committee RESOLVED to: The Committee received the patient story update regarding Dylan Cope and were assured by the outcomes.

7. MONTHLY INTEGRATED QUALITY PERFORMANCE REPORT (MIQPR)

- 7.1 Hugh Bennett advised that the MIQPR report had already been reviewed by the Trust Board and the Finance and Performance Committee. Hugh pointed out that paragraph 2 specifies the relevant indicators for the Committee, but the full report provides broader context, including system pressures and handover issues. Hugh highlighted that the average response time for concerns exceeded the target at 88%, compared to a two-year average of 57%. Hugh added that while there are encouraging signs from transformation efforts and system improvements, it is too early to adjust risk scores for patient harm, and sustained improvement is needed, especially through winter.
- 7.2 Ceri Jackson enquired about the independent review of the 111 call handler rostering, seeking details on timelines, progress and the review's impact given the seven month duration. Hugh Bennett explained that an interim report has been shared with the Commissioner and will be discussed at an upcoming Joint Commissioning Committee Board Development Session. The review indicated that improved roster patterns are feasible and would benefit both staff and performance, but additional staffing is required to meet demand and that decisions on staffing or performance levels rest with the Commissioners. The next stage involves detailed staff engagement on preferred roster patterns, with positive responses and Trade Union support. Roster changes are planned for Q4, after winter pressures, to avoid disruption.
- 7.3 Lee Brooks explained that the ongoing rostering work is complicated by the need to transition from the current tool, Shift Track, to GRS cloud within the financial year, as Shift Track will no longer be supported. This transition coincides with a third party review of rostering practices, adding complexity for the team. Liam Williams agreed with Lee, expressing confidence in the strategic direction and understanding from Commissioners and emphasised that any Commissioner wanting to reduce service quality would need an Assessment of Quality Impact Assessment (AQIA) to evidence the decision and its impact. Liam doubted that an AQIA would support reducing 111 cover due to the likely negative impact on system utilisation, reinforcing that both strategic direction and the AQIA process protect service quality.
- 7.4 Hugh Bennett clarified that the commissioned target for the 111 abandonment rate is not clearly defined, with no specific Welsh Government target, and it's unclear whether it should be measured hourly, daily, or monthly. Hugh indicated that hourly modelling gives better performance, but there needs to be clarification on what is being commissioned, as this is currently unclear. There were no further questions regarding the MIQPR.

The Committee RESOLVED to: The Committee considered the June 2025 Integrated Quality & Performance Report and actions being taken and agreed that:

- 1. The report provides sufficient assurance;**
- 2. No further information, scrutiny or assurance is required;**
- 3. No further remedial actions are to be undertaken through Executives.**

8. REVISED PERFORMANCE UPDATE – PHASE 1

- 8.1 Jonathan Chippendale provided an update on the new ambulance performance metrics introduced from 01 July 2025. Key highlights as follows:
- Traditional RED priority calls are now split into "PURPLE" (cardiac or respiratory arrest) and emergency "RED" (immediately life-threatening), each with distinct performance metrics.
 - An additional category, Return of Spontaneous Circulation (RCS0), has been introduced to include the remaining prioritisation codes from the previous RED priority incidents to give opportunity for a clinician to review the call to decide if the patient would benefit from further assessment or an immediate face-to-face response.
 - The main measure for PURPLE calls is clinical indicators, especially ROSC, focusing on cardiac arrest recognition, time to CPR instructions and defibrillator availability.
 - For RED calls, clinical indicators are being developed with Commissioners, including both generic and condition specific metrics. The first publication of these metrics is scheduled for August, with further indicators for RED to be published in October, including retrospective data from July.
- 8.2 Rhiannon Beaumont-Wood enquired about the evidence or literature review for selecting the new clinical indicators, emphasising the importance of using existing evidence. Jonathan explained that the selection was based on available data and alignment with established standards such as National Institute for Health and Care Excellence (NICE) and Resuscitation Council guidelines, confirming that the approach uses existing clinical standards and available information.
- 8.3 Hugh Bennett added that the literature review is retrospective and part of the evaluation process. Liam Williams explained that national standards and the International Academy's evidence base were applied, ensuring triangulation with UK standards. While a full literature review for every code set was not done, the approach is evidence based where possible; with ongoing learning expected. Liam emphasised the importance of strengthening clinical outcome data reporting and using patient feedback for continuous improvement. Jonathan clarified that generic indicators link to the chief complaint during the call and collect "condition codes" after clinical assessment to understand underlying causes.

- 8.4 Ceri Jackson asked about the equal prioritisation of red and purple calls and whether "WAST resource" includes volunteer responders. Jonathan explained that WAST resources include organised responders such as Community First Responders (CFRs), but not passing volunteers. Lee Brooks added that they monitor mobilisation times for both categories to ensure equal responses to RED and PURPLE calls. Hugh clarified that CFRs count toward the 6–8 minute response metric but not the 20 minute backup metric.

The Committee RESOLVED to: The Committee received assurance regarding the implementation of the Revised Performance Framework – Phase 1.

9. MINISTERIAL ADVISORY GROUP WAIT 45 TASKFORCE

- 9.1 Liam Williams explained that the Ministerial Advisory Group Wait 45 Taskforce is chaired by Jeremy Griffiths and includes full Welsh Government and NHS representation, with executive technical directors from Health Boards and the Welsh Ambulance Service involved. The group's focus is on achieving and sustaining 45 minute handover times, with an expectation to continue improving beyond that target. Maxine Power, a respected Quality Improvement professional, will lead workshops in each Health Board during August and September, focusing on system and pathway improvements to support the Wait 45 goal.
- 9.2 The approach emphasises whole system accountability, with metrics being developed to measure improvement and sustainability, including sharing predicted demand data to assess ongoing progress. Liam added that the current effort feels different from previous initiatives, with a stronger sense of shared purpose, mutual accountability, and executive oversight across organisations; which is contributing to tangible improvements. Liam observed that there is already some evidence of improvement, especially in pathway changes within hospitals, and expressed increased confidence in the process compared to past experiences.
- 9.3 The Chair expressed appreciation for Liam's update and enquired as to when tangible feedback or results from the group's work could be expected. Liam advised that a key meeting with the Cabinet Secretary is scheduled, where all workshop outcomes and improvement plans will be presented, and that the Committee can expect feedback at the next meeting following this session in November 2025.
- 9.4 Rhiannon Beaumont-Wood expressed how positive it is to see a system approach to this significant issue and asked if the group can help address barriers identified in the Wales audit report; specifically clinicians in Health Boards not accepting EMS paramedics bringing patients directly to the right

pathway. Based on her observations, Rhiannon emphasised that improvements should cover all entry points, and not just A&E, to ensure patients flow through the right pathways, referencing a recent visit where delays occurred in the emergency assessment unit despite available beds.

- 9.5 Ceri Jackson offered to discuss the Ministerial Advisory Group (MAG) and handover progress at the Vice Chairs meeting. Liam Williams supported this but will first check with the Taskforce due to political sensitivities. Ceri agreed and will follow Liam's guidance on timing.

The Committee RESOLVED that: The Committee were assured by the update received from the Executive Director of Quality and Nursing regarding the progress of the Ministerial Advisory Group Wait 45 Taskforce.

10.1 PUTTING THINGS RIGHT Q1 2025/26

10.1.1 Lucie Jones summarised key points from the PTR quarterly report:

- There has been a sustained increase in concerns related to patient waits and delayed responses in emergency services.
- 52% of concerns are linked to ambulance care services, particularly short term cancellations, and challenges remain in providing timely responses, which the recovery plan aims to address.
- The emotional impact on families and patients is significant, leading to more contact with MPs, the Cabinet Secretary and the Ombudsman.
- Seven learning from events reports are overdue, but improvements are underway to prevent this in the future.
- Positive developments include a regional integrated intelligence review for better data collection and analysis, and improved relationships with coroners to reduce Schedule 5 risks.
- All actions from a previous Public Services Ombudsman report have been completed, and new processes have been introduced for high risk overdose markers, resulting in no adverse incidents since implementation.
- Work is ongoing to address concerns about NHS 111 changes related to patient gender questions, and proactive sharing of safety information about equipment has led to immediate risk assessments in the clinical directorate.

10.1.2 Ceri Jackson thanked Lucie for the summary and report and acknowledged the colleagues hard work. Ceri enquired about Schedule 5 notifications and a cluster of significant patient safety incidents. Wendy Herbert explained that Schedule 5 notices from coroners are new and mainly from one coroner in the southeast, with recent decreases in coroner activity making it manageable. The cluster of incidents is regional, with early findings showing themes such as education and safeguarding, but nothing unusual compared to other Health Boards.

- 10.1.3 The Chair highlighted the high and concerning numbers in the report, emphasising external risks. Rhiannon Beaumont-Wood echoed concerns about the need for transformational action and asked about influencing regional coroner practices and the seriousness of safeguarding concerns. Wendy Herbert explained that the cluster involved several incidents, with early analysis showing no immediate need for intervention. Liam Williams clarified that the review was initiated due to several issues arising in a short period, emphasising the importance of improving data flow. Wendy added that the review process was collaborative.
- 10.1.4 The Chair also highlighted the rise in ambulance care cancellations linked to Non-Emergency Patient Transport Services (NEPTS) capacity pressures. Lee Brooks explained the challenges and possible options being prepared for Commissioners. The Chair asked about compliance with the Duty of Candour initial letters; Wendy advised that it was a minor issue. The Chair referred to the complaints related to attitude and behaviour, Liam described initiatives to improve communication and values.
- 10.1.5 The Chair reported that there are improvements to be made to the framework for recording and reporting of near miss incidents, and that consequently only limited assurance can be given at this time on the robustness of those arrangements. Liam added that near miss reporting is still developing and needs further work, the Chair agreed to provide an assurance report to the Audit Risk and Assurance Committee regarding near misses and low harm incident reporting.
- 10.1.6 The outcomes of the discussion included acknowledgment of the ongoing challenges with increased patient concerns, especially around ambulance care cancellations and delays. The Committee noted improvements in internal assurance processes and data analysis, actions taken to address overdue learning from events, and proactive steps to strengthen relationships with coroners to reduce Schedule 5 notifications. Safeguarding clusters were being reviewed with integrated data analysis, and assurance was provided that no immediate interventions were needed. The Committee agreed the report had been received and discussed, and that assurance requirements had been met, with continued emphasis on transparency and improvement in complaint handling.

The Committee RESOLVED to:

- 1. The Committee received the report for discussion.**
- 2. The Committee addressed assurance requirements.**
- 3. The Committee assessed whether the current format and content of the report provides sufficient information and assurance on Low harm and Near-miss learning and improvement.**

10.2 PUTTING THINGS RIGHT AND LEGAL SERVICES PERFORMANCE ORGANISATIONAL RECOVERY PLAN

- 10.2.1 Liam Williams reported that the Putting Things Right Recovery Plan was developed collaboratively across Directorates to drive improvement, however achieving full assurance will be challenging due to the scale of work required. The plan was presented to Executive Leadership Team (ELT), who requested more detail on actions, timelines and improvement trajectories, with monthly updates to follow.
- 10.2.2 Jonathan Chippendale addressed ongoing data access issues and is preparing investment options to address these challenges.
- 10.2.3 Rhiannon Beaumont-Wood emphasised the importance of specifying "what by when" and raised the potential for AI in data interrogation. Liam Williams advised that priorities are based on achievability, with a focus on managing complexity and addressing serious incidents.
- 10.2.4 Jonny Sammut outlined five key areas to address for improving data and digital processes: enabling better self-serve reporting to eliminate manual "cottage industries," creating a central group, Digital Transformation and Innovation Programme (DTIP) for prioritising digital and data requests, advancing data sharing by working with the national data repository, improving interpretation and education around data variation, and focusing on data quality at source. Jonny emphasised these are prerequisites for effective AI use and that resource investment is needed to progress.
- 10.2.5 Ceri Jackson asked about ensuring protected capacity for the plan, Wendy Herbert confirmed the risk is being redrafted as part of the risk management approach.
- 10.2.6 The Chair summarised that the PTR recovery plan is a sobering read and, while she is assured by the commitment and hard work, she is apprehensive about the ability to deliver everything as outlined due to ongoing pressures and complexity. The Chair emphasised the need to continually review staff support, training and development, recognising that complexity is likely to increase, and urged ongoing attention to these areas. The Chair also confirmed the committee's discussion and assurance requirements, emphasising the need for close monitoring and welcoming the monthly ELT meetings for oversight
- 10.2.7 Liam Williams acknowledged the Chair's caution, stating that the Executive Team shares this concern due to the scale of ongoing transformation and the move away from a protocol driven model to one requiring greater clinical judgment. Liam highlighted that this shift increases complexity and demands

more robust governance, both organisationally and for individual clinicians. Liam also mentioned commissioning legal and risk reviews to ensure appropriate decision making as the organisation moves beyond traditional compliance structures.

The Committee RESOLVED to: The Committee noted the information and assurance provided in the Putting Things Right and Legal Services Performance Organisational Recovery Plan and advised on additional assurance requirements.

11. ANNUAL SAFEGUARDING REPORT 2024/25

- 11.1 Vicky Maxwell presented the Annual Safeguarding Report for 2024/25, highlighting the team's achievements and the organisation's commitment to safeguarding. The report showed a significant increase in safeguarding work, attributed to cultural improvements and encouragement to speak up. Despite the team's small size, they remain dedicated to excellent practice. The discussion covered various topics, including fire risk referrals, the impact of the "speaking up safely" agenda, and the increase in internal safeguarding allegations being reported. The importance of robust safeguarding procedures, effective partnership working and ongoing training was emphasised.
- 11.2 The Chair praised the Safeguarding Annual Report for its clarity and visual appeal, highlighting the strong collaborative work and effective safeguarding procedures. The Chair also expressed concern about variations in safeguarding report numbers across regions, Vicky explained the complexity of interpreting these numbers. Liam suggested using incident rates and demographics for better benchmarking and highlighted upcoming changes in safeguarding expectations. Lee Brooks addressed fire risk referrals, highlighting low numbers in North Wales and suggesting more efforts are needed, Vicky agreed, emphasising the importance of increasing fire risk referrals and innovative ways to encourage them.
- 11.3 Rhiannon Beaumont-Wood complimented the report and enquired about various safeguarding issues, Vicky responded with details on regional reviews and training plans. Liam Williams added that rising safeguarding allegations reflect increased reporting confidence and ongoing cultural change.
- 11.4 Ceri Jackson echoed praise for the report, emphasising the positive trend in reporting but raising concerns about capacity, Vicky confirmed efforts to improve reporting processes and manage workload impacts.
- 11.5 The Chair concluded by asking the committee to approve the report and note the increased demand on the safeguarding team.

The Committee RESOLVED to:

- 1. The Committee approved the Annual Safeguarding Report 2024/25.**
- 2. The Committee noted and considered the sustained increase in demand and the cumulative impact on the Safeguarding Team.**

12. ANNUAL INFECTION AND PREVENTION CONTROL REPORT 2024/25

12.1 This item was deferred.

13. CLINICAL AUDIT PLAN AND ACTION TRACKER Q1 (UPDATE) 2025/26

13.1 The Clinical Audit Plan and Action Tracker Q1 (Update) 2025/26 was presented by Jonathan Chippendale, who explained that the plan is dynamic and can be updated throughout the year to reflect new priorities or *ad hoc* audit requests. Of the audits indicated on the plan, three have been completed, four are progressing as planned, and six are yet to start, with some dependent on Electronic Patient Care Record (EPCR) user interface changes. Seventeen actions have arisen from completed audits, with ten completed, a few on track, and five delayed, with mitigation in place. Jonathan emphasised that audits can be commissioned by anyone in the organisation and are prioritised using a tool that considers links to Integrated Medium-Term Plan, Personal Learning and Development Plans and incident trends. The Chair pointed out a discrepancy in the reported audit numbers listed in the executive summary, Jonathan agreed to review and correct.

13.2 Rhiannon Beaumont-Wood raised questions about potential bias in audit selection and the effectiveness of disseminating findings, to which Jonathan advised that multiple communication channels are used and re-audits are built in to assess impact. In response to a question regarding resource continuity following staff changes, Jonathan advised that a new Head of Clinical Intelligence and Assurance is in post. Liam Williams added that future audit work will increasingly focus on areas of warranted variation and remote care, with improvements expected as data capabilities mature.

The Committee RESOLVED that: The Committee noted the Q1 2025-26 Clinical Audit Plan and Action Tracker update.

14. CLINICAL PLAN (PROOF OF CONCEPT/DRAFT) 2025-2023

14.1 The Clinical Plan progress update was presented by Jonathan Chippendale, who introduced a new, innovative approach for the 2025–2030 plan using an interactive, web-based platform featuring a fictitious family to illustrate patient journeys and service developments. The plan aims to make the clinical strategy more engaging and accessible, with multimedia elements such as podcasts and animations.

- 14.2 Members welcomed the concept. Jonny Sammut emphasised the need to clarify technical solutions, hosting and prioritisation, cautioning against overextending digital resources given current pressures. Rhiannon Beaumont-Wood highlighted the importance of early stakeholder engagement, alignment with the forthcoming organisational strategy and the potential for behavioural science to enhance user engagement. Ceri Jackson and Trish Mills both stressed the need for robust Equality Impact Assessment (EQIA), accessibility, and diverse representation in the family model, with Trish confirming that the EQIA would be integrated from the outset. Wendy Herbert enquired about involvement of new clinical nurse specialists; Jonathan confirmed their engagement in relevant content areas.
- 14.3 The Committee agreed that while the digital approach is promising, its implementation should be reviewed by the Executive Leadership Team for prioritisation, and the content could be reformatted if technical barriers arise.

The Committee RESOLVED that: The committee noted the Clinical Plan (Proof of Concept/Draft) 2025-2030.

15. RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK

- 15.1 Julie Boalch explained the revised approach to reporting the highest rated risks, 223 & 224, now separating what the Trust can directly manage from what it can only influence. The new format aligns risks with strategic objectives, includes draft risk appetite statements and maps controls and assurances against the three lines of assurance. Julie advised that detailed operational action plans exist at Directorate level, and the new structure should make it easier to identify gaps and escalate issues.
- 15.2 Next steps include developing internal and external scores to show the impact of actions and eventually scoring the effectiveness of controls and assurances. Julie also highlighted how recent Committee discussions on transformation, performance frameworks, complaints, safeguarding and the national Wait 45 Taskforce, all connect to these risks and their mitigations.

The Committee RESOLVED that: The Committee considered the contents of the report.

16. AUDIT TRACKER Q1 2025/26

- 16.1 Trish Mills explained that the audit tracker now uses only two revision dates to monitor completion of audit actions. Trish reported that 63% of internal audit actions due this quarter were closed, which she considered impressive given current pressures. Trish highlighted a few older actions, including those related to the Electronic Patient Care Record (EPCR), and added that Internal

Audit are comfortable with the revised dates since responsibility recently shifted to the Director of Digital Services.

- 16.2 Regarding the Clinical Audit, the plan is to integrate outstanding actions into the new Clinical Plan, and the closure process may need to reflect this. Regarding external audits, 30% of actions due this quarter were closed, with many Welsh Risk Pool actions extended due to team pressures.

The Committee RESOLVED that:

- 1. Received assurance on the monitoring of management actions to address recommendations in the Tracker, noting any revised dates for actions.**
- 2. Received assurance regarding revised dates applied to a high number of audit actions related to the Welsh Risk Pool Concerns Assessment 2024.**

16.1 INTERNAL AUDIT REPORT: START OF SHIFT PROCEDURE

- 16.1.1 The report was received.

The Committee RESOLVED that: With the onward receipt of the Start of Shift Procedure Internal Audit Report, the Committee were assured of the outcome of the audit and noted the discussion at the meeting of the Audit Risk and Assurance Committee 24 June 2025.

16.2 INTERNAL AUDIT REPORT: EMERGENCY COMMUNICATION NURSE SYSTEM (ECNS) IMPLEMENTATION

- 16.2.1 The report was received.

The Committee RESOLVED that: With the onward receipt of the Emergency Nurse Communication System Intern Audit Report, the Committee were assured from the outcome of the audit and noted the discussions at both the Audit Risk and Assurance Committee on 24 June 2025 and the Finance and Performance Committee on 21 July 2025.

It was noted that the Committee were content with the Finance and Performance Committee monitoring the actions in relation to these audits.

17. AUDIT WALES URGENT AND EMERGENCY CARE REPORT ARRANGEMENTS FOR MANAGING DEMAND

The Audit Wales Urgent and Emergency Care Report Arrangements for managing Demand was received for information.

18. COMMITTEE CYCLES OF BUSINESS MONITORING REPORT AND 2025/26 PRIORITIES

The Committee Cycle of Business Monitoring Report and Priorities update was received for information.

19. KEY MESSAGES FOR THE BOARD

- 19.1 The link between the Ministerial Advisory Group WAIT 45 Task Force and the Vice Chairs meeting was highlighted, with Ceri Jackson set to discuss this and Liam Williams. Updates on progress are expected at the next QuEST meeting.
- 19.2 The Chair will provide an assurance report to ARAC regarding near miss and low harm intelligence reporting, as has been agreed to be required on an annual basis.
- 19.3 The Board should note that Executive Leadership Team will receive monthly updates on the PTR Recovery Plan, which was welcomed for assurance.
- 19.4 The Safeguarding Annual Report was approved.
- 19.5 The Executive Leadership Team will review prioritisation of digital teamwork related to the Clinical Plan, due to multiple pressures and asks.

20. REFLECTIONS AND SUMMARY OF DECISIONS/ACTIONS

- 20.1 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.

21. ANY OTHER BUSINESS

- 21.1 None declared.

22. DATE OF THE NEXT MEETING

- 22.1 The next meeting is scheduled for 04 November 2025.

The meeting concluded at 14:25



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Agenda Item No. 4

REPORT TITLE

Call Categorisation:
Phase Two Incident Coding (Orange/Yellow/Green) Assurance Pack

MEETING

Name of meeting	Quality, Patient Experience and Safety Committee (extraordinary)
Date of meeting	10 October 2025
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Liam Williams, Executive Director of Quality & Nursing
Author(s) of report	Gareth Taylor, Senior Project Manager

PURPOSE OF REPORT

<input type="checkbox"/> Approval	<input checked="" type="checkbox"/> Endorsement
<input checked="" type="checkbox"/> Assurance	<input type="checkbox"/> Discussion
<input checked="" type="checkbox"/> Information (goes in consent items)	<input type="checkbox"/> Noting



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REPORT SUMMARY:

[See writing and presentation guidance [here](#) to inform this section]

Background

WAST's ongoing transition to an integrated Clinical Services Model reflects a wider movement towards patient-centred care. The new model aims to enhance efficiency and responsiveness, positioning the service to meet evolving healthcare demands.

Development

Rapid Clinical Screening was implemented between November 2024 and February 2025. This was followed by the implementation of **Phase One of the Ambulance Performance Framework**, encompassing the launch of **Purple** (Arrest) and **Red** (Emergency) incident coding targeting cardiac/respiratory arrest, and those at risk of deterioration into arrest. This Phase (Call Categorisation Phase One) was implemented as planned on the 1 July 2025.

The Quality Impact Assessment (QIA) for these process changes was approved by the Clinical Quality Governance Group (CQGG) in October 2024 (V6).

The Phase Two QIA and Equality Impact Assessment (EqIA) presented at Committee today reflect the transition into **Phase Two of the Ambulance Performance Framework** and a more comprehensive intervention targeting the largest cohort of patients entering the system via 999 services, which will be coded against **Orange Now**, **Yellow Soon**, and **Green Planned** Incident Coding.

Governance

The QIA and EqIA (and accompanying pack) was presented for endorsement at Clinical Advisory Group on the 16 September 2025 (V0.8), followed by approval at CQGG on the 29 September 2025 (V0.9). Following scrutiny at both forums, these two documents are recommended to QuEST for endorsement subject to minor additions ahead of approval at the extraordinary Trust Board on 23 October 2025.

The pack (including QIA, EqIA, Monitoring and Assurance Framework, and Ambulance Performance Framework Explainer Document) will be included within the Annex of an Assurance Report to be presented to Trust Board at that meeting.

Assurance Report

The Ambulance Performance Framework (Phase 2) was endorsed by Finance & Performance Committee on [16 September 2025](#) and will proceed to implementation, with oversight of delivery to be provided by the Clinical Model Transformation Board following approval by Trust Board on 23 October 2025.



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Review

Following Clinical Advisory Group on the 16 September 2025, the following feedback was incorporated into the Quality Impact Assessment;

- Enhanced reference to patient safety measures.
- Enhanced reference to Quality Assurance approach.
- Enhanced reference to legislative drivers and dependencies relating to national frameworks.
- Enhanced reference to impact on staff.
- Enhanced reference to positive impacts on the wider system (enablers).
- Amendments to approval pathways.
- Additional section on Lessons Learnt.
- Additional section on external and public communication planning.
- Enhanced reference to pilot approach.
- Enhanced reference to clinical competence of the screeners.

Following review at CQGG on 29 September 2025, approval was received subject to the following additions within the opening narrative;

- Reference to identification and use of proxy quality measures in the absence of agreed metrics, where possible
- Inclusion (or reference to) auditable training and competency evidence.
- Enhanced reference to the use of clinical evidence including NICE Guidelines when agreeing the revised clinical categorisations.
- Improved contextual framing of adverse outcomes, noting that the transition to a new model is one based on improving patient safety compared to the existing system.

RECOMMENDATION(S)

See writing and presentation guidance [here](#) to inform this section

The Quality, Patient Experience and Safety Committee is requested to:

1. **ENDORSE** and recommend for approval the Quality Impact Assessment and Equality Impact Assessments by the Trust Board on 23 October 2025.



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ADDITIONAL PAPER(S)

Set out here any annexes. See writing and presentation guidance [here](#) regarding materiality and use of the Reading Room

QuEST is requested to receive the following:

Annex 001 Ambulance Performance Framework Phase Two QIA V1.0 CQGG Approved 290925

Annex 002 Integrated Equality Impact Assessment ERS Workstream

Annex 003 Orange/Yellow/Green Monitoring and Assurance Action Plan

Annex 004 Ambulance Performance Framework Explainer V2 (CAG)

Annex 005 Ambulance Performance Framework Phase 2 Assurance Report V0.9

Governance and assurance checks to support decision-making and demonstrate alignment and risk mitigation

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [[link to objectives and what good looks like](#)]

SO1: Providing the right care or advice, in the right place, every time

SO2: Enabling our people to be the best they can be

SO3: Being at the forefront of innovation and technology

SO4: Developing services in collaboration

SO5: Being quality driven and clinically led

SO6: Delivering exceptional value

RISK(S) THIS REPORT MITIGATES

Where relevant note the local, directorate, corporate or BAF risk number

Corporate

223 – The Trust’s inability to reach patients in the community causing patient harm or death (Score – 25)

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 (Score – 25)

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

Quality Domains (select all that apply) [[link to standards](#)]

Safe

Timely

Effective



<input checked="" type="checkbox"/> Efficient	<input checked="" type="checkbox"/> Equitable	<input checked="" type="checkbox"/> Person Centred
Quality Enablers (select all that apply) [link to standards]		
<input checked="" type="checkbox"/> Leadership	<input checked="" type="checkbox"/> Workforce	<input checked="" type="checkbox"/> Culture
<input checked="" type="checkbox"/> Information	<input checked="" type="checkbox"/> Learning Improvement and Research	<input checked="" type="checkbox"/> Whole Systems Approach

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [link to goals]		
<input type="checkbox"/> A socially responsible and inclusive employer	<input checked="" type="checkbox"/> An innovative and sustainable organisation	<input checked="" type="checkbox"/> A pro-active, accessible and equitable care provider
<input type="checkbox"/> n/a	<input type="checkbox"/> n/a	<input type="checkbox"/> n/a

IMPACT ASSESSMENTS FOR CONSIDERATION

Where a strategic decision is being sought, an Equality Impact Assessment must accompany this paper. You may need to do other impact assessments also so please refer to this signpost document [here](#) for further details.

Does this paper require an impact assessment	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
If yes, what impact assessment is attached	QIA and EqIA

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
2 nd September 2025	Call Categorisation Project Group
16 th September 2025	Clinical Advisory Group
22 nd September 2025	Strategic Transformation Board
23 rd September 2025	Call Categorisation Project Group
29 th September 2025	Clinical Quality Governance Group
10 th October 2025	QuEST (extraordinary)
23 rd October 2025	Trust Board (extraordinary) (Annex to Trust Board Paper)

Quality Impact Assessment Guidance and Template

Welsh Ambulance Services NHS Trust					
Date of Approval	29 th September 2025	Version No	V1.0		
Review Date	29 th September	Type of document	Quality Impact Assessment	Approved by	Clinical Quality Governance Group
Summary of document	<p>This Guidance sets out the requirements and a recommended template for Quality Impact Assessments (QIA) when undertaken on service redesign/transformation, projects, and cost improvements.</p> <p>The Health & Social Care (Quality and Engagement) Act 2020 came into force on 1 April 2023 placing both an enhanced duty of quality and an organisational duty of candour that will strengthen the approach to quality in NHS Wales.</p> <p>The duty of quality requires each organisation to provide demonstrable evidence that all strategic decisions and plans have been made through a quality lens for both clinical and non-clinical aspects. A key element of demonstrating this are Quality Impact Assessments (QIA).</p> <p>The Trust have developed a QIA Framework and template that has been agreed at the Clinical Quality Governance Group and is reflective of the National Guidance and Template. The framework and template have been updated to reflect the new Health Care Standards 2023.</p>				
Executive Director	Liam Williams Director of Nursing and Quality				

Version Control

Version	Date	Author	Summary of Changes
0.1	29 th July 2025	Gareth Taylor	First Draft
0.2	18 th August	Gareth Taylor	<p>Additional context added to introduction. This included</p> <ul style="list-style-type: none"> - Requirement for evaluation of Phase One implementation, and assumed impact of Phase One on patient safety

Version	Date	Author	Summary of Changes
			- Addition of detail regarding suggested impact of capacity issues
0.3	22nd August 2025	Gareth Taylor Kate Blackmore Hugh Bennett	Reviewed document approach Amendments and additions to Quality measures
0.4	23 rd August 2025	Gareth Taylor	Further amendments to screening tool content.
0.5	25 th August 2025	Gareth Taylor	Amendments to screening tool content and additions to risk assessment
0.6	26th August 2025	Gareth Taylor	Mitigations added to risk assessment and further clarity provided regarding process changes (introduction).
0.7	27 th August 2025	Ceri Griffiths Hugh Bennet Gareth Taylor	Review
0.8	3 rd September 2025	Gareth Taylor Mike Brady	Re-wording of patient safety impacts
0.9	18 th September 2025	Gareth Taylor Penny Durant Ceri Griffiths	<ul style="list-style-type: none"> • Following review at CAG inclusion of, • Enhanced reference to patient safety monitoring and assurance arrangements • Enhanced reference to Quality Assurance approach and enhanced reference to legislative drivers and dependencies relating to national frameworks. • Enhanced reference to evidence base for proceeding with Phase Two • Enhanced reference to impact on staff

Version	Date	Author	Summary of Changes
			<ul style="list-style-type: none"> Enhanced reference to positive impacts on the wider system (enablers) Amendments to approval pathways Additional Section on Lessons Learnt Additional section on external and public communication planning Enhanced reference to pilot approach Enhanced reference to clinical training competencies of the screeners, and subsequent monitoring and assurances
V1.0	30 th September 2025	Gareth Taylor	<p>Following review and approval at CQGG, approval was received subject to the following additions within the opening narrative;</p> <ul style="list-style-type: none"> Reference to identification and use of proxy quality measures in the absence of agreed metrics, where possible Inclusion (or reference to) auditable training and competency evidence. Enhanced reference to the use of clinical evidence including NICE Guidelines when agreeing the revised clinical categorisations. Improved contextual framing of adverse outcomes, noting that the transition to a new model is one based on improving patient safety compared to the existing system.
Keywords	Quality Impact Assessment Safety/Experience/Effectiveness/Engagement		

1. Executive Summary

This Guidance sets out the requirements and a recommended template for Quality Impact Assessments (QIA) when undertaken on service redesign/transformation, projects, and cost improvements.

The Health & Social Care (Quality and Engagement) Act 2020 came into force on 1 April 2023 placing both an enhanced duty of quality and an organisational duty of candour that will strengthen the approach to quality in NHS Wales.

The duty of quality requires each organisation to provide demonstrable evidence that all strategic decisions and plans have been made through a quality lens for both clinical and non-clinical aspects. A key element of demonstrating this are Quality Impact Assessments (QIA).

Other strategic requirements that will be benefited through QIA's include The Well-being of Future Generations (Wales) Act 2015, A Healthier Wales (WG, 2018), National Clinical Framework (WG 2021) and National Quality and Safety Framework (WG 2021).

The Trust have developed a QIA Framework and template that has been agreed at the Clinical Quality Governance Group and is reflective of the National Guidance and Template. The framework and template have been updated to reflect the new Health Care Standards 2023.

This QIA demonstrates that Phase Two of the Ambulance Performance Framework is legally compliant, ethically grounded, and morally defensible. The Trust will meet all statutory duties (Duty of Quality, Duty of Candour, Equality Act, Health & Safety at Work, Data Protection Act) and has established clear escalation triggers, independent oversight, and transparent reporting to protect patients, staff and the public.

2. Purpose

Quality Impact Assessments provide a mechanism to identify, mitigate and monitor impacts on quality resulting from service redesign/transformation, projects, and cost improvements.

This Trust wide approach, which has been adopted across NHS Wales, will enable capture of learning and improvement opportunities across the organisation, while enabling local leadership teams to make improvement happen.

Roles and responsibilities are outlined identifying governance and assurance processes for the development, accountability and monitoring of quality impact assessments.

All full QIAs should be considered for inclusion on local / corporate risk registers as appropriate. Equality impact assessments (EQIA) must also be undertaken as per Trust policy. This remains separate to the QIA process, however the Trust is considering how various impact assessments can be 'brought together' to improve usability.

3. Scope

All new or existing improvement schemes that have the potential to impact on workforce and/or clinical and non-clinical services are required to undertake a quality impact assessment as part of their development and proposal stages.

4. Policy Context

This Guidance should be read in association with;

- The Well-being of Future Generations (Wales) Act 2015 which promotes community and patient involvement in the design and review of services.
- Health and Social Care (Quality and Engagement) (Wales) Act (WG 2020)
- A Healthier Wales (WG, 2018)
- National Clinical Framework (WG 2021)
- National Quality and Safety Framework (WG 2021)

5. Quality Impact Assessment Organisational Assurance

The duties and responsibilities of key individuals and departments that are required to be involved in QIAs are listed below; organisational policies are expected to include clear accountabilities for Quality Impact Assessments at all levels of the organisation.

Oversight of the QIA framework occurs at a Clinical Quality Governance Group, with onward report to the Quality and Safety Committee and Board as appropriate.

6. Roles and Responsibilities

Clinical Quality Governance Group (CQGG) will:

- a) Be assured that there is an appropriate QIA process undertaken for all new and existing Trust wide service redesign/transformation, projects, and cost improvements.
- b) Receive oversight reports on new and existing Trust wide schemes/projects that have undergone a Full QIA to ensure risk planning is robust and the impact on quality and performance is being thoroughly assessed and negative impact mitigated.
- c) Have oversight of the framework and central repository for all QIA's, initial screening and full QIA.
- d) Oversight of onward report to the Executive Management Team; Quality, Patient Experience and Safety (QuEST) Committee and; Trust Board, as appropriate.

Operational Teams/ Corporate Teams/Project Boards/Programme Boards will:

- a) Ensure QIAs are completed for service redesign/transformation projects and cost improvements with areas of responsibility.
- b) Undertake the initial QIA screen.
- c) If a Full QIA is not required (Score <8), include decision & rationale in documentation, with a caveat to review the need for QIA in the event of changes to the project.
- d) Ensure the respective clinical director (Director of Quality and Nursing / Medical Director / Director of Paramedicine) or designated deputy have reviewed and authorised the QIA initial screening once completed.
- e) Submit the QIA Screen to CQGG for noting and retention as evidence for future Duty of Quality reporting.
- f) If a full QIA is required (score >8), complete full QIA template with mitigations and monitoring measures.
- g) Ensure the respective director is sighted on the QIA once completed for review and submission to CQGG.
- h) Submit to Clinical Quality Governance Group for approval or escalation to full EMT where clinical directors identify significant organisational risk resulting from the proposed change.
- i) AAA reports to QuEST will identify QIAs completed and explicitly identify those that have required EMT review and authorisation.
- j) CQGG secretariat to maintain a digital QIA repository.
- k) Provide regular updates to CQGG on all full QIAs approved.

Quality, Safety and Patient Experience Directorate will:

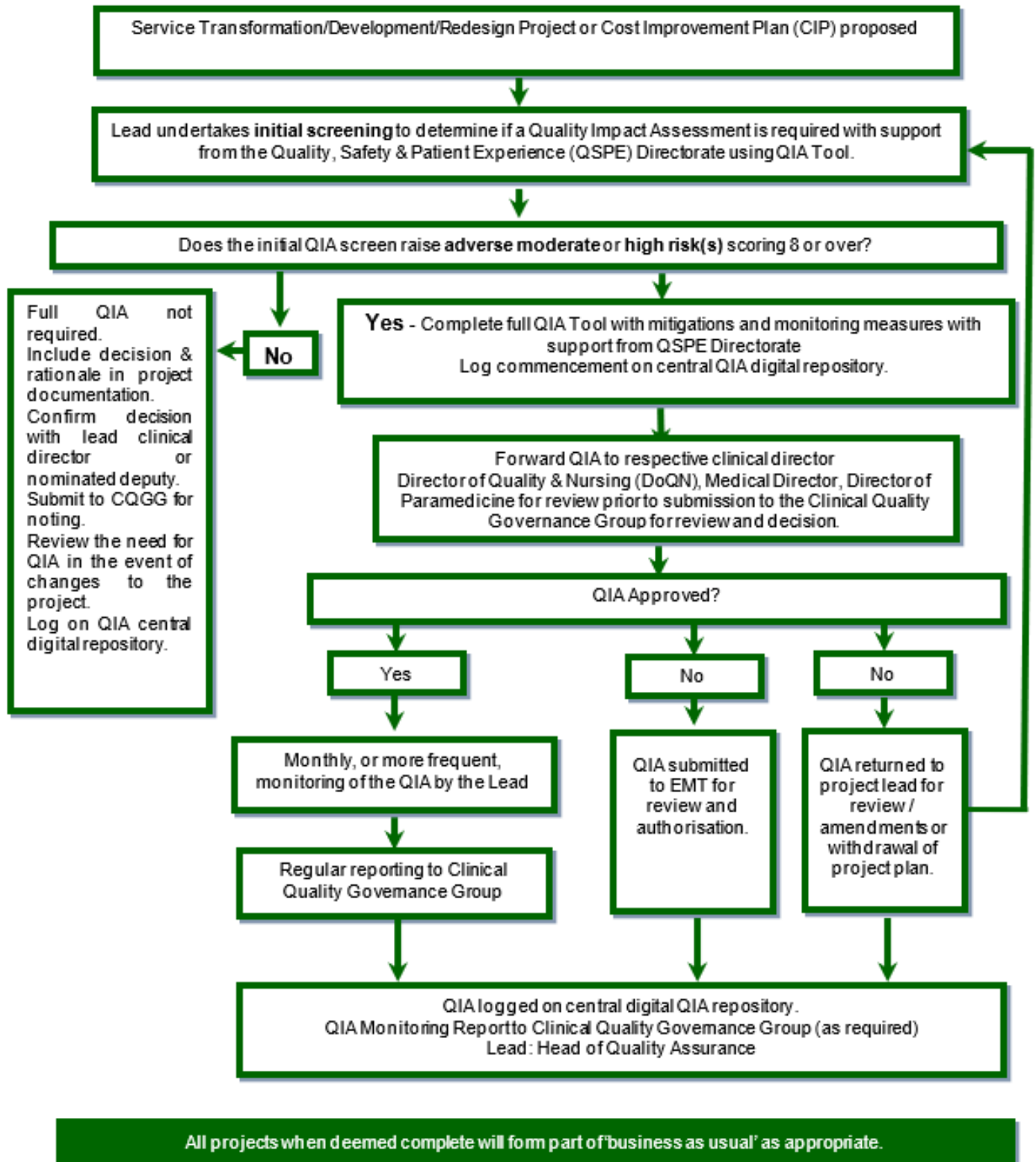
- a) Provide QIA tools, advice, and support to leads undertaking quality impact assessments related to clinical and governance Trust wide service changes/schemes/projects.
- b) Prepare information for the QIA oversight report under the requirements of the Duty of Quality.

7. Horizon Scanning

Continued horizon scanning is key to ensuring the organisation is capturing all learning and improvement opportunities through scrutiny of external reports, inspections, and inquiries in NHS Wales and wider in relation to quality impact assessment.

8. Flowchart Quick Reference Quality Impact Assessment (QIA)

Appendix 1 – Flowchart Quick Reference Quality Impact Assessment (QIA)



The governance process supporting the QIA can be categorised under initial screening and full QIA. Both approaches assess the quality impact (positive, neutral, or adverse) on service provision for any proposal to change the way commissioned services are delivered.

Completion of the QIA template under initial screening of quality impact requires judgement on whether the impact on the key areas of quality are neutral (N), positive (P) or adverse (A). Where potential adverse impacts on quality are identified they should be risk assessed using the risk scoring matrix identifying the likelihood of the adverse impact occurring and the consequence.

Scoring the likelihood of impact and consequence is not required for positive or neutral quality impacts. Where the adverse (A) impacts score greater than eight in any health care standard domain and/or enabler this will result in the need to undertake a more detailed full QIA.

All full QIAs should be considered for inclusion on local / corporate risk registers as appropriate. Equality impact assessments (EQIA) must also be undertaken as per Trust policy. This remains separate to the QIA process, however the Trust is considering how various impact assessments can be 'brought together' to improve usability.

AGENDA ITEM No	
OPEN or CLOSED	OPEN
No of ANNEXES ATTACHED	

Quality Impact Assessment (QIA): Clinical Model Transformation: Ambulance Performance Framework Phase Two (Incident Coding: Orange/Yellow/Green) PILOT

MEETING	Clinical Quality Governance Group
DATE	29 th September 2025
EXECUTIVE	Lee Brooks (Executive Director of Operations)
AUTHOR	Gareth Taylor (Senior Project Manager)
CONTACT DETAILS	Gareth.taylor3@wales.nhs.uk
CORPORATE OBJECTIVE	Providing the right care or advice, in the right place, every time.
CORPORATE RISK (Ref if appropriate)	223 – The Trust’s inability to reach patients in the community causing patient harm or death (Score – 25) 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 (Score – 25)
QUALITY THEME	Governance Leadership and Accountability
Quality Health & Care Standards 2023 Domains	Safe Timely Effective Efficient Equitable Person Centred Care
Quality Health & Care Standards 2023 Enablers	Leadership Culture Workforce Information Whole System Learning Improvement and Research

REPORT PURPOSE	1. CONSIDER and APPROVE this QIA in principle	
CLOSED MATTER REASON	N/A	
REPORT APPROVAL ROUTE		
WHERE	WHEN	WHY
Call Categorisation Project Group	2nd September 2025	Project Group review and endorsement
Change Advisory Group	16th September 2025	To provide governance, clinical leadership, and accountability in support of a transition from a clinical response model to clinical service model, within which an element consists of a review of current call categories and implementation of revised categories that best ensure appropriate allocation of services.
Strategic Transformation Board	22nd September 2025	For information.
Clinical Quality Governance Group	29th September 2025	To provide governance, clinical leadership, and accountability in support of a transition from a clinical response model to clinical service model, within which an element consists of a review of current call categories and implementation of revised categories that best ensure appropriate allocation of services.
QuEST	10th October 2025	To provide governance, clinical leadership, and accountability in support of a transition from a clinical response model to clinical service model, within which an element consists of a review of current call categories and implementation of revised categories that best ensure appropriate allocation of services.
Trust Board (appendix to Trust Board Paper)	23rd October 2025	To provide governance, clinical leadership, and accountability in support of a transition from a clinical response model to clinical service model, within which an element consists of a review of current call categories

		and implementation of revised categories that best ensure appropriate allocation of services.
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ANNEXES:

- 000 Clinical Advisory Group Cover Paper
- 002 Integrated Equality Impact Assessment ERS Workstream
- 003/004/005 Data Definitions V2.1
- 006 OrangeYellowGreen Monitoring and Assurance Action Plan 20250827
- 007 Ambulance Performance Framework Explainer V2.2
- 008a/b/c Clock Start Diagrams

QIA

Annex 2 – Part 1 QIA Screening Tool & Part 2 Full QIA

Governance, Leadership & Accountability

Title of service change/proposal	Call Categorisation and Incident Coding (Phase Two)
Date of QIA assessment:	29 th July 2025 (QIA Initiated) 16 th September 2025 (CAG) 29 th September 2025 (CQGG)
Date logged on central QIA digital repository.	29 th September 2025

Project overview (summary)

1. SITUATION AND BACKGROUND

In response to the increasing complexity of healthcare needs, WAST is transitioning from a traditional Clinical Response Model, which prioritises emergency care and transport, to a Clinical Services Model, which expands the role of ambulance services beyond emergency response to encompass a broader range of clinical services. Whilst the current model has been effective in addressing acute, time-sensitive emergencies, this is no longer fit for purpose and often limits the scope of care and fails to fully leverage integrated care pathways.

The proposed Clinical Services Model broadens the role of ambulance services, incorporating a wider range of clinical services for both emergency and urgent care. This approach aims to reduce hospital admissions and improve patient outcomes by providing a more comprehensive, integrated care continuum that aligns with national policies such as the Six Goals and 'shift left' initiatives.

This transition reflects a wider movement towards patient-centred care, with ambulance services playing a critical role in meeting the diverse needs of those accessing care via 999. The new model will enhance efficiency and responsiveness, positioning the service to meet evolving healthcare demands.

Rapid Clinical Screening was implemented between November 2024 and February 2025. This was followed by the implementation of **Phase One of the Ambulance Performance Framework**, encompassing the launch of **Purple** (Arrest) and **Red** (Emergency) incident coding targeting cardiac/respiratory arrest, and those at risk of deterioration into arrest. This Phase (Call Categorisation Phase One) was implemented as planned on the 1st July 2025.

The Quality Impact Assessment for these process changes was developed in September 2024 and approved at CQGG in October 2024 (V6).

This QIA reflects the progression into **Phase Two of the Ambulance Performance Framework**, a more comprehensive intervention targeting the largest cohort of patients entering the system via 999 services, which will be coded against **Orange Now**, **Yellow Soon**, and **Green Planned** Incident Coding.

Both QIAs outline the potential impact of the transition on certain areas of service delivery, but it is important to consider the wider context that the new model is based on reduction and prevention of the unnecessary harm which may currently exist in the present model. Each adverse incident is presented against a backdrop of a system that is designed to be safer and leads to better clinical outcomes for our patients. For example, should patients experience longer waits in triage or assessment, the intention is that it will lead to a more appropriate intervention and better overall outcome.

2. SUMMARY OF IMPLEMENTED CHANGES TO THE CLINICAL SERVICE MODEL AND CALL CATEGORISATION

2.1. AMBULANCE PERFORMANCE FRAMEWORK: PHASE ONE (LIVE)

Changes to Existing RED Category – Subdivided into the ARREST, EMERGENCY and RCS0 categories. MPDS code alignment shall be clinically determined with clinical governance.

- a. **ARREST Category:** The **ARREST** category prioritises cardiac and respiratory ARRESTs, where immediate intervention is critical. The focus on rapid dispatch and swift attendance ensures that these time-sensitive cases are handled with urgency.
- b. **EMERGENCY Category:** The **EMERGENCY** category encompasses incidents that are potentially life-threatening and demand immediate intervention. Due to the urgency and likelihood of conveyance to secondary care, cases may bypass any clinical screening and proceed directly to dispatch, or be returned for dispatch following RCS0 review.
- c. **Rapid Clinical Screening Category – RCS0 Sub-group:** Covers current RED Category patients. These are high-priority calls, but by refining the response to better fit individual needs, we can optimise emergency resource use for those most in need, improving care quality and efficiency.

Changes to AMBER and GREEN Processes:

- d. **AMBER 1** – This transitioned to the new RCS1 process
- e. **AMBER 2** – This transitioned to the new RCS2 process
- f. **GREEN** – This transitioned to the new RCS3 process
- g. **Rapid Clinical Screening Category – RCS1, RCS2, and RCS3 Sub-groups:** These subgroups are determined by analysing high-risk markers from clinical records. This approach prioritises incidents based on the risk of deterioration, ensuring urgent cases receive timely care, while others can be managed through remote clinical assessments or alternative pathways.

2.2. Rapid Clinical Screening – Queue Safety

Early clinical screening provides an opportunity to review a defined code-list of 999 incidents populated on a screening queue by EMD Call takers, once a final MPDS code has been generated. Queue Safety is a key component, overseen by a clinician assigned to the role of navigator. These trained clinicians are responsible for;

- Continuous live clinical oversight of the EMSC waiting queue for scene response, including resourcing and dispatch prioritisation decisions for patients returned by screeners and CSD.
- Assurance of clinical need for scene response, including recommendation for suitable resource type such as EMS, NEPTS, APP or alternative volunteer response for every patient waiting.
- Recommendation of welfare call follow up by acuity and timing recommendations within new welfare module if not already actioned.
- Review of the EMSC queue to mitigate patient safety concerns, including escalation of calls, dispatch out of order or return to CSD for further assessment and clinical intelligence where indicated.
- Use clinical strategies where required to gain clinical intelligence from scene to inform patient centred decision making, such as enhanced screening or recommended dispatch of CWRS.
- Be a point of contact for clinical checkpoints or advice with the ODU. Allocators and EMSC Managers for communications regarding the EMSC waiting resource queue.
- Be a point of contact for duty Teams in EMSC and CSD for clinical or welfare concerns for patients waiting in the community for resources and scene response
- Actively manage and co-ordinate the operational shift, including rest breaks, allocation to daily workstreams and agile flexing to step up additional capacity for screening, in-coming telephony requests or Red Review when demand or UHP dynamically changes.

3. SUMMARY OF PROPOSED CHANGES TO THE CLINICAL SERVICE MODEL AND CALL CATEGORISATION

3.1. AMBULANCE PERFORMANCE FRAMEWORK: PHASE TWO

To align with the evolving clinical model, new categories are proposed to replace 'Amber' and 'Green'.

Orange Now: time sensitive

Yellow Soon: assess and respond

Green Planned: planned response

As referenced in WAST's Winter Plan 2025/26, the core change is to further evolve its clinical model and deliver phase 2 (**Orange Now**, **Yellow Soon** and **Green Planned**) of the New Ambulance Performance Framework. This will see WAST move away from the Medical Priority Dispatch System (MPDS) code as the final disposition for the first time in its history. This transforms the model of care, with a remote clinician determining the disposition and identifying the resource required to meet each patients' needs. WAST wants to implement this change at the earliest opportunity to give its clinicians and operations managers as much time as possible to familiarise themselves with this major transformation before the winter. WAST is currently on target for the 01 December go live, subject to the CAD third party supplier now completing its planned work on the required changes.

In accordance with the Phase One, **Purple Arrest** and **Red Emergency** incidents should continue to be dispatched in time order with the closest suitable and available resource. A mechanism for supporting clinically informed dispatching is to be established in due course and updates regarding this will be shared once available.

If the Remote Integrated Care Service deems a face-to-face response is required then the ambulance service will either dispatch immediately (**Arrest/Emerg/Now**), within a short time frame (**Soon**), or schedule a person's care or transport to the right place (**Planned**). They may also decide for a face-to-face assessment to better inform the remote clinical decision e.g. sending a volunteer Community Welfare Responder.

RCS0 will continue to be utilised in line with current practice. As noted in the Phase One QIA (V6), if screening cannot commence within 60 seconds of notification to the screening queue, this category will default to **Red Emergency** and be presented to the dispatch queue as a safety measure.

	PHASE ONE		CURRENT STATE		
	ARREST	EMERG	AMBER 1	AMBER 2	GREEN
	c. 10% of calls		c. 70% of calls		c. 20% of calls
Category description	Cardiac or respiratory arrest	At high risk of cardiac or respiratory arrest	Serious but not immediately life-threatening		Neither serious nor life threatening
Typical conditions	Cardiac arrest Respiratory arrest	Choking Major haemorrhage Major trauma	Most medical and trauma cases including: Chest pain Fractures Most stroke		Minor injuries Generally unwell Earache
Response type	Immediate dispatch (no rapid clinical screening)	Immediate dispatch (no rapid clinical screening)	Emergency response – most suitable clinical resource based on response profile – includes management via remote “hear & treat” services		Ideally suited to management via secondary telephone assessment
Standards	Median response 6-8mins 90% within 20mins		No current time standards / targets		

RAPID CLINICAL SCREENING

Figure 1: Phase One and Phase Two (current state) of ambulance response target review

Coupled with Phase One, Phase

Two would see the introduction of **five** distinct response categories.

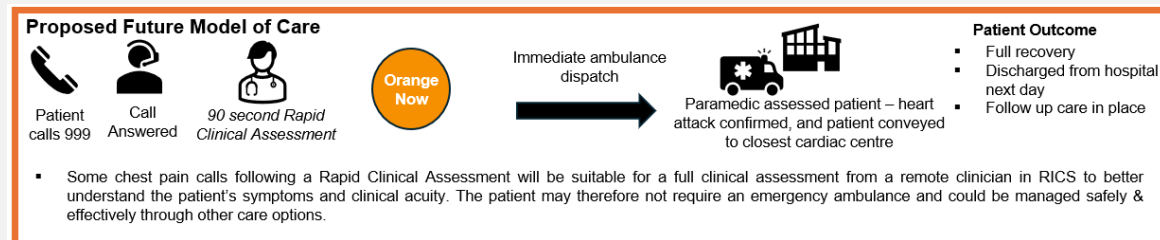
PURPLE ARREST
 RED EMERGENCY
 ORANGE NOW
 YELLOW SOON

GREEN PLANNED

4. OVERVIEW OF AMBULANCE PERFORMANCE FRAMEWORK PHASE TWO CATEGORIES

ORANGE NOW

This change aims to manage time-sensitive complaints in the current 'Amber' category differently by prioritising ambulance dispatch. Examples include suspected stroke or STEMI.



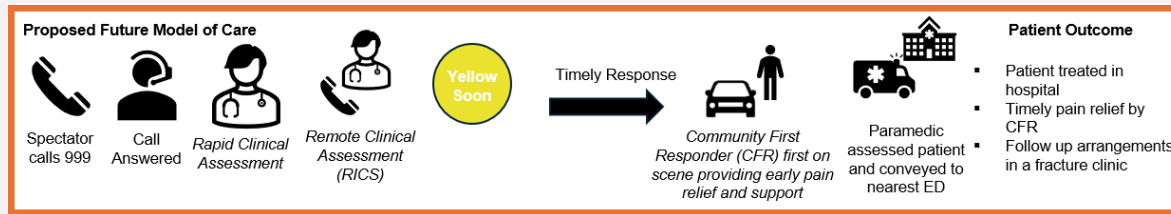
Definition: A patient likely to need timely diagnostics, treatment and/or transport to hospital or specialist care e.g. a person in stroke or heart attack.

Response: Determined by the clinical need of the patient and recommended by the triaging clinician. In the case of STEMI or Stroke, this will in almost all cases be an emergency ambulance, but additional responses can be considered. Auto dispatch disabled, this category will normally be responded to with emergency warning devices.

Purpose of Attendance and Skillset: Rapid arrival at specialist or emergency care facility as soon as possible.

YELLOW SOON

The screening process is designed to enable more detailed clinical decision-making for individuals who have experienced a serious injury or are acutely unwell in an environment that may affect their outcome. An example of a serious sports injury in harsh weather conditions is illustrated below.



Definition: Further clinical assessment to support clinician decision making (remote or face to face) for discharge at scene, and/or alternative pathway, and/or planned transport to treating facility, e.g. a person with abdominal pain.

Response: Determined by the clinical need of the patient and recommended by the triaging clinician. An emergency ambulance may be required, but suitable alternative response options may be able to resolve the situation. Conveying resource requirement to be identified at remote assessment if possible. Auto dispatch disabled, this category would not normally be responded to with emergency warning devices.

Purpose of Attendance and Skillset: To prevent unnecessary escalation of care, provide a prompt response to cases to minimise pain or distress, assist with gathering further information to inform appropriate care planning. Skillsets will be determined by the clinical need, and as closely aligned with best practice as possible. The use of the volunteer network may support effective deployment of resources.

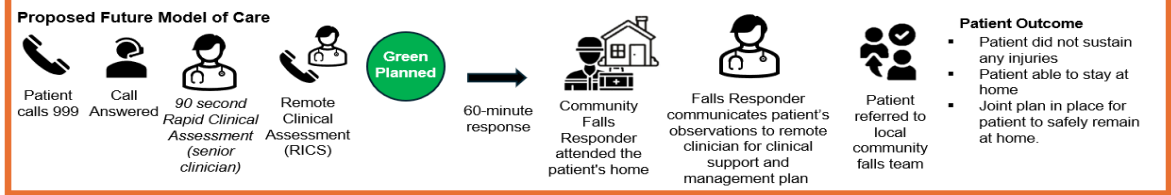
GREEN PLANNED

Individuals who have fallen will have their needs evaluated through the screening process. If it is determined that a fall responder may be necessary, one will be dispatched while simultaneously forwarding the case to the Remote Integrated Care Service. This allows for a remote clinician to conduct an intervention and assessment before the fall responder arrives, thereby decreasing the chances of prolonged lying on the floor or other negative outcomes.

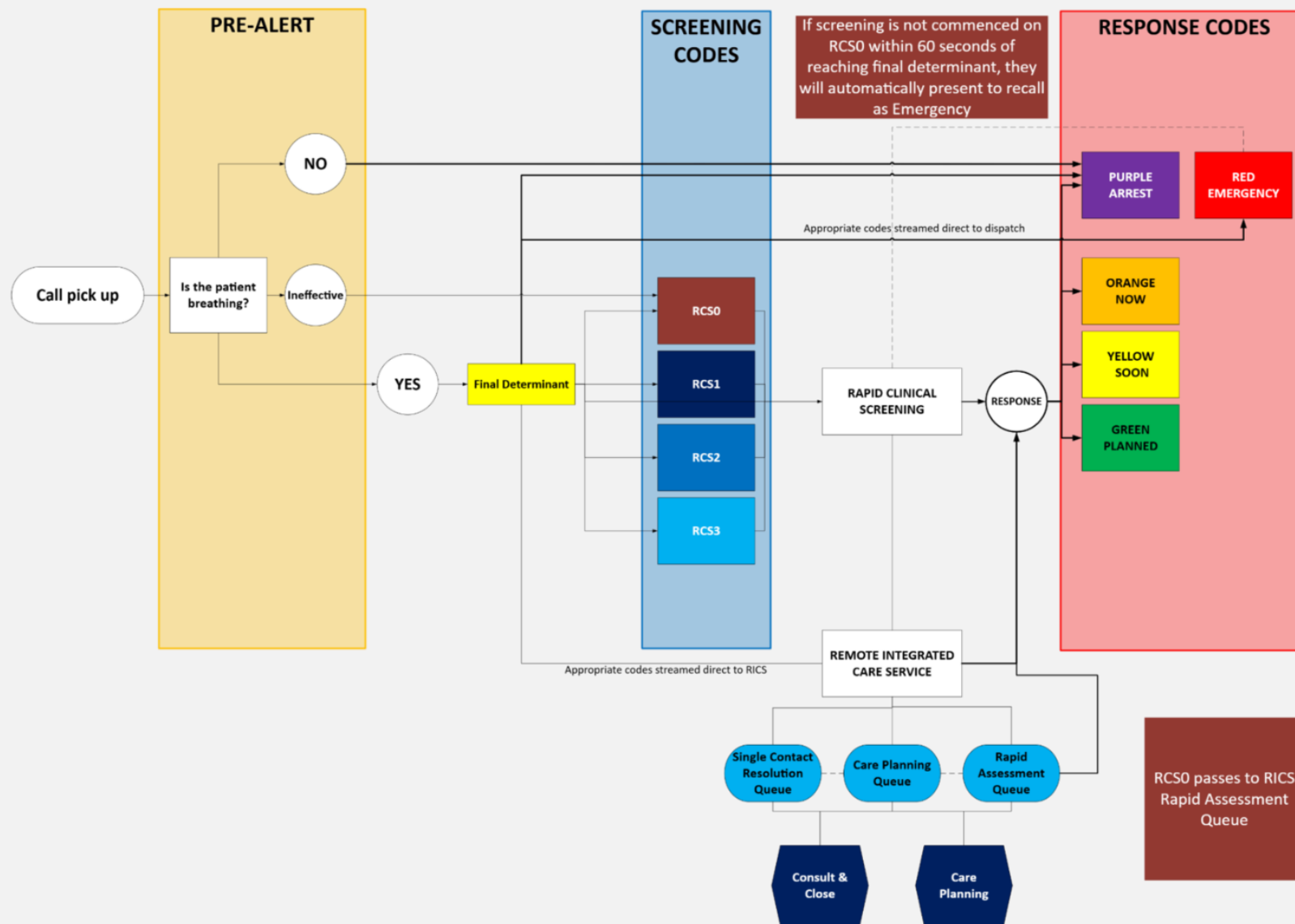
Definition: High potential for discharge at scene or referral to community or another planned pathway, e.g. a person with earache.

Response: Community or non-emergency based responses. Auto dispatch disabled.

Purpose of Attendance and Skillset: Right response for need and this may be for a see and treat/refer disposition or for a conveyance to a definitive care centre away from the Emergency Department (e.g. Minor Injury Unit). Skillset will be aligned with the most suitable for clinical presentation (e.g. Falls Responder for fallen person).



5. MAIN OPERATIONAL SYSTEM CHANGE



As noted in previous sections. See Ambulance Performance Framework Explainer for detailed process flow mapping of current and proposed model. Graphic noted above.

6. EVIDENCE BASE

This pilot aims to **develop** the evidence base for further adoption of the revised model. While there is a lack of benchmarking available to the categorisation of call priorities outlined in the Performance Framework Explainer document, there is a basis for commencing the pilot drawing on international evidence relating to outcome-based triage including,

- **The Canadian Triage and Acuity Scale (reformed):** A five-level triage system used in emergency departments that aids triage based on severity and risk (e.g. CTAS 1 – Resuscitation-immediate)
- **NHS England Clinical Triage System:** A model of determination of severity and urgency.

The pilot is not a standalone workstream, but also an enabler of wider NHS Transformation where the goal is to share data, co-design pathways, and provide mutual support to health and social care partners. It is aligned in particular to national policy including the **Six Goals** for Urgent and Community Care, ongoing work around paramedic referral to SDEC (same day emergency care), Regional Partnership Board interventions, as well as major Acts such as;

- Well-being of Future Generations Act 2015
- Health and Social Care (Quality and Engagement) (Wales) Act 2020

This transformation positions WAST as an integrated system partner across urgent and emergency care. By aligning call categorisation with the Six Goals for Urgent & Emergency Care strengthens whole-system flow, reduces avoidable ED conveyance, and supports local community and primary care services.

In designing the model and subsequent call categories, accountable forums such as CPAS have considered the national and international clinical guidance available in order to present a rationale. These would have included NICE Guidelines, and the NHS Performance Framework. In addition to the defining of call categories, the role of the clinical navigator in actioning the changes is also driven by robust training plans, thorough recruitment, and demonstration of competencies. This is evidenced by clinical audit, and evidence of training stored in the Project Document Repository.

7. PERFORMANCE MEASURES OF SUCCESS

Performance measures attributed to each category, are included in the table below (figure 2).

	Category	Description	Aim	Measures
Respond Immediately	PURPLE: ARREST	Cardiac or respiratory arrest	Increase ROSC rates	<ul style="list-style-type: none"> • ROSC rate • Median time to identify cardiac arrest • Median time to commence CPR instruction • Median time for defibrillator arrival • Median response (6-8 minutes) • 90th percentile (20 minutes)
	RED: EMERGENCY	At high risk of cardiac or respiratory arrest	Prevent deterioration into arrest	<ul style="list-style-type: none"> • Median response (6-8 minutes) • 90th percentile (20 minutes) • Outcome measure (Pain, NEWS, Spo2)
Time Sensitive	ORANGE: NOW	Likely to need diagnostics and transport to hospital or specialist care e.g. a person in stroke or heart attack	Rapid arrival at specialist or emergency care facility as soon as possible	<ul style="list-style-type: none"> • Median response of most appropriate resource • 90th percentile • Stroke care bundle inc. call to door median and % arrival at specialist site • STEMI care bundle inc. call to door median and % arrival at specialist site • Further measures developed over time
Assess and Respond	YELLOW: SOON	Further clinical assessment to support clinician decision making (remote or face to face) for discharge at scene, and/or alternative pathway, and/or planned transport to treating facility, e.g. a person with abdominal pain.	Prevent unnecessary escalation of care	<ul style="list-style-type: none"> • Median response of most appropriate resource • 90th percentile • % by disposition
Planned Response	GREEN: PLANNED	High potential for the Ambulance Service to manage the care episode in its entirety or in collaboration with community service or planned care provider, e.g. chest infection, palliative care, mental health or UTI.	Right response for need	<ul style="list-style-type: none"> • Median response of most appropriate resource • 90th percentile • % by disposition

Figure 2: Revised Category Definitions and Measures

8. QUALITY-RELATED MEASURES OF SUCCESS

It is acknowledged that in development and delivery of this pilot, focus on development of performance measures have been subject to increased scrutiny in order to satisfy the terms of the Welsh Government mandate around monitoring, assurance, and evaluation. However, this doesn't disregard the urgent requirement for robust quality measures to demonstrate the positive impact on patient outcomes. The Trust (and this pilot) is obliged to comply with Health and Social Care (Quality and Engagement) (Wales) Act 2020, specifically the Duty of Quality and the Duty of Candour. As noted in the Section *Patient Safety*, all instances of patient harm will be investigated and disclosed in line with these statutory duties and the NHS Wales Putting Things Right Process.

Monitoring and evaluation of experiential, people-centred data will take place across the entire Clinical Model Transformation Programme via the development of balanced scorecards. These scorecards were created through consultation with stakeholders across all specialties and contain measures of success relating to each workstream within the programme. They include four key quadrants *Staff*, *Patient*, *System Partners*, and *Value* and aim to demonstrate the tangible and measurable impact of the overall service change on the people who come into contact with WAST.

Alongside the this, there is an ambition to generate PREMS that align with the single national PREM, while allowing for more targeted data collection, specific to our service. Any PREM development however is subject to ICO recommendations.

Clinically, indicators will be used to measure clinical effectiveness of the service changes.

9. OBJECTIVE(S)

As this clinical model transition is implemented, and in line with the summary above, the overall objectives for Phase Two will be to,

- Expand the adoption of outcome-based metrics to encompass the full spectrum of emergency ambulance care, moving beyond the initial focus on cardiac arrest and critical illness.
- Refine performance targets and measurement methods to ensure they remain clinically meaningful and aligned with both patient outcomes and service improvement.
- Consolidate learning from the first phase to establish best practices and set new operational standards for emergency response in Wales.
- Engage with a broad range of stakeholders—including clinical teams, commissioning bodies, and governance groups—to ensure robust implementation and accountability.

10. OUT OF SCOPE OF THIS QIA*

- Achieve full operational capacity under the **Clinical Services Model** with **RICS** fully integrated

* The development of RICS and the formal establishment of the service will be supported by a separate QIA, outlining the clinical and operational arrangements for management of inbound and outbound call flows.

11. GOVERNANCE ARRANGEMENTS

A Call Categorisation Task & Finish Group was initially established with Executive Sponsorship from the Executive Director of Operations. The purpose of the group is to collaboratively design and develop the revised Call Categorisation Flow Process. Following internal confirmation of the call categorisation model and formal engagement and initiation with Trade Union Partners, Commissioners, Welsh Government, and MIS (system supplier), a decision was made by the CMT Board on the 27th September that the Task & Finish Group would be closed and that a Call Categorisation Implementation Group would be established to oversee delivery of the agreed model.

As noted in the Phase One QIA, a Rapid Clinical Screening Project Group and a Call Categorisation Task & Finish Group were subsequently established and reported into the CMT Programme Board via the Emergency Response Service Workstream, allowing dependencies between Rapid Clinical Screening and Call Categorisation changes to be managed effectively with joint operational and clinical leadership from the Assistant Director of Operations, Integrated Care and the Assistant Director of Clinical Delivery. Group membership comprises of Senior Leaders from across the organisation including Operations, Clinical, QSPE, Digital Services, and Strategy Planning & Performance. The groups formally report into the Clinical Model Transformation (CMT) Programme Board, with additional fortnightly Executive CMT meetings.

Due to the significant clinical considerations associated with the introduction of the proposed changes and the associated revisions to call categorisations, clinical assurances have been reported into Clinical Quality Governance Group (CQGG) where required. Alongside this QIA, an eQIA and Monitoring and Assurance Framework has also been completed.

Serious Clinical Incident Forums will also monitor incidents linked to clinical transformation and enable opportunities to act and mitigate.

The Call Categorisation Task & Finish Group format continues into Phase Two, allowing for a seamless reporting and approval processes in line with existing arrangements. These are outlined in the next section.

12. FORMAL GO-LIVE APPROVAL

Approvals:

- 18/08 - Data Definitions Documents Presented to Call Categorisation Group, and provided to MIS
- 28/08 - Data Definitions and Codes Presented to CQGG
- 08/09 - CMT Programme Board delegation of authority for Call Categorisation Phase 2 to the Call Categorisation Implementation Group
- 16/09 – CAG Review of QIA
- 16/09 - Finance and Performance Group (Monitoring and Assurance)
- 17/09 - DCR Review - Codes (ORANGE/YELLOW/GREEN)
- 23/09 - CPAS - Approval of Codes (ORANGE/YELLOW/GREEN)
- 29/09 - CQGG Review of the QIA and eQIA (Phase Two V1)
- 10/10 - QuEST
- 23/10 - Trust Board notified of intention to proceed

Go-Live:**Delegation of Go/No-Go to the Call Categorisation Task & Finish Group as follows:**

- 20/10 - Group Intent to Proceed. Final Approvals
- 27/10 - Go/No Go

***Go-live consent will be required from the Call Categorisation SRO and the Strategic Commander and will need to be formally signed off by the Executive Director of Operations (and Emergency Response Service Workstream SRO).**

13. QUALITY ASSURANCE PROCESS

As noted above, the Trust (and this pilot) is obliged to comply with Health and Social Care (Quality and Engagement) (Wales) Act 2020, specifically the Duty of Quality and the Duty of Candour. As noted in the Section *Patient Safety*, all instances of patient harm will be investigated and disclosed in line with these statutory duties and the NHS Wales Putting Things Right Process.

The Trust also recognises its legal duty under the Health and Safety at Work etc. Act 1974 to provide a safe system of work. A formal stress risk assessment will be undertaken pre-go-live, with results and mitigation plans shared with Trade Unions and may be included on the corporate risk register.

An independent, external audit (commissioned through NWSSP or equivalent) will review safety, equity, and workforce impact at 3 and 6 months post-launch, with findings reported publicly to the Trust Board and Welsh Government. Residual risks scoring ≥ 8 will remain on the Corporate Risk Register with named Executive leads and explicit Board sign-off of accepted residual risk.

Key Performance Indicators (KPIs) have also been proposed for all categories within scope of this QIA (see *Measures of success* above). These have been developed collaboratively through the Call Categorisation Task & Finish Group workshops and a series of technical meetings. A performance dashboard will be developed against these KPIs and will be monitored alongside the existing performance dashboard to enable comparative evaluation of old and new call flows, and to evidence improvement in patient outcomes.

These are further outlined in the Ambulance Performance Framework Explainer 2.2, and within the Ambulance Performance Framework Phase Two Monitoring and Assurance Plan, which is in development and includes audit criteria, volumes required, KPIs, and feedback to clinicians as a performance standard.

NOTE: It is acknowledged that transition into Phase Two pre-Winter will require retrospective evaluation of the impact of Phase One implementation, and as such is not determined by the outcome of a phased evaluation. A comprehensive evaluation of the wider Clinical Model Transformation will incorporate all areas of service change alongside agreed monitoring and assurance arrangements.

Legal and Ethical Compliance.

This Quality Impact Assessment is underpinned by the statutory duties set out in the Health and Social Care (Quality and Engagement) (Wales) Act 2020, the Equality Act 2010, and the Health and Safety at Work etc. Act 1974. The Trust will evidence compliance with these requirements through established governance and assurance processes, including routine reporting to the Clinical Quality Governance Group and the Board, transparent application of the Duty of Candour, and ongoing equality monitoring.

The Trust reaffirms its statutory Duty of Quality and Duty of Candour, committing to disclose, investigate, and learn from any instance of patient harm or near-miss arising from this pilot. Breaches will be reported through Datix, SCIF, and to the Board within established PTR timelines.

14. LESSONS LEARNT

A thorough lesson learnt exercise will be undertaken as part of the project closure. A reduced exercise was completed between Phase One and Phase Two to determine approaches to project delivery that worked well, and those that could have been improved. Themes identified included the following

What Went Well

- The Task & Finish group was formed quickly and included cross-functional representation.
- The Executive Sponsor was actively engaged, while the SRO led delivery. A de facto Vice-SRO role supported continuity and decision-making.
- Governance clarity (e.g. SOP plan, QIA, Monitoring & Assurance Plan) was established early.
- Early work on definitions via CMT Metrics accelerated delivery.
- Dual project management ensured pace and structure without overburdening the team

- Weekly meetings and daily stand-ups near go-live helped maintain momentum
- Internal and external comms plans were developed and executed.
- Feedback loops via CAG and operational teams helped refine outputs.

What Didn't Work as Well

- External supplier issues with documentation, transparency, and interface
- Lengthy data definitions process
- Short timeline

The feedback gathered helped shape the approach to Phase Two, with improved communication with suppliers (including outlining the need for key documents ahead of time), and ringfenced development time for colleagues to work on the definitions. While timelines were externally determined, the above has allowed buffers to be built into the development timeline.

As noted, a full lessons learnt exercise will be undertaken internally and externally to collate feedback on the overall process, as part of the collation of quality measures.

15. PATIENT SAFETY ARRANGEMENTS

Patient Safety, Datix, and SCIF arrangements are outlined in the table below, referenced from the Orange, Yellow Green Monitoring and Assurance Framework Developed alongside this document

Process	Lead	Comment
Twice weekly Serious Case Incident Forum (SCIF) if required	WH	This will enable the early identification of potential patient harm. SCIFs are dependent on information from clinical audit. Prioritisation is given to: coroners, litigation and next should be this categorisation change. WH and CA to follow up on additional capacity to support this work. NDR governance another important consideration that would help.
Daily review of incidents reported through Datix	CA	Early identification of avoidable harm and immediate escalation
Themes from EMSC "Missed Incident" Analysis	TBC	The definitions do not include a range/service standard (the letter from WG indicated this may be considered at a

		<p>future point). Interim approach to utilise the long-waits report.</p> <p>Following is wording from the Arrest/Emerg M& Plan: “On-duty Operations Manager completes Missed Call Analysis – EMSC management should determine mechanism to review and produce weekly report with themes, and any lessons learned.”</p>
Improved Datix Reporting	TBC	Improved DATIX analysis functionality is a top 5 priority in the IDS CMT Metrics Work Plan. The immediate focus is phase 1/phase 2, which once capacity is released from these, can be directed onto this high priority.
Points of learning for patient safety will be identified	WH	<p>Existing governance routes will be used to ensure timely learning is taking place these will be for example;</p> <ul style="list-style-type: none"> • SCIF • CAG • Complex Case Panel • Learning from Deaths
Patient deterioration analysis	TBC	The QIA has identified that there may be a risk of patient deterioration in RICS. Monitoring arrangements are being developed as per the risk assessment
Delay to intervention analysis/report	TBC	The QIA has identified that there may be the rare possibility of a patient bouncing between categories and not being assessed. Monitoring arrangements are being developed as per the risk assessment.

16. PATIENT ENGAGEMENT AND COMMUNICATIONS

The call flow categorisation aligns with the Clinical Model Transformation (CMT) workstreams, which are designed to enhance the service user experience, streamline workflows within the CCC environment, and strengthen the NHS's ability to deliver effective patient care pathways.

Ensuring patient expectations are managed throughout the process will depend on a robust and effective communications plan. A Phase One Communications Plan was developed for the period ending July 2025, and while a new plan is in development for Phase Two the approach remains largely the same.

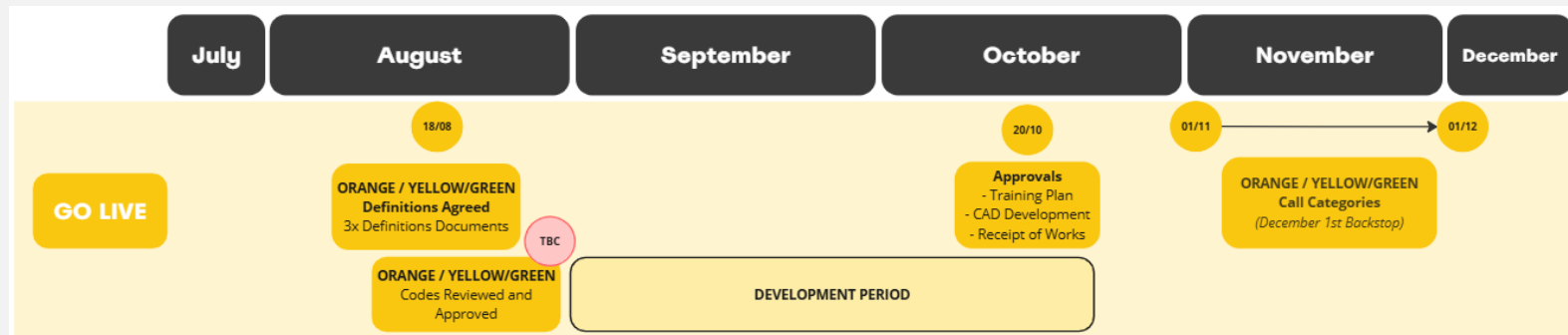
16.1. External Communications

The external communication approach includes the following;

- Stakeholder identification exercise
- Briefing Packs
- FAQs
- Stakeholder Letters (tailored and generic)
- Public Posters and other material (bi-lingual)
- Evaluation
- Patient Animation Videos (bi-lingual)
- Press Releases
- Social Media Campaign
- Internet Page Material

It is expected that a thorough and varied external communications plan will support the management of expectations and ensure any concerns are managed as early as possible. This will include a finalised Phase Two communication strategy, with a clear timeline of key messages, named leads, and a commitment to real-time patient feedback (e.g., PREM-lite SMS or CIVICA rapid survey).

17. PROPOSED CHANGES IMPLEMENTED – ‘GO LIVE’



Target Audience

- WAST Clinical Advisory Group
- WAST Clinical Quality Governance Group
- QuEST
- WAST Clinical Model Transformation Programme Board
- WAST Executive Leadership Team
- Trust Board

To Read in Conjunction With

- 000 Clinical Advisory Group Cover Paper
- 002 Integrated Equality Impact Assessment ERS Workstream
- 003/004/005 Data Definitions V2.1
- 006 OrangeYellowGreen Monitoring and Assurance Action Plan 20250827
- 007 Ambulance Performance Framework Explainer V2.2
- 008a/b/c Clock Start Diagrams

Clinical Model Transformation Board (information)
CQGG (approval)

Reporting route (oversight group of QIA and monitoring of quality measures)	
How will quality measures be obtained? (Full QIA only)	<p>Performance Measures – The proposed revisions to call flows and categorisations is accompanied by the introduction of a performance framework explainer document (appendix), and This will be supported by a series of three data definition documents that underline the measures against which the success of this implementation is determined.</p> <p>Quality Measures – As noted above, the Call Categorisation Task & Finish Group will ensure that appropriate arrangements are in place to capture staff feedback as part of the process (demonstrated in the Balanced Scorecards and development of specific PREMs to compliment the national PREM now in use), including rapid identification of any perceived or evidenced impact on patient safety, particularly as we move from time-based, to outcome-based response.</p> <p>The group will also consider patient safety throughout, and how incidents that could relate to the revised call flows are appropriately captured to ensure that any relationship between the complaint/incident and revisions to the call flow and categorisations can be investigated appropriately.</p> <p>The group will collate experience data relating to staff alongside people, taking into account the importance of staff wellbeing, clinical empowerment, and role satisfaction alongside impact on those who utilise our services.</p> <p>Note: To date, there is no evidence to suggest that patient safety will be compromised with the intended changes. However, there will continued monitoring, assessment, and management of incidents that may be linked to the changes, throughout the lifecycle of the pilot. The pilot is a opportunity to learn, assess, and optimise an approach that is intended to lead to better patient outcomes across the system.</p>
Executive lead	Lee Brooks (Executive Director of Operations)
Project lead(s)	Phase Two SRO – Ceri Griffiths Clinical - Greg Lloyd Operational – Elliot Miller Performance and Evaluation – Kayleigh Malson and Hugh Bennett
Outcome of QIA (screen only or full QIA)	Full
Comments (including brief rationale for not progressing to full QIA if appropriate) Log commencement on central QIA digital repository	Full QIA required for adverse risks associated with Patient Care, Effective Care, Timely Care, and Workforce domains.

**Date submitted to Clinical
Quality Governance
Group (full QIAs) and
inclusion on QIA
Database (all QIAs) by
CQGG secretariat.
[Quality.amb@wales.nhs.u
k](mailto:Quality.amb@wales.nhs.uk)**

29th September 2025

Annex 2 – Part 1 QIA Screening Tool continued

Health & Care Standards Domains 2023	Potential / Actual Impact Question	Potential Impacts? Positive (P), Neutral (N), Adverse (A)	Likelihood Score	Consequence (impact) Score	Score Likelihood X consequence	Score 8 & above. = Full QIA
<p>Safe</p> <p>1 Patient Safety</p> <p>Our healthcare system is a high quality, highly reliable and safe system that avoids preventable harm, maximising the things that go right and learning from when things go wrong to prevent them occurring again. People’s health, safety and welfare are actively promoted and protected; risks are identified and monitored and where possible, risks to safety are reduced or prevented. We promote and protect the wellbeing, and safety of children and adults who become vulnerable or at risk at any time. Where children or adults may be experiencing or are at risk of abuse or neglect, we take appropriate, timely action and report concerns.</p>	<p>Could the proposal impact on any of the following? Impact on serious incidents, their reporting and learning, systems in place to safeguard patients /staff and prevent harm?</p>	<p>Adverse (A)</p> <ul style="list-style-type: none"> The Phase One QIA referenced possible degradation in performance in early reporting. The Phase Two implementation (ORANGE, YELLOW, and GREEN categories) focusses on the ambition to deliver the most appropriate care on the first occasion. In doing so, some patients may experience delays in the process of determining the most appropriate care response and or management plan as they’re held. There is no existing evidence to support this potential degradation however ongoing review will be undertaken, supported by a clinical audit of outcomes. This however should contribute to an overall more positive and appropriate outcome for the patient. Alternative mitigations (such as welfare checks on the RICS queue and close daily monitoring of the Rapid Assessment Queue) may be introduced should the evidence suggest a degradation, however the role of the navigator early in the process and lack of current evidence negates this. 	3	3	9	Full QIA
		<p>Adverse (A)</p> <ul style="list-style-type: none"> There is potential for insufficient capacity, or remote workforce resource to manage the revised call flows effectively. This would have a significant impact on WAST’s ability to deliver planned service improvements and to provide assurances that in incidents where patients may be held remotely for longer, no harm has resulted from workforce capacity. Modelling exercises will support capacity planning and all decisions are made in line with the Duty of Quality expected from the Trust. 	3	4	12	Full QIA
		<p>Adverse (A)</p>	3	2	6	Screening Only

		<ul style="list-style-type: none"> There is potential for insufficient capacity regarding available response. It may be possible that attending resource may not always be the ideal intervention. 				
		<p>Adverse (A)</p> <ul style="list-style-type: none"> It has been suggested that there may be instances where patients are sent for screening and monitoring based on resource availability over clinical need. There is no evidence of this occurring. Those colleagues selected for screening duties are done so based on clinical competency and are highly trained allowing for decisions being made in the best interests of the patient, and not on other influences. This assertion will be underpinned by audit. 	1	4	4	Screening Only
		<p>Positive (P)</p> <ul style="list-style-type: none"> As in Phase One, Phase Two aims to deliver the right outcome for the patient, through clinical intervention rather than automated, time-determined processes. This will be measured using data evidencing of ideal interim vs time standard. 	N/A	N/A	N/A	Screening Only
		<p>Positive (P) –</p> <ul style="list-style-type: none"> As noted in the Phase One QIA, the introduction of new service processes will improve the appropriateness of response based on clinical presentation. Particularly for current AMBER calls that would have been stacked for allocation of resource, the Clinical Navigator will be able to direct these calls to a remote clinician. 	N/A	N/A	N/A	Screening Only
		<p>Positive (P) –</p> <ul style="list-style-type: none"> It is expected that the overall people (patient) experience will improve based on earlier and more appropriate contact with a clinician, avoiding deterioration and avoidable delays. 	N/A	N/A	N/A	Screening Only
		<p>Positive (P) –</p> <ul style="list-style-type: none"> As noted in the Phase One QIA, transitioning the model from a response model to a service model, provides an evidence-based (case for change) opportunity to implement a system that best suits the developing needs of our patients based on the principles of right care right time. 	N/A	N/A	N/A	Screening Only
<p>Effective Care Our healthcare system ensures decision-making, care and treatment reflects evidence-based best practice, to ensure that people receive the right care to achieve the optimal and possible outcomes that</p>	<p>Could the service change impact on evidence-based practice, clinical standards (NICE/JRCALC), clinical leadership and/or engagement?</p>	<p>Positive (P) –</p>	N/A	N/A	N/A	Screening Only
		<p>Positive (P) –</p>	N/A	N/A	N/A	Screening Only

<p>matter to them. We design transformative, evidenced-based, whole-of-life pathways that cover prevention, care and treatment, rehabilitation and embed these into local service delivery.</p>	<ul style="list-style-type: none"> As noted in the Phase One QIA, the introduction of Rapid Clinical Screening will introduce the Clinical Navigator as a backstop to determine whether the call is appropriate for remote assessment or for dispatch with the most appropriate priority assigned based on the information available. Clinically determined response ensures that equitable and efficient care processes are in place. 				
	<p>Adverse (A)</p> <ul style="list-style-type: none"> There is significant clinical consideration to the category definitions, and while CPAS has approved the request for change and clinical reviews are ongoing, there may be clinical discomfort with existing codes transitioning into ORANGE, YELLOW, and GREEN categories where clinical judgement is determining the final disposition. 	3	3	9	Full QIA
	<p>Adverse (A) -</p> <ul style="list-style-type: none"> There is a possibility that the changes during the pilot could adversely impact patient expectations and understanding of the service they are likely to receive. The changes represent a shift from traditional response models, and without a robust external communication plan and/or effective messaging there could be a potential rise in complaints. Alternative solutions to this may be utilising existing systems such as CIVICA to pre-empt patient feedback on the effectiveness of their care. 	2	3	6	Screening Only
	<p>Adverse (A)</p> <ul style="list-style-type: none"> There is a risk around failure to deliver on the agreed category revisions, and subsequent continued risk to delivering the appropriate resource to the correct incident. Effective and appropriate case management delivered first time is dependent on delivery of Phase Two. 	2	4	8	Full QIA

<p>Efficient</p> <p>Our health care system takes a value-based approach to improve outcomes that matter most to people in a way that is as sustainable as possible and avoids waste. We make the most effective use of resources to achieve best value in an efficient way. We only do what is needed and undertake treatments that ensure any interventions represent the best value that will improve outcomes for people.</p>	<p>Does this proposal increase waste?</p> <p>Does this proposal improve value-based approach?</p>	<p>Adverse (A)</p> <ul style="list-style-type: none"> While the intention is that the process of screening and assessment of patients presents a more effective approach and aims to provide a more value-based outcome, there may be the possibility that the initial process of holding and assessing patients may not be perceived to be the most efficient approach available i.e. remote clinicians are more expensive than EMDs. There is no evidence to support this currently, but will be explored via evaluation. 	2	3	6	Screening Only
		<p>Positive (P) –</p> <ul style="list-style-type: none"> As noted in the Phase One QIA, every patient that does not require auto-allocation to dispatch will be screened by a Clinical Navigator to determine the most appropriate care pathway, ensuring the most efficient allocation of resource based on clinical presentation. 	N/A	N/A	N/A	Screening Only
		<p>Positive (P) –</p> <ul style="list-style-type: none"> As noted in the Phase One QIA, it is anticipated that this will lead to an increase of incidents closed at scene and/or signposted to the most appropriate care provider, reducing patients presenting at Emergency Departments (EDs) by ambulance, and increasing resource availability for patients that need an assessment at scene response. 	N/A	N/A	N/A	Screening Only
<p>Equitable</p> <p>Our healthcare system provides everyone with an equal opportunity to attain their full potential for a healthy life which does not vary in quality by</p>	<p>Could the proposal impact on patient choice, dignity and respect, service user experience? Could</p>	<p>Adverse (A) -</p> <ul style="list-style-type: none"> The eQIA completed alongside this document noted the possibility of inequity towards certain age groups, in particular disability, older persons, or young people. There may be the possibility of time-based differentials when these groups access our services, however this does not present an increased risk on our current services. 	3	3	9	Full QIA

<p>organisation providing care, location where care is delivered or personal characteristics (such as age, gender, sexual orientation, race, language preference, disability, religion or beliefs, socio-economic status, political affiliation). We embed equality and human rights in our health care system.</p> <p>Person-centred Our health care system meets people's needs and ensures that their preferences, needs and values guide decision-making that is made in partnership between individuals and the workforce. We care about the well-being of individuals, their families, carers, and our staff. We ensure that everyone is always treated with kindness, empathy and compassion and we respect their privacy, dignity, and human rights. We are committed to working better together to put people and their families at the centre of decisions, seeing them as experts working alongside professionals to get the best outcome and experience.</p>	<p>the proposal impact on eliminating discrimination, on eliminating harassment and on promoting good community relations /positive attitudes?</p>	<p>Adverse (A) –</p> <ul style="list-style-type: none"> There is a possibility that the changes during the pilot could adversely impact patient expectations and understanding of the service they are likely to receive. The changes represent a shift from traditional response models, and without a robust external communication plan and/or effective messaging there could be a potential rise in complaints. Alternative solutions to this may be utilising existing systems such as CIVICA to pre-empt patient feedback on the effectiveness of their care. 	2	3	6	Screening Only
	<p>For example, if people could be treated differently in terms of race, religion, disability, gender, sexual orientation pregnancy, gender reassignment, civil partnerships, or age. (This can be a separate assessment, but the outcome recorded in the QIA)</p>	<p>Positive (P) –</p> <ul style="list-style-type: none"> As noted in both the Phase One QIA, and the Phase Two eQIA, this transformation is focussed on streaming each patient to the right services for their individual clinical needs. 	N/A	N/A	N/A	Screening Only
		<p>Positive (P) –</p> <ul style="list-style-type: none"> Likely increase in incidents closed at scene, without conveyance to ED, improving patient experience for WAST patients and patients in the community due to reduction in unnecessary ED conveyance and associated impact on waiting times. Proactive mitigations will further demonstrate this, including (where possible) welfare checks, and equality monitoring 	N/A	N/A	N/A	Screening Only
		<p>Neutral (N) –</p> <ul style="list-style-type: none"> Those service users identifying protected characteristics will be treated equally within the clinical model transformation as prioritisation and the alignment to care provided is based on the identified clinical priority of the patient. 	N/A	N/A	N/A	Screening Only
<p>Timely Care Our healthcare system ensures people have access to the high-quality advice, guidance and care they need quickly and easily, in the right place, first time. We care for those with the greatest health need first, and where</p>	<p>Could the proposal impact on care being provided in a timely way?</p>	<p>Adverse (A) –</p> <ul style="list-style-type: none"> There may in rare cases be a delay to intervention for patients re-categorised more than once, however modelling and testing will evidence the potential impact, especially during periods of Clinical Safety Plan escalation. There is a risk to the risk identification and subsequent clinical assessment of calls during certain periods. 	3	3	9	Full QIA Required

treatment is identified as necessary, we treat people based on their identified and agreed clinical priority.	<p>Adverse (A) –</p> <ul style="list-style-type: none"> There is potential for insufficient capacity, or remote workforce resource to manage the revised call flows effectively. This would have a significant impact on WAST’s ability to deliver planned service improvements and to provide assurances that in incidents where patients may be held remotely for longer, no harm has resulted from workforce capacity. Modelling exercises will support capacity planning. 	3	4	12	Full QIA Required
	<p>Positive (P) -</p> <ul style="list-style-type: none"> There is the possibility that while some patients may wait longer for initial assessment than they traditionally would for dispatch. However, the position is agreed that it is unlikely that they would receive an intervention sooner via dispatch, instead receiving a more appropriate response, where long waits may be experienced. The additional time to assessment is not currently considered a risk but will be monitored. 	N/A	N/A	N/A	Screening Only
	<p>Positive (P) –</p> <ul style="list-style-type: none"> As noted in the Phase One QIA, the introduction of five categories and the subsequent streaming of RCS0 patients to the Clinical Navigator prior to dispatch will reduce the overall number of calls allocated for dispatch. This should improve response times and outcomes for our most acutely unwell patients. 	N/A	N/A	N/A	Screening Only
	<p>Positive (P)</p> <ul style="list-style-type: none"> As noted in the Phase One QIA, patients requiring dispatch following screening, will be categorised by the Clinical Navigator and allocated based on clinical priority, ensuring that the timeliness of response is driven by clinical need. 	N/A	N/A	N/A	Screening Only
	<p>Neutral (N) –</p> <ul style="list-style-type: none"> Clock start times are to be amended, which may impact on response times reported however the real time experience for patients will be unchanged other than the Rapid Clinical Screening timeframe referenced above. 	N/A	N/A	N/A	Screening Only
	<p>Neutral (N) -</p>				

		<ul style="list-style-type: none"> During periods of heightened pressure, the available (most appropriate) resource may be limited, and response times may be adversely affected. This is the current position and will be supported by Clinical Safety Plan action cards. (no additional risk compared to existing processes) 	N/A	N/A	N/A	Screening Only
<p>Workforce Our healthcare system recruits, retains, develops, and extends roles to ensure we have enough, confident people with the right knowledge and skills available at the right time to deliver safe care. We value our people and the commitment and resilience they demonstrate in the care they provide. We care about their wellbeing, protect their rights, and support them to feel well and happy at work; and provide them with the tools, systems, and environment to work safely and effectively. Our workforce planning focuses on investing in our people and nurturing, growing, and transforming our workforce to create a sustainable workforce for the future.</p>	<p>Could the proposal impact on staff satisfaction and/or sickness retention and recruitment skill and knowledge to undertake the proposal. Public perception of the Trust or its services? Wellbeing Safe systems at work to safeguard staff and prevent harm? serious incidents & reporting and learning?</p>	<p>Adverse (A) –</p> <ul style="list-style-type: none"> There is risk of substantially harming workplace morale and disrupting the existing workplace culture by implementing further operational service changes. The Trust has undergone significant developmental and transformational work over recent years with all teams having been impacted by Organisational Change Processes, Model for Improvement Testing and introductions of new systems of work. There is a risk, by introducing a new way of working, that staff may struggle with additional system changes and experience episodes of burnout, and stress, resulting in increased sickness rates during the busiest period of the year. 	2	4	8	Full QIA Required
		<p>Adverse (A) -</p> <ul style="list-style-type: none"> As noted in Patient Safety, there is a risk that there will be insufficient workforce to manage the new workflows, presenting a significant risk to staff as well as service users. 	3	4	12	Full QIA
		<p>Adverse (A) –</p> <ul style="list-style-type: none"> As is the case with the entire Clinical Model Transformation Programme, attention must be given to the adverse impact, recruitment and training requirements will place on the Trust's existing infrastructure. The limited capacity of the Education and Professional and Clinical Practice Teams to deliver training will be impacted, as well the clinical audit teams' capacity. 	2	3	6	Screening Only
		<p>Positive (A) –</p> <ul style="list-style-type: none"> The Section <i>Queue Safety</i> outlines the core responsibilities of the clinical navigator role. This highlights the development of a highly specialised and highly trained role, which provides significant assurances to the Trust and professional bodies that our patients received the right intervention as often as possible. 	N/A	N/A	N/A	Screening Only
		<p>Neutral (N) -</p> <ul style="list-style-type: none"> There remains risk of industrial action, however not explicitly linked to this clinical transformation. 	N/A	N/A	N/A	Screening Only

		Positive (P) - <ul style="list-style-type: none"> The new approach to screening calls may clinically empower screening and senior clinicians. 	N/A	N/A	N/A	Screening Only
		Positive (P) - <ul style="list-style-type: none"> The new approach to screening calls may positively impact certain cohorts of staff, with greater specificity of response leading to higher conveyance rates, and subsequently less time on scene or outside hospital during handover. There is also the possibility of increased 'on-time' finishes as patients are more likely to be held for assessment. 	N/A	N/A	N/A	Screening Only
		Positive (P) - <ul style="list-style-type: none"> The new model will present new opportunities for development and role progression (e.g. development of the clinical screener roles) 	N/A	N/A	N/A	Screening Only
Summary rating = highest individual risk score						12

Health and Care Standard Enablers- no requirement to score only to reference any impact.

Enabler	Potential impact	Narrative
Leadership Our health care system has visible and focused leadership at all levels, with its activities driven by the organisations' vision and values for quality. Our leaders and managers take a long-term, stakeholder-centric view to develop a clear organisational vision. They have the appropriate skills and capacity to create the conditions for a functioning quality management system. We ensure our governance, leadership and accountability is effective in sustainably delivering care.	Could the proposal impact: <ul style="list-style-type: none"> Leadership of the service Trust Quality Management System Governance arrangements 	<p>Leaders have been offered change management training in preparation for large scale transformation and have had the opportunity to engage over the proposed transformation and design of a Clinical Service Model. Opportunities to engage have included Leadership symposiums, CEO Roadshows and internal planning workshops.</p> <p>Whilst there will be no direct impact on leadership arrangements, leaders involved in the Clinical Model Transformation (CMT) programme in addition to business-as-usual operational leadership requirements and wider Local Development Plan activities may feel increased pressure.</p> <p>The impact on workforce will also create increased activity and challenging working environments for leaders as they support their teams through large and continuing periods of transformational change.</p> <p>Prioritisation of the CMT programme as part of the winter plan for operational service delivery may also lead to de-prioritisation of other key work deliverables including</p>

		<p>the introduction of robust quality management systems supported by QPMF self-assessment.</p> <p>Introduction of new key performance indicators aligned with the chain of survival will require leadership support through roll out and management of quality management systems and learning/feedback for team members.</p>
<p>Culture</p> <p>Our healthcare system creates the right climate and culture to nurture and encourage quality and system safety, valuing people in a supportive, collaborative, and inclusive workplace so that our people feel psychologically safe to raise concerns and try out new ideas and approaches. Relationships within teams and with the people we serve are effective and based on transparency, accountability, ethical behaviour, trust and just culture, where people can thrive.</p>	<p>Will the proposal effect the culture of the Trust?</p>	<p>There is acknowledgment of potential impacts on staff culture, particularly as operational changes will be occurring within a system of continued operational changes, and external pressures.</p> <p>The Trust aims to embed a culture of sustainable learning and improvement; however, it must be conscious of the pressures associated with continuous redesign.</p> <p>Attention must be given to supporting colleagues adequately through change, both in terms of internal pressures and potential external pressures. There is also a wider risk associated with the Trust's reputation. Should any of the work result in negative public perceptions, the subsequent impact on staff will also be negative.</p> <p>A change management approach has been adopted in relation to the CMT programme, with Change Management leads participating in relevant project groups and workshops. Additionally, a Change Management working group has been established to:</p> <ul style="list-style-type: none"> • Support leaders and managers at all levels across WAST to facilitate change and lead their teams through large-scale transformation • Support colleagues impacted by change to deal with uncertainty and embrace change, to proactively contribute in WAST's transformation journey • Offer a robust change management approach that contributes to successful adoption of transformed ways of working and benefits realisation • Ensure change-related lessons learned during this programme are incorporated into WAST's change approach for future transformation programmes • Align change management approach with WAST's culture as much as possible.
<p>Whole System Approach</p> <p>Our healthcare system ensures safety in healthcare goes beyond individual patient safety. We will look within and beyond our organisational boundaries to learn how we can continually, reliably, and sustainably meet the evolving needs of people. We will strengthen relationships and work with all our partners to</p>	<p>Are we working with external as well as internal partners as part of the proposal?</p> <p>Does it impact on the Trust Policies i.e.? Well-being goals and five ways of working in the</p>	<p>This work has been and will continue to engage with internal and external partners, with Trade Union and Commissioning colleagues having been part of the two workshop discussions to date.</p> <p>Welsh Government have also been made aware via the commissioners of the intention to transition from response to service model, however the political considerations of revised categories and subsequent performance monitoring have also been factored into the project risks.</p>

<p>achieve good outcomes. Our policies incorporate the broader ambitions within the seven well-being goals and five ways of working in the Well-being of Future Generations Act.</p>	<p>Well-being of Future Generations Act.</p>	<p>As a key system partner, WAST commits to:</p> <ul style="list-style-type: none"> • Joint performance dashboards and shared data with Health Boards and the NHS 111/Wales programme to enable real-time escalation and mutual aid. • Collaborative winter planning with Regional Partnership Boards to balance ambulance capacity with community and hospital resources. • Supporting same-day emergency care and community pathways to reduce pressure on EDs and acute beds <p>As noted previously, this QIA recognises that patient outcomes depend on the performance of the entire urgent-care system. WAST's call-categorisation reforms are therefore designed not only to enhance ambulance service quality but to act as an enabler of wider NHS Wales transformation—sharing data, co-designing pathways, and providing mutual support to health and social-care partners.</p> <p>To reiterate, the pilot is not a standalone workstream, but also an enabler of wider NHS Transformation. Phase One evaluation results (response times, harm rates, patient outcomes) and a commitment to a published 3 and 6 month peer-reviewed evaluation presented to CQGG and the Trust Board. This transformation positions WAST as an integrated system partner across urgent and emergency care. By aligning call categorisation with the Six Goals for Urgent & Emergency Care strengthens whole-system flow, reduces avoidable ED conveyance, and supports local community and primary care services providing significant mutual benefit across the whole system.</p>
<p>Information Our healthcare system ensures information is available and shared appropriately for all who need it. We turn data to knowledge by triangulating quantitative and qualitative performance, experience, and outcome measures to understand the quality of services, efficacy of improvement work and impact of decisions made. We monitor, report, and escalate indicators through our governance structures to ensure that appropriate action is taken at every level in terms of learning, improvement, and accountability.</p>	<p>Will the proposal data to knowledge by triangulating quantitative and qualitative performance, experience, and outcome measures to understand the quality of services, efficacy of improvement work and impact of decisions made?</p>	<p>Data is a key enabler, and the evidence base utilised for further implementation will be available where appropriate.</p> <p>Given the scale of changes to call flow and categorisation and the associated impact on performance and quality measures, a CMT Quality & Performance Metrics group has been established with Executive Sponsorship from the Executive Director of Strategy, Planning, and Performance and cross-Directorate membership. This group is responsible for ensuring that the impact on current reporting is fully understood and that outcome measures associated with call flow and categorisation are robustly discussed, approved, and implemented before go-live.</p> <p>The proposed changes to call flow and categorisation may impact the actual experience of patients including response times. The objective is to improve response times and outcomes for the most critically unwell patients, and to provide the right response (including remote clinical assessment) based on clinical need.</p>

		<p>However, monitoring of patient experience, complaints, and incidents data will be essential.</p> <p>The ERS Workstream (as accountable for Call Categorisation) will be responsible for monitoring staff experience and experience data following implementation of the revised call flow. The group will ensure that any incidents recorded in Datix resulting from the revised call flows (including Rapid Clinical Screening) are appropriately categorised to ensure that any relationship between the complaint/incident and revisions to the call flow and categorisations can be investigated appropriately. The group will also ensure that there are mechanisms in place for capturing staff feedback both during and post go-live.</p> <p>Reporting and Dashboards will also provide insight, including;</p> <ul style="list-style-type: none"> • ODU Dashboard • Splash Report • Daily Operations Overview • Missed Red Reporting <p>Other reports (ITK, Local Authority Report, EMS Performance Tracker) were also utilised in the weeks following Phase One implementation.</p>
<p>Learning Improvement and Research Our healthcare system creates the conditions and capacity for an organisation and system-wide approach to continuous learning, quality improvement and innovation, which it actively promotes. We use new knowledge to influence improvements in practice and to inform our decision-making. We ensure our learning and improvement activity is linked to our strategic vision to deliver transformational, organisation-wide change. We commit to participating in research because research-active organisations provide improved quality of care and outcomes for people.</p>	<p>Does the proposal evidence continuous learning, quality improvement and innovation?</p>	<p>The Clinical Model Transformation Programme is the result of, and dependent on, continuous learning and development to create not only an effective and efficient service for the patient whereby they receive the most appropriate care in the right place but also ensures long-term sustainability in an increasingly challenging climate.</p> <p>An exercise has been completed to tender a consultancy for undertaking a clinical evaluation of the Clinical Service Model. The outputs of this exercise will guide learning and improvement as we continue to develop appropriate services for changing demographics.</p> <p>Many elements of this pilot are new, for example new roles such as the clinical screeners. Continuous learning from reviewing activity will support optimisation of the model and aid decision making in future developments.</p>

Annex 2 – Part 2 Full QIA Tool

To be completed for each Quality Health and Care standard Domain that has an adverse score of >8.

QIA Part 2: Health & Care Quality Standards 2023 Domain: PATIENT CARE

QIA Part 2: Health & Care Quality Standards 2023 Domain: PATIENT CARE								
		Initial Risk Rating (No mitigations)				Mitigated Risk Rating (Residual)		
Reference number	Brief Description & Actual / Potential Adverse Impacts	Likelihood	Impact	Initial Risk Score	Key controls / assurances established. (What is already in place?)	Likelihood	Impact	Residual risk score
001	Degradation in performance is likely during Phase Two Phase Two implementation (ORANGE, YELLOW, and GREEN categories) focusses on the ambition to deliver the most appropriate care on the first occasion. In doing so, some patients, may experience delays in the process of determining the most appropriate care response and or management plan.	3	3	9	<p>A monitoring and assurance framework has been developed alongside this work, to be approved by CQGG, Welsh Government and the JCC.</p> <p>This Framework sets out intentions to monitor performance and manage and report overall trends externally through clear command structures and governance routes such as daily safety huddles.</p> <p>Internally, dashboard development will aid reporting, and degradation of performance will be identified as early as possible and mitigated where necessary.</p> <p>Among the reports outlined within this framework, are the EMS Performance Tracker, and Longest Patient Wait Time.</p>	1	3	3
002	There is potential for insufficient capacity, or workforce resource to manage the revised call flows effectively. This would have a significant impact on WAST's ability to deliver planned service improvements and to provide assurances that in incidents where patients may be held remotely for	3	4	12	<p>There are several approaches to be applied to managing capacity, including</p> <ul style="list-style-type: none"> Continued robust modelling with suppliers Managing and reporting abstractions Regular and robust workforce capacity planning. 	2	3	6

	longer, no harm has resulted from workforce capacity.				<ul style="list-style-type: none"> • Rotational Workforce • Incident audit to explore correlation between insufficient capacity and harm <p>As noted previously, a monitoring and assurance framework has been developed alongside this work, to be approved by CQGG, Welsh Government and the JCC.</p> <p>This Framework sets out intentions to monitor performance and manage and report overall trends externally through clear command structures and governance routes such as daily safety huddles.</p>			
003	There is potential for insufficient capacity regarding available response. It may be possible that attending resource may not always be the ideal intervention.	3	3	9	<p>There are several approaches to be applied to managing resource availability , including</p> <ul style="list-style-type: none"> • Continued robust modelling with suppliers • Managing and reporting abstractions • Regular and robust resource capacity planning. • Flexible resource capacity • Incident audit to explore correlation between insufficient resource capacity and harm 			

Quality measures (monitoring unintended consequences and positive impacts)-

- What are the quality outcome measures? Quality outcome measures will be determined via the National PREM work, and reported in the short term via patient experiences as noted in the Balanced Scorecards.
- What is the source data for the quality metrics? Both clinical indicators and patient feedback, coupled with existing subscription reports (performance tracker, area reports, patient wait times)
- How often will they be monitored? Yet to be agreed, however daily safety huddles and monthly reporting will ensure patterns and issues are captured across several functions, and insights and audit findings will be reported back through the appropriate channels (CAG/CQGG) where applicable.
- Where will they be reported for monitoring and discussion? Via Daily Safety Huddles, Command Structures, Call Categorisation Group, and should escalation be necessary, to CMT and CQGG. The Daily Ops Meeting Report will also provide a source of data relating to wait times.

- How will you capture patient feedback? Approach to be developed with PEI team (based on ICO and IG recommendations)
- How will you capture staff feedback? As above – to be developed

Any further mitigations planned (with accountabilities and timescales)?

- **What are the mitigations? Approval from relevant forums and continued engagement.**
- **Who is accountable to monitor? Relevant stakeholders, include Exec Sponsor area specialists**
- **What are the timescales? Ongoing – see Monitoring and Assurance Framework**

Comments:

QIA Part 2: Health & Care Quality Standards 2023 Domain: EFFECTIVE CARE

Reference number	Brief Description & Actual / Potential Adverse Impacts	Initial Risk Rating (No mitigations)			Key controls / assurances established. (What is already in place?)	Mitigated Risk Rating (Residual)		
		Likelihood	Impact	Initial Risk Score		Likelihood	Impact	Residual risk score
004	There is significant clinical consideration to the category definitions, and while CPAS has approved the request for change and clinical reviews are ongoing, there may be clinical discomfort with existing codes transitioning into ORANGE, YELLOW, and GREEN categories where clinical judgement is determining the final disposition	3	3	9	Mitigations include; <ul style="list-style-type: none"> • A robust clinically-led training plan • Transparency of decision making with internal and external stakeholders. • Clear processes for recording staff feedback and experiences. • Clear processes for escalation. • Opportunities to access and utilise supervision. • Regular clinical audit • Robust wellbeing arrangements are in place with access to wellbeing services and shared information for external providers to support individual needs. 	1	4	4

					<ul style="list-style-type: none"> Involvement with representatives from key internal stakeholder groups as part of design workshop 			
005	There is a risk around failure to deliver on the agreed category revisions, and subsequent continued risk to delivering the appropriate resource to the correct incident. Effective and appropriate case management delivered first time is dependent on delivery of Phase Two.	2	4	8	Mitigations include <ul style="list-style-type: none"> Regular contact maintained with the supplier with agreed upon timelines managed proactively. Any cause for issue or concern can be raised immediately. Bi-weekly supplier meetings underway. A clear Statement of Works has also been received from the supplier. 	2	3	6

Quality measures (monitoring unintended consequences and positive impacts) - How will you source these metrics?

- What are the quality outcome measures? Quality outcome measures will be determined via the National PREM work and reported in the short term via patient experiences as noted in the Balanced Scorecards.
- What is the source data for the quality metrics? Both clinical indicators and patient feedback, coupled with existing subscription reports (performance tracker, area reports, patient wait times)
- How often will they be monitored? Yet to be agreed, however daily safety huddles and monthly reporting will ensure patterns and issues are captured across several functions.
- Where will they be reported for monitoring and discussion? Via Daily Safety Huddles, Command Structures, Call Categorisation Group, and should escalation be necessary, to CMT and CQGG. The Daily Ops Meeting Report will also provide a source of data relating to wait times.
- How will you capture patient feedback? Approach to be developed with PECl team (based on ICO and IG recommendations)
- How will you capture staff feedback? As above – to be developed

Any further mitigations planned (with accountabilities and timescales)?

- **What are the mitigations? Approval from relevant forums and continued engagement.**
- **Who is accountable to monitor? Relevant stakeholders, include Exec Sponsor area specialists**
- **What are the timescales? Ongoing - see Monitoring and Assurance Framework**

Comments:

QIA Part 2: Health & Care Quality Standards 2023 Domain: TIMELY CARE

Reference number	Brief Description & Actual / Potential Adverse Impacts	Initial Risk Rating (No mitigations)			Key controls / assurances established. (What is already in place?)	Mitigated Risk Rating (Residual)		
		Likelihood	Impact	Initial Risk Score		Likelihood	Impact	Residual risk score
006	There may in rare cases be a delay to intervention for patients re-categorised more than once, however modelling and testing will evidence the potential impact, especially during periods of Clinical Safety Plan escalation. There is a risk to the risk identification and subsequent clinical assessment of calls during certain periods.	3	3	9	Key controls include processes for monitoring and tracking the patient end-to-end to ensure waiting times for intervention are captured.	1	3	3
007	There is potential for insufficient capacity, or remote workforce resource to manage the revised call flows effectively. This would have a significant impact on WAST's ability to deliver planned service improvements and to provide assurances that in incidents where patients may be held remotely for longer, no harm has resulted from workforce capacity. Modelling exercises will support capacity planning.	3	4	12	<p>There are several approaches to be applied to managing capacity, including</p> <ul style="list-style-type: none"> Continued robust modelling with suppliers Managing and reporting abstractions Regular and robust workforce capacity planning. Rotational Workforce Incident audit to explore correlation between insufficient capacity and harm <p>As noted previously, a monitoring and assurance framework has been developed alongside this work, to be approved by CQGG, Welsh Government and the JCC.</p>	2	3	6

					This Framework sets out intentions to monitor performance and manage and report overall trends externally through clear command structures and governance routes such as daily safety huddles.			
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Quality measures (monitoring unintended consequences and positive impacts)-								
<ul style="list-style-type: none"> • What are the quality outcome measures? Quality outcome measures will be determined via the National PREM work and reported in the short term via patient experiences as noted in the Balanced Scorecards. • What is the source data for the quality metrics? Both clinical indicators and patient feedback, coupled with existing subscription reports (performance tracker, area reports, patient wait times) • How often will they be monitored? Yet to be agreed, however daily safety huddles and monthly reporting will ensure patterns and issues are captured across several functions. • Where will they be reported for monitoring and discussion? Via Daily Safety Huddles, Command Structures, Call Categorisation Group, and should escalation be necessary, to CMT and CQGG. The Daily Ops Meeting Report will also provide a source of data relating to wait times. • How will you capture patient feedback? Approach to be developed with PECl team (based on ICO and IG recommendations) • How will you capture staff feedback? As above – to be developed 								

Any further mitigations planned (with accountabilities and timescales)?								
<ul style="list-style-type: none"> • What are the mitigations? Approval from relevant forums and continued engagement. • Who is accountable to monitor? Relevant stakeholders, include Exec Sponsor area specialists • What are the timescales? Ongoing - see Monitoring and Assurance Framework 								

Comments:								
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QIA Part 2: Health & Care Quality Standards 2023 Domain: WORKFORCE

Reference number	Brief Description & Actual / Potential Adverse Impacts	Initial Risk Rating (No mitigations)			Key controls / assurances established. (What is already in place?)	Mitigated Risk Rating (Residual)		
		Likelihood	Impact	Initial Risk Score		Likelihood	Impact	Residual risk score

008	<p>There is risk of substantially harming workplace morale and disrupting the existing workplace culture by implementing further operational service changes. The Trust has undergone significant developmental and transformational work over recent years with all teams having been impacted by Organisational Change Processes, Model for Improvement Testing and introductions of new systems of work. There is a risk, by introducing a new way of working, that staff may struggle with additional system changes and experience episodes of burnout, and stress, resulting in increased sickness rates during the busiest period of the year.</p>	2	4	8	<p>As noted in the Phase One QIA, the following mitigations include;</p> <ul style="list-style-type: none"> • A robust executive-led communication approach over a series of years as the possibility of movement to a clinical service model was explored. This included opportunities to discuss with executives as part of recurrent CEO roadshows. • Regular and consistent updates of progress from the transformation teams will help team members feel informed and involved in the change process. • Transparency of decision making with internal and external stakeholders. • Embedding and upskilling colleagues regarding approaches to change management. In August 2023, Change Management training was made available to all staff. • Change Management approach to the Clinical Model Transformation (CMT) programme supported by a dedicated Change Management Working Group to share and embed best practice. • Robust wellbeing arrangements are in place with access to wellbeing services and shared information for external providers to support individual needs. • Involvement with representatives from key internal stakeholder groups as part of design workshop • Protected breaks access to mental health support (TRiM), monitoring 	1	4	4
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					of wellness (sickness absence, turnover) with escalation thresholds, and formal stress risk assessment where deemed appropriate			
009	As noted in Patient Safety, there is a risk that there will be insufficient workforce to manage the new workflows, presenting a significant risk to staff as well as service users.	3	4	12	<p>There are several approaches to be applied to managing capacity, including</p> <ul style="list-style-type: none"> Continued robust modelling with suppliers Managing and reporting abstractions Regular and robust workforce capacity planning. 	2	3	6

Quality measures (monitoring unintended consequences and positive impacts)-

- What are the quality outcome measures? Quality outcome measures will be determined via the National PREM work, and reported in the short term via patient experiences as noted in the Balanced Scorecards.
- What is the source data for the quality metrics? Both clinical indicators and patient feedback, coupled with existing subscription reports (performance tracker, area reports, patient wait times)
- How often will they be monitored? Yet to be agreed, however daily safety huddles and monthly reporting will ensure patterns and issues are captured across several functions.
- Where will they be reported for monitoring and discussion? Via Daily Safety Huddles, Command Structures, Call Categorisation Group, and should escalation be necessary, to CMT and CQGG. The Daily Ops Meeting Report will also provide a source of data relating to wait times.
- How will you capture patient feedback? Approach to be developed with PECl team (based on ICO and IG recommendations)
- How will you capture staff feedback? As above – to be developed

Any further mitigations planned (with accountabilities and timescales)?

- **What are the mitigations? Approval from relevant forums and continued engagement.**
- **Who is accountable to monitor? Relevant stakeholders, include Exec Sponsor area specialists**
- **What are the timescales? Ongoing - see Monitoring and Assurance Framework**

Comments:

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	Frequency:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
1 Highly Unlikely: Will probably never happen/recur	Not for years	1	2	3	4	5
2 Unlikely: Do not expect it to happen/recur but it is possible	At least annually	2	4	6	8	10
3 Likely: It might happen/recur occasionally	At least monthly	3	6	9	12	15
4 Highly Likely: Will probably happen/recur, but not a persisting issue	At least weekly	4	8	12	16	20

Consequence:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Safety & Well-being - Patients/ Staff/Public	Minimal injury requiring no/minimal intervention or treatment. No time off work. Physical injury to self/others that requires no treatment or first aid. Minimum psychological impact requiring no support. Low vulnerability to abuse or exploitation - needs no intervention. Category 1 pressure ulcer.	Minor injury or illness, requiring minor intervention. Requires time off work for >3 days Increased hospital stay 1-3 days. Slight physical injury to self/others that may require first aid. Emotional distress requiring minimal intervention. Increased vulnerability to abuse or exploitation, low level intervention. Category 2 pressure ulcer.	Moderate injury/professional intervention Requires time off work 4-14 days. Increased hospital stays 4-15 days. RIDDOR/Agency reportable incident. Impacts on a small number of patients. Physical injury to self/others requiring medical treatment. Psychological distress requiring formal intervention by MH professionals. Vulnerability to abuse or exploitation requiring increased intervention. Category 3 pressure ulcer.	Major injury leading to long-term disability. Requires time off work >14 days. Increased hospital stay >15 days. RIDDOR Reportable. Regulation 4 Specified Injuries to Workers. Patient mismanagement, long-term effects. Significant physical harm to self or others. Significant psychological distress needing specialist intervention. Vulnerability to abuse or exploitation requiring high levels of intervention. Category 4 pressure ulcer.	Incident leading to death. RIDDOR Reportable. Multiple permanent injuries or irreversible health effects. An event which impacts on many patients.
Quality/ Complaints/ Assurance/ Patient Outcomes	Peripheral element of treatment or service suboptimal. Informal complaint/inquiry.	Overall treatment/service suboptimal. Formal complaint (Stage 1). Local resolution. Single failure of internal standards. Minor implications for patient safety. Reduced performance.	Treatment/service has significantly reduced effectiveness. Formal complaint (Stage 2). Escalation. Local resolution (poss. independent review). Repeated failure of internal standards. Major patient safety implications.	Non-compliance with national standards with significant risk to patients. Multiple complaints/independent review. Low achievement of performance/delivery requirements. Critical report.	Totally unacceptable level or quality of treatment/service. Gross failure of patient safety. Inquest/ombudsman/inquiry. Gross failure to meet national standards/requirements.

Workforce/ Organisational Development/ Staffing/ Competence	Short-term low staffing level that temporarily Reduces service quality (< 1 day).	Low staffing level that Reduces the service quality.	Late delivery of key objective/service due to lack of staff. Unsafe staffing level (>1 day)/competence. Low staff morale. Poor staff attendance for mandatory/key professional training.	Uncertain delivery of key objective/ service due to lack/loss of staff. Unsafe staffing level (>5 days)/competence. Very low staff morale. Significant numbers of staff not attending mandatory/key professional training.	Non-delivery of key objective/service due to loss of several key staff. Ongoing unsafe staffing levels or competence/skill mix. No staff attending mandatory/professional training.
Statutory Duty, Regulation, Mandatory Requirements	No or minimal impact or breach of guidance/statutory duty.	Breach of statutory legislation. Reduced performance levels if unresolved.	Single breach in statutory duty. Challenging external recommendations/improvement notice.	Enforcement action. Multiple breaches in statutory duty. Improvement notices. Low achievement of performance/ delivery requirements. Critical report.	Multiple breaches in statutory duty. Zero performance rating. Prosecution. Severely critical report. Total system change needed.
Adverse Publicity or Reputation	Rumours. Low level negative social media. Potential for public concern.	Local media coverage - short-term Reduction in public confidence/trust. Short-term negative social media. Public expectations not met.	Local media coverage - long-term Reduction in public confidence & trust. Prolonged negative social media. Reported in local media.	National media coverage <3 days, service well below reasonable public expectation. Prolonged negative social media, reported in national media, long-term Reduction in public confidence & trust. Increased scrutiny: inspectorates, regulatory bodies and WG.	National/social media coverage >3 days, service well below reasonable public expectation. Extensive, prolonged social media. MP/MS questions in House/Senedd. Total loss of public confidence/trust. Escalation of scrutiny status by WG.
Business Objectives or Projects	Insignificant cost increase/ schedule slippage.	<5 per cent over project budget. Schedule slippage.	5–10 per cent over project budget. Schedule slippage.	Non-compliance with national targets. 10-25 per cent over project budget. Schedule slippage. Key objectives not met.	>25 per cent over project budget. Schedule slippage. Key objectives not met.
Financial Stability & Impact of Litigation	Small loss. Risk of claim remote.	Loss of 0.1–0.25% of budget Claim less than £10,000.	Loss of 0.25–0.5% of budget. Claim(s) between £10,000 and £100,000.	Uncertain delivery of key objective. Loss of 0.5-1.0% of budget. Claim(s) between £100,000 and £1 million. Purchasers failing to pay on time.	Non-delivery of key objective. Loss of >1 per cent of budget. Failure to meet specification. Claim(s) >£1 million. Loss of contract/payment by results.
Service/ Business Interruption	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours. Some disruption manageable by	Loss/interruption of >1 day. Disruption to several operational areas in a location, possible flow to other locations.	Loss/interruption of >1 week. All operational areas of a location compromised; other locations may be affected.	Permanent loss of service or facility. Total shutdown of operations.

		altered operational routine.			
Environment/Estate/Infrastructure	Minimal or no impact on environment/service/property.	Minor impact on environment/service/property.	Moderate impact on environment/service/property.	Major impact on environment/service/property.	Catastrophic impact on environment/service/property.
Health Inequalities/Equity	Minimal or no impact on attempts to Reduce health inequalities/improve health equity.	Minor impact on attempts to Reduce health inequalities or lack of clarity on the impact on health equity.	Lack of sufficient information to demonstrate Reducing equity gap, no positive impact on health improvement or health equity.	Validated data suggests no improvement in the health of the most disadvantaged, whilst supporting the least disadvantaged, no impact on health improvement and/or equity.	Validated data demonstrates a disproportionate widening of health inequalities, or negative impact on health improvement and/or equity.

Annex 3 – Questions and Prompts for QIAs

Safe Care

- What is the impact on partner organisations and any aspect of shared risk?
- Will the proposed scheme impact on the organisations duty to protect children, young people, and adults?
- What is the impact on patient safety?
- What is the impact on preventable harm?
- Will it affect the reliability of safety systems?
- How will it impact on systems and processes for ensuring that the risks of healthcare acquired infections to patients is Reduced?
- What is the impact on clinical workforce capability care and skills?

Equitable and Person-Centered Care

- Has consideration been given to patients, carers, the public and stakeholder engagement in line with the Welsh Equality Duties including Welsh language?
- What is the impact on race, sex, gender reassignment, age, disability, sexual orientation, religion, or belief (including those with no belief), marriage or civil partnership and pregnancy/ maternity for individual and community health access to services and experience?
- What is the likely impact on self-reported experience of patients and service users? (Response to concerns & feedback from service users).
- How will it impact on the patient choice agenda?
- How will it impact on the compassionate care and personalised care agenda?

Effective & Timely Care and Workforce

- What is the impact on implementation of evidence-based practice?
- What is the impact on leadership?
- Does it reduce or have a negative impact on variations in care provision / equal to all groups?
- Does it affect supporting staff to stay well / staff experience?
- Does it promote self-care for people with long terms conditions?
- Does it impact on ensuring that care is delivered in the most clinically and cost-effective setting?
- Does it eliminate inefficiency and waste by design?
- Does it lead to improvements in care pathways?

Annex 4 – Examples of monitoring measures (not exhaustive)

Safe Care:

- incidents including Never Events
- concerns, claims & service user feedback.
- staffing levels and skill mix
- clinical audit results
- harm free care data
- internal audit results

- Outcomes of external reviews.

Effective & Timely

- clinical outcomes
- clinical audit results
- activity data
- contract performance
- Implementation of national guidance.

Equitable & Person-Centered Care

- patients, carers, and public feedback
- Patient Voice feedback
- Concerns data.

Workforce

- staff feedback
- sickness / absence
- turnover
- appraisal rates
- mandatory training uptake
- National surveys.

Annex 5 - Stakeholders & partners (not exhaustive)

- NHS Wales Delivery Unit
- Welsh Government
- GPC Wales
- Executive Medical Directors
- Executive Nursing Directors
- Executive Directors of Therapies & Health Science
- Primary Care Reference group
- Mortality Review Steering Group
- Patient Safety / Risk Managers
- Welsh Risk Pool - Once for Wales Concerns Management System
- Assistant Directors for Primary Care & Community Care

Evidencing Due Regard – Integrated Equality Impact Assessment form

These assessments will help to gather and record evidence of due regard to the equality duties. The key purpose to purpose is to provide evidence that the Trust Board's decisions are compliant with **statutory requirements for the** Public Sector Equality Duty, Socio-economic Duty, Welsh Language Duty, Human Rights Act and Armed Forces Covenant.

Step 1

Complete Part A

Section 1

- General Information
- Which Assessments are Required
- Links to WAST Behaviours and Strategic Equality Objectives
- Wellbeing of Future Generations

Section 2 – Evidence to support assessment

- a. Record of Engagement and Consultation activity
- b. Additional information

Complete Step 2 and 3 if required.

Format as Arial 12 black font.

Step 2

Complete Part B – Equality Impact Assessment (EqIA)

Section 1 - Equality Impact

Section 2 - Human Rights

Section 3 – Armed Forces Due Regard

Section 4 - Welsh Language

Section 5 - Assurance for Compliance

Section 6 – EQIA Action Plan

Section 7 – Equality Risks

Section 8 – Sign Off

Step 3

Complete Part C - Socio-economic Impact Assessment (SEIA)

Section 1 - Assessment information

Section 2 - Impacts on Socio-economic Duty Domain Areas

Section 3 – SEIA Action plan

Section 4 – Sign Off

Part A – Information on assessment work required

Section 1 – General information

Title: Emergency Response Workstream
Assessment Lead:
Who has been involved in undertaking this equality assessment: Beth MacClelland (Project Manager) Gareth Taylor (Senior Project Manager)

Quick guide on what assessments are required: This section will help guide you to which assessments are required for your proposal.			
Types of decision being assessed:	What is being assessed? please tick the one which applies ✓	EQIA Required [Part B]	SEIA Required [Part C]
Strategic policy development with strategic directive and intent, including those developed at Regional Partnership Boards and Public Service Boards which impact on a public bodies functions			

Trust Wider Plans. Medium to long term plans (for example, corporate plans, development plans, service delivery and improvement plans)			
Business Case/Capital Involvement/Options Appraisal required			
Setting objectives (for example, well-being objectives, equality objectives, Welsh language strategy)			
Changes to and development of public services/Closure of Services			
Decisions affecting service users, employees or the wider community including (de)commissioning or revised services			
Efficiency or saving proposals, e.g., resulting in a change in community facilities, activities, support or employment opportunities			
Directorate Financial Planning			
Divisional policies and procedures affecting staff			
New policies, procedures or practices that affect service delivery	✓	✓	N/A
Large Scale Public Events			
Major procurement and commissioning decisions			
Local implementation of National Strategy/Plans/Legislation (e.g. vaccination programme)			
Other – please state (seek advice if not sure what assessments are required)			

Equality Impact Assessment	Socio-economic Impact Assessment
Start date: 11/08/25 Completed date: 21/08/2025	Start date: N/A Completed date: N/A
If not undertaking EqIA state reason: N/A	If not undertaking SEIA state reason: Not required as the introduction of process changes will not have any socio-economic impact on staff or patients.
Please complete the rest of this section if EQIA / SEIA is required.	
Summary of the purpose and aims of the decision / service / policy / function / change being assessed:	

The overall aim of this project is to ensure that ambulance services are operating efficiently and effectively, providing high-quality care to patients in need. The objectives include evaluating response times, patient outcomes, and the overall efficiency of the service.

The primary beneficiaries of this assessment will be the patients who rely on ambulance services, as well as the healthcare providers who work within the system. By identifying areas for improvement, the assessment aims to enhance the quality of care and ensure that resources are being used effectively.








To achieve these aims, the assessment will involve collecting and analysing data on various performance metrics, such as response times, patient outcomes, and resource utilisation. This data will be used to identify trends, pinpoint areas for improvement, and develop strategies for enhancing performance.

Outcomes and success will be measured through a combination of quantitative and qualitative metrics. Quantitative metrics may include improvements in response times and patient outcomes, while qualitative metrics may involve feedback from patients and healthcare providers. Regular monitoring and reporting will be essential to track progress and ensure that the objectives are being met.

The timeframe for this work will depend on the specific goals and the availability of data. The implementation date for this project based on Welsh Government deadline will be 1st December, 2025. However, it is anticipated that the initial assessment will be completed within six months, with ongoing monitoring and evaluation to ensure continuous improvement.

Links to WAST Behaviours

Indicate any behaviours that relate to the decision / service / policy / function / change being assessed. **please tick the one which applies** ✓

 <p>Take ownership</p>	 <p>Broaden our understanding</p>	 <p>Respect others</p>	 <p>Show belief in each other</p>	 <p>Practice ethically</p>	 <p>Continually improve our service</p>	 <p>Be inclusive of the whole team</p>
	✓			✓	✓	








Links to WAST Equality Objectives 2024 - 2028

The Trust published the Strategic Equality Plan (SEP) in 2024, for the period 2024 - 2028. Please indicate which objectives align for this decision / service / policy / function / change being assessed. **please tick the one which applies** ✓

Equality Objectives	Tick if decision relates	Any supporting narrative
1 We will design equitable services	✓	
2 We will lead by example	✓	
3 We will be an employer of choice		
4 We will create allyship		

Well-being of Future Generations (WFG)

Indicate any goals of the WFG Act that are being considered within the decision / service / policy / function / change being assessed.
 please tick the one which applies ✓

 <p>A Prosperous Wales</p>	 <p>A Resilient Wales</p>	 <p>A More Equal Wales</p>	 <p>A Healthier Wales</p>	 <p>A Wales of Cohesive Communities</p>	 <p>A Wales of Vibrant Culture & Thriving Welsh Language</p>	 <p>A Globally Responsible Wales</p>
	✓		✓			

For descriptors of these goals - [Well-being of Future Generations \(Wales\) Act 2015 – The Future Generations Commissioner for Wales](#)

Is the decision / service / policy / function / change being assessed related to, or influenced by, other Policies or areas of work?

- WAST Clinical Safety Plan
- Six Goals for Urgent and Emergency Care Policy Handbook
- WAST Clinical Model Transformation Programme
- Ambulance Performance Framework

Governance Route for this assessment and Executive Sponsor (usually Director level):

Call Categorisation Project Group 26th August 2025
 CMT Board 8th August 2025
 Extraordinary CQGG 11th September 2025

Trust Board (as an appendix to the Call Categorisation Paper) 25th September 2025

Section 2 - Evidence to support assessment

a. Record of Engagement and Consultation

The drive towards closer integration of health and social services with improved public engagement is reflected in the aims of [A Healthier Wales](#). This sets out the goal of ensuring citizens are placed at the heart of a whole-system approach to health and social care services and stresses the importance of listening to all voices through continual engagement. We also have a legal duty to engage with people who share protected characteristics and who are socio-economically disadvantaged under the Equality Act 2010. This is particularly important when considering proposals for changes in services that could potentially impact upon people / groups.

Please record here details of any engagement and consultation you have planned / undertaken / or analysed. This may include engagement with patients, carers, communities, stakeholders and staff.

a. What steps have you taken, or planned in order to engage and consult with people who share protected characteristics and how have you done this? Include consideration for co-design.

In 2024, an eQIA was completed to assess the impact of RCS implementation, in conjunction with early call flow changes. The change to policy and process was rigorously assessed and should be read in conjunction with this document. It stated

*Call Categorisation is part of the Trust-wide Clinical Model Transformation (CMT) Programme and a comprehensive **Programme Engagement Plan has been developed** that outlines a structured approach to communication and engagement to ensure all stakeholders are informed, engaged, and aligned throughout the programme lifecycle. Delivery of this plan will be facilitated by two dedicated communication and engagement groups:*

Change Management (led by the Director of People & Culture): responsibility for internal communications and change readiness
Partnerships & Engagement (led by the Director of Partnerships & Engagement): responsibility for external communications and engagement with patients and system partners

Additionally, the CMT Programme has evolved from the WAST strategy to 'Invert the Triangle' (ITT) which has been a widely socialised ambition for several years through a broad range of mediums including CEO roadshows, collaborative planning workshops, our Integrated Medium-Term Plan, our Long-Term Strategy, and public engagement events (for example).

Monitoring of progress and subsequent impact (if applicable) will be undertaken through regular evaluation cycles. It is intended that a full evaluation of Arrest and Emergency codes will be undertaken 12 months-post Go Live (July 2026) while a full evaluation of all codes will be undertaken 18 months-post Go Live (Q2 2026/27).

The Trust has a legal duty to engage with the public to capture their experiences, and the PEI team will be involved in collating data against the patient-led experience measures included in the evaluation process. PEI utilises a continuous engagement model, which will be invaluable in ascertaining impact of process changes during the 12-month evaluation on our service users.

This work has been and will continue to engage with internal and external partners, with Trade Union and Commissioning colleagues. Welsh Government have also been made aware via the commissioners of the intention to transition to a Clinical Service Model and an externally led Task & Finish Group was commissioned to review current call categorisations and to consider an alternative approach to RED performance that aligns with the Chain of Survival principles. The outcomes of that review was a mandate to proceed with amendments to incident coding.

Regarding accountability, this is a Welsh government-mandated project, and subject to increased levels of scrutiny. Overall accountability for delivery lies with the Health Minister, with delegated accountability via the JCC to the Chief Executive Officer (WAST).

Responsibility for delivery lies with the Clinical Model Transformation Programme Board, with delegated responsibility to the Call Categorisation Task & Finish Group. This Task & Finish Group is comprised of senior specialists from clinical, operational, and quality background, as well as external stakeholders from the JCC (Director of Commissioning), and TU Partners. Clinical and Quality assurances are maintained via the Clinical Quality Governance Group, and overall (internal) assurances are provided to Trust Board.

b. Give a summary on how the decision / service / policy / function / change will be shared? (E.g. dissemination of new policy)

A project-level communications plan has been developed (both internally and externally) which includes communications through several mediums (including but not limited to: Siren, spotlights, FAQs, emails, and notices)

c. Are there planned arrangements for gathering feedback during implementation of the decision / service / policy / function / change being assessed? Please give brief summary

Yes, directly from staff involved in the process and through performance data. Evaluations to follow

d. Summarise any emerging themes from the engagement work carried out:

Positive: Decision making to be more clinically-led, and focussed on outcomes over time. New processes aim to ensure the patient receives the most appropriate care, at the right time. Improved response times and better resource allocation can lead to quicker medical attention, which is crucial for older adults who may have chronic conditions or acute medical emergencies.

Negative: There is significant pace to the changes being implemented, with staff wellbeing a key theme emerging from over the last 12-18 months. While not directly attributed to the work undertaken with ERS, there is a responsibility to support colleagues through change. All patient cohorts should be treated equally within the new model, however specific mitigations for the following groups will be actioned.

For Older People: Implement training programs for paramedics to better understand and address the needs of older adults. Ensure that communication aids and support systems are in place to assist those with cognitive impairments.

For Children and Young People: Develop protocols for handling paediatric emergencies with sensitivity and care. Provide training for paramedics on how to manage the stress and anxiety of young patients during emergencies.

e. How has the engagement work influenced / or how will the planned engagement influence your work/guide your policy/proposal? Does the engagement work highlight any opportunities to address adverse impacts?

b. Additional information

Evidence to support assessment - your decisions must be based on robust evidence. What evidence base have you used in support?

Additional evidence may include both quantitative and qualitative information, for example evidenced based research relating to protected characteristics, government research and reports, census and nationally recognised public accessible data sets. WAST data such as performance data and employment data may also be appropriate to include. All data and information should be disaggregated by protected characteristics where possible. Please include the source for any information used. Further info on [EqIAs - Equality Impact Assessments \(sharepoint.com\)](#)

The Welsh Government commissioned a clinically-led Task & Finish Group (that included patient-led Groups such as Llais) to assess the evidence for maintaining or amending the previous response codes. Prior to this;

- Review of similar models in other ambulance services (i.e. Yorkshire Ambulance Service)
- Computer Aided Dispatch (CAD) data
- CMT workshops (May-24) with cross-organisational specialist input
- Call Flow and Categorisation Task & Finish Group (Aug-Oct-24) with cross-organisational specialist input to propose revised call flows and categorisations



End of Part A

Part B – Equality Impact Assessment with Human Rights

Section 1 - Equality Impact Assessment

Assessment – due regard relating to people / group who share protected characteristics

This section should record any known or potential impacts for those who share protected characteristics and other key groups. Impacts may be both negative and positive and the assessment will help to identify how different groups may be disproportionately impacted. Include consideration for any intersectional impacts. Evidence can link to Part A. You can copy and paste this tick: ✓

Age	Positive effect	Negative effect	Neutral
	✓		

Evidence / supporting narrative:

Improved response times and better resource allocation can lead to quicker medical attention, which is crucial for older adults who may have chronic conditions or acute medical emergencies.

The positive impacts are selected based on the anticipated improvements in response times, resource allocation, and specialised training, which are expected to enhance the quality of care for all age groups.

Mitigation action if adverse impact found:

There is significant pace to the changes being implemented, with staff wellbeing a key theme emerging from over the last 12-18 months. While not directly attributed to the work undertaken with ERS, there is a responsibility to support colleagues through change. All patient cohorts should be treated equally within the new model, however specific mitigations for the following groups will be actioned.

For Older People: Implement training programs for paramedics to better understand and address the needs of older adults. Ensure that communication aids and support systems are in place to assist those with cognitive impairments.

For Children and Young People: Develop protocols for handling paediatric emergencies with sensitivity and care. Provide training for paramedics on how to manage the stress and anxiety of young patients during emergencies.

Disability (Including long term conditions, mental health, neurodivergence and invisible impairments)	Positive effect	Negative effect	Neutral
	✓		
<p>Evidence / supporting narrative:</p> <p>Improved response times and better resource allocation can lead to quicker medical attention, which is crucial for individuals with disabilities who may have chronic conditions or acute medical emergencies.</p> <p>Enhanced training for paramedics on handling various disabilities can lead to more sensitive and effective care.</p> <p>Better-equipped ambulances with necessary medical equipment and aids can improve the overall experience and outcomes for people with disabilities.</p> <p>The positive impacts are selected based on the anticipated improvements in response times, resource allocation, and specialised training, which are expected to enhance the quality of care for people with disabilities.</p>			
<p>Mitigation action if adverse impact found:</p> <p>There may be challenges in ensuring that all types of disabilities are adequately addressed, particularly hidden disabilities and neurodiversity, which may require specialized training and resources. Potential communication barriers between paramedics and individuals with sensory loss or learning disabilities, which could affect the quality of care.</p> <p>For Hidden Disabilities and Neurodiversity: Implement specialized training programs for paramedics to better understand and address the needs of individuals with hidden disabilities and neurodiversity. Ensure that communication aids and support systems are in place to assist these individuals.</p> <p>For Sensory Loss and Learning Disabilities: Develop protocols for handling emergencies involving individuals with sensory loss and learning disabilities with sensitivity and care. Provide training for paramedics on how to manage communication barriers and ensure effective care.</p> <p>By addressing these potential negative impacts, the framework aims to provide equitable and effective care for people with disabilities, ensuring that everyone benefits from the improvements in ambulance services.</p>			

Sexual Orientation	Positive effect	Negative effect	Neutral
			✓
Evidence / supporting narrative:			
The Ambulance Performance Framework is designed to ensure that all individuals receive equitable and high-quality care, regardless of their background or circumstances. The new measures are focused on treating everyone the same, with an emphasis on efficiency, effectiveness, and patient-centered care			
Mitigation action if adverse impact found:			
N/A			
Gender Reassignment / Gender identity (Including non-binary, gender fluid and intersex)	Positive effect	Negative effect	Neutral
			✓
Evidence / supporting narrative:			
The Ambulance Performance Framework is designed to ensure that all individuals receive equitable and high-quality care, regardless of their background or circumstances. The new measures are focused on treating everyone the same, with an emphasis on efficiency, effectiveness, and patient-centered care			
Mitigation action if adverse impact found:			
N/A			
Sex / Gender	Positive effect	Negative effect	Neutral
			✓

Evidence / supporting narrative:			
The Ambulance Performance Framework is designed to ensure that all individuals receive equitable and high-quality care, regardless of their background or circumstances. The new measures are focused on treating everyone the same, with an emphasis on efficiency, effectiveness, and patient-centered care			
Mitigation action if adverse impact found:			
N/A			
Race (including ethnicity)	Positive effect	Negative effect	Neutral
			✓
Evidence / supporting narrative:			
The Ambulance Performance Framework is designed to ensure that all individuals receive equitable and high-quality care, regardless of their background or circumstances. The new measures are focused on treating everyone the same, with an emphasis on efficiency, effectiveness, and patient-centered care			
Mitigation action if adverse impact found:			
N/A			
Religion and Belief (including non-belief and Philosophical belief)	Positive effect	Negative effect	Neutral
			✓
Evidence / supporting narrative:			
The Ambulance Performance Framework is designed to ensure that all individuals receive equitable and high-quality care, regardless of their background or circumstances. The new measures are focused on treating everyone the same, with an emphasis on efficiency, effectiveness, and patient-centered care			

Mitigation action if adverse impact found: N/A			
Pregnancy and Maternity	Positive effect	Negative effect	Neutral
	✓		
Evidence / supporting narrative: Improved response times and better resource allocation can lead to quicker medical attention, which is crucial for pregnant individuals who may experience complications or require urgent care. The positive impacts are selected based on the anticipated improvements in response times, resource allocation, and specialized training, which are expected to enhance the quality of care for pregnant individuals			
Mitigation action if adverse impact found: N/A			
Marriage and Civil Partnership	Positive effect	Negative effect	Neutral
			✓
Evidence / supporting narrative: The Ambulance Performance Framework is designed to ensure that all individuals receive equitable and high-quality care, regardless of their background or circumstances. The new measures are focused on treating everyone the same, with an emphasis on efficiency, effectiveness, and patient-centered care			
Mitigation action if adverse impact found:			

N/A			
Other groups at risk of poorer health outcomes:			
Unpaid Carers	Positive effect	Negative effect	Neutral
	✓		
Evidence / supporting narrative: The positive impacts are selected based on the anticipated improvements in response times, resource allocation, and specialised training, which are expected to enhance response times which may relieve pressures upon unpaid carers who are caring for people when they need an ambulance.			
Mitigation action if adverse impact found: N/A			
Socio-economically disadvantaged	Positive effect	Negative effect	Neutral
			✓
Evidence / supporting narrative: The Ambulance Performance Framework is designed to ensure that all individuals receive equitable and high-quality care, regardless of their background or circumstances. The new measures are focused on treating everyone the same, with an emphasis on efficiency, effectiveness, and patient-centered care			

Mitigation action if adverse impact found:			
Other groups / communities of interest - please state	Positive effect	Negative effect	Neutral
			✓
Explanation:			
Mitigation action if adverse impact found:			
Intersectional disadvantages - summary potential impacts – this may include how potential impacts may be more adverse due to the interconnected nature of multiple disadvantages.			

Section 2 – Human Rights Assessment

Assessment – based on human rights-based approach in health	
Do you think that this policy will have a positive or negative impact on people’s human rights? For more information on Human Rights, see our Betsi pages and additional information the Equality and Human Rights Commission (EHRC) Human Rights Treaty Tracker https://humanrightstracker.com	
Here is a list of Human Rights (articles) and UN Conventions that may potentially impact on our patients, carers and staff. Please tick which are relevant to the proposal?	Use a tick ✓
Article 2 - Right to life	✓
Article 3 - Prohibition of inhuman or degrading treatment	N/A
Article 5 - Right to liberty and security	N/A
Article 8 - Right to respect for family and private life	N/A
Article 9 - Freedom of thought, conscience and religion	N/A
Article 14 – Prohibition of discrimination	N/A
UN Convention on the Rights of the Child	N/A
UN Convention on the Rights of Persons with Disabilities	✓
UN Convention on the Elimination of All Forms of Discrimination against Women.	N/A
UN Principles for Older Persons	✓
Other articles – <i>please state:</i>	N/A

Is the proposal aligned to the FREDA principles? You can copy and paste this tick: ✓

Fairness	Respect	Equality	Dignity	Autonomy
✓	✓	✓	✓	✓

If any negative impacts are identified, how will this be reduced/addressed?

Section 3 – Armed Forces Covenant

All decision makers are required under the Armed Forces Act 2022 to have due regard to the principles of the Armed Forces Covenant. WP7 contains guidance and information to help complete this section. Decision makers should recognise the unique obligations of, and sacrifices made by, the Armed Forces and ensure there are no adverse effects and where possible a positive or increased positive effect on the armed services community. Special provision for Service People may be justified by the effect on such people of membership, or former membership, of the Armed Forces.

Due regard to the Armed Forces Covenant - Factors regarding impact to the Armed Forces community have been considered. You can copy and paste this tick: ✓	Positive impact	Negative impact	Neutral / No impact
Considering the unique obligations of, and sacrifices made by, the Armed Forces have you identified any potential impacts?			✓
<p>Reasons for your decision (including brief summary that has led you to decide on the level of impact) If any negative impacts have been identified, how will this be reduced/addressed? Include here any special provisions if appropriate.</p> <p>Clinical Incident Coding based on clinical need.</p>			

Section 4 – Welsh Language

In this section you need to consider the impact, the evidence and any action you are taking for improvement. This is to ensure that the opportunities for people who choose to live their lives and access services through the medium of Welsh are not inferior to what is afforded to those choosing to do so in English, in accordance with the requirement of the Welsh Language Measure 2011.

Welsh Language Impact Assessment		
You can copy and paste this tick: ✓		
Will the proposal ensure that patients and carers can choose to live and receive services through the medium of Welsh? For example - delivered bilingually in Welsh & English.	Yes	No
	✓	
Provide explanation and evidence to support your answer. What actions will be taken to mitigate any negative impacts or better contribute to positive impacts: N/A – the service will remain a bilingual service		
Will the proposal have a positive effect on opportunities for persons to use the Welsh language? Will the proposal encourage staff to use Welsh in the workplace and to have opportunities to learn and improve their Welsh?	Yes	No
		✓
Provide explanation and evidence to support your answer. What actions will be taken to mitigate any negative impacts or better contribute to positive impacts: N/A – the service will remain a bilingual service		
Will the proposal act as a catalyst for Welsh cultural awareness, understanding, activity and integration? For example, encouraging new staff and students to take up Welsh language learning opportunities and to appreciate the socio-economic and cultural context of Wales.	Yes	No

Provide explanation and evidence to support your answer. What actions will be taken to mitigate any negative impacts or better contribute to positive impacts:

N/A – the service will remain a bilingual service

Will the proposal increase the department/division’s ability to deliver services through the medium of Welsh?

e.g. Considerations for the proposal ensuring that people can access services in their preferred language, Welsh or English, and increases or reduces the opportunity for persons to use the Welsh language within the workplace. Consider impacts on the number of Welsh speaking staff within the service and if the proposal increases or reduces the opportunity for staff to improve their Welsh language skills or access training via the medium of Welsh.

Yes	No
	✓

Provide explanation and evidence to support your answer. What actions will be taken to mitigate any negative impacts or better contribute to positive impacts:

N/A – the service will remain a bilingual service

Will the proposal treat the Welsh language no less favourably than the English language?

e.g. Consider how Welsh speakers receive services to the same standard as those who access the same services through the medium of English.

Yes	No
✓	

Provide explanation and evidence to support your answer. What actions will be taken to mitigate any negative impacts or better contribute to positive impacts:

N/A – the service will remain a bilingual service

Section 5 – Summary of assurance for compliance – Public Sector Equality Duty and Human Rights

Equality Legal Duties – summary of compliance	
Has WAST given due regard and given consideration for this proposal with the following:	
Eliminating unlawful discrimination, harassment, and victimisation? <i>Unlawful discrimination takes place when people are treated 'less favorably' as a result of having a protected characteristic</i>	Yes
Advancing equality of opportunity between people who share a protected characteristic and those who do not? <i>Making sure that people are treated fairly and given equal access to opportunities and resources</i>	Yes
Fostering good relations between people who share a protected characteristic and those who do not? <i>Creating a cohesive and inclusive environment for all by tackling prejudice and promoting understanding of difference</i>	Yes
Are there any potential Human Rights concerns?	No
Compliance to the Welsh Language requirements?	Yes
Compliance to giving 'due regard' to the principles of the Armed Forces Covenant?	Yes
Supporting narrative to support the above responses: <i>This section must be completed</i>	
The aim is to ensure that clinical expertise informs patient care decisions from the earliest stages of the call process through to resolution. By developing and implementing care pathways that prioritise early clinical input, we can provide a more personalised care approach that aligns the response to each patient's specific needs and reduces instances of inappropriate conveyance.	
Do you consider the evidence used in this assessment to be robust? If you answer no, address this in the action plan (section 6)	Yes

Has this assessment been subject to scrutiny / been reviewed?	Yes – 26 th August
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Section 6 – EQIA Action Plan and Recommendations

This needs to address negative impacts, which may represent a potential equality risk. All equality risks should be reviewed in line with WAST risk management procedures. Include any positive action.					
Action identified	Potential Outcomes	Resource implications	Target date	Monitoring arrangements	Lead person/ owner
<p>None identified – no adverse impacts.</p> <p>Project to be delivered and overseen by the Call Flow Prioritisation Project Group, with Executive-level oversight via CMT Board and CQGG</p>					

Section 7 Equality Risks

This section helps you work out the level of risk posed by any equality related risks identified above. Guidance is available [here](#) on completing this section, which may be helpful if you are not familiar with risk score analysis. If you have not identified any equality risks, please note this in the narrative box below. Examples include retrospective assessments and decisions that treat a protected characteristic unfavourably without objective justification.

Equality Related Risk Assessment Section					
If you have identified an equality risk, please use the table below to work out the risk score. Use the table below to record the highest risk score. If you have a score of 9 and above you should escalate to risk management procedures .					
	Level of risk				
Level of consequence	RARE: 1	UNLIKELY: 2	POSSIBLE: 3	LIKELY: 4	VERY LIKELY:5
1. Negligible	1	2	3	4	5
2. Minor	2	4	6	8	10
3. Moderate	3	6	9	12	15
4. Major	4	8	12	16	20
5. Catastrophic	5	10	15	20	25

If you have identified an equality risk: What is the consequence? What is the likelihood? Risk score = consequence x likelihood	Risk Score =
Any narrative relating to risk score:	

Section 8 – EQIA Sign off

<p>Name of persons who signed-off this Equality Impact Assessment (see below): <i>As per the Trust’s Standing Orders, the Board may agree the delegation of any of their functions, except for those set out within the ‘Schedule of Matters Reserved for the Board’, to Committees and others. These functions may be carried out by a prescribed Committee, sub-Committee, or officer of the Trust as per the Standing Orders Schedule 1, in accordance with their delegated limits. Strategic decisions <u>must</u> have appropriate sign off. If you are in any doubt as to the correct approving body for a strategic decision, please contact the Office of the Board Secretary.</i></p>
<p>Approval Date: TBC 26th August 2025 (Call Categorisation Project Group)</p>
<p>Review Date: 11th Aug</p>

<p>Project Lead Sign-off I confirm that this Equality Impact Assessment has been carried out in accordance with Welsh Ambulance Services NHS Trust’s Procedure for assessment work for evidencing Due</p>	<p>Equality Team Sign-off (Required when both EQIA and SEIA is required) I confirm that I have reviewed this Equality Impact Assessment and I am assured that it contains sufficient</p>	<p>Committee Chair Sign-off I confirm that this Equality Impact Assessment represents evidence that we (The Trust), in making this decision, have given due regard to the need to: 1. Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.</p>
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<p>Regard for: Equality Impact, Socio economic Impact, Human rights, Welsh Language requirements and Armed Forces Covenant.</p> <p>Signed: Ceri Griffiths (Call Categorisation SRO)</p>	<p>evidence and rigour to be considered by the decision-making committee.</p> <p>Signed: TBC (no SEIA) (Head of Inclusion and Engagement)</p>	<p>2. Advance equality of opportunity between people who share a protected characteristic and those who do not.</p> <p>3. Foster good relations between people who share a protected characteristic and those who do not.</p> <p>Signed: TBC CQGG (Committee Chair)</p>
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End of Part B. Only complete Part C if required.

Part C – Socio-economic Impact Assessment

The requirement for completion of Part C will have been identified in Part A and relates to complying with the Socio-economic Duty. This is a statutory duty with the aim of improving decision making to help improve outcomes for those who are socio-economically disadvantaged. The Socio-economic Duty gives us an opportunity to do things differently in Wales. It puts tackling inequality at the heart of decision-making and will build on the good work public bodies are already doing.

This SEIA procedure should be commenced at the outset and inform the development of both new strategic decisions and when reviewing previous strategic decisions. It provides a clear audit trail for all decisions made under the 2010 Act.

For a comprehensive guide to the Socio-Economic Duty in Wales and supporting resource please see <https://gov.wales/more-equal-wales-socio-economic-duty>

Section 1 - Assessment information – evidence	
Has this assessment identified Stakeholder groups: <i>Supporting narrative if different to Part A.</i>	Yes / No

<p>Has this assessment used a range of evidence: <i>Supporting narrative to consider socio-economic disadvantage and inequalities of outcome in relation to this decision? Note additional evidence if different to information within Part A.</i></p>	<p>Yes / No</p>
<p>Has this proposal engaged with those impacted by the Policy / Strategy Proposal / Policy? <i>Supporting narrative if different to Part A.</i></p>	<p>Yes / No</p>

<p>Relevant communities of interest identified that may be impacted by this proposal and engagement work undertaken:</p>	<p>Proposal may impact these groups Use a tick ✓</p>	<p>Engagement undertaken Yes / Planned</p>	<p>Any supporting narrative / comments</p>
People experiencing poverty			
Carers			
People who share a common first language			
People experiencing homelessness			
Lone parent families			
Those seeking sanctuary			
Experience of local health and social care system			
Military Veterans and Armed Forces Community			
University students			
Long term caravan residents and second home visitors			
Other – please state:			
<p>Relevant communities of place</p>			
Urban areas			

Rural areas			
Areas of high levels of unemployment / deprivation			
Other – please state:			
How has / will this influence your work/guided your policy/proposal, or changed your recommendations? Supporting narrative:			

Section 2 - Impacts on Socio-economic Duty Domain Areas:

The Equality and Human Rights Commission monitor progress on equality and human rights across a range of areas of life in Great Britain. These domain areas include education, work, living standards, health, justice and personal security and participation.

It is helpful to consider where action can be taken to reduce inequality of outcome resulting from socio-economic disadvantage in regard to each of these areas, evidence is provided below and issues for consideration suggested.

Consider evidence from both research and any engagement already carried out. Who is being affected? Are some communities of interest or communities of place more affected by disadvantage than others? WAST Equality pages provides further guidance.

What are the main socio economic impacts of the proposal?			
Domain area: Education	Positive impact	Negative impact	Neutral / No impact
You can copy and paste this tick: ✓			

Supporting narrative:

How does your proposal take account of the impact of education on the local population, children and adults with additional learning needs, basic literacy levels and those less likely to have or have had access to training opportunities and qualifications?

Think about how careers support at WAST and with partners, including apprenticeships and volunteer work placements can be promoted to support young people furthest from the job market.

Action / Opportunities that can be taken to reduce inequality of outcome resulting from socio-economic disadvantage:

What are the main socio economic impacts of the proposal?

Domain area: Health

You can copy and paste this tick: ✓

**Positive
impact**

**Negative
impact**

**Neutral / No
impact**

Supporting narrative:

How does your proposal take account of the expected health outcomes of the local population? What are the current health needs and what action can be taken to increase access to healthcare for those who experience socio-economic disadvantage? Have the costs of transport and travel been taken into account? Think about the design of the built environment on the physical and mental health of patients, staff and visitors.

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Action / Opportunities that can be taken to reduce inequality of outcome resulting from socio-economic disadvantage? What are the opportunities for collaboration, have local third sector organisations been engaged and opportunities to promote access to financial wellbeing, social and other support maximised?

What are the main socio economic impacts of the proposal?

Domain area: Living standards You can copy and paste this tick: ✓	Positive impact	Negative impact	Neutral / No impact

Supporting narrative:
*How does your proposal take account of the impact of poverty and deprivation?
 Are there groups who may be disproportionately impacted by poverty e.g. disabled people / lone parents / unemployment / homelessness. This domain includes issues of accessibility of transport, healthy food, leisure activities, road safety and the quality and safety of play areas and open spaces.*

As part of your proposal what are the opportunities to reduce the impact of poverty on living standards?

What are the main socio economic impacts of the proposal?

Domain area: Work

You can copy and paste this tick: ✓

**Positive
impact**

**Negative
impact**

**Neutral / No
impact**

Supporting narrative:

Welsh Ambulance Services NHS Trust provides numerous opportunities for people to access work. Will this plan impact on employment / apprenticeship / volunteering opportunities? What are the implications of the proposal for people on low income, those who are economically inactive, unemployed, workless, and people who are unable to work due to ill-health. Consider people living in work poverty. During the pandemic lower earners are three times as likely to have lost their job or been furloughed as high earners.

How can procurement and commissioning arrangements be optimised to reduce inequalities of outcome caused by socio-economic disadvantage?

As part of your proposal what are the opportunities to increase employment opportunities for people who experience socio-economic disadvantage?

What are the main socio economic impacts of the proposal?			
Domain area: Justice and personal security You can copy and paste this tick: ✓	Positive impact	Negative impact	Neutral / No impact
Supporting narrative: <i>How does your proposal take account of local crime rates and feeling safe? Think about people who live in less safe areas and those more likely to be victims of domestic violence and abuse. Evidence suggests that domestic violence incidents are becoming more complex and serious, with higher levels of physical violence and coercive control.</i>			
How can your proposal promote and protect people's rights and increase their access to justice and personal security?			

What are the main socio economic impacts of the proposal?			
Domain area: Participation You can copy and paste this tick: ✓	Positive impact	Negative impact	Neutral / No impact
Supporting narrative: <i>How is participation enabled, how is engagement sustained with people with lived experience of socio-economic disadvantage and how has this informed your proposal? Think about digital exclusion and digital poverty, people living in rural areas and those unable to access services and facilities.</i>			

How can your proposal increase participation for people who experience socio-economic disadvantage?

Section 3 – Socio-economic Duty Action plan

Socio-economic Impact Assessment Action Plan and Recommendations					
Please include any related recommendations arising from this assessment. Include any positive action.					
Action identified	Potential Outcomes	Resource implications	Target date	Monitoring arrangements	Lead person/ Owner

Section 4 – SEIA Sign off

<p>Who signed-off this SED Impact Assessment: <i>As per the Trust’s Standing Orders, the Board may agree the delegation of any of their functions, except for those set out within the ‘Schedule of Matters Reserved for the Board’, to Committees and others. These functions may be carried out by a prescribed Committee, sub-Committee or officer of the Trust as per the Standing Orders Schedule 1, in accordance with their delegated limits. Strategic decisions <u>must</u> have appropriate sign off. If you are in any doubt as to the correct approving body for a strategic decision, please contact the Office of the Board Secretary.</i></p>
<p>Approval Date:</p>
<p>Review Date:</p>

<p>Project Lead Sign-off I confirm that this Socio-economic Impact Assessment has been carried out in accordance with Welsh Ambulance Services NHS Trust Procedure for assessment work for evidencing Due Regard for: Equality Impact, Socio economic Impact, Human rights, Welsh Language requirements and Armed Forces Covenant.</p> <p>Signed: (Project Lead)</p>	<p>Equality Team Quality Check (required when both EQIA and SEIA is required) I confirm that I have reviewed this Socio-economic Impact Assessment and I am assured that it contains sufficient evidence and rigour to be considered by the decision-making committee.</p> <p>Signed: (Equality and Inclusion Manager)</p>	<p>Committee Chair Sign-off I confirm that this Equality Impact Assessment represents evidence that we (The Trust), in making this decision, have given due regard to the need to reduce the inequalities of outcome resulting from socio-economic disadvantage.</p> <p>Signed: (Committee Chair)</p>
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End of SED assessment

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Action	Lead	Start	Finish	RAG	Comment / Corrective Action
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Go Live

Updated ODU Dashboard - For active management of balance of risk between remote and dispatch queues.	AD Ops Resourcing & EMS Co-ordination	02/12/25	Indefinitely		QIA has identified that there could be protracted waits for patients in RICS during periods of high demand. No back stop on wait-times, so dynamic management of RICS and EMS Response queues via ODU Dashboard.
Daily Safety Huddle, with enhanced arrangements for go live	Head of Service ODU	02/12/25	BAU		Operational Delivery Unit-National Delivery Manager. BAU now. Amended to take account of new categories from 01/12/25.

Command Structures & Governance

Enhanced command structure	AD Ops Resourcing & EMS Co-ordination	02/12/25	xx/12/25 End date dependent on operational order (see next line)		Command structure to be put in place, in the same way that there was for phase 1, supported by operational order.
Operational Order (which will include a go live log)	AD Ops Resourcing & EMS Co-ordination	02/12/25	05/12/25		As above. Clinical Services Directorate and QSPE Directorate to be included and to include rotas.
Call Categorisation Task & Finish Group	Deputy Director of Remote	02/12/25	TBD		The task & finish group will need to continue to run to focus on the further development of metrics but should

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Action	Lead	Start	Finish	RAG	Comment / Corrective Action
	Clinical Care				also continue for a period of time to focus on the go live and benefits realisation.

Historic Reports (in month)

Subscription Reports (External Audience) <ul style="list-style-type: none"> • Day 1 e.g. splash reports, daily operational overview. • Weeks 1-2 e.g. local authority level. • Later. 	AD Digital Services: Data & Analytics	02/12/2025	Indefinitely		IDS to bring report to Call Categorisation Task & Finish Group on 07/10/25, to confirm the suite of reports and metrics to be switched on.
Power BI Access (External) <ul style="list-style-type: none"> • JCC EMS Ops app (they have their own version) 	AD Digital Services: Data & Analytics	Tbc	Indefinitely		Tbc by IDS as part of above report.
SQL Views (External) <ul style="list-style-type: none"> • ED conveyances per HB • Monthly metrics to NHS Exec • Public Health Wales • JCC • DHCW • NHS England 	AD Digital Services: Data & Analytics	Tbc	Indefinitely		Tbc by IDS as part of above report.
Other Organisations/Systems/Feeds to consider <ul style="list-style-type: none"> • Optima/OMDA imported data, model tune etc • Launchpad – still have Health Boards and possibly WG accessing it 	AD Digital Services: Data & Analytics	Tbc	Indefinitely		

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Action	Lead	Start	Finish	RAG	Comment / Corrective Action
<ul style="list-style-type: none"> Lightfoot/Regional Partnership Board (not too sure about this one) Integrated Unscheduled Care Dashboard 					
Internal Reports e.g. EMS Ops Daily Meeting Report - NEW FORMAT, Daily Operational Overview	AD Digital Services: Data & Analytics	Tbc	Indefinitely		
3 hourly "Splash Report"	AD Digital Services: Data & Analytics	02/12/25	For 6 weeks thereafter		

Historic Reports (Monthly)

Emergency Ambulance ASIs	AD Digital Services: Data & Analytics	02/12/25	22/01/26		
WG Stats Release	AD Digital Services: Data & Analytics	02/12/25	22/01/26		
Internal Report on Locality Performance and Local Authority Performance (weekly or monthly)	AD Digital Services: Data & Analytics	From 02/01/26	Indefinitely		The Trust is held to account at a health board level, but from a patient safety perspective, looking for geographic outliers below health board level.

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Action	Lead	Start	Finish	RAG	Comment / Corrective Action
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Evaluations

Initial internal evaluation (end of week one)	AD C&P	08/12/25	15/12/25		Initial safety review with report being made available to JCC/WG.
Second internal evaluation (end of month one)	AD C&P	01/01/26	14/01/26		Second safety review with report being made available to JCC/WG.
Collaborative & independent evaluation (end of year one) of Orange/Yellow/Green	AD C&P	02/12/25	30/11/26		Edge Hill University appointed. This evaluation plan is drafted but needs agreement. The plan is for the entire CMT programme. The dates to the left are not firm at this stage.

Equity/Equality

Remote v F2F: risk that some patients may find remote services more difficult to interact with than F2F e.g. people learning disabilities, people with hearing impairments etc.	Assistant Clinical Director Remote Clinical Care	BAU (with further developments)	BAU (with further developments)		A range of training modules for remote clinical staff in place. A specific level 7 module being developed for remote clinical decision making with HEIW. This includes a section on: Inclusive, Equitable and Compassionate Remote Consultation.
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Datix, SCIFs and patient safety

Twice weekly Serious Case Incident Forum (SCIF) if required	Deputy Director of Quality & PTR	BAU	BAU		This will enable the early identification of potential patient harm. SCIFs are dependent on information from clinical audit. Prioritisation is given to:
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Pilot Orange, Yellow & Green Monitoring & Assurance Action Plan (approved at CQGG 29/09/25)

Action	Lead	Start	Finish	RAG	Comment / Corrective Action
					coroners, litigation and next should be this categorisation change. WH and CA to follow up on additional capacity to support this work. NDR governance another important consideration that would help.
Daily review of incidents reported through Datix	Head of PTR	BAU	BAU		Early identification of avoidable harm and immediate escalation
12 hours wait report - Update current 12 hour wait report to reflect new categories.	AD Digital: Data & Analytics	02/12/25	Weekly Indefinitely		The definitions do not include a range/service standard (the letter from WG indicated this may be considered at a future point). Agreed with Executive Director of Operations to continue using the 12-hour community back stop measure.
Improved DATIX reporting	AD Digital Services: Data & Analytics	17/11/25	Indefinitely		Improved DATIX analysis functionality is a top 5 priority in the IDS CMT Metrics Work Plan. The immediate focus is phase 1/phase 2, which once capacity is released from these, can be directed onto this high priority.
Points of learning for patient safety will be identified	Deputy Director of Quality & PTR	BAU	BAU		Existing governance routes will be used to ensure timely learning is taking place these will be for example: <ul style="list-style-type: none"> • SCIF • CAG • Complex Case Panel

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Action	Lead	Start	Finish	RAG	Comment / Corrective Action
					<ul style="list-style-type: none"> Learning from Deaths
Patient deterioration analysis / delay in intervention panel/report - Cross section of clinicians, and rotating membership	Tbc	02/12/25	End date will depend on findings and external evaluation		The QIA has identified that there may be a risk of patient deterioration in RICS and this not being detected. How to respond to this is still under consideration, but the potential approach is for a panel of clinicians to dip sample some of the longest waits and assess.
Estimated Time of Arrival (ETA)	AD Operations (National Operations & Support)	02/12/25	Indefinitely		The Trust using a statistical technique to enable EMSC to provide patients with ETAs, where a resource is dispatched. This will need to be reviewed in the light of category changes.

Staff & TU Partners

Executive level walk arounds in EMSC, CSD, stations etc. (week one)	Executive Director of Operations	Two weeks after go-live	Two weeks after go-live		
Director level meeting with national TU leads (end of week one)	Executive Director of Operations & Director of Paramedicine	Within first two weeks of go live	Within first two weeks of go live		

Pilot Orange, Yellow & Green Monitoring & Assurance Action Plan (approved at CQGG 29/09/25)

Action	Lead	Start	Finish	RAG	Comment / Corrective Action
Short survey to affected staff groups (focus on change management and perception of patient impact)	Head of Change & People Insights	01/03/26	31/03/23		<p>Short survey to be developed, aiming to seek feedback from affected staff and volunteer groups regarding impact of new call category. Format: MS Forms; anonymous; QR code to be supplied.</p> <p>The usual registrant routes apply in terms of raising patient safety concerns. This survey is separate and does not substitute for the normal mechanisms.</p>
Training plan(s)	AD Ops Resourcing & EMS Co-ordination + AD Ops Remote Clinical Care	01/10/25	31/10/25		QIA identifies possible “clinical discomfort” with move to final categorisation/disposition being a clinical decision not EMD/CAD. Mitigation: robust clinically led training plan(s).
Internal Communications Plan	Director of Partnerships & Engagement	01/11/25	31/01/26		QIA identifies adverse impact on workforce morale from pace of change (conversely it could be a positive impact) with good internal communications a key mitigation.

Pilot Orange, Yellow & Green Monitoring & Assurance Action Plan (approved at CQGG 29/09/25)

Action	Lead	Start	Finish	RAG	Comment / Corrective Action
Change Management Training	Head of Change & People Insights	Available	Available		All staff have been offered this training.
Wellbeing & support arrangements	AD Inclusion, Culture & Well-Being	Available	Available		The Trust has a good offer in place but QIA/CQGG also identified undertaking stress management risk assessment, where appropriate.
December to January change pause	CMT Boad	01/12/25	31/01/26		Learning from the previous winter included avoiding go live on major changes during the heart of winter. The Trust is aiming to switch on Orange/Yellow/Green at the earliest opportunity with a back stop date of 01/12/25 with the letter to WG identifying that if the go live is delayed beyond 01/12/25 it would not go live until 01/02/26. Confirmed the Trust is going for the 01/12/25 date.

Clinical Audit (or internal clinical evaluation)

Automated report on Orange clock stops where the median was stopped by a CFR1, CFRX, UFRC	AD Digital: Data & Analytics	Report to Call Cat T&F 07/10/25 to agree on reports	Report to Call Cat T&F 07/10/25 to agree on reports		The resources stop the clock but are not ideal for this category of patient demand.
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Pilot Orange, Yellow & Green Monitoring & Assurance Action Plan (approved at CQGG 29/09/25)

Action	Lead	Start	Finish	RAG	Comment / Corrective Action
Longer patient pathway time - 12 hour waits	AD Digital: Data & Analytics	Report to Call Cat T&F 07/10/25 to agree on reports	Report to Call Cat T&F 07/10/25 to agree on reports		The old process was: EMD/Dispatch (if not through CSD), the new process is EMD/RCS/RCA and dispatch (if a dispatch made), so the patient pathway is intentionally longer, with the aim of being more precise in identifying what the patient need is. A clinical evaluation aimed at assessing whether there is any unintended patient harm from this longer pathway. As identified in the QIA.

Patient Experience

999 People's Experience Survey	Deputy Director of Nursing, Quality & Governance	Dependent on Information Commissioner's Office	Dependent on Information Commissioner's Office		The standard WG survey is too generic, so WAST will need more specific questions to assess patient experience of the new performance framework. This is dependent on the ICO. The CMT Scorecards are predicated on an ability to ask about patient experience at a more granular level.
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Clinical Outcomes

Unconscious Bias (Human Factors) - Considered via clinical supervisory process in RICS.	Deputy Director Remote Clinical Care	BAU	BAU		This was identified directly in the QIA process. This will be an area of interest in the external evaluation.
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Pilot Orange, Yellow & Green Monitoring & Assurance Action Plan (approved at CQGG 29/09/25)

Action	Lead	Start	Finish	RAG	Comment / Corrective Action
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Accountability Mechanisms

Engagement of Director of Commissioning for Ambulance Services & 111	AD C&P	01/07/25	02/12/25		RW engaged and member of the Call Categorisation Task & Finish Group for phase 2 and actively involved in development of the definitions.
Formal sign off by key external stakeholders on the proposed definitions	Executive Director of Operations	30/09/25	14/10/25		Formal submission to WG. Director of Commissioning for Ambulance Services & 111 has signed off. Supplied to WG for information.
F&P	Executive Director of SP&P	20/01/26	20/01/26		Initial report to committee on phase 2 go live.
QUEST	Executive Director of Quality & Nursing	03/02/26	03/02/26		Initial report to committee on phase 2 go live.
JCC (sub-committee)	AD C&P	05/02/26	05/02/26		Initial report to committee on phase 2 go live.
IQPD	AD C&P	Confirm Date	Confirm Date		
Initial Two Weekly Monitoring & Assurance Meetings with JCC/WG	Director of Paramedicine	01/12/25	31/01/26		Once go live date confirmed (dependent on MIS) confirm who attending, agenda approach and set up.

Pilot Orange, Yellow & Green Monitoring & Assurance Action Plan (approved at CQGG 29/09/25)

Action	Lead	Start	Finish	RAG	Comment / Corrective Action
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Communications

External Communications Plan	LH	01/10/25	31/12/25		Update existing phase 1 plan. Will include managing patient expectations (this point raised in CQGG)>
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Workforce Capacity & Modelling

Revisit RICS (remote) capacity modelling	HB	Post winter	Post winter		QIA identifies potential workforce capacity issue in RICS. Review data from winter, potentially model demand and remote capacity required. Previous modelling has been undertaken (x2).
Revisit EMS (response) modelling					It is anticipated that WAST will not be able to dispatch the “ideal” or “interim” response to every incident. The new categories and definitions will provide improved information with which to model the required level (capacity) of ideal/interim resource based on patient demand.
Active management of existing workforce capacity - This is BAU and will be further supported in December through specific forecasting, modelling and capacity planning linked to the Winter Plan.	Ops SLT	BAU Festive Plan Period (WG requirement)	BAU Festive Plan Period (WG requirement)		QIA identifies potential workforce capacity issue

Pilot Orange, Yellow & Green Monitoring & Assurance Action Plan (approved at CQGG 29/09/25)

Action	Lead	Start	Finish	RAG	Comment / Corrective Action
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CSP / REAP

Incorporate new categories into the CSP and REAP	AD Ops Resourcing & EMS Co-ordination	01/11/25	02/12/25		
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GIG
CYMRU
NHS
WALES

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

Welsh Ambulance Services University NHS Trust

Ambulance Performance Framework



Explainer Document

Version 2.0

26th August 2025

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Version Control Sheet

Version	Date	Author	Summary of Changes	Review Due
0.5	13/05/2025	Elliot Miller	Draft document released to key roles to inform review of training material and SOPs	28/05/2025
1.0	20/05/2025	Elliot Miller	Formal Approval of Document	30/06/2026
1.1	10/06/2025	Elliot Miller	Updates to Red Emergency definition [Exec Summary, 2.1, 5.1, 5.4.]	30/06/2026
2.0	26/08/2025	Elliot Miller	Expansion of Document to incorporate Phase 2 changes. Introduction of Orange Now, Yellow Soon, and Green Planned categories.	01/12/2026
Keywords	Purple Arrest, Red Emergency, RCS0, Ambulance Performance Framework			

Document Approval Route

Meeting Title	Meeting Date	Purpose/Outcome
Call Flow Prioritisation Project Group	26 th August 2025	Approved

Disclaimer

If the review date of this document has passed, please ensure that the version you are using is the most up to date either by contacting the document author or the Operations Support Manager.

Executive Summary

This executive summary provides a focused overview of Phase 2 of the Ambulance Performance Framework (APF) for the Welsh Ambulance Services University NHS Trust (WAST), building on the foundations established during Phase 1. The main priority of this document is to detail the objectives, developments, and anticipated outcomes of Phase 2, as WAST continues its drive for improved emergency response, patient safety and clinical effectiveness.

Background

The Call Flow Prioritisation Project Group was formed in response to the Health and Social Care Committee's recommendations surrounding existing ambulance response time targets. The initial assessment led to significant changes in how emergency responses are categorised and measured, culminating in the introduction of new categories - '**Purple Arrest**' and '**Red Emergency**' - in Phase 1 (from 1 July 2025).

Transition to Phase 2

Following the launch of Phase 1, focused on outcome-based performance for cardiac arrest and immediately life-threatened patients, Phase 2 represents a further and comprehensive evolution of the remaining call categories. This represents most patients presenting to 999 services and the core aim of Phase 2 is to extend the principles of outcome-driven, clinically relevant performance measurement across all emergency ambulance service categories. This document introduces the further 3 new categories: **Orange Now**, **Yellow Soon**, and **Green Planned**, and their respective definitions and metrics.

Objectives of Phase 2

- Expand the adoption of outcome-based metrics to encompass the full spectrum of emergency ambulance care, moving beyond the initial focus on cardiac arrest and critical illness.
- Refine performance targets and measurement methods to ensure they remain clinically meaningful and aligned with both patient outcomes and service improvement.
- Consolidate learning from the first phase to establish best practices and set new operational standards for emergency response in Wales.

- Engage with a broad range of stakeholders including clinical teams, commissioning bodies, and governance groups, to ensure robust implementation and accountability.

Key Activities in Phase 2

- Continued evaluation and adjustment of the framework based on real-world data and feedback from frontline staff and patients.
- Introduction of additional performance indicators tailored to the unique needs of various emergency situations (such as ST Elevated Myocardial Infarction (STEMI) and Stroke).
- Enhanced reporting and monitoring mechanisms, enabling more detailed insights into patient journeys and clinical outcomes.

Expected Impact

- Broader and more nuanced measurement of ambulance service effectiveness, capturing not just speed, but the quality and result of care delivered.
- Improved patient outcomes through a sharper focus on clinical interventions.
- Ongoing service development driven by evidence, partnership, and a shared commitment to excellence in urgent and emergency care.

Conclusion

Phase 2 of the Ambulance Performance Framework marks a pivotal stage in the transformation of pre-hospital and emergency care in Wales. By expanding outcome-based standards and involving a wider array of clinical and organisational stakeholders, WAST aims to ensure the ambulance service remains responsive, clinically effective, and continually improving for all patients.

Updates on further developments, time standards, and additional performance metrics will accompany the roll-out of Phase 2 as the framework matures and evolves in line with national health priorities and patient needs.

Transitioning to the Ambulance Performance Framework (Phase 2)

1. INTRODUCTION

- 1.1.** Following the implementation of Phase 1 of the Ambulance Performance Framework (APF), WAST is now able to transition the rest of the APF. The purpose of this 'version 2' of the Explainer Document is to summarise the findings of the second phase of work undertaken by the task group established to review the emergency APF and provide detail of the full APF moving forward.
- 1.2.** In February 2025, the Cabinet Secretary received advice (MA-JMHSC-0429-25) on the findings and recommendations from a National Ambulance response target task group. This group was established in response to a Health and Social Care Committee recommendation to assess whether the existing national ambulance response time target continues to be appropriate.
- 1.3.** In summary, the task group, which included representation from a number of clinical executive directors, the national clinical lead for emergency care, the NHS Wales Joint Commissioning Committee and Welsh Government, found the pre-existing target for the 'Red' (immediately life threatened) category of patients was no longer appropriate.
- 1.4.** The Cabinet Secretary subsequently approved implementation of a new APF for WAST introducing the new '**Purple Arrest**' and '**Red Emergency**' categories with a focus on clinical outcomes, especially outcomes from cardiac arrest. This was 'phase one' of the review work programme.
- 1.5.** It was agreed that phase one of the APF would take effect from 1 July 2025, and (commencing in August) the **Purple Arrest** category will report on (but not limited to):

 - The percentage of people to have a heartbeat restored after a period of cardiac arrest which is subsequently retained until arrival at hospital (return of spontaneous circulation (ROSC)); and

- The median time it takes for a 999 call handler to identify a cardiac or respiratory arrest, median time to commence cardio pulmonary resuscitation (CPR) instructions, and median time for an automated electronic defibrillator (AED) to be brought to the scene following an out of hospital cardiac or respiratory arrest.
- 1.6.** Additionally, WAST will report performance for both the **Purple Arrest** and **Red Emergency** categories against the following time standards:
- Median emergency ambulance response standard of 6-8 minutes.
 - Aim for 90% receive an emergency ambulance response within 20 minutes.
- 1.7.** As part of work to evolve its clinical model, WAST has implemented operational changes to enable '*rapid clinical screening*' for all calls not classified as an arrest or emergency. This brings a clinician to the forefront of decision making, ensuring a more tailored approach which takes account both of a person's symptoms and their environment (where the incident occurred).
- 1.8.** Recognising the need to focus, as far as possible, on outcomes for all service users, and particularly those with time-critical conditions, the Cabinet Secretary committed to a phase two of the review work.
- 1.9.** This saw the extension of the review to 999 incidents which fall outside of the **Purple Arrest** and **Red Emergency** categories – i.e. the current 'Amber' (serious but not immediately life threatening) and 'Green' (neither serious nor life threatening) categories. Table one illustrates the phased approach and status following the launch of phase 1.

	PHASE ONE		CURRENT STATE		
	ARREST	EMERG	AMBER 1	AMBER 2	GREEN
	c. 10% of calls		c. 70% of calls		c. 20% of calls
Category description	Cardiac or respiratory arrest	At high risk of cardiac or respiratory arrest	Serious but not immediately life-threatening		Neither serious nor life threatening
Typical conditions	Cardiac arrest Respiratory arrest	Choking Major haemorrhage Major trauma	Most medical and trauma cases including: Chest pain Fractures Most stroke		Minor injuries Generally unwell Earache
Response type	Immediate dispatch (no rapid clinical screening)	Immediate dispatch (no rapid clinical screening)	Emergency response – most suitable clinical resource based on response profile – includes management via remote “hear & treat” services		Ideally suited to management via secondary telephone assessment
Standards	Median response 6-8mins 90% within 20mins		No current time standards / targets		

RAPID CLINICAL SCREENING

1.10. *Table 1: phase one and two (current state) of ambulance response target review*

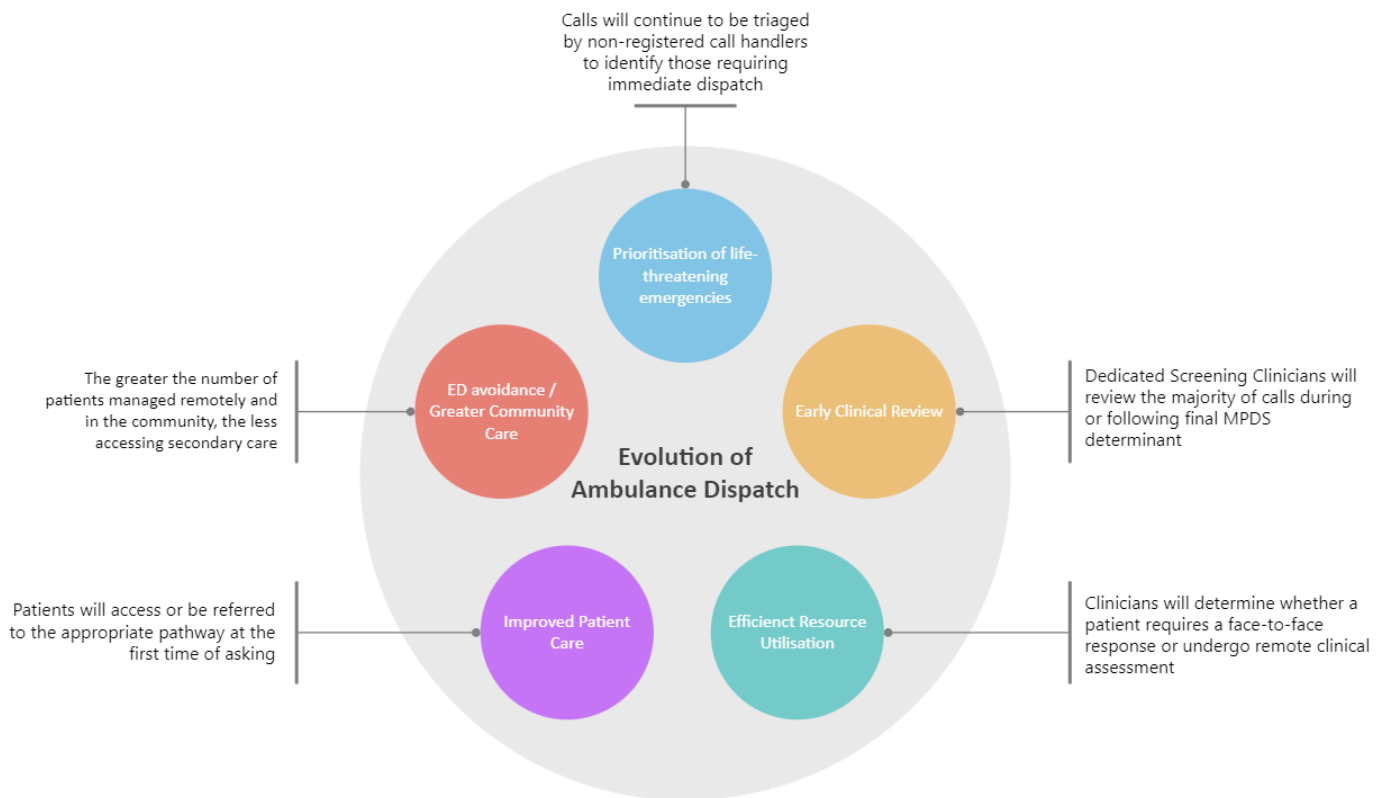
1.11. As it stands, statistics published by Welsh Government include call volumes and a combined median response time for Amber one and Amber two calls.¹ There is no target response time for the Amber or Green categories.

1.12. This transition reflects a movement within healthcare towards integrated, patient-centred care models, where ambulance services play a role both in

¹ [Emergency responses: minute-by-minute performance for amber calls, by Local Health Board and month](#)

emergency situations and in supporting the system to meet diverse patient needs. The WAST Integrated Clinical Services Model aims to enhance the efficiency, effectiveness, and responsiveness of our ambulance service, ensuring it is equipped to meet the evolving needs of the population it serves.

1.13. The review of the new and current categories aligns with the Trust’s strategic intention to deliver a ‘whole system’ approach to responding to emergencies, whilst also ensuring that the response sent is the most clinically suitable on the first occasion. This document has been developed to provide information on these changes and provides further details on the new categories and process flows.



1.14. Figure 1: Future Evolution of Ambulance Dispatch in the Integrated Clinical Services Model

2. PHASE 2: THE CASE FOR CHANGE

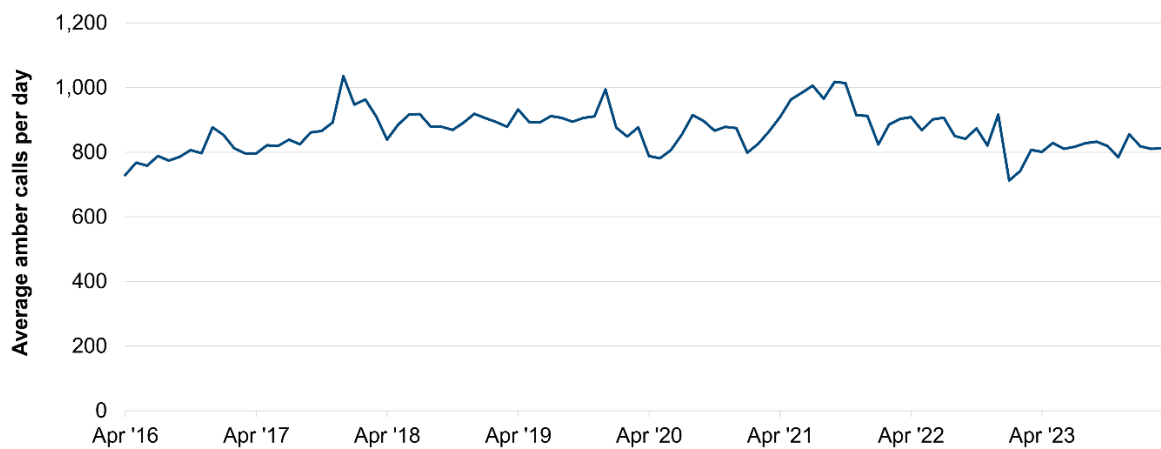
2.1. The second phase of the task group focused on;

- Current performance outcomes for Amber / Green incidents;
- UK and international measures for equivalent categories / conditions;
- Evidence relating to *what matters* to patients and staff; and
- Proposed categories and performance measures.

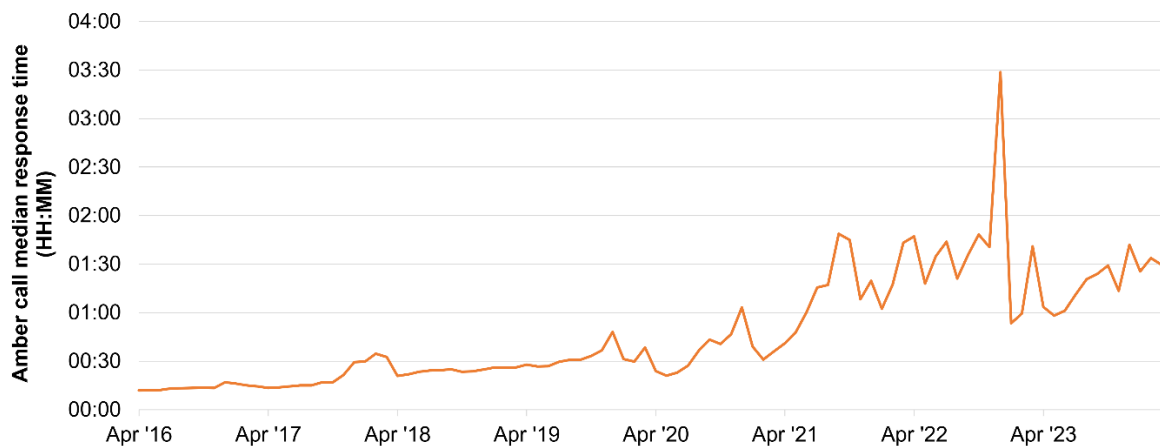
The group's findings are summarised below:

2.2. Limitations with current Amber category

2.3. The Amber category accounts for the majority of total 999 incidents / calls (c.70%). The volume of these incidents has been relatively stable over the long term, as shown in Graph 1. Median response times to Amber category incidents have increased significantly, reaching around five times higher than in 2016, as shown in Graph 2.



2.4. *Graph 1: Average Amber calls per day, April 2016 to March 2024*



2.5. Graph 2: Median Amber call response times, April 2016 to March 2024

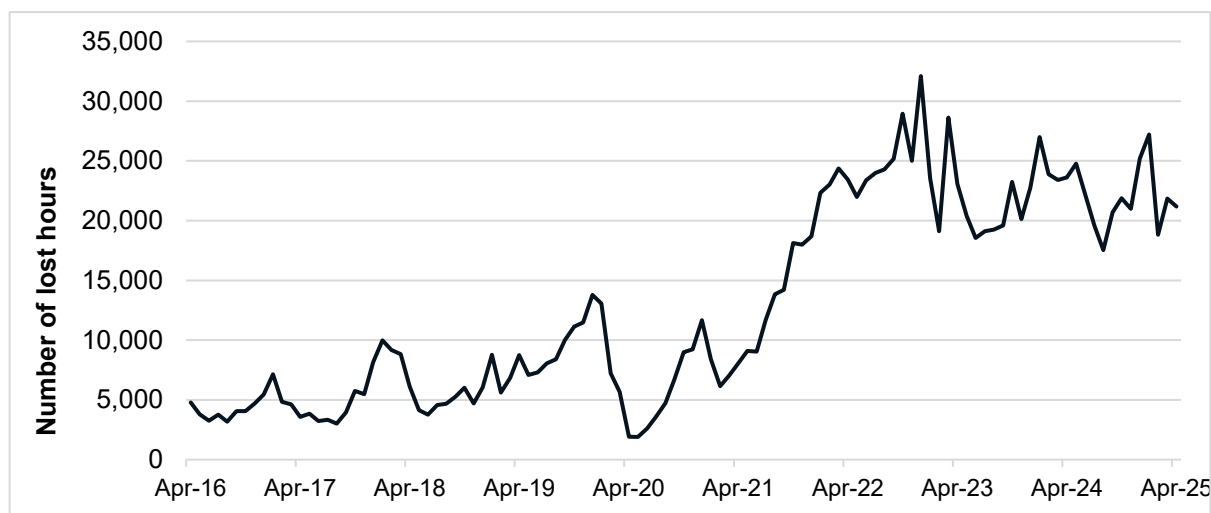
2.6. In December 2022, the median response time for Amber category incidents was a record 3 hours and 29 minutes. This was due to a high volume of 'Red' category calls using most resources, along with reduced availability caused by ambulance handover delays (see section 2.11).

2.7. The types of conditions within the Amber category include most medical and trauma cases such as chest pain, strokes and limb fractures. A number of these conditions require an ambulance response and transport to the right diagnostics, care and treatment in a timely manner to optimise outcomes. For example, for a patient in stroke, every minute counts as evidence suggests a loss of 2 million brain cells every minute.

2.8. The current management of the Amber category, which represents around 70% of total demand, does not allow for a nuanced response to *truly* time-sensitive complaints. Patients with evident symptoms of stroke, STEMI (a type of heart attack) or fractured hips are grouped in this broad category and managed through a system that, despite being internationally accredited and well-evidenced, has high sensitivity but sometimes low specificity. This approach can have an impact on how quickly people who have a clear clinical need for a rapid response receive help.

2.9. Operational challenges faced by the ambulance service

2.10. There is a clear correlation between increasing Amber response times and rising lost hours due to ambulance patient handover delays. There has been a significant increase in ambulance patient handover delays in recent years, with around five times as many hours lost in 2023-24 compared with 2016-17. This position has shown little sign of improving with an additional 1.5% of capacity lost in 2024-25 when compared to the previous year (Graph 3).



2.11. *Graph 3: Lost hours for the ambulance service following notification to handover at Emergency Departments, April 2016 to April 2025*

2.12. Currently, the reduced ambulance availability because of Emergency Department handover delays is having a significant impact on response times. This has also resulted in patients either being informed that an ambulance is not able to be sent or led to the patient cancelling an ambulance before it arrives and taking measures themselves.

2.13. Health boards will need to significantly improve ambulance patient handover performance to maximise the opportunities the new APF model could bring. The national ambulance patient handover guidance (WHC/2024/04) reaffirms that every effort should be made to handover the care of a patient from ambulance clinicians to Emergency Department staff within 15 minutes of the ambulance arrival.

2.14. Meeting recommendations set by the Ministerial Advisory Group for a **maximum** 45-minute ambulance patient handover has been communicated

as an expectation to health boards. Additional support will be provided via an executive director clinical taskforce, WAST and NHS Performance and Improvement.

2.15. Increasing focus on outcomes where time matters

2.16. Ambulance response time performance is measured and reported differently across the UK and internationally. England, Scotland, Northern Ireland and the Republic of Ireland all use an outcomes-driven approach to ambulance performance frameworks.

2.17. Stroke

The Stroke Association Wales (SAW) has raised concerns about the lengthy ambulance response times for stroke patients in Wales, which are slower compared to the rest of the UK. SAW reports that 80% of stroke patients now wait over 30 minutes for an ambulance. WAST indicates an average 'call-to-door time' of 2.5 hours for stroke responses, whereas other parts of the UK perform better. This issue is exacerbated by ambulance handover delays, which are significantly higher in Wales than in other UK regions.

2.18. SAW also felt there is a need to raise the profile of 'onset' or 'call-to-door times' for people in stroke, and to use Stroke Sentinel National Audit Programme (SSNAP) data to hold health board executive teams to account for their role in this metric to help drive improvement in diagnostic, assessment and treatment times.

2.19. Dr Shakeel Ahmad, National Clinical Lead for Stroke, acknowledges that prioritising all stroke calls could cause harm due to about 52% being false alarms or 'mimics'. Thus, efficiently assessing these calls is crucial to ensure ambulance resources are allocated to patients truly in need of rapid response and onward transport to the right specialist service.

2.20. ST-Elevation Myocardial Infarction (STEMI) – a type of heart attack

Wales is also an outlier for 'call-to-door' times for STEMI compared to the rest of the UK. In a letter to the Cabinet secretary on 25 November 2024, the Welsh Cardiovascular Society highlighted that delayed ambulance

responses in Wales are contributing to longer call-to-door and call-to-treatment times, which was resulting in avoidable harm to patients. The British Heart Foundation advised that long ambulance and emergency department delays are leaving seriously ill patients worse off and even costing lives.

2.21. Dr Jonathan Goodfellow and the Wales Cardiac Network identified STEMI 'call-to-balloon time' as crucial for improving patient outcomes. They also emphasised the importance of early access to ECG results to ensure proper treatment.

2.22. The network raised concerns around patients who self-present to hospital, who have longer treatment times because of the triage required in the emergency department and often need inter-hospital transfer to a primary percutaneous coronary intervention (PPCI) centre. Calling 999 for heart attack symptoms enables swift assessment, accurate diagnosis with an ECG, resuscitation (if needed), and direct admission to PPCI centres, bypassing emergency departments and other non-primary PCI hospitals.

2.23. Different approaches used across the UK

2.24. To understand the impact of ambulance response on patients with stroke and STEMI, the NHS in England and Scotland use a set of 'Clinical Quality Indicators' to measure patients' experience and outcomes. These indicators focus on both clinical outcomes and 'care bundle' compliance by ambulance clinicians and the continuum of the patient journey.

2.25. Some of the related key performance measures used internationally are listed below.

2.26. For Stroke:

- Time from call to hospital arrival (call-to-door)
- Time from hospital arrival to CT scan
- Time from call to thrombolysis (if applicable)
- Overall call to intervention time
- Stroke care bundle compliance, which includes:

- Face Arm Speech Test (FAST) documented
- Blood glucose recorded
- Time of onset recorded

2.27. For STEMI:

- Time from call to arrival at a specialist heart centre (call-to-door)
- Door to angiography or primary percutaneous coronary intervention (PPCI) (call-to-ballon)
- Overall call to intervention time
- STEMI care bundle compliance, which includes:
 - 12-lead ECG performed
 - Aspirin administered
 - Glyceryl trinitrate (GTN) administered
 - Pain score recorded

2.28. In England and Scotland these indicators are collected and published monthly and are used to assess both timeliness and quality of pre-hospital care, which are critical for improving outcomes in time-sensitive conditions like stroke and STEMI.

2.29. Additionally, measuring the remainder of the patient journey as an overall call to intervention time provides a comprehensive assessment of the entire process, from accessing help to the delivery of the required intervention.

2.30. Comprehensive measurement of the pathway is crucial for accurate reporting of clinical outcomes. A plan to enable data linkage is currently being developed.

2.31. Wider approach to performance measurement

2.32. The current performance framework is at odds with performance frameworks used for ambulance performance in all other parts of the UK where 'average' response time performance is captured and reported alongside a suite of clinical indicators and a 90th or 95th percentile (representing the 'longest response' time) for all categories.

2.33. Following the Institute for Healthcare Improvement's (IHI) recommendation, both the median and the 90th percentile have been adopted in Wales and will be used to better understand overall performance and variability in response times from 1 July 2025 for **Purple Arrest** and **Red Emergency** incidents.

3. PHASE 2: THE TASK GROUP FINDINGS

- 3.1. The proposed changes after phase 2 review completion are closely tied to WAST's management of patient flows and how the Trust aims to respond based on clinical prioritisation.
- 3.2. The involvement of clinicians much earlier in a patient's 999 journey is the foundation of WAST's evolved clinical model. It also sees much closer working between 999 and 111 services. This is intended to ensure that whatever the entry point to the ambulance service, a patient receives an equitable, clinically prioritised response (remote *or* face-to-face) which is focused on improving outcomes. This aligns to the principles of the health and care quality standards and the six goals policy handbook.
- 3.3. Based on the efforts of phase 1, WAST aims to consolidate its pilot program for Rapid Clinical Screening for all 999 service users who are **not** classified as '**Purple Arrest**' or '**Red Emergency**'.
- 3.4. The Rapid Clinical Screening (RCS) will occur immediately after the call handler stage. For the most serious calls (**RCS0**), ambulance resources will be dispatched immediately if the screening is not completed quickly enough based on the caller's assumed clinical priority (commenced within 60 seconds of final MPDS code).
- 3.5. The clinical screening process itself is not expected to take longer than 90 seconds and will provide a 'safety net' to ensure a rapid face-to-face ambulance response is not required for those not already categorised at call handler stage as '**Purple Arrest**' or '**Red Emergency**'.
- 3.6. The NHS Wales JCC and WAST will monitor and report, via the JCC website, monthly on the following indicators:
 - the median time to clinical screening;
 - the median time to a clinical decision by screener; and
 - the outcome of the clinical interaction.
- 3.7. Most service users will be screened and likely will not need a rapid face-to-face response. They will be prioritised for a detailed clinical assessment by WAST clinicians through the Remote Integrated Care Service. Users can

expect a callback within one to four hours, depending on their symptoms and the incident location. Higher-risk callers, for example patients with breathing difficulties, will receive priority for this assessment.

- 3.8.** 999 calls pre-identified for the Remote Integrated Care Service will bypass Rapid Clinical Screening and be warm transferred to a call handler for a CPSS (111 non-clinical call handler) assessment. For example, this would typically include presentations such as lower back pain, abdominal pain and people who are vomiting and can often have their care successfully managed without an emergency ambulance attendance.
- 3.9.** WAST and its commissioners will monitor and report monthly on:
- the median time and 90th percentile time to remote clinical assessment; and
 - the disposition following in-depth remote clinical assessment.
- 3.10.** If the Remote Integrated Care Service deems a face-to-face response is required then the ambulance service will either dispatch immediately (**Arrest/Emerg/Now**), within a short time frame (**Soon**), or schedule a person's care or transport to the right place (**Planned**). They may also decide for a face-to-face assessment to better inform the remote clinical decision e.g. sending a volunteer Community Welfare Responder.
- 3.11.** The proposed modifications to the APF are centred on the face-to-face response component.
- 3.12.** During the initial introduction of these changes, officials will hold fortnightly quality and safety assurance meetings with the NHS Wales JCC and WAST from the launch to track progress against all new measures, including those not captured within the APF. These arrangements will be scaled back accordingly as confidence is established, with future monitoring led by the NHS Wales JCC.

3.13. Changes to Amber and Green categories

3.14. To align with the evolving clinical model, new categories are to replace 'Amber' and 'Green'. These are:

Orange Now: time sensitive

Yellow Soon: assess and respond

Green Planned: planned response

3.15. Task group members concluded there is a need for new measures and standards for emergency ambulance response to incidents not categorised in the '**Purple Arrest**' or '**Red Emergency**' categories. This should be driven by available clinical evidence and what matters most to the public.

3.16. There was consensus for using median and the 90th percentile for any new categories, in line with IHI advice.

3.17. The group felt there should be *more* emphasis on measuring patient outcomes rather than solely median response times for calls. This is consistent with the changes already introduced as part of phase 1 and aligns to approaches used by the rest of the UK.

3.18. Like phase 1, there is an opportunity to introduce a 'bundle' of out-of-hospital care measures for time-sensitive complaints. This would improve public understanding of how each part of the pathway, including ambulance interventions, contributes to outcomes.

3.19. During the Task Groups Options Appraisal, there was an emphasis on the importance of directing individuals with time-sensitive complaints to the appropriate specialist promptly, ensuring that the treatment is administered in a timely fashion. Transitioning to the publication of call-to-door times and eventually call-to-treatment times for conditions such as stroke and STEMI will enhance transparency regarding the entire system's focus on outcomes, aligning with health and care quality standards.

3.20. The first phase found that time-based targets may lead to 'hitting the target but missing the point'. For instance, prioritising rapid response vehicles for stroke victims to meet the target, despite these vehicles being unable to

transport patients for proper diagnostics and treatment, could cause delays and impact outcomes. Therefore, enabling more nuanced assessment and response without a blunt time target is the preferred route- subsequently the new category targets will be without specified response targets.

- 3.21.** Although there would be no time-based target initially, this would be reviewed after 12 months to consider if a target would add value. This pilot approach would enable a thorough evaluation to be undertaken to determine whether time standards would contribute to improved outcomes and experience.
- 3.22.** It has been agreed that as part of the new approach, commissioners/LHBs will revisit setting of aspirations for 'consult and close' as part of the commissioning performance framework to coalesce with the new response approach.

4. CALL CATEGORISATION AND FLOW: THE INTEGRATED CLINICAL SERVICES MODEL

4.1. Phase 1- Call Flow & Screening

4.2. In accordance with the July 1st pilot, **Purple Arrest** and **Red Emergency** incidents should continue to be dispatched in time order with the closest suitable and available resource.

4.3. **RCSO** will continue to be utilised in line with current practice. If this screening cannot commence within 60 seconds of final MPDS code, this category will default to **Red Emergency** and be presented to the dispatch queue as a safety measure.

4.4. These measures will continue to be reported to the JCC and Welsh Government as the suitability and effectiveness of these measures continues to be assessed.

4.5. Phase 2- Screening

4.6. In line with the Integrated Clinical Services Model and a 'Screen first' approach, all other calls will be subject to Rapid Clinical Screening prior to a dispatch decision being made.

4.7. These screening codes will align to the definitions relating to propensity for high-risk markers and present to the Clinical Navigators accordingly. Median time to both clinical screening and clinical decision will be measured, as well as the percentage breakdown of outcome per screening category. Although no time target has been formally set against these codes, they will continue to be monitored and reviewed for patient safety purposes.

4.8. A smaller subset of calls will continue to be identified at final determinant (this is the incident code as determined by the 999-call handler using the Medical Priority Dispatch System (MPDS) as suitable for direct transfer to the Remote Integrated Care Service (RICS). These will continue to be streamed to the most appropriate RICS queue and measures for these are established later in this explainer document.

4.9. A breakdown of the initial screening approach to 999 calls can be found in the table below.

Respond Immediately	PURPLE	RED	See face to face response table for measures
	ARREST Cardiac or respiratory arrest	EMERGENCY At high risk of cardiac or respiratory arrest	
Screen Now* *A proportion of RCS codes will stream directly to RICS as appropriate (driven by MPDS coding)	RCS0	High priority for rapid clinical screening	<ul style="list-style-type: none"> • Median time to clinical screening • Median time to clinical consultation • % outcome
	RCS1	High propensity for high-risk markers	
	RCS2	Medium propensity for high-risk markers	
	RCS3	No/Low propensity for high-risk markers	

4.10. RCS1-3 are new categories introduced as part of the Phase 2 pilot. These screening categories are used to support Clinical Navigators in identifying call propensity for high-risk markers and provide a priority order for assessment.

4.11. During the transitional phase of the model, the RCS codes will be adapted from the current Amber1, Amber2 and Green code sets. This will form an initial approach to delivery of the new screening codes and aid a swift delivery of the revised approach. This will be continuously reviewed and developed based upon an evidence-based quality improvement approach that will respond to findings as the model embeds.

4.12. Some incidents will be identified at the MPDS stage as unsuitable for RCS (such as the current Amber1 CHARU dispatch codes). A small number of incidents will continue to stream direct to the Recall Queue and bypass RCS.

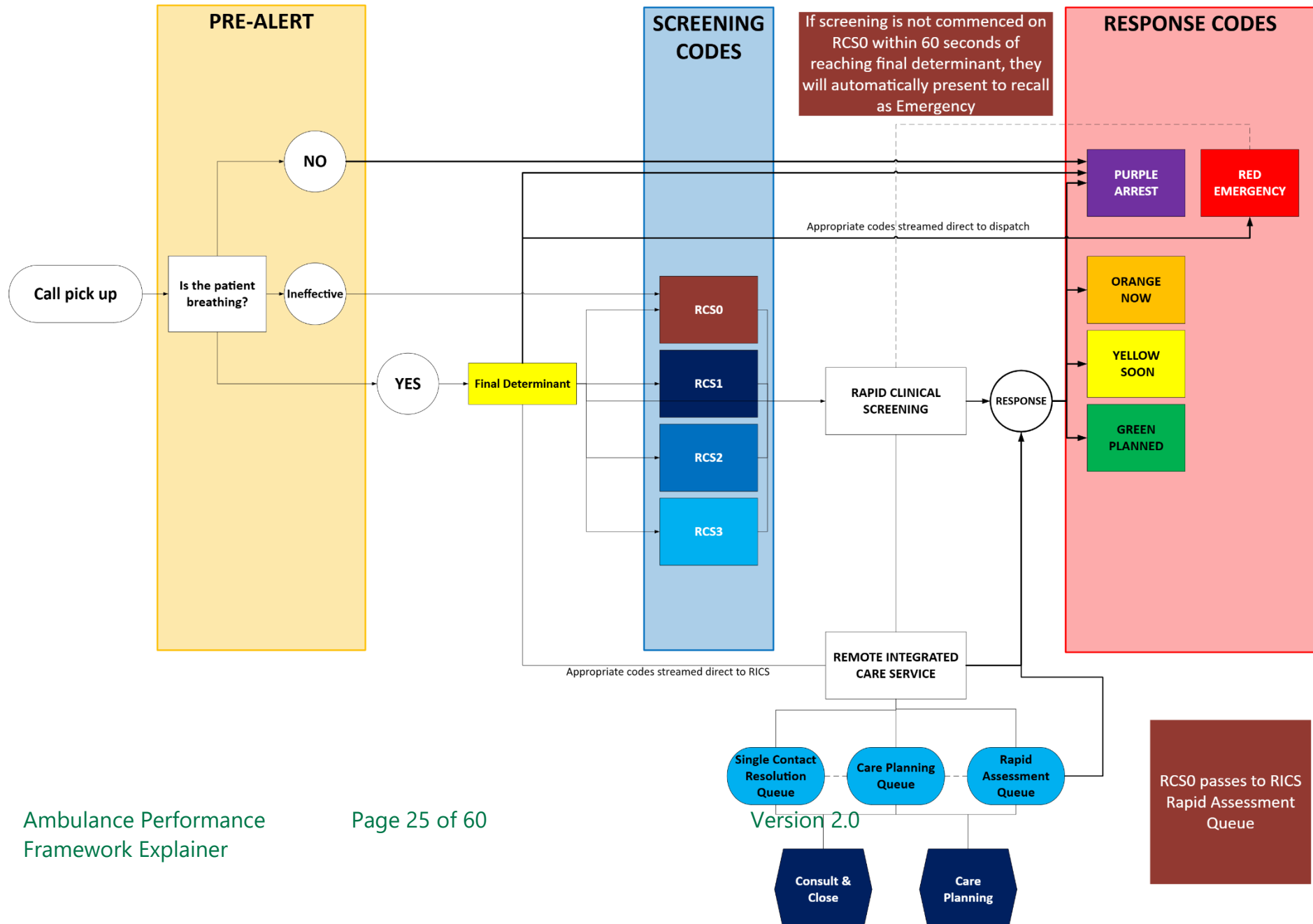
4.13. Phase 2 Response Categories

4.14. The Phase 2 pilot now means that WAST will have 5 distinct response categories available for the dispatch of assets. The categories provide a patient centric approach to resource allocation that support decision making rather than dictate it. The timeliness of response will continue to be an important focus of response (particularly for **Purple Arrest**, **Red Emergency** and **Orange Now** categories), but the category now supports the wider goal of ensuring the most appropriate care is delivered on the first occasion.

4.15. A summary of the 5 targets, their respective descriptions and measures, as well as a full flow diagram of the Phase 2 process can be found on the following pages.



	Category	Description	Aim	Measures
Respond Immediately	PURPLE: ARREST	Cardiac or respiratory arrest	Increase ROSC rates	<ul style="list-style-type: none"> ROSC rate Median time to identify cardiac arrest Median time to commence CPR instruction Median time for defibrillator arrival Median response (6-8 minutes) 90th percentile (20 minutes)
	RED: EMERGENCY	At high risk of cardiac or respiratory arrest	Prevent deterioration into arrest	<ul style="list-style-type: none"> Median response (6-8 minutes) 90th percentile (20 minutes) Outcome measure (Pain, NEWS, Spo2)
Time Sensitive	ORANGE: NOW	Likely to need diagnostics and transport to hospital or specialist care e.g. a person in stroke or heart attack	Rapid arrival at specialist or emergency care facility as soon as possible	<ul style="list-style-type: none"> Median response of most appropriate resource 90th percentile Stroke care bundle inc. call to door median and % arrival at specialist site STEMI care bundle inc. call to door median and % arrival at specialist site Further measures developed over time
Assess and Respond	YELLOW: SOON	Further clinical assessment to support clinician decision making (remote or face to face) for discharge at scene, and/or alternative pathway, and/or planned transport to treating facility, e.g. a person with abdominal pain.	Prevent unnecessary escalation of care	<ul style="list-style-type: none"> Median response of most appropriate resource 90th percentile % by disposition
Planned Response	GREEN: PLANNED	High potential for the Ambulance Service to manage the care episode in its entirety or in collaboration with community service or planned care provider, e.g. chest infection, palliative care, mental health or UTI.	Right response for need	<ul style="list-style-type: none"> Median response of most appropriate resource 90th percentile % by disposition

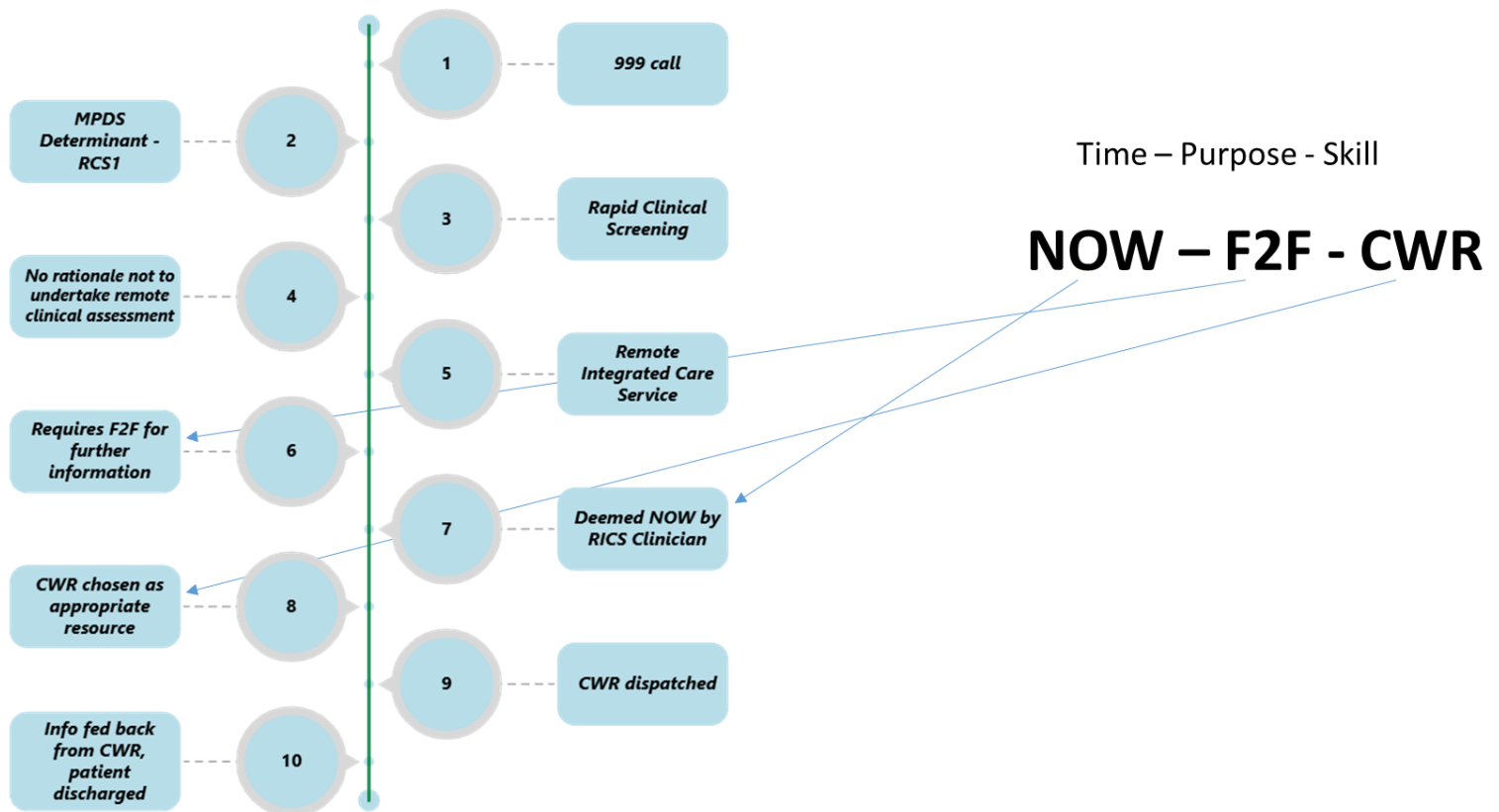


4.16. Time Purpose Skill

- 4.17.** The categories form part of the revised, clinically focussed and patient centred approach to the ambulance service's response model. Categories are intended to allow for identification to Emergency Medical Services Coordination (EMSC) staff and responding clinicians the urgency and priority order that must be considered in providing a suitable response. The category will reflect the 'Time' scale in which a resource must ideally be allocated.
- 4.18.** However, to ensure the most effective and appropriate response possible it is recognised that the *purpose* of the response (what are we anticipating the outcome to be), and the most appropriate *skill* set of the response also have an impact on the patient outcome (to best resolve or manage the presenting condition). Therefore, the new framework will reflect a move towards this with a '**Time-Purpose-Skill**' decision deployed.
- 4.19.** The 'Purpose' of a response will be 'Face to Face' (F2F) or 'Convey'. This will assist Resource Coordinators with identifying suitable resources based upon the need for a conveying asset.
- 4.20.** The 'Skill' will provide a range of suitable options for the dispatcher to choose from, as well as assist in guiding the most optimal resource choice. The skill required could be a range of suitable clinical responses or identified as requiring a specialist asset (such as an APP or Mental Health Practitioner). This supports the deployment of the most suitable resource to patients, ensuring effective utilisation, improved patient care and greater emphasis upon resolving cases as close to the patient's home as possible.
- 4.21.** The Time-Purpose-Skill will be provided by the Clinical Navigator or RICS clinician prior to passing the incident to the Recall Queue (dispatch queue).
- 4.22.** Additionally, the triaging clinician in RICS will provide a Time-Purpose-Skill specification when streaming calls to ensure that the most appropriate assessment queue is utilised. The 'Time' in this instance will be indicated by the RCS code of the call. Clinical Navigators will pass the call across at the current RCS code for review and a process to alert cases that are needing to

be assigned to the Rapid Assessment Queue will be available for situations that are felt to be of a highly urgent nature.

4.23. An example of a potential application of the Time-Purpose-Skill model is detailed below.



4.24. The primary intention behind Time-Purpose-Skill is to ensure that patients receive the correct response on the first occasion. At times, there may be an unavailability of the most appropriate response and therefore Resource Coordinators will be required to utilise the 'Time' category to understand if the urgency of the situation can wait for the correct response to become available.

- 4.25.** This is a key shift in concept to the Integrated Services Clinical Model- resources may be available to respond to an incident but do not align with the most appropriate clinical response to the case. As such, holding calls for a period of time awaiting the correct response may be the most appropriate course of action to take. This differs from the current model whereby an incident of any category would have the next available resource dispatched to it regardless of whether a more appropriate unit was scheduled to become available in the near future.
- 4.26.** This key change is instrumental in the delivery of the new service model. Ensuring the most appropriate response on the first occasion is likely to improve the subsequent care for the individual and provide a more efficient provision of services. This will require a greater level of decision making and risk stratification during the dispatch process than at present. Clinicians tasked with setting the Time-Purpose-Skill matrix should ensure that clear rationales and instruction are provided to support Resource Coordinators in interpreting and actioning the requests.
- 4.27.** The protection of Emergency Ambulances (EA) to respond rapidly to time sensitive situations must be maintained to provide the safe service required to our most acutely unwell patients. This is of paramount importance as WAST aims to provide a high level of conveyance to Emergency Departments and Specialist Centres for this resource and therefore cases that are likely to be discharged at scene or managed via an alternative care pathway should aim to avoid the EA dispatch.

5. CALL CATEGORISATION AND FLOW: PURPLE ARREST CATEGORY

- 5.1.** The first and most significant change within our new call categorisation system is **Purple Arrest**, which specifically focuses on cardiac and respiratory arrest incidents. These are the most time-sensitive emergencies, where swift identification, early effective CPR, access to a defibrillator, rapid dispatch, and immediate attendance, are crucial to patient survival. Our commitment to providing a prompt and effective response for these cases will be strengthened under the new model. Our protocols shall ensure that these incidents are prioritised and handled with the utmost urgency including CAD auto-dispatch.
- 5.2. Definition:** Incidents where a person is in cardiac or respiratory arrest.
- 5.3. Response:** Immediate dispatch (supported by auto-dispatch CAD functionality) with the fastest possible response, ensuring that paramedic and conveying resources also attend the scene as soon as possible. This will include the use of volunteer responders and GoodSam. Enhanced Care capabilities, such as CHARU, **must** be dispatched, where available. **Purple Arrest** and **Red Emergency must** be dispatched upon in time order.
- 5.4. Purpose of Attendance and Skillset:** To swiftly respond to patients in cardiac or respiratory arrest, increasing ROSC rates that are subsequently transferred to an appropriate hospital facility. This includes the early provision of bystander CPR and the retrieval/use of a defibrillator to the patient, and a paramedic-led attendance to undertake high-quality resuscitative and post-ROSC care.
- 5.5. Measurement**
- 5.6.** While our operational response remains consistent, this represents a significant shift in how we measure the effectiveness of our response to cardiac and respiratory arrests. Traditionally, the 8-minute response time has been used as the standard metric for these cases. However, this time-based target lacks direct clinical evidence linking it to improved patient outcomes, particularly in terms of survival rates.

5.7. Instead, we shall measure performance according to the **Chain of Survival**. This concept encompasses a series of critical steps that have been clinically proven to increase the likelihood of survival and recovery for patients experiencing cardiac arrest. The links in the Chain of Survival are:

- Early recognition of a cardiac arrest,
- Early CPR initiation,
- Early use of a defibrillator,
- Prompt ambulance crew response and access to enhanced/critical care, particularly in the post resuscitation phase.

5.8. By focusing on the **Chain of Survival** rather than an arbitrary response time, we can more accurately assess and improve the quality of care provided. This approach emphasises the entire continuum of care, from the moment of arrest to the delivery of advanced life support and hospital transport, ensuring that each step is optimised to enhance patient outcomes. Measuring our performance based on these clinically relevant indicators aligns our practices with the best available evidence and reinforces our commitment to delivering the highest standard of care in the most critical situations

5.9. The overarching metric against which the service will be measured against in this category is **ROSC sustained to hospital arrival**. This will ensure that 'success' of the system can be aligned to multiple factors aimed at improving overall patient care, not simply whether an ambulance arrived within an arbitrary time.

5.10. Other metrics such as time taken to recognise cardiac arrest, time taken to commence CPR instruction, time taken for a defibrillator to arrive at the patient, and time taken to get a WAST resource to scene will also be recorded and allow for data points across the whole chain of survival to be taken and addressed. A comprehensive list of these metrics can be found in the Appendix.

5.11. The clock start measures can be found in Appendix H.

Purple Arrest Key Points

- Immediate dispatch and rapid response are crucial for **Purple Arrest** incidents. Auto-dispatch will be active for these incidents, and they are to be treated as the same dispatch priority as **Red Emergency**.
- Performance will be measured according to the Chain of Survival, focusing on steps proven to enhance patient survival.
- Metrics such as recognition time, time to commence CPR instruction, defibrillator arrival time, WAST resource arrival time, and ROSC sustained to hospital arrival will be recorded for comprehensive analysis.
- The target median response time for **Purple Arrest** incidents is 6-8 minutes, with a 90th percentile response in 20 minutes.

6. CALL CATEGORISATION AND FLOW: **RED EMERGENCY CATEGORY**

- 6.1.** The **Red Emergency** category is designated for incidents where a person is identified as being at high risk of cardiac or respiratory arrest and therefore require immediate clinical intervention. These situations are clinically determined as inappropriate for rapid clinical screening before dispatch due to the urgency and severity of the patient's condition and the likelihood of conveyance to secondary care. As a result, once the initial call handling process is completed, these incidents bypass any further assessment and proceed directly to dispatch, ensuring that help is on the way without delay. CAD auto-dispatch functionality shall be enabled for the **Red Emergency** category.
- 6.2.** Calls within this category are time-sensitive and are likely to necessitate a higher level of clinical skill for effective intervention. These cases often involve complex emergencies where swift, expert care is critical to preventing deterioration and improving patient outcomes. Therefore, it is essential that our response to these emergencies remains both rapid and well-equipped, with highly skilled clinicians prepared to deliver enhanced medical interventions on scene.
- 6.3.** Maintaining this direct to dispatch approach (including CAD system driven auto-dispatch) for the **Red Emergency** category aligns with our commitment to prioritising patient safety and delivering timely care where it is most needed. This approach ensures that our resources are mobilised quickly and effectively to address the most urgent cases, minimising the time to intervention and enhancing the chances of a positive outcome.
- 6.4. Definition:** Incidents where a person is identified as at high risk of cardiac or respiratory arrest.
- 6.5. Response:** Immediate dispatch. To attend the scene as soon as possible (supported by auto-dispatch CAD functionality), with both a WAST median response time measure and 90th percentile measure in 20 minutes inclusive of CFR & UFR for the median response time (90th percentile excludes CFR/UFR response times). **Purple Arrest** and **Red Emergency must** be dispatched in time order.

6.6. Purpose of Attendance and Skillset: To prevent patient deterioration into cardiac or respiratory arrest and to provide immediate aid to high-acuity patients. Paramedic with advanced life support capabilities should, subject to local dispatch protocols and where possible, be dispatched to these patients. Some of these cases may be clinically determined as appropriate for a single paramedic responder ahead of a determination for transport, like the pre-existing approach to some of the Red activity.

6.7. Measurement

6.8. It is to remain our priority to attend incidents in this category with the appropriately skilled clinician as soon as possible with an expectation that the median response time will be in 6-8 minutes.

6.9. To maintain the integrity of the **Purple Arrest** category and sustain patient safety, a 90th percentile measurement in 20 minutes will also apply to the **Red Emergency** category. This ensures that calls within this category receive a timely response while preventing the inappropriate reclassification of cases into the **Purple Arrest** category merely to achieve faster response times. This issue has been observed since the introduction of the Clinical Response Model in 2015, where some MPDS determinants were shifted to the Red category to limit in-community wait times. It ensures that the **Red Emergency** category is managed independently of the **Purple Arrest** category, with each maintaining its specific criteria and response measurement. This approach not only protects the integrity of both categories but also reinforces our commitment to patient safety, ensuring that the right resources are deployed to the right cases based on clinical need rather than arbitrary time targets.

6.10. The median response time of the first WAST response shall be 6-8 minutes with a 90th percentile time to WAST response of 20 minutes. Any uniformed WAST response will 'stop the clock'; however, CFR & UFR will be excluded from the 90th centile metric. Additional measurements will record the arrival of 'conveying resources', appreciating that this could be different from the first resource on scene.

6.11. The 'Clock Start' time is measured from time of presentation to the dispatch queue (e.g. if received from **Rapid Clinical Screening - RCS/ Remote Integrated Care Service - RICS**, or via **Pre-Triage Sieve**) or at time of final **MPDS** Determinant.

6.12. The clock start measures can be found in Appendix I.

Red Emergency Key Points

- **Red Emergency** category incidents require immediate dispatch to prevent cardiac or respiratory arrest. These are to be treated as the same priority as **Purple Arrest** incidents.
- Maintaining rapid response times with skilled clinicians is essential for patient safety and positive outcomes.
- **Red Emergency** has a targeted median response time of 6-8 minutes with a Best Response 90th percentile time of 20 minutes.

7. CALL CATEGORISATION AND FLOW: RAPID CLINICAL SCREENING PRIOR TO DISPATCH (**RCS0**, **RCS1**, **RCS2**, **RCS3**)

- 7.1. Rapid Clinical Screening (RCS)** encompasses incidents that require a preliminary clinical assessment before dispatching emergency resources and is completed before the incident presents to a dispatch queue.
- 7.2.** This provides a clinician-led review of incidents to identify those who require immediate face-to-face response, versus those who may benefit from an extensive remote clinical assessment to determine an appropriate pathway. By tailoring our response to better meet the specific needs of these individuals, we can ensure that emergency resources are preserved for those who require them most urgently. This approach allows us to provide high-quality care while optimising the allocation of emergency response units.
- 7.3.** This will allow a clinically informed decision to respond to a patient immediately, or stream individuals to a further remote assessment as a priority patient. The intention of RCS is to ensure that the first response is the correct response and reduce incidents where emergency ambulance response does not result in an emergency transfer to hospital.
- 7.4. Definition:** Incidents that, by virtue of not requiring an immediate response, have been identified as appropriate for rapid clinical screening to determine the appropriate next steps.
- 7.5. Response: RCS0** High Acuity Live Review of incidents, including the active listening to calls in progress. Screening to commence within 60 seconds of final determinant, by a **Clinical Navigator** within the Emergency Medical Services Coordination Centre (EMSCC). A default backstop to **Red Emergency** exists for safety. All other calls to be streamed in priority order given the propensity for high-risk markers. No backstop is prescribed but calls should be screened as promptly as possible.
- 7.6. Purpose of Intervention and Skillset:** Identification of incidents that require immediate intervention versus those that would benefit from additional time to gather information and inform the most appropriate response. The **Clinical Navigators** should assess the incident and determine

if there are any reasons that a remote clinical assessment should not take place and stream accordingly. The **Clinical Navigator** skillset is well defined and provides a suitably senior review capacity for the role undertaken.

7.7. Measurement and Safety Backstops

7.8. For this category, the key metric will be **median time to clinician**, measuring how quickly a patient is reviewed by a **Clinical Navigator** after the call handling process. Additional internal measures will be introduced to identify how long a clinician was engaged in the incident (median), as well as the recording of the outcomes of these assessments (**Purple Arrest/Red Emergency**, other response category, RICS).

7.9. **RCSO** has a safety backstop: if rapid clinical screening does not commence within 60 seconds of the final MPDS determinant, these cases will automatically flow to dispatch as **Red Emergency**. This safeguard ensures that even if remote management is being considered, patients at the highest risk will still receive a timely and appropriate response, maintaining patient safety as the top priority. Other RCS categories will not have a backstop timeframe but will continue to be screened in priority order as soon as possible.

7.10. The clock start measures can be found in Appendix J.

7.11. Clinical Navigator Review

7.12. A key innovation in this category is the introduction of the **Clinical Navigator**, a more senior clinician responsible for reviewing cases within these subgroups. The **Clinical Navigator** will apply their expertise and clinical judgment to assess whether the identified incident is suitable for deeper remote management or if it requires a more immediate response.

7.13. This represents a significant paradigm shift: to a position that these cases should receive further remote consultation by **RICS**, rather than an immediate ambulance dispatch, unless there are clear, clinical reasons why this should not happen. This change allows for more flexible and effective

management of potential emergency cases, ensuring that patients receive care that is both timely and appropriate to their clinical needs.

7.14. Progression to dispatch from RCS

7.15. After the **RCS** process, if it is determined that an incident is not suitable for management through **RICS**, the case will progress to dispatch at the clinically appropriate priority for response. This progression is part of a carefully structured system that ensures patients receive the most appropriate level of care based on their clinical needs.

7.16. Our broader ambition is to direct as much clinically appropriate activity as possible to **RICS**, thereby leveraging the efficiency and comprehensive care options that the service and wider urgent and emergency care system offers. However, recognising the complexity of this transition, there shall be a phased approach. This allows us to carefully monitor and adjust the process as we gain confidence in **RICS** operations, ensuring a smooth and safe transition.

7.17. Initially, a wide spectrum of response categories will be available to the **Clinical Navigator** during this transition (all 5 categories will be available for selection). These categories will provide flexibility as we fine-tune the **RICS** processes and gradually shift more activity into the **RICS** system. Over time, as we refine and optimise these processes, we anticipate narrowing the range of dispatch options available to the **Clinical Navigator**.

RCS Key Points

- **Rapid Clinical Screening (RCS)** will screen the vast majority of incidents prior to dispatch, ensuring clinical assessment informs the most appropriate response.
- A **Clinical Navigator** will review incidents to determine if they are suitable for remote assessment via the **Remote Integrated Care Service (RICS)** or require an immediate or time-sensitive face-to-face response.
- Key metrics, including time to clinician and outcomes of assessments, will be used to measure the effectiveness and safety of this approach.

8. CALL CATEGORISATION AND FLOW: **ORANGE NOW** CATEGORY

8.1. Definition: A patient likely to need timely diagnostics, treatment and/or transport to hospital or specialist care e.g. a person in stroke or heart attack.

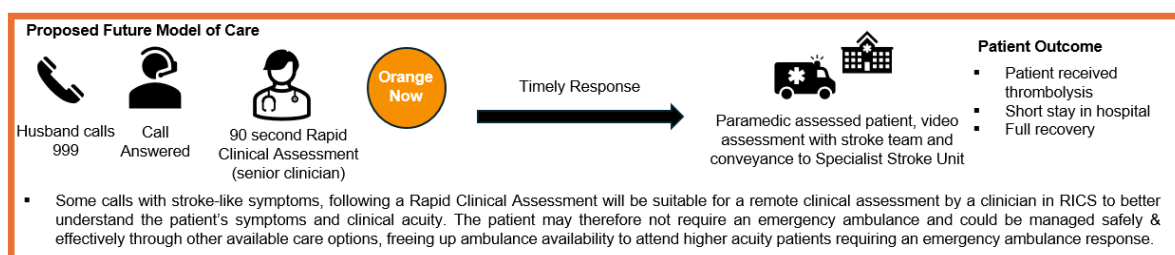
8.2. Response: Determined by the clinical need of the patient and recommended by the triaging clinician. In the case of STEMI or Stroke, this will in almost all cases be an emergency ambulance, but additional responses can be considered. Auto dispatch disabled, this category will normally be responded to with emergency warning devices. It is anticipated that this would occur within 1 hour of categorising or prioritising as an **Orange Now** incident.

8.3. Purpose of Attendance and Skillset: Rapid arrival at specialist or emergency care facility as soon as possible.

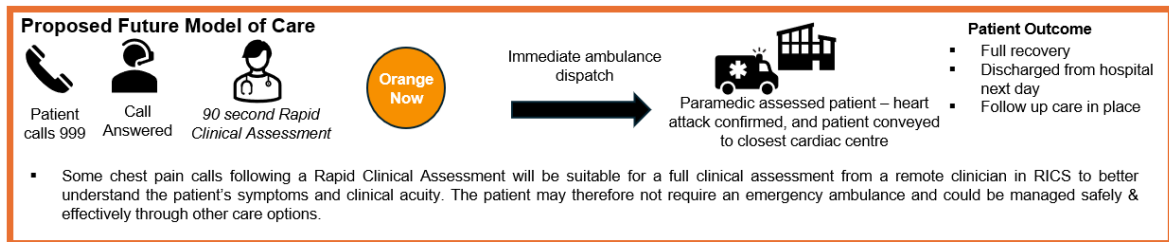
8.4. Measurement

- Median response of most appropriate resource
- 90th percentile
- Stroke care bundle inc. call to door median and % arrival at specialist site
- STEMI care bundle inc. call to door median and % arrival at specialist site
- Further measures developed over time

8.5. This change aims to manage time-sensitive complaints in the current 'Amber' category differently by prioritising ambulance dispatch. Case study examples of a suspected stroke and a significant heart attack 'STEMI' are provided below (at figure one and two) to illustrate the changes to current model.



8.6. *Figure one: Case study example of stroke management*



8.7. *Figure two: Case study example of STEMI management*

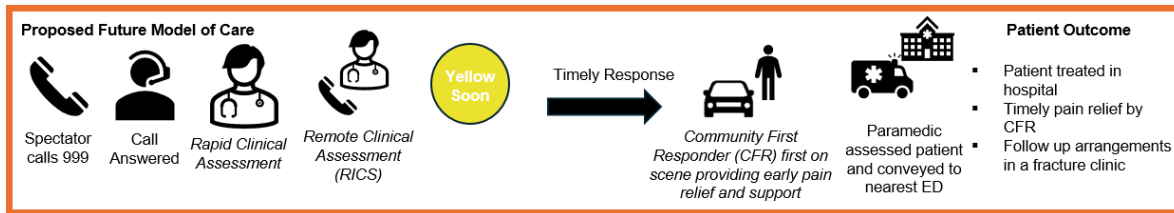
8.8. The clock start measures can be found in Appendix K.

Orange Now Key Points

- For cases where there is a confirmed or potentially time sensitive marker present and the patient may require a face-to-face assessment as soon as possible.
- It is anticipated that this would occur within 1 hour of categorising or prioritising as an **Orange Now** incident.
- In the case of Stroke and STEMI, separate clinical bundles will be measured as well as 'call-to-door' times.
- Median and 90th percentile measured, focus on a 'timely response'.

9. CALL CATEGORISATION AND FLOW: **YELLOW SOON** CATEGORY

- 9.1. Definition:** Further clinical assessment to support clinician decision making (remote or face to face) for discharge at scene, and/or alternative pathway, and/or planned transport to treating facility, e.g. a person with abdominal pain.
- 9.2. Response:** Determined by the clinical need of the patient and recommended by the triaging clinician. An emergency ambulance may be required, but suitable alternative response options may be able to resolve the situation. Conveying resource requirement to be identified at remote assessment if possible. Auto dispatch disabled, this category would not normally be responded to with emergency warning devices. It is anticipated that this would occur within 4 hours of categorising or prioritising as a **Yellow Soon** incident.
- 9.3. Purpose of Attendance and Skillset:** To prevent unnecessary escalation of care, provide a prompt response to cases to minimise pain or distress, assist with gathering further information to inform appropriate care planning. Skillsets will be determined by the clinical need, and as closely aligned with best practice as possible. The use of the volunteer network may support effective deployment of resources.
- 9.4. Measurement**
- Median response of most appropriate resource
 - 90th percentile
 - % by disposition
- 9.5.** The screening process is designed to enable more detailed clinical decision-making for individuals who have experienced a serious injury or are acutely unwell in an environment that may affect their outcome. An example of a serious sports injury in harsh weather conditions is illustrated below.



9.6. *Figure three: Case study example of management of leg fracture on a rugby field.*

9.7. The clock start measures can be found in Appendix K.

Yellow Soon Key Points

- Resource utilisation should be focussed upon resolving case in most effective way possible.
- No time sensitive markers identified but requires prompt response to minimise pain or discomfort and prevent deterioration.
- It is anticipated that this would occur within 4 hours of categorising or prioritising as a **Yellow Soon** incident.
- Alternatives to Emergency Ambulance response may be of high impact.

10. CALL CATEGORISATION AND FLOW: GREEN PLANNED CATEGORY

10.1. Definition: High potential for the Ambulance Service to manage the care episode in its entirety or in collaboration with community service or planned care provider, e.g. chest infection, palliative care, mental health or UTI.

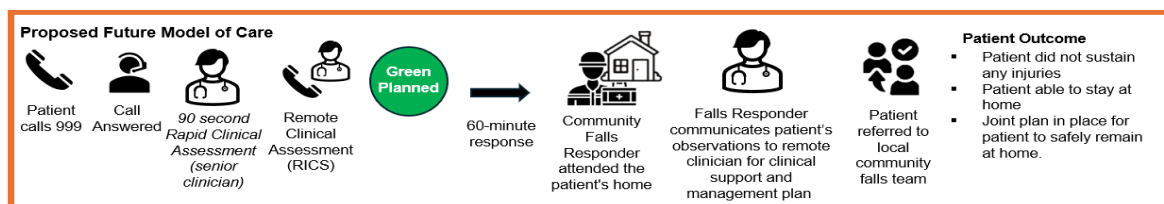
10.2. Response: Community or non-emergency based responses. Auto dispatch disabled. This will be responded to in a timeframe that is most appropriate for the nature of the planned response and may exceed 4 hours if appropriate (e.g. for 6 hours overnight whilst awaiting transfer to an in-hours service such as an Advanced Paramedic Practitioner).

10.3. Purpose of Attendance and Skillset: Right response for need and this may be for a see and treat/refer disposition or for a conveyance to a definitive care centre away from the Emergency Department (e.g. Minor Injury Unit). Skillset will be aligned with the most suitable for clinical presentation (e.g. Falls Responder for fallen person).

10.4. Measurement

- Median response of most appropriate resource
- 90th percentile
- % by disposition

10.5. Individuals who have fallen will have their needs evaluated through the screening process. If it is determined that a fall responder may be necessary, one will be dispatched while simultaneously forwarding the case to the Remote Integrated Care Service. This allows for a remote clinician to conduct an intervention and assessment before the fall responder arrives, thereby decreasing the chances of prolonged lying on the floor or other negative outcomes.



10.6. Figure four: Case study example of elderly falls management

10.7. The clock start measures can be found in Appendix K.

Green Planned Key Points

- To facilitate effective community-based care or non-emergency hospital transportation.
- Focussed upon 'planned' work rather than a specific timeframe- this could be within an hour (e.g. falls responder) or held overnight until services open the following day (supported by clear communication and risk-based decision making).
- Aligns with the Care Planning functions of RICS.

11. REMOTE INTEGRATED CARE SERVICE (RICS)

11.1. RICS represents a significant advancement that goes beyond the simple merging of our **Clinical Support Desk (CSD)** and **NHS 111 Wales** services. **RICS** is an expanded, multi-disciplinary team (MDT) with enhanced capabilities, offering more than traditional triage, 'consult and close' or 'consult and refer' functions. This unified approach combines the expertise and resources of both services to deliver a more comprehensive and patient-centred care model. By utilising the full range of skills and support from our teams, **RICS** ensures improved delivery of care and effectiveness.

11.2. Flow to Assessment or Care Planning

11.3. Following the flow determination in the **RCS** process, it is anticipated that a majority of **RCS** incidents will stream to **RICS**. These will transfer across as an '**RCS**' code, streamed to the most appropriate queue by the Clinical Navigator.

11.4. Any **RCS0** incident identified as suitable for remote assessment by the Clinical Navigator will stream to the Rapid Assessment Queue. These consultations will happen as soon as possible; however, the aim is to commence a consultation within 15 minutes of the incident presenting to the queue.

11.5. Other **RCS** codes will pass to the queue most relevant to their clinical need. Again, this will be streamed by the Clinical Navigator in the same process in place for the Amber and Green calls now. A flag to indicate a need for a Rapid Clinical Assessment requirement will continue to be available to highlight non-RCS0 incidents that are felt to require a faster assessment.

11.6. It is anticipated that a proportion of incidents streamed to **RICS** will not require an ambulance dispatch and may be managed appropriately via an alternative arrangement. These calls may result in a single contact resolution, or a transfer into Care Planning for ongoing management. Transfer to Care Planning may require the incident to be recategorised to the most appropriate response category to allow the dispatch of ideal or interim responses.

11.7. All **RCS** screening codes will pass from **RCS** to **RICS** and transition to the identified queue by the **Clinical Navigator**, as is current process now. The nature of the call may be assessed by the **Senior Clinician (SC)**, **Point of Contact (POC)**, or **Operations Manager (OM)** who can identify amendments to an alternative queue if required. If this does not occur (e.g. due to capacity of the SC), all non-**RCSO** cases will stream to the Single Contact Queue as a default fallback position.

11.8. At the launch of the new categories, the Trust will be utilising the existing C3/CAD system and therefore the mechanism for moving calls between queues will be broadly akin the current approach. However, the intention will be to transition to a single CAD model that will improve the ease of transferring and/or holding calls within the Integrated Care space. Details of this will be shared in due course.

11.9. Call Flow from RICS to Dispatch

11.10. When an incident is assessed within the **RICS** and deemed necessary for a face-to-face assessment or conveyance, the case will flow to dispatch with an ideal and interim resource(s) recommendation. This pathway is also applicable for any patient accessing healthcare via NHS 111 Wales but needs a physical response. This process is designed to ensure clarity and precision in how dispatch staff manage and allocate resources, with specific categories to illustrate response times, and purposes of attendance clearly defined. The single CAD solution will support this when live, but the interim measure mirrors current process; the category reflects the *Time* nature of the response, and the Ideal response will provide an indication of both *Purpose* (Face to Face or Convey) and the *Skill* level required.

11.11. When passing this call back to dispatch, the **RICS** clinician will select most appropriate category for the incident type. For example, if the clinician undertakes a rapid assessment and identifies that the patient may be critically unwell (high risk of cardiac arrest), they could amend and pass back the call as **Red Emergency**. However, if the patient is identified as requiring a face-to-face response but is more clinically stable, this could be streamed back to the dispatch queue as a different category incident as appropriate

(such as **Orange Now** or **Yellow Soon**). All incidents will need to be amended from their 'RCS' status, thereby prompting a decision by the triaging clinician regarding the urgency of the response.

11.12. The RICS clinician should also indicate the most appropriate *Purpose* and *Skill* when streaming the call to the Recall Queue to assist the Resource Coordinator in identifying the correct asset to respond to the incident. This will be via the Ideal and Interim resources. When selecting these resources, the IC clinician should consider the anticipated clinical course of the patient and aim to provide a recommendation that will provide a definitive solution for the patient. This may be for a conveying resource to transfer the patient to a definitive treatment location, or face-to-face resources to support information gathering (such as a Community Welfare Responder).

11.13. Measurement

11.14. All categories within RICS will be measured for median time to assessment, as well as the ultimate final disposition for incidents.

	Category	Measure
Remote Integrated Care Service – Clinical Assessment	RCS0	<ul style="list-style-type: none"> • Median time to remote assessment • % Outcome
	RCS1	<ul style="list-style-type: none"> • Median time to remote assessment • % disposition
	RCS2	<ul style="list-style-type: none"> • Median time to remote assessment • % disposition
	RCS3	<ul style="list-style-type: none"> • Median time to remote assessment • % disposition

11.15. The clock start measures can be found in Appendix L.

Remote Integrated Care Service Key Points

- **RICS** combines the Clinical Support Desk and NHS 111 Wales services into a unified, multi-disciplinary team to provide comprehensive patient-centred care.
- **RCS** incidents identified as suitable for **RICS** are streamed to the most appropriate queue for assessment by clinicians, ensuring safe and timely evaluation of cases.
- Incidents requiring physical intervention or face-to-face response are passed to dispatch with appropriate categorisation to optimise resource allocation and response times/intentions.

12. APPENDIX A: PURPLE ARREST DATA MEASURES

12.1. GREEN – EXTERNAL MEASURE BLUE – INTERNAL MEASURE

REF	METRIC
ARR1a	PURPLE ARREST Coded Calls
ARR1b	PURPLE ARREST Scene Attendance Time
ARR2	ROSC at Hospital
ARR3a	Time to Identify Cardiac Arrest
ARR3b	Time to Identify if the Patient is not Breathing
ARR3c	Time to Commence CPR Instructions
ARR3d	Time to ARREST MPDS Code
ARR4a	Incidents with Bystander CPR
ARR4b	Number of ARREST Calls with no Time to Commence CPR
ARR5a	Incidents where a PAD was Available
ARR5b	Incidents where a PAD was Allocated
ARR5c	Incidents where a PAD was Brought to Scene
ARR6a	Instruction to Retrieve an Available PAD
ARR6b	PAD Retrieval Time
ARR6c	Time to PAD Arrival
ARR7a	Time to First Alert: WAST Resource
ARR7b	Time to First Mobilisation: WAST Resource
ARR8a	Time to First Alert: Paramedic Resource
ARR8b	Time to First Mobilisation: Paramedic Resource
ARR9a	Time to First Alert: GoodSAM
ARR9b	Time to First Mobilisation: GoodSAM
ARR9c	Response Time: GoodSAM
ARR10a	Time to Conveying Resource Response
ARR10b	Time to Enhanced Care Response

13. APPENDIX B: RED EMERGENCY DATA MEASURES

13.1. GREEN – EXTERNAL MEASURE BLUE – INTERNAL MEASURE

REF	METRIC
EMR1a	RED EMERGENCY Coded Calls
EMR1b	RED EMERGENCY Scene Attendance Time
EMR2	EMERGENCY Calls with CPR Instructions
EMR3	Time to Conveying Resource Response

14. APPENDIX C: RCS DATA MEASURES

14.1. GREEN – EXTERNAL MEASURE BLUE – INTERNAL MEASURE

14.2. RCS0

REF	METRIC
RCS 1	RCS0 Categorised Incidents
RCS 2a	How long does a clinical navigator take to open an RCS0 call for review?
RCS 2b	How many RCS0 calls wait longer than 60 seconds for screening?
RCS 3	How long is the clinical navigator engaged with a RCS0 call?
RCS 4a	How many RCS0 calls are streamed to dispatch as PURPLE ARREST or RED EMERG?
RCS 4b	How many RCS0 calls are streamed to dispatch as ORANGE NOW, YELLOW SOON or GREEN PLANNED?
RCS 4c	How many RCS0 calls are sent to Integrated Care?
RCS 4d	How many RCS0 calls timeout and do not have a High Acuity Live Review (HALR) applied?
RCS 4e	RSC0 Exceptions

14.3. RCS1

REF	METRIC
RCS 5a	How many RCS1 categorised calls are received?
RCS 5b	How many RCS1 categorised call are streamed directly to remote integrated care without screening?
RCS 6a	How long does a clinical navigator take to open an RCS1 call for review?
RCS 6b	How long is the clinical navigator engaged with a RCS1 call?
RCS 7a	How many RCS1 calls are streamed to dispatch?
RCS 7b	How many RCS1 calls are streamed to remote integrated care?

14.4. RCS2

REF	METRIC
RCS 8a	How many RCS2 categorised calls are received?
RCS 8b	How many RCS2 categorised call are streamed directly to remote integrated care without screening?
RCS 9a	How long does a clinical navigator take to open an RCS2 call for review?
RCS 9b	How long is the clinical navigator engaged with a RCS2 call?
RCS 10a	How many RCS2 calls are streamed to dispatch?
RCS 10b	How many RCS2 calls are streamed to remote integrated care?

14.5. RCS3

REF	METRIC
RCS 11a	How many RCS3 categorised calls are received?



RCS 11b	How many RCS3 categorised call are streamed directly to remote integrated care without screening?
RCS 12a	How long does a clinical navigator take to open an RCS3 call for review?
RCS 12b	How long is the clinical navigator engaged with a RCS3 call?
RCS 13a	How many RCS3 calls are streamed to dispatch?
RCS 13b	How many RCS3 calls are streamed to remote integrated care?

15. APPENDIX D: ORANGE NOW DATA MEASURES

15.1. GREEN – EXTERNAL MEASURE

BLUE – INTERNAL MEASURE

REF	METRIC
NOW 1a	How many ORANGE NOW incidents are received?
NOW 1b	How long do ORANGE NOW incidents take to receive a response to scene?
NOW 1c	How long do ORANGE NOW calls take to receive a conveying resource response to scene?
NOW 2	Percentage of suspected stroke patients who are documented as receiving appropriate stroke care bundle with a subsequent conveyance to an appropriate care setting
NOW 3	Percentage of ST segment elevation myocardial infarction (STEMI) patients who are documented as receiving appropriate STEMI care bundle with a subsequent conveyance to an appropriate care setting
NOW 4a	How many ORANGE NOW incidents are resolved through remote clinical assessment (Consult and Close)?
NOW 4b	How many ORANGE NOW incidents are resolved (see, treat, refer) at scene after a response has arrived?
NOW 4c	How many ORANGE NOW incidents result in a conveyance to hospital and what type of hospital are they conveyed to?

16. APPENDIX E: YELLOW SOON DATA MEASURES

16.1. GREEN – EXTERNAL MEASURE BLUE – INTERNAL MEASURE

REF	METRIC
SOON 1a	How many YELLOW SOON incidents are received?
SOON 1b	How long do YELLOW SOON incidents take to receive a response to scene?
SOON 1c	How many YELLOW SOON incidents receive an ideal or interim response?
SOON 1d	How long do YELLOW SOON incidents take to receive an ideal or interim response to scene?
SOON 2a	How many YELLOW SOON incidents are resolved through remote clinical assessment (Consult and Close)
SOON 2b	How many YELLOW SOON incidents are resolved (see, treat, refer) at scene after a response has arrived?
SOON 2c	How many YELLOW SOON incidents result in a conveyance to hospital and what type of hospital are they conveyed to?

17. APPENDIX F: GREEN PLANNED DATA MEASURES

17.1. GREEN – EXTERNAL MEASURE BLUE – INTERNAL MEASURE

REF	METRIC
PLAN1a	How many GREEN PLANNED incidents are received?
PLAN 1b	How many GREEN PLANNED incidents receive an ideal or interim response as determined by a clinician?
PLAN 1c	How long do GREEN PLANNED incidents take to receive a response to scene?
PLAN 1d	How long do GREEN PLANNED incidents take to receive an ideal or interim response to scene?
PLAN 2a	How many GREEN PLANNED incidents are resolved through remote clinical assessment (Consult and Close)
PLAN 2b	How many GREEN PLANNED incidents are resolved (see, treat, refer) at scene after a response has arrived?
PLAN 2c	How many GREEN PLANNED incidents result in a conveyance to hospital and what type of hospital are they conveyed to?

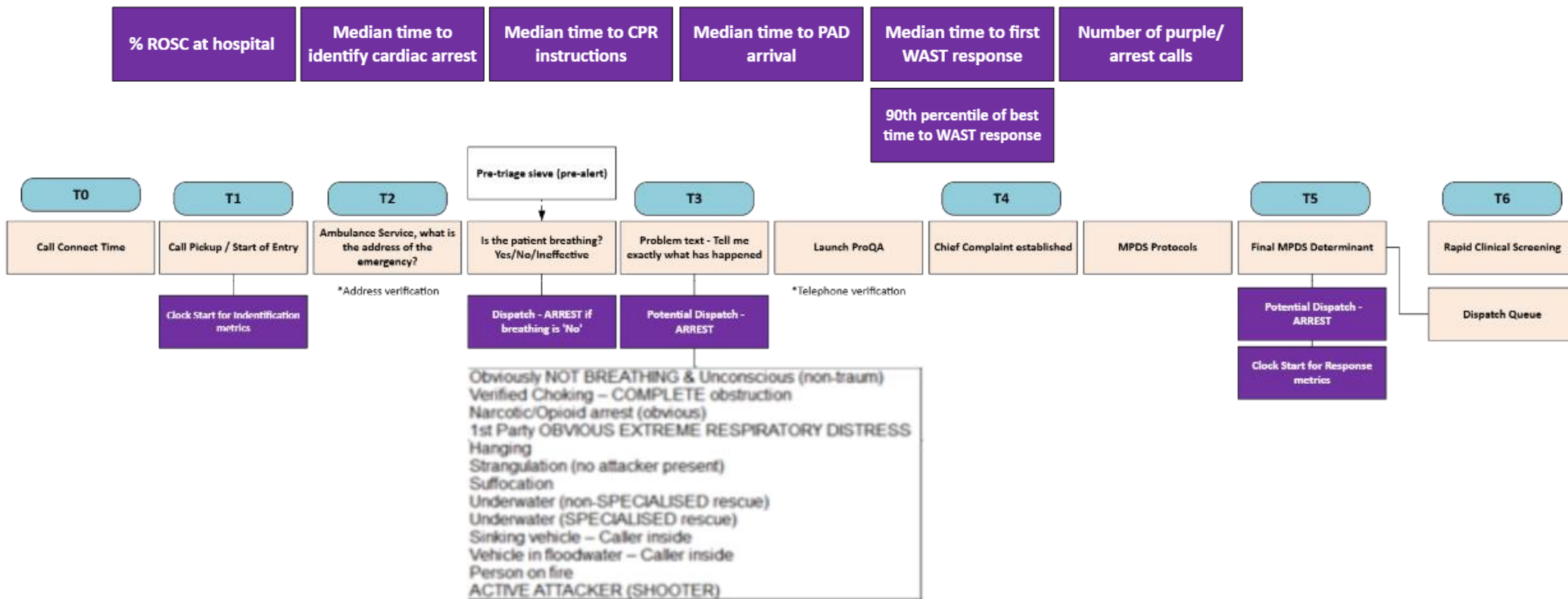
18. APPENDIX G: RICS DATA MEASURES

18.1. GREEN – EXTERNAL MEASURE BLUE – INTERNAL MEASURE

REF	METRIC
RICS 1	How many 999 incidents flow to remote integrated care service (RICS)?
RICS 2	How long does a remote integrated care service (RICS) call take to open for consultation?
RICS 3	How long does the care episode in remote integrated care service (RICS) take?
RICS 4	How many remote integrated care service (RICS) consultations are prioritised for response and what response category are they?
RICS 5	How many remote integrated care service (RICS) consultations are resolved as consult and close and what outcomes are they?

19. APPENDIX H: PURPLE ARREST CLOCK START MEASURES

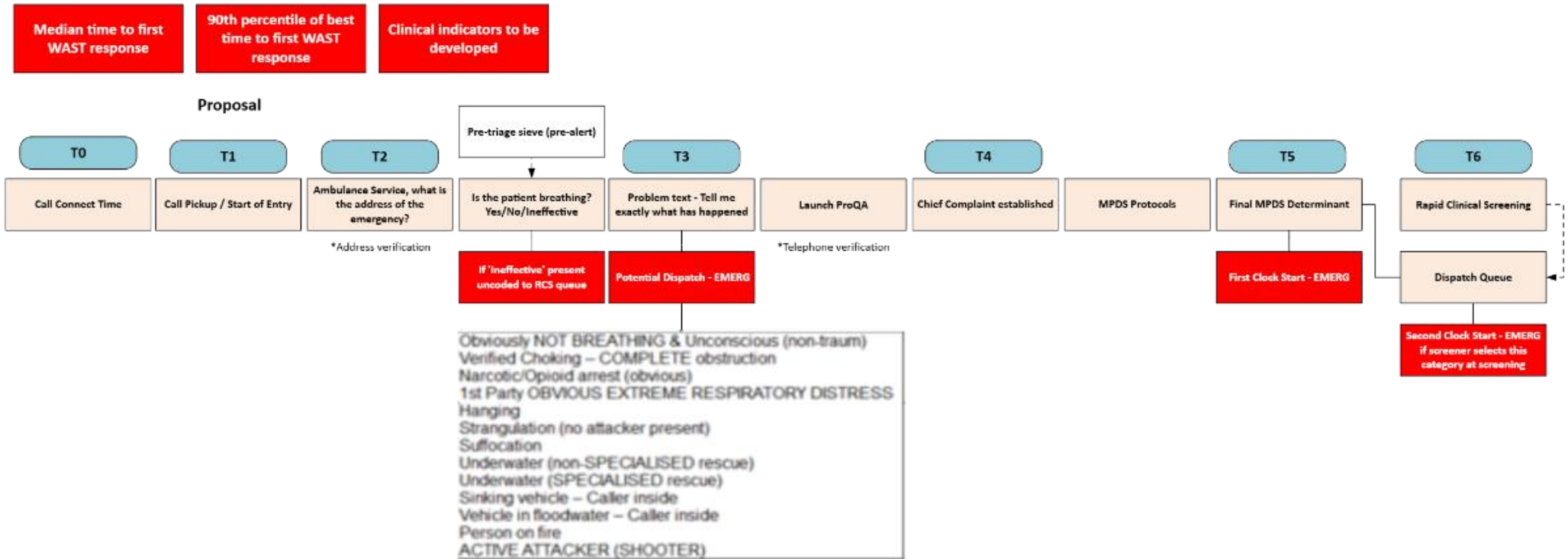
ARREST measurement





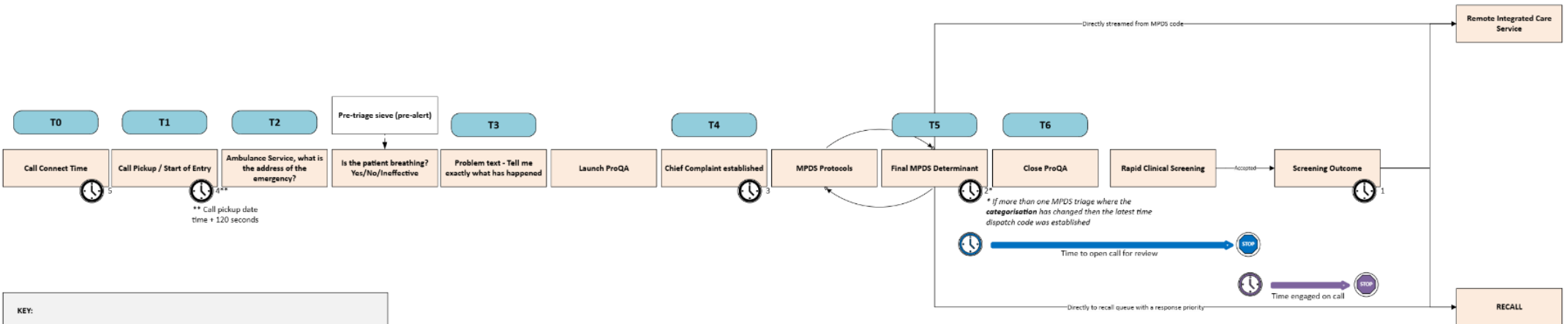
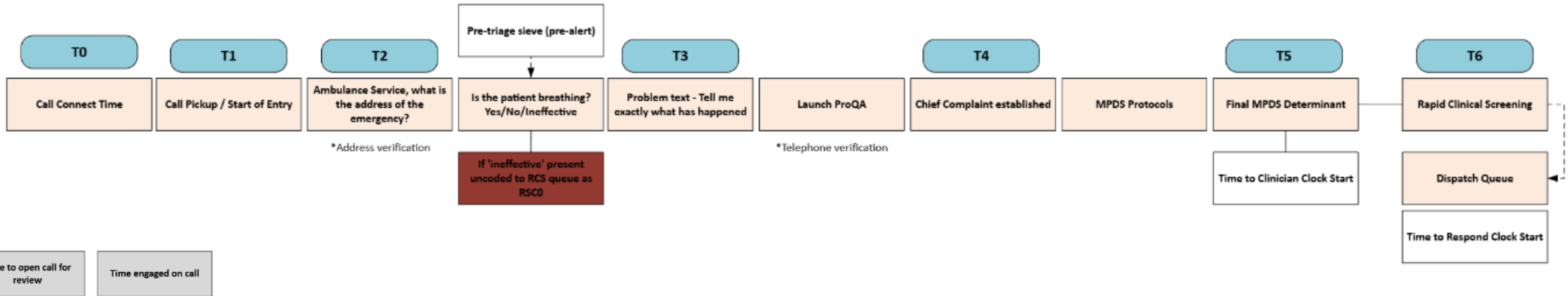
20. APPENDIX I: RED EMERG CLOCK START MEASURES

EMERGENCY measurement





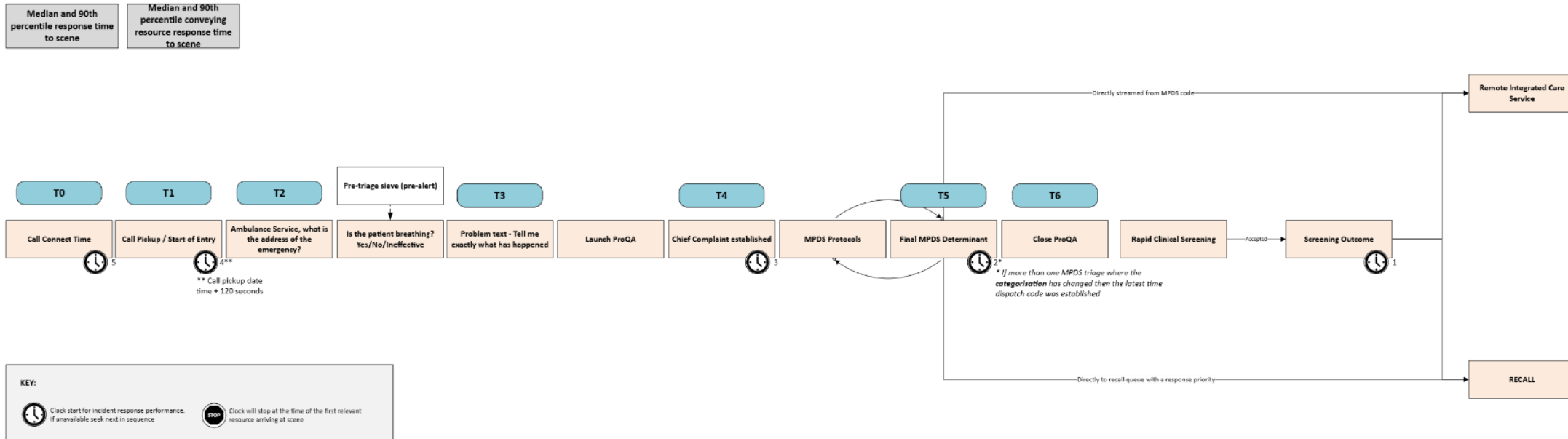
21. APPENDIX J: RCS CLOCK START MEASURES



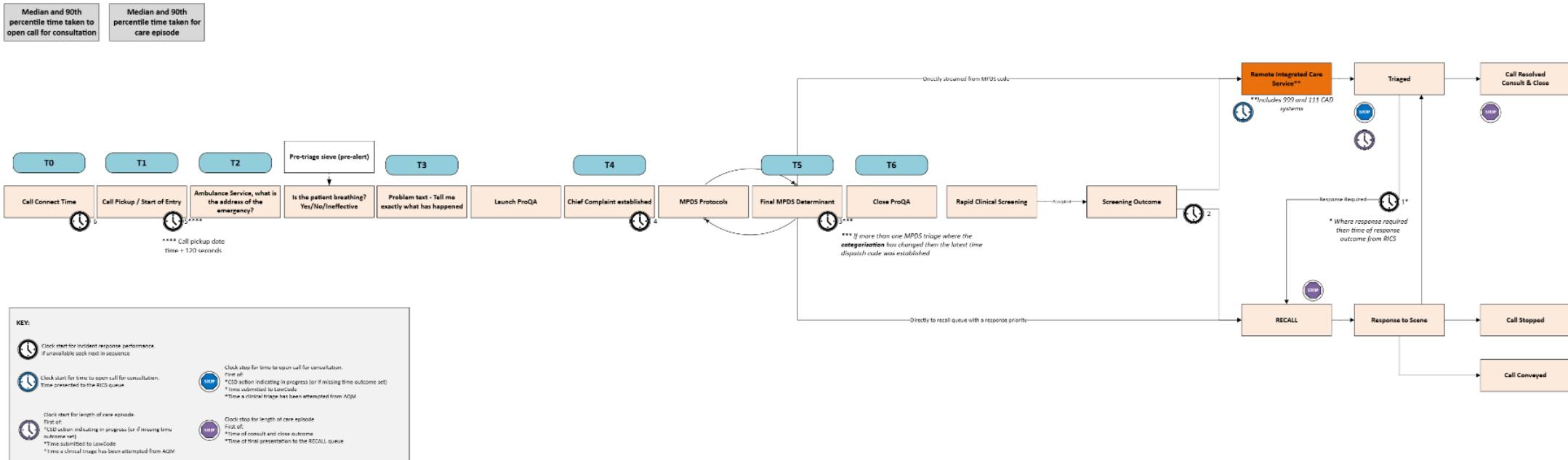
KEY:

- Clock start for incident response performance. If unavailable seek next in sequence.
- Clock start for time to open call for review is the time the call presents for review.
- Clock start for time engaged on call is the time the call is accepted for review.
- Clock stop for time to open call for review is time call has been accepted for review.
- Clock stop for time engaged on call is the time of the RCS outcome.

22. APPENDIX K: ORANGE NOW, YELLOW SOON, GREEN PLANNED CLOCK START MEASURES



23. APPENDIX L: RICS CLOCK START MEASURES



KEY:

- Clock start for incident response performance. If unavailable clock next in sequence.
- Clock start for time to open call for consultation. Time presented to the RICS queue.
- Clock start for length of care episode. First of:
 - 1) CSO action indicating in progress (or if missing time outcome set)
 - 2) Time submitted to LowCode
 - 3) Time a clinical triage has been attempted from A2QM
- Clock stop for time to open call for consultation. First of:
 - 1) CSO action indicating in progress (or if missing time outcome set)
 - 2) Time submitted to LowCode
 - 3) Time a clinical triage has been attempted from A2QM
- Clock stop for length of care episode. First of:
 - 1) Time of consult and close outcome
 - 2) Time of time presentation to the RECALL queue



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Agenda Item No.

ASSURANCE REPORT: PHASE 2 AMBULANCE PERFORMANCE FRAMEWORK GO LIVE AND 'WAIT 45' INITIATIVE

MEETING

Name of meeting	Finance and Performance Committee
Date of meeting	16 September 2025
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Lee Brooks (Executive Director of Operations) Estelle Hitchon (Interim Executive Director of Strategy, Planning and Performance)
Author(s) of report	James Houston (Head of Strategy Development) Oliver Watson (Strategy Development Manager)

PURPOSE OF REPORT

<input type="checkbox"/> Approval	<input checked="" type="checkbox"/> Endorsement
<input checked="" type="checkbox"/> Assurance	<input type="checkbox"/> Discussion
<input type="checkbox"/> Information (goes in consent items)	<input type="checkbox"/> Noting



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Welsh Ambulance Services
University NHS Trust

REPORT SUMMARY:

[See writing and presentation guidance [here](#) to inform this section]

1. The purpose of this paper is to provide Committee with an assurance update regarding the internal arrangements in place to implement and pilot the second phase of changes to the Ambulance Performance Framework.
2. On 1st July 2025, the Trust successfully implemented the Phase 1 changes to the Ambulance Performance Framework for a 12-month pilot period. This involved replacing the previous 'Red' category with a new 'Purple Arrest', 'Red Emergency' and 'RCS0' call categories. This change was undertaken to provide greater emphasis on clinical outcomes over time-based targets, with a bundle of measures related to the 'Chain of Survival'.
3. Upon announcement of the Phase 1 changes described above, the Welsh Government led Ambulance Target Review group reconvened to review the remaining Amber and Green categories.
4. The review found that the broad scope of the current Amber category does not allow for a nuanced response to truly time sensitive incidents, such as patients with symptoms of stroke, STEMI (a type of heart attack) and fractured hips. With increasing handover delays and higher volumes of 'Red' categorised incidents, Amber response times have increased. Furthermore, variation was identified in how ambulance performance is measured across the UK, with England and Scotland making use of a set of 'Clinical Quality Indicators' to measure patient experience and outcomes.
5. Following consideration of the available clinical evidence and evidence relating to what matters most to patients & staff, the review group concluded new categories were required to replace the current Amber and Green categories. These three new response categories are: Orange Now, Yellow Soon and Green Planned, descriptions of which are shown in Table 1.

Table 1: New Phase 2 Ambulance Categories

Category	Descriptor	Types of Complaint
ORANGE NOW	Refers to incidents likely to need diagnostics and transport to hospital or specialist care e.g. a person in stroke or heart attack	<ul style="list-style-type: none"> ▪ Stroke ▪ Heart attack
YELLOW SOON	Refers to incidents where further clinical assessment to support clinician decision making (remote or face to face) is required for discharge at scene and/or an alternative pathway, and/or planned transport to a treating facility.	<ul style="list-style-type: none"> ▪ Abdominal pain
GREEN PLANNED	Refers to incidents where there is high potential for the ambulance service to manage the care episode in its entirety or in collaboration with a community service or planned care provider.	<ul style="list-style-type: none"> ▪ Chest infection ▪ Palliative care ▪ Mental health ▪ Urinary tract infection.



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6. As seen for the new Purple Arrest and Red Emergency categories in Phase 1, a bundle of out of hospital care measures are being introduced for time-sensitive complaints, including stroke and STEMI. WAST will also report on the median and 90th percentile of response times in line with the Institute of Healthcare Improvement’s (IHI) advice for all three new categories. Table 2 below shows the full breakdown of the proposed measures.

Table 2: New Measures for Ambulance Response Categories

Category	Measures
ORANGE NOW	<ul style="list-style-type: none"> ▪ Median and 90th percentile of response of most appropriate resource ▪ Stroke care bundle including call to door median and % arrival at a specialist site. ▪ STEMI care bundle including call to door median and % arrival at specialist site. ▪ Further measures to be developed over time.
YELLOW SOON	<ul style="list-style-type: none"> ▪ Median response of most appropriate resource ▪ 90th percentile. ▪ % by disposition
GREEN PLANNED	<ul style="list-style-type: none"> ▪ Median response of most appropriate resource ▪ 90th percentile. ▪ % by disposition

7. The proposed changes to the Ambulance Performance Framework were accepted by the Cabinet Secretary for Health & Social Care in July. WAST has been requested to implement these changes by 1st December 2025. However, given of the proximity to winter pressures, the Trust is, if possible, seeking to go-live sooner. However, should 1st December not be achievable given a high dependency on the external CAD supplier to develop software changes, we would seek to go-live in February 2026 to maximise operational capacity on reducing patient risk during the busiest operational period.

8. Phase 2 also includes the introduction of new screening codes RCS1-3 alongside RCS0. RCS1-3 will be used as part of the Phase 2 pilot to support prioritisation of calls for screening based on the propensity of the presentation having high risk markers. During the transitional phase, RCS codes will be adapted from the current Amber 1, Amber 2 and Green code sets with further development due as the new model embeds.

9. In preparation to introduce and operationalise Phase 2 of the Ambulance Performance Framework, the Trust has rapidly commenced detailed planning and implementation arrangements. To deliver the changes, a range of key packages of work have been identified and are being progressed at pace, including:

9.1 Project Management & Delivery: The Task & Finish group established in Phase 1 remains in place to lead all aspects of operational delivery and performance reporting arrangements to successfully embed the changes for Phase 2.



9.2 Quality Impact Assessment (QIA) / Equality Impact Assessment (EqIA): A detailed QIA and EQIA have been developed and are currently being reviewed. Both impact assessments will be available to the Trust Board as part of the assurance paper submission.

9.3 Data Definitions & Performance Reporting: Development of key data definitions for the three new response categories is now complete. These were reviewed by key leads on 14th August 2025 and received support from commissioners prior to submission to the CAD supplier on 18th August 2025. This is in line with project timescales agreed for go-live for 1st December 2025.

9.4 Monitoring & Assurance: In addition to the key performance metrics for the new categories, a key requirement is to ensure that there are robust daily performance and quality reporting arrangements in place to monitor the patient safety and service delivery impacts of when the changes are introduced. Work is currently underway to develop the monitoring and assurance approach which will include both the requirements for quantitative performance and quality data, alongside qualitative patient level experience information.

9.5 Operational Readiness: A significant amount of work is underway to ensure the operational readiness for the changes, including:

- *Technical CAD Development:* Significant technical changes are required to the 999 CAD architecture to reflect the new categories. Urgent engagement has commenced with the external CAD supplier given this is the most significant risk for the success of the project. As a result, an additional layer of senior oversight and a specific process to streamline formal raising of any issues from either party has been introduced. Internal teams have prioritised data definition development to provide these to the supplier in accordance with deadlines set.
- *Operational Procedures:* The same approach taken in Phase 1 to support systematic review and prioritised refresh of all relevant Standard Operating Procedures (SOPs) will be applied. Plans are in place to undertake this work, supported by a streamlined approval process where changes are made consistent with the category changes.
- *Staff Familiarisation & Training:* A staff Familiarisation and Training plan will be created and delivered as seen Phase 1 to ensure that all staff directly affected fully understand the changes and the impact on their day-to-day role.

9.6 Communications: Following positive feedback from the approach taken in Phase 1, the communications approach taken previously will be largely replicated for Phase 2. Key materials are now being reviewed and updated, again following a hybrid approach using different communication tools and collateral to maximise reach.

9.7 Finance: There are currently no known direct financial implications for the Trust to enable the changes to be successfully implemented. Whilst not a dependency for Phase 2 of the performance framework, to fully realise the benefits of our integrated clinical services model, an options appraisal has identified a preferred option to have a combined remote assessment queue across both of our CAD systems. This has received support from CMT Programme Board and is due to be considered at Capital Management Board for final approval.



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9.8 Risks: There are two high level risks with a risk score of 16 or over that have been identified. These relate to the ability of an external supplier to deliver the technical CAD changes and to the potential time constraints of establishing internal reporting. Both risks are being closely monitored and proactively managed.

9.9 Evaluation: Implementation of Phase 2 changes will be independently evaluated as part of the broader comprehensive evaluation approach for the entire Clinical Model Transformation programme. The Trust is nearing completion of the procurement process to confirm the preferred external evaluation partner.

10. **Next Steps:** Following consideration by the committee, the assurance report and copies of the QIA and EQIA (subject to separate governance processes) will be submitted to an extraordinary Trust Board meeting being arranged for Mid-October for assurance and endorsement to proceed with implementation of the phase 2 changes. Following completion of the Phase 1 and 2 pilots, the findings of the independent external evaluation will inform the next steps. If the new Ambulance Performance Framework is adopted permanently, consideration should be given to undertaking a further Demand & Capacity review given these changes, the wider changes being delivered by the Clinical Model Transformation programme and potential implications of the Wait-45 initiative.

11. **Wait-45 Initiative:** A national handover taskforce has been established to oversee the recommendation from an independent Ministerial Advisory Group that no ambulance handover should exceed 45 minutes. A series of workshops are taking place in Q2 with WAST attendance for accelerated design and planning.

RECOMMENDATION(S)

See writing and presentation guidance [here](#) to inform this section

1. **Note** that the QIA and EQIA are being developed, and each shall be subject to the appropriate quality governance mechanisms, and both shall accompany this paper at the time of final approval being sought from the Trust Board. The committee is asked to note that it may be necessary to make minor adjustments to this paper ahead of its final submission to Trust Board following the internal review process. It is requested that the committee allow for minor changes to this assurance paper prior to submission to Trust Board, providing any change does not materially alter the direction or outcomes.
2. **Endorse** onward submission to Trust Board, confirming that the Committee is **assured** that the organisational preparedness meets with the appropriate requirements to implement the changes safely and effectively.
3. **Endorse** that the Ambulance Performance Framework (phase 2) proceed to implementation, with oversight of implementation be provided by the Clinical Model Transformation Board.



ADDITIONAL PAPER(S)

Set out here any annexes. See writing and presentation guidance [here](#) regarding materiality and use of the Reading Room

Appendix 1 – Phase 1 Ambulance Performance Framework Trust Board Paper

Appendix 2 – Letter from Welsh Government – 14/07/2025

Appendix 3 – WAST Response to Letter from Welsh Government

Appendix 4 – New Ambulance Performance Framework Explainer Document

Governance and assurance checks to support decision-making and demonstrate alignment and risk mitigation

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [\[link to objectives and what good looks like\]](#)

SO1: Providing the right care or advice, in the right place, every time

SO2: Enabling our people to be the best they can be

SO3: Being at the forefront of innovation and technology

SO4: Developing services in collaboration

SO5: Being quality driven and clinically led

SO6: Delivering exceptional value

RISK(S) THIS REPORT MITIGATES

Where relevant note the local, directorate, corporate or BAF risk number

Corporate Risks (BAF) 223 & 224

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

Quality Domains (select all that apply) [\[link to standards\]](#)

Safe

Timely

Effective

Efficient

Equitable

Person Centred

Quality Enablers (select all that apply) [\[link to standards\]](#)

Leadership

Workforce

Culture

Information

Learning Improvement and Research

Whole Systems Approach

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [\[link to goals\]](#)

A socially responsible and inclusive employer

An innovative and sustainable organisation

A pro-active, accessible and equitable care provider

n/a

n/a

n/a



IMPACT ASSESSMENTS FOR CONSIDERATION

Where a strategic decision is being sought, an Equality Impact Assessment must accompany this paper. You may need to do other impact assessments also so please refer to this signpost document [here](#) for further details.

Does this paper require an impact assessment	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
If yes, what impact assessment is attached	This change requires the completion of a Quality Impact Assessment (QIA) and Equality Impact Assessment (EQIA). Both impact assessments are being taken through the respective governance and approvals routes and will be available for inclusion in the assurance paper being presented to Trust Board.

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
26/08/2025	Call Flow Categorisation Group
08/09/2025	Clinical Model Transformation Programme Board
16/09/2025	Finance and Performance Committee
22/09/2025	Strategic Transformation Board
October (date tbc)	Extraordinary Trust Board (being arranged for Mid-Oct)

SITUATION

1. The purpose of this paper is to provide Committee with an assurance update regarding the internal arrangements to implement and pilot the second phase of changes to the Ambulance Performance Framework, in addition to providing an update on the Wait-45 initiative.

BACKGROUND

2. On the 1st July, the Trust successfully implemented the Welsh Government endorsed Phase 1 changes to the Ambulance Performance Framework for a 12-month pilot period and subsequent evaluation. These changes included the introduction of a Purple Arrest, Red Emergency and RCS0 call categories, replacing the previous 'Red' call category. Further information is provided in the WAST Trust Board Phase 1 Assurance Paper (see Appendix 1).
3. Initial data on the first phase of changes to the Ambulance Performance Framework was released on the 21st August. For patients in cardiac arrest for whom resuscitation was attempted, 21.4% had a return of spontaneous circulation



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(ROSC) at the time of arrival to hospital. There was a total of 814 calls categorised as Purple Arrest (2.3% of all calls) and 4,449 calls categorised as Red Emergency (12.6% of all calls). The median response times for Purple Arrest and Red Emergency calls were 7 minutes and 35 seconds, and 8 minutes and 47 seconds respectively.

4. Upon announcement of the Phase 1 changes, the Welsh Government led Ambulance Target Review group reconvened to review the remaining Amber and Green categories to ensure that they are fit for purpose and support improved clinical outcomes and patient experience.
5. Details of the current Amber and Green categories are shown in Table 3. There are no formal time standards/targets set by Welsh Government for these categories. Welsh Government currently publish the combined call volume and combined median response times for Amber 1 and 2 calls.
6. The Amber 1 & 2 call categories are the largest category by volume and account for circa 70% of all 999 reported incidents. The volume and broad scope of 'complaints' included in the Amber category can lead to challenges responding to these calls, with patients often experiencing long delays for an ambulance response.

Table 3: Current Amber and Green categories

Category	Descriptor	Types of Complaint	Response Standard
Amber 1 & 2	Serious but not immediately life-threatening incidents	Most medical and trauma cases including: <ul style="list-style-type: none"> ▪ Chest pain ▪ Fractures ▪ Most types of stroke 	<ul style="list-style-type: none"> ▪ No current time standards/targets.
Green	Neither serious nor life-threatening.	<ul style="list-style-type: none"> ▪ Minor injuries. ▪ Generally unwell. ▪ Earache 	<ul style="list-style-type: none"> ▪ No current time standards/targets.

ASSESSMENT

National Ambulance Target Review Task Group

7. The National Target Review Task Group was re-established to lead the Phase 2 review of the Amber and Green Categories with the responsibility of putting forward recommendations to the Cabinet Secretary for Health & Social Care on the future Ambulance Performance framework for these categories.



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8. The Task Group, led by Welsh Government included a broad mix of senior experts including policy leads, statisticians, ambulance commissioners and operational / clinical leaders with ambulance and pre-hospital emergency care experience. The Trust was represented by senior executive directors including Rachel Marsh, Andy Swinburn, Liam Williams and Lee Brooks.
9. This second phase of the review process considered the available evidence from across the UK and internationally to inform the proposed changes for the Amber and Green categories. The high-level findings of the review were as follows:

- The current Amber category accounts for the majority of total 999 calls (around 70%). Whilst the number of incidents categorised as Amber has remained fairly stable, a higher volume of 'Red' incidents and increasing handover delays have reduced resource availability. This has increased Amber response times.
- The broad scope of the current Amber category does not allow for a nuanced response to incidents that are truly time sensitive, such as patients with symptoms of stroke, STEMI (heart attack) or fractured hips.
- Ambulance response time performance is measured and reported differently across the UK and internationally. All other UK nations (excluding Wales) use an outcomes-driven approach to ambulance performance frameworks. In England and Scotland, a set of 'Clinical Quality Indicators' measure patients' experience and outcomes.
- WAST indicates an average time of 2.5 hours for stroke responses from a 999 call being received to a response arriving on scene, which is the highest of all UK nations.
- Response times for STEMI patients are also higher in Wales than in other UK nations, with the Welsh Cardiovascular Society identifying avoidable harm as a result of increased times for response and treatment.

New Ambulance Performance Framework (Phase 2)

10. Following careful consideration, the task review group concluded that changes to the Amber and Green categories were required and proposed three new response categories, for patients requiring a face-to-face response including new 'Orange Now', 'Yellow Soon' and 'Green Planned' categories.
11. The Orange Now category is for time-sensitive incidents that are likely to need diagnostics and transport to hospital or specialist care (e.g. stroke). The aim is for rapid arrival at a specialist or emergency care facility as soon as possible. As such, it is anticipated that dispatch would occur within 1 hour of an incident being categorised as Orange Now.



12. The Yellow Soon category will include cases where attendance at scene is required for further clinical assessment which could support remote clinical decision making to an alternative care pathway, and/or discharge at scene, and/or planned transport to a treating facility (e.g. a patient with abdominal pain). This category seeks to prevent unnecessary escalation of care through a view of supporting patients to remain in the community.

13. The Green Planned category will include those cases which have a high potential for the ambulance service to manage the care episode in its entirety or in collaboration with a community service or planned care provider e.g. chest infection, palliative care, mental health or UTI. This category aims to ensure the right resource attends for the need of the patient in a planned way. This may include managing the incident for a period of time within the system whilst awaiting the ideal clinical response to become available.

Table 4: Phase 2 New Ambulance Categories

Category	Descriptor	Types of Complaint
ORANGE NOW	Refers to incidents where patients are likely to need diagnostics and transport to hospital or specialist care e.g. a person in stroke or heart attack	<ul style="list-style-type: none"> ▪ Stroke ▪ Heart attack
YELLOW SOON	Refers to incidents where further clinical assessment to support clinician decision making (remote or face to face) is required for discharge at scene and/or an alternative pathway, and/or planned transport to a treating facility.	<ul style="list-style-type: none"> ▪ Abdominal pain ▪ Lower leg fracture.
GREEN PLANNED	Refers to incidents where there is high potential for the ambulance service to manage the care episode in its entirety or in collaboration with a community service or planned care provider.	<ul style="list-style-type: none"> ▪ Chest infection ▪ Palliative care ▪ Urinary tract infection

Orange Now Category Measures

14. As seen in Phase 1 of the ambulance target review group’s recommendations, it was agreed that there should be more emphasis on measuring patient outcomes rather than solely on median response times for incidents.

15. The first phase found that response time targets alone do not provide the right focus on truly improving patient care. For instance, prioritising rapid response vehicles for stroke victims to meet the target, despite these vehicles being unable to transport patients for treatment, could cause delays and impact outcomes. As a result, the Orange Now category includes a bundle of out-of-hospital care measures for time-sensitive complaints (see Table 5 for a full breakdown).



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16. Transitioning to the publication of call-to-door times and eventually to call-to-treatment times for conditions such as stroke and STEMI will enhance transparency on the entire system’s focus on outcomes, aligning with health and care quality standards.
17. Although there will be no time-based target initially, this will be reviewed after 12 months to consider if such a target would add value. This pilot approach will be supported by a thorough evaluation to determine if time-based targets would contribute to improved outcomes and experience.
18. In line with advice from the Institute of Healthcare Improvement (IHI), WAST will report on the median and 90th percentile of response for all categories. This is a change from the current position whereby statistics published by Welsh Government only include a combined median response time for Amber 1 and 2 calls.

Table 5: Orange Now measures

Category	Measures
ORANGE NOW	<ul style="list-style-type: none"> ▪ Median and 90th percentile of response of most appropriate resource ▪ Stroke care bundle including call to door median and % arrival at a specialist site. ▪ STEMI care bundle including call to door median and % arrival at specialist site. ▪ Further measures to be developed over time.

Yellow Soon Category Measures

19. For the Yellow Soon category, it is recognised that a prompt response is required to minimise pain/discomfort and prevent deterioration. A response will also assist with gathering further information to inform appropriate care planning. Therefore, it is anticipated that dispatch of a resource would occur within four hours of a call being categorised as a Yellow Soon incident.
20. As with current Amber and Green categories, there will not be set response time targets for the Yellow Soon or Green Planned categories. WAST will report on the following measures for the Yellow Soon category:

Table 6: Yellow (Soon) measures

Category	Measures
YELLOW SOON	<ul style="list-style-type: none"> ▪ Median response of most appropriate resource ▪ 90th percentile.



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	▪ % by disposition
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Green Planned Category Measures

21. The aim of the Green Planned category is to ensure patients receive the right response based on clinical need which could be for a see and treat/refer pathway or conveyance to a definitive care centre away from the Emergency Department (e.g. Minor Injury Unit). Responses will be in a timeframe that is most appropriate for the nature of the planned response and may exceed four hours (e.g. for 6 hours overnight whilst waiting for an Advanced Paramedic Practitioner to be available to respond). The planned nature of this category will also allow for multiple contacts as appropriate to support the safe delivery of care. This may be via the Remote Integrated Care Service to remotely monitor the patient condition, supported by our volunteer network providing face to face contact and/or undertaking observations to inform decision making.

22. WAST will report on the following measures for the Green Planned category:

Table 7: Green (Planned) measures

Category	Measures
GREEN PLANNED	<ul style="list-style-type: none"> ▪ Median response of most appropriate resource ▪ 90th percentile. ▪ % by disposition

Welsh Government Approval

23. The proposed changes were approved by the Cabinet Secretary for Health & Social Care. The Trust received formal correspondence of this by letter from Welsh Government on 14th July 2025 (Appendix 2).

24. The Cabinet Secretary’s letter requested that the Trust implement the changes by the 1st December 2025. Feasibility of the proposed implementation date has been considered by the executive team and key leads who have noted the potential challenges and risks associated with making the changes in close proximity of winter pressures and during our busiest months of the year. The Trust recognises the additional challenge this could pose, and as such will seek to go live sooner than 1st December, if possible. This carries a high dependence on the external supplier to make the technical changes required to the CAD system. Should the original deadline not be achievable, we would seek to go live in February 2026 to avoid additional strain on operational capacity during the busiest period. This option has been presented to the Cabinet Secretary for consideration, and the Trust is awaiting a formal decision (Appendix 3).



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25. We are awaiting further guidance from Welsh Government and NHS Wales Joint Commissioning Committee on the length of the pilot of the second phase of changes to the performance framework and how this may link to the first phase.

Internal Screening Categorisation Codes

26. Our Integrated Clinical Services Model adopts a ‘screen first’ approach for all calls, except for those categorised as Purple Arrest or Red Emergency (i.e. patients in or at high risk of cardiac or respiratory arrest).

27. Phase 1 of the Ambulance Performance Framework introduced a new RCS0 code to prioritise incidents from the previous Red category that were deemed suitable for Rapid Clinical Screening.

28. Phase 2 will see the introduction of new screening codes RCS1-3 alongside RCS0. RCS1-3 will be used as part of the Phase 2 pilot to support Clinical Navigators in prioritising calls for screening based on the likelihood of the presentation (propensity) having high-risk clinical markers. Table 8 lists the new RCS categories.

Table 8: New Rapid Clinical Screening Codes

Category	Descriptor	Measures
RCS1	High propensity for high-risk markers	<ul style="list-style-type: none"> ▪ Median time to clinical screening. ▪ Median time to clinical consultation. ▪ % outcome
RCS2	Medium propensity for high-risk markers	
RCS3	No/low propensity for high-risk makers.	

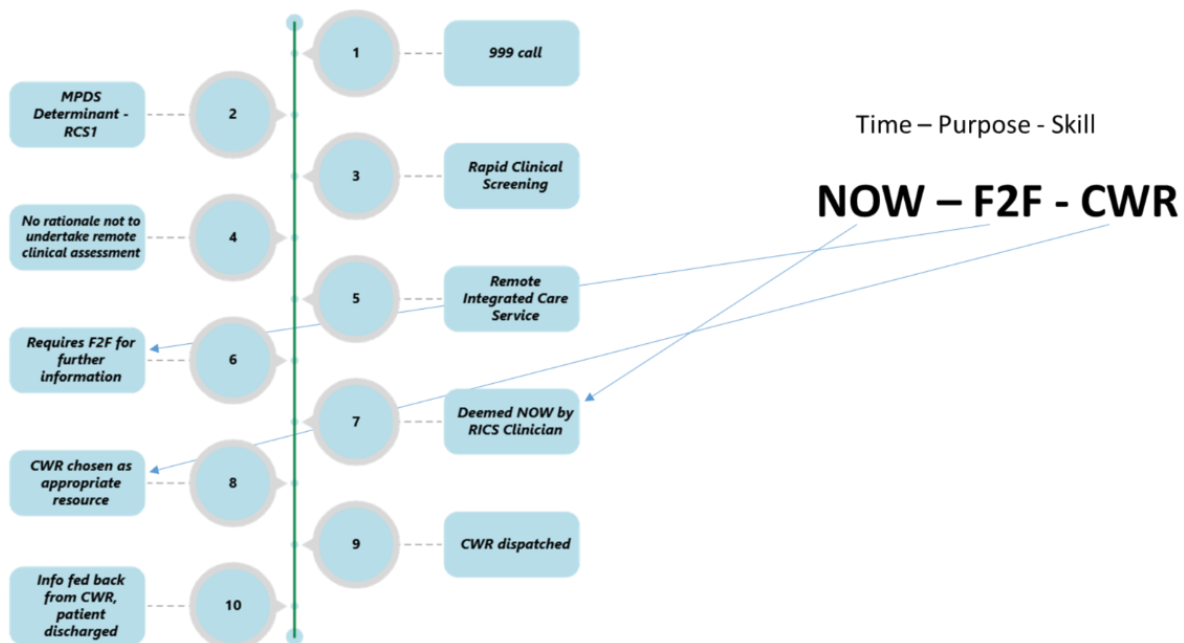
29. The new RCS codes will also be used for prioritisation of remote assessment internally to promote uniformity in categorisation across the service. This has been agreed at the Clinical Prioritisation Assessment Software (CPAS) group. For external reporting of 111 activity, cases categorised internally as RCS1 will continue to be reported externally as P1. This also applies to RCS2/P2 and RCS3/P3.

30. During the transitional phase of the model, the RCS codes will be adapted from the current Amber 1, Amber 2 and Green code sets. This will form an initial approach for delivery of the new screening codes. There will be further continuous review and development based upon an evidence-based quality improvement approach that will respond to findings as the new model embeds.



Wider Internal Categorisation Changes: Time-Purpose-Skill

31. Categories from both Phase 1 and Phase 2 form part of our broader changes towards a more integrated clinical services model. The five new categories address the important 'Time' element for colleagues to identify urgency and priority.
32. However, the 'Purpose' of a response is also key to providing the most effective and appropriate resource. The 'Purpose' of a response will be based on the anticipated outcome, either for 'Face-to-Face' (F2F) assessment or to 'Convey'. This will assist Resource Coordinators in identifying the most suitable resources based upon the need for attendance.
33. The third aspect of 'Skill' provides the Resource Coordinator with an indication of the most appropriate skillset a patient would require, guiding the most optimal resource choice. This could provide a range of resource options or identify the need for specialist clinicians (e.g. APP or Mental Health Practitioner). Overall, this promotes effective resource utilisation and supports patient care remaining in the community.
34. Time-Purpose-Skill classification will be undertaken by the Clinical Navigator reviewing the incident or by the Integrated Care Clinician in RICS passing the incident to the dispatch queue.
35. The figure below demonstrates how Time-Purpose-Skill is applied in practice.





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36. This concept will continue to develop and be subsequently formally implemented as we further transform our services towards a more integrated clinical services model. We wait to understand how this can be integrated into the CAD system by our supplier.

WAST Preparedness

37. This section of the paper provides a progress update across the preparatory work underway to implement and embed the Phase 2 changes.
38. Overall, the planning and project delivery areas are progressing well and are on track for the proposed go-live date of the 1st December. All key work streams have been identified, and plans are either in place or being developed, with actions being assigned to key leads.
39. As with Phase 1, there remains a high dependency on the external CAD system supplier (MIS) to deliver the technical system changes in readiness for go-live (this is further explored in the Technical Development section).

Project Management & Delivery

40. The Task & Finish group (T&F Group) project delivery arrangements for Phase 1 remain in place and are taking forward the responsibility of leading the detailed planning, implementation and delivery of Phase 2.
41. The Executive Sponsor for the group remains in place for Phase 2 with Lee Brooks (Executive Director of Operations) continuing in this role. There is however a change to the Senior Responsible Owner (SRO) with Ceri Griffiths (Deputy Director of Remote Clinical Care) stepping into this role. We would like to put on record our thanks to the Phase 1 SRO Gregory Lloyd for his outstanding leadership during the implementation of Phase 1 and to all colleagues who were involved in delivering the changes.
42. The T&F group continues to include a broad range of internal WAST leads covering the breadth of expertise required for this work along with external representatives from the Commissioning team. The T&F group continues to meet weekly with the full suite of project management processes and support in place. In line with best practice project governance, the Terms of Reference have been reviewed and updated to reflect the required changes for Phase 2.

Governance Process



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43. The Call Categorisation T&F group continues to report to the Emergency Response work stream as part of the broader Clinical Model Transformation (CMT) programme structure.
44. To ensure robust internal governance arrangements, all of the key outputs from the work stream that require formal review & approval will be submitted to the following groups, Call Categorisation T&F group, Clinical and Quality Governance Group (CQGG), Clinical Priority Assessment Group (CPAS) for incident categorisation changes and Clinical Model Transformation (CMT) Programme Board. Key risks and issues that may impact the successful delivery of the work will be escalated by the Executive Sponsor / SRO through the formal CMT Programme channels.
45. To ensure that the Joint Commissioning Committee (JCC) is robustly sighted and assured on the planned changes, it has been agreed that the assurance paper will be shared with the Director of Commissioning for Ambulance Services and 111 following Trust Board to inform the JCC Board.
46. In the Cabinet Secretary's letter, the Trust was required to respond to the implementation timescales by the 31st July and confirm the conclusion of the development of the data definitions by the 30th September. The Trust completed the data definitions and submitted these to the system supplier and commissioners by 18th August 2025. There is no formal requirement to submit the monitoring and assurance plan for Phase 2, despite this being a requirement for Phase 1. For transparency the Trust has offered to share this information with Welsh Government if requested.

Impact Assessment

47. A comprehensive Quality Impact Assessment (QIA) is being undertaken on the Phase 2 changes. This assessment has been conducted in collaboration with key work stream leads. The QIA has been reviewed and endorsed by the T&F group and will be reviewed by the Clinical Advisory Group (CAG) on the 16th Sept and then CQGG on 22nd September. The QIA will be submitted to an extraordinary Trust Board with the assurance report for Phase 2 in October.
48. As part of the Trust's commitment to embedding Equality, Diversity and Inclusion (EDI) across its transformation agenda, an Equality Impact Assessment (EQIA) has been developed for the Emergency Response work stream. This has been conducted with support from organisational EQIA experts and key leads from the work stream. The EQIA will include and give full consideration to the impact of the phase 2 changes along with the wider pieces of work being led by the group.



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The EQIA has been reviewed by the T&F group and SRO and will be submitted to CAG for endorsement. A copy of the EQIA will be available for submission with the assurance report to extraordinary Trust Board as outlined above.

Technical CAD System Development & Data Definitions

- 49.** Significant technical changes are required to the 999 CAD architecture to reflect the new categories. Urgent engagement has commenced with the external CAD supplier (MIS) who have confirmed the allocation of dedicated developer capacity to undertake the technical changes to the CAD.
- 50.** The technical CAD changes are the most critical and highest risk factor to the success of the project. To effectively mitigate this risk an additional layer of senior oversight has been built into the supplier relationship arrangements to ensure a 'tight' grip and increased expediency of issue resolution. These arrangements include weekly meetings between WAST project leads and technical supplier experts and a fortnightly executive level meeting. A revised process to raise 'issues' has also been put into place which will flow direct to a senior MIS manager and formally logged.
- 51.** Technical changes are also required to the CAD in Integrated Care to reflect the internal change of categorisation from P1/2/3 to RCS 1/2/3. These changes are to be made by our CAD administration teams internally and are not dependent on the system supplier. Enacting this change has been factored into readiness plans.
- 52.** The detailed data definitions for the new Orange Now, Yellow Soon and Green Planned categories have been produced and were reviewed by key leads on the 14th August 2025. These were submitted to commissioners on the same day who provided support, allowing for submission to our CAD system supplier on 18th August 2025. This is in accordance with the agreed project timescales between WAST and MIS for go-live by 1st December 2025. The data definitions received retrospective approval from the Call Categorisation Group on 19th August 2025 and will be received by the CMT Programme Board on 8th September 2025.
- 53.** The Information and Data Services (IDS) team have continued to prioritise this work and the development of the performance reporting processes. The team has been organised into two sub-team. The first team are continuing to concentrate on the completion of the remaining actions for Phase 1 which is on track and no reported issues), and the second team are working on the Phase 2 changes.



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Monitoring & Assurance

- 54.** A key requirement in readiness for go-live is to ensure that there are robust daily performance and quality reporting arrangements in place to monitor the patient safety and service delivery impacts of the changes. An overview of the monitoring and assurance arrangements will be shared with Welsh Government for information.
- 55.** Work is currently underway to develop the monitoring and assurance approach which will include both the requirements for quantitative performance and quality data alongside qualitative patient level experience information. This will include detailed operational level reporting and performance information (e.g., Splash reports). This work has also been prioritised by the IDS team to ensure that there is full accessibility to the right performance data to ensure the changes and impacts can be effectively and proactively monitored.
- 56.** Fortnightly quality and safety assurance meetings will be held with the JCC and WAST from the outset of delivery of phase two to track progress against all new measures, including those not captured within the performance framework. These arrangements will be scaled back accordingly as confidence is established. Future monitoring will be led by the JCC.

Operational Readiness

- 57.** Considerable work is also required, aligned to the changes undertaken as part of the Phase 1 implementation plan to ensure operational teams are well prepared and ready for go-live. This includes a review of key operational procedures, process familiarisation and training for all staff directly impacted by the changes.
- 58.** Explainer Document: A detailed explainer document has been developed outlining the objectives, developments, and anticipated outcomes of Phase 2, as WAST continues its drive for improved emergency response and clinical effectiveness (Appendix 4).
- 59.** Operational Procedures: The same approach adopted during Phase 1 to support the systematic review and refresh of all of the operational Standard Operating Procedures (SOPs) will be applied for Phase 2. This work has already commenced with operational colleagues. Plans are in place to undertake this work at pace over the coming months and SOPs will be reviewed in priority order, supported by a streamlined review and approval process.



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60. *Staff Familiarisation & Training:* A similar approach to that taken in Phase 1 will be repeated for Phase 2 to develop the staff familiarisation and training plan. Once data definition development has been completed, a full training need analysis for specific roles, creation of materials, and subsequent delivery of training will be planned & undertaken. This will ensure all operational teams fully understand the changes and the impact on their day-to-day role.

Communications (Internal & External)

61. The changes outlined for Phase 2 will require effective communication across a broad range of internal and external stakeholders to ensure they are appropriately informed and understand the changes to the Ambulance Performance Framework.

62. Following the completion of the Phase 1 changes, the Trust received positive feedback from a small sample of stakeholders regarding the communication materials. This feedback has helpfully informed the decision to largely replicate the approach for the Phase 2 communication plan.

63. Work has commenced to refresh the internal and external communications plans which will continue to be managed and delivered by the P&E work stream with key materials being reviewed by the Call Categorisation T&F Group and signed off by the CMT Programme Board.

64. The communication plans will adopt a hybrid communications approach and will include a range of tailored communication materials including FAQs, letters, briefing packs, videos and social media content to maximise its reach and describe the changes in an easy and understandable way. All public facing information will be created bi-lingually and will be available on the website.

65. It is understood that Welsh Government will maintain the position that WAST holds the delegated responsibility to manage the communications approach in line with the position for Phase 1. Key materials will be shared with Welsh Government for sighting and comment to ensure policy alignment with the key messaging prior to formal release.

Evaluation

66. Implementation of the phase 2 changes will be independently evaluated as part of the broader evaluation approach for the entirety of the Clinical Model Transformation programme. The evaluation will include an assessment of the



patient, service and system impacts considering a broad range of qualitative and quantitative data.

67. The Trust is nearing the completion of the procurement processes to confirm the preferred external partner. Work will then commence to finalise the evaluation work portfolio and key evaluation priorities.

Finance

68. There are currently no known direct financial implications for the Trust to enable the Phase 2 changes to be successfully implemented. The technical system changes on the CAD, as with Phase 1, are covered within the development arrangements with the supplier (MIS) with no additional costs as the changes are policy and Welsh Government led.
69. Whilst this is not a dependency for the implementation of Phase 2, it is important to note that there has been additional investment approved by the Executive Finance Group (EFG) to increase the Band 6 Integrated Care Clinical workforce by up to 12FTEs from November, which is expected to return to establishment by the new financial year.
70. Whilst not a dependency for Phase 2, as part of broader changes for the integrated clinical services model, an £138k capital and £42k recurrent revenue cost is required to adopt a combined remote assessment queue across both CAD systems. An options appraisal identified this as the preferred option to provide the safest and most consistent care for all patients and improves internal efficiencies. Identification of this as the preferred option has been supported at CMT Programme Board and is due for consideration at Capital Management Board on 12th September for financial approval.

Risks

71. The changes to the Ambulance Performance Framework will form part of the broad suite of mitigating actions against corporate 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).
72. As part of the project arrangements, the T&F group regularly review and assess the associated risks. There are two high level risks with a risk score of 16 or over. One is related to the ability of an external supplier to deliver the technical CAD changes described in the system developments section (see paragraph 50).



73.The other risk relates to potential time constraints of establishing internal reporting for these changes. This work is being prioritised by the Insights and Data team with a timeline to be produced that ensures those reports required prior to go-live will be available.

Table 9: Project Risk Log (High Level Risk only)

<p><u>Phase 2 - Failure to deliver due to capacity and understanding of the third party supplier (MIS)</u></p>	<p>IF the third party supplier (MIS) does not have the capacity or understanding to undertake the CAD development in the required timeframe</p>	<p>THEN the trust will not be able to deliver the required changes for the 1st December</p>	<p>Resulting in: 1 - Reputational damage</p>	<p>Project or Progr... 4</p>	<p>4</p>	<p>16</p>
<p>Delay of Internal Reporting</p>	<p>IF there is not sufficient time for the creation of internal reporting for the go-live of the phase 2 call categories changes</p>	<p>THEN there will be limited assurance available on the changes to patient flow</p>	<p>Resulting in: 1 - Inability to provide consistent data on the safety and patient experience of the new call flows</p>	<p>People or Huma... 4</p>	<p>4</p>	<p>16</p>

Wait 45 Initiative

74.In October 2024, the Cabinet Secretary for Health and Social Care announced appointment of an external independent Ministerial Advisory Group (MAG) on Performance and Productivity in NHS Wales. The MAG published a series of recommendations in April 2025, one of which was to adopt a maximum ambulance handover time of 45 minutes by October 2025. This recommendation was partially accepted by Welsh Government, noting the need to explore feasibility of the timescale proposed.

75.In response, the NHS Wales Leadership Board launched a national handover taskforce to oversee delivery of the programme of work that will take a clinical collaborative approach to handover improvement. Liam Williams (Executive Director of Quality and Nursing) and Andy Swinburn (Executive Director of Paramedicine) represent WAST as members of this group.

76.Each health board will host an accelerated design workshop in Q2 to support development of plans to achieve the 45-minute maximum ambulance handover time expectation. Arrangements have been made for operational, clinical and planning leads from WAST to attend each of these workshops.



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RECOMMENDATION

Committee is asked to: -

- 77. Note** that the QIA and EQIA are being developed, and each shall be subject to the appropriate quality governance mechanisms, and both shall accompany this paper at the time of final approval being sought from the Trust Board. The committee is asked to note that it may be necessary to make minor adjustments to this paper ahead of its final submission to Trust Board following the internal review process. It is requested that the committee allow for minor changes to this assurance paper prior to submission to Trust Board, providing any change does not materially alter the direction or outcomes.
- 78. Endorse** onward submission to Trust Board, confirming that the Committee is **assured** that the organisational preparedness meets with the appropriate requirements to implement the changes safely and effectively.
- 79. Endorse** that the Ambulance Performance Framework (phase 2) proceed to implementation, with oversight of implementation be provided by the Clinical Model Transformation Board.

NEXT STEPS

- 80.** Following consideration by the committee, the assurance report and copies of the QIA and EQIA will be submitted to an extraordinary Trust Board meeting being arranged for Mid-October for assurance and approval to proceed with implementation of the phase 2 changes.
- 81.** Following completion of the phase 1 & 2 pilots, the findings of the independent external evaluation will inform the next steps and subsequent actions that may be required to permanently adopt the changes.
- 82.** If the outcome of the evaluation determines that the new Ambulance Performance Framework should be implemented on a permanent basis consideration should be given to undertaking a further Demand & Capacity review. This would be a prudent approach considering the significant changes to the Ambulance Performance Framework, wider changes being delivered by the Clinical Model Transformation Programme and the potential system and operational implications following the implementation of the Wait 45 initiative. Undertaking this work would be consistent and in-line with the Trust's approach of undertaking regular strategic modelling of demand and capacity requirements.