

# Bundle Quality, Patient Experience and Safety Committee 4 November 2025

## Agenda attachments

- 00 QuEST Agenda
- 0 09:30 – OPENING ITEMS
- 1 Chair's Welcome, Apologies and Quorum
- 2 Declarations of Interest
  - Item 02 Board Member Register of Interests – Updated 21 October 2025
- 3.1 Minutes of the Open Meeting: 5 August 2025 [Minutes not included as they were approved at Extraordinary Meeting 10 October 2025]
- 3.2 Committee Highlight Report 5 August 2025
  - Item 03.2 Quest Committee Highlight Report 5 August 2025
- 3.3 Minutes of the Extraordinary Meeting 10 October 2025
  - Item 03.3 2025–10–10 unconfirmed QUEST Open Minutes Extraordinary
- 3.4 Committee Highlight Report Extraordinary Meeting 10 October 2025
  - Item 03.4 Quest Committee Highlight Report October 2025 – Extraordinary
- 4 Action Log
  - Item 04 Action Log
- 5 09:40 – Operations Quarterly Report for Committees 2025–26 Q2
  - Item 05 Operations Quarterly Report for Committees 2025–26 Q2
- 6 10:10 – Patient Story

*Mrs Alison Clarke had contacted the (previous) Chief Executive several times and spoken to him regarding her concerns about Ambulance Care (NEPTS) and her transfers to Hospital appointments. Alison lives with respiratory failure, heart failure and take oxygen through 24 hours a day using an oxygen concentrator machine, she is required to have regular checks at the hospital including blood gas tests to measure the levels of oxygen and carbon dioxide in her blood. Alison relies on Ambulance Care and is concerned about transport arrangements being cancelled at the last minute, her inability to be able to make alternative arrangements and the impact this then has on her health.*
- 6.1 Patient Story Updates [Verbal]
- 7 10:40 – Monthly Integrated Quality Performance Report
  - Item 07 MIQPR SBARN QUEST August September 2025
  - Item 07 Annex 1 MIQPR QUEST August September 2025
- 7.1 11:00 – COMFORT BREAK
- 8 11:15 – Strategic Quality Plan 2025/28 Implementation Update
  - Item 08 Strategic Quality Implementation Plan Update
- 9 11:35 – Putting Things Right Report Q2 & Recovery Plan
  - Item 09 Putting Things Right Report Q2 2025–26
  - Item 09 Annex 1 Putting Things Right Report Q2 2025–26
  - Item 09 Annex 2 Putting Things Right Report Q2 2025–26
- 10 12:05 – AAA from ARAC to Quest – Near Miss and Low Harm Reporting
  - Item 10 ARAC AAA to QuEST from 02092025
- 11 12:10 – Mental Health Annual Report 2024/25
  - Item 11 Mental Health Annual Report 2024–2025
  - Item 11 Annex 1 Mental Health Annual Report 2024–25
- 12 12:30 – Learning from Deaths (Mortality Reviews) Report
  - Item 12 Learning from Deaths (Mortality Reviews) Report Quarter 1 & 2 2025–26
- 12.1 12:50 – LUNCH
- 13 13:30 – Patient Experience and Community Involvement (PECI) Biannual Report April – September 2025
  - Item 13 PECI SBARN Bi–Annual Report (April – September 2025)
  - Item 13 Annex 1 PECI Bi–Annual Report April–September 2025
- 14 13:45 – Clinical Audit Plan and Action Tracker Q2 (Update) 2025/26
  - Item 14 Clinical Audit Plan Update Q2 2025–26
  - Item 14.1 Clinical Audit Plan Q2 2025–26

- Item 14.2 Clinical Audit Action Tracker September 2025
- 15 14:00 – Risk Management and Board Assurance Framework to include Risk Appetite Statements  
Item 15 Executive Summary Risk Management Report QuEST 041125
- 16 14:10 – 2025/26 Quality Governance Reviews  
Item 16 QUEST Committee 2025–26 Quality and Governance Review SBARN  
Item 16 Annex 1 QuEST Terms of Reference 2026–27 DRAFT  
Item 16 Annex 2 Changes to board and committee operating arrangements 2025–26
- 17 14:30 – Audit Tracker 2025/26 Q2 Reporting  
*The following Annexes are available in the Reading Room:*  
*Annex 1: Audit Tracker 2.0 – 2526 Q2 Updates – Internal Audit up to 2324 (QuEST)*  
*Annex 2: Audit Tracker 2.0 – 2526 Q2 Updates – Internal Audit 2425 (QuEST)*  
*Annex 3: Audit Tracker 2.0 – 2526 Q2 Updates – External Audit up to 2324 (QuEST)*  
*Annex 4: Audit Tracker 2.0 – 2526 Q2 Updates – External Audit 2425 (QuEST)*  
Item 17 Audit Tracker 25–26 Q2 Reporting (Jul–Sep25) – QuEST 041125
- 18 14:40 – Policies for Approval: Prevent Policy  
Item 18.1 Policies for Committee Approval  
Item 18.2 Prevent Policy 2025 DRAFT for QuEST Approval
- 19 14:45 – Committee Cycle of Business Monitoring Report and 2025/26 Priorities  
Item 19 Priorities and Cycle Monitoring Report November 2025  
Item 19 Annex 1 Cycle of Business Monitoring Report  
Item 19 Annex 2 Cycle of Business Notes
- 19.1 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.
- 19.2 14:50 – CLOSING ITEMS
- 20 Key Messages for the Board
- 21 Reflections and Summary of Decisions/Actions
- 22 Any Other Business
- 23 Date & Time of the Next Meeting: 3 February 2026

Length of Meeting: 05:30		Agreed [OPEN] QUEST COMMITTEE - 4 NOVEMBER 2025						Deadline for Papers: 24 October 2025		Last good practice Exec Review: 29 October 2025		
Time	Mins allotted	Agendum	Title	Format	Item for	Item requested by	Paper prepared by	Item presented by	Colleagues to cc	Scheduled at ELT	Further approval route (if app.)	Notes
<b>OPENING ITEMS</b>												
09:30	00:10	1	Chair's Welcome, Apologies 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	3.1 Minutes of the Open Meeting 5 August 2025 [Approved at Extraordinary meeting 10 October 2025] 3.2 Committee Highlight Report 5 August 2025 3.3 Minutes of the Extraordinary Meeting 10 October 2025 3.4 Committee Highlight Report Extraordinary Meeting 10 October 2025	Paper	Approval	Standing	n/a	Chair	n/a			
		4	Action Log & Matters Arising	Paper	Discussion	Standing	n/a	Chair	n/a			
<b>FOR APPROVAL, ASSURANCE AND DISCUSSION</b>												
09:40	00:30	5	Operations Directorate Quarterly Report Q2 2025/26	Paper	Assurance	CoB	Operations	Lee Brooks (Mark Harris)	Judith Bryce Toni-Marie Norman			
10:10	00:30	6	Patient Story	Video	Discussion	CoB	Quality	Liam Williams	Leanne Hawker Alison Kelly			
		6.1	Patient Story Updates	Verbal	Assurance	CoB	Quality	Liam Williams	Leanne Hawker Alison Kelly			
10:40	00:20	7	Monthly Integrated Quality Performance Report	Paper	Assurance	CoB	SPP	Rachel Marsh	Alison Kelly Hugh Bennett Mark Thomas			
<b>COMFORT BREAK</b>												
11:00	00:15											
11:15	00:20	8	Strategic Quality Plan 2025/28 Implementation Update	Paper	Assurance	CoB	Quality	Liam Williams	Kate Blackmore Penny Durrant			
11:35	00:30	9	Putting Things Right Report Q2 & Recovery Plan	Paper	Assurance	CoB	Quality	Liam Williams	Wendy Herbert Alison Kelly			
12:05	00:05	10	AAA from ARAC to Quest - Near Miss and Low Harm Reporting	Paper	Assurance	Ad hoc	Gov	Trish Mills	Alex Payne			
12:10	00:20	11	Mental Health Annual Report 2024/25	Paper	Assurance	CoB	Quality	Liam Williams	Alison Kelly			
12:30	00:20	12	Learning from Deaths (Mortality Reviews) Report	Paper	Assurance	CoB	Clinical	Liam Williams	Alison Kelly			
<b>LUNCH</b>												
12:50	00:40											
13:30	00:15	13	Patient Experience and Community Involvement (PECI) Biannual Report April - September 2025	Paper	Assurance	CoB	Clinical	Liam Williams	Leanne Hawker			
13:45	00:15	14	Clinical Audit Plan and Action Tracker Q2 (Update) 2025/26	Paper	Assurance	CoB	Clinical	Andy Swinburn	Jonathan Chippendale			
14:00	00:10	15	Risk Management and Board Assurance Framework to include Risk Appetite Statements	Paper	Assurance	CoB	Gov	Julie Boalch	n/a			
14:10	00:20	16	2025/26 Quality Governance Reviews	Paper	Approval	CoB	Gov	Trish Mills	Julie Boalch, Alex Payne			
14:30	00:10	17	Audit Tracker 2025/26 Q2 Reporting	Paper	Assurance	CoB	Gov	Trish Mills	Lisa Trounce Skye Banks			
14:40	00:05	18	Policies for Approval: Prevent Policy	Paper	Approval	Ad hoc	Gov	Trish Mills	Lisa Trounce Skye Banks			
14:45	00:05	19	Committee Cycle of Business Monitoring Report and 2025/26 Priorities	Paper	Approval	CoB	Gov	Trish Mills	Sarah Harland			
<b>CONSENT ITEMS</b> 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.												
<b>CLOSING ITEMS</b>												
14:50	00:10	20	Key Messages for the Board	Verbal	Discussion	Standing	n/a	Chair	n/a			
		21	Reflections and Summary of Decisions/Actions	Verbal	Discussion	Standing	n/a	Chair	n/a			
		22	Any Other Business	Verbal	Discussion	Standing	n/a	Chair	n/a			
		23	Date & Time of the Next Meeting: 3 February 2026	Verbal	Information	Standing	n/a	Chair	n/a			
<b>15:00</b>	<b>05:30</b>	<b>CLOSE</b>										

#### LEAD PRESENTERS

Name	Position
Julie Boalch	Assistant Director of Corporate Governance and Risk
Mark Harris	Assistant Director of Operations NEPTS
Bethan Evans	Chair and Non-Executive Director
Rachel Marsh	Executive Director of Strategy Planning and Performance
Trish Mills	Director of Corporate Governance/Board Secretary
Andy Swinburn	Executive Director of Paramedicine
Liam Williams	Executive Director of Quality and Nursing

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Left Trust
BEAUMONT-WOOD, Rhiannon	<b>Non-Executive Director</b> * 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	<b>Non-Executive Director</b> * 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	<b>Executive Director of Operations</b>	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		
CURRAN, Peter	<b>Non-Executive Director</b> * 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	Trustee of Action for Children [1097940]	Position in Charity or Voluntary Organisation	01 February 2021		
		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	<b>Chair of Trust Board and Non-Executive Director</b> * 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	<b>Non-Executive Director</b> * 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		
		[Previously called Homes of Excellence Healthcare Limited, Company name changed 12.08.2022 - #12513139]	Directorships	12 March 2020		

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Left Trust
<b>EVANS, Bethan</b> [continued]	<b>Non-Executive Director</b> * 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 - Glyncomel 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		
		<b>HITCHON, Estelle</b>	<b>Director of Partnerships and Engagement</b>	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		
<b>HUTCHINGS, Hayley</b>	<b>Non-Executive Director</b> * 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	
		Emeritus Professor, Swansea University	Non-Financial Professional	31 May 2025		
		Consultancy (temporary cover for the Director of Operations - Clinical Trials Unit) at Wolverhampton University	Financial Interest	10 October 2025	31 December 2025	
<b>JACKSON, Ceri</b>	<b>Non-Executive Director &amp; Vice Chair of the Trust Board</b> * 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		
<b>KNEESHAW, Carl</b>	<b>Director of People</b>	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		
<b>LEWIS, Angela</b>	<b>Director of Culture Change</b>	Nil Declaration				
<b>MARSH, Rachel</b>	<b>Executive Director of Strategy, Planning and Performance</b>	Nil Declaration				
<b>MILLS, Patricia (Trish)</b>	<b>Director of Corporate Governance/ Board Secretary</b>	Nil Declaration				
<b>PARRY, Hugh</b>	<b>Trade Union Partner</b>	Nil Declaration				
<b>ROBERTS, Edward</b>	<b>Interim Finance Director (from 09 September 2025)</b>	Nil Declaration				
<b>ROWAN, Hannah</b>	<b>Non-Executive Director</b> * 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		
<b>SAMMUT, Jonathan (Jonny)</b>	<b>Director of Digital Services [appointed 26.09.2023]</b>	Relative (Parent) is a Non-Executive Director for Social Care Wales	Any Other Interest	01 April 2017		
		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		
<b>SWINBURN, Andrew (Andy)</b>	<b>Executive Director of Paramedicine</b>	Co-opted into the BCS Community Board	Any Other Interest	12 August 2025	11 August 2026	
		Strategic Advisor to College of Paramedics	Any Other Interest	01 January 2020		
<b>TURLEY, Christopher</b>	<b>Executive Director of Finance and Corporate Resources</b>	Treasurer of Royal Gwent Hospital League of Friends.	Position in Charity or Voluntary Organisation	01 February 2022	05 November 2024	
<b>TURNER, Damon</b>	<b>Trade Union Partner</b>	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	July 2025		
		Sub-Yoga Teacher - Burnham Swim and Leisure Centre	Financial Interest	July 2025		



## QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE HIGHLIGHT REPORT TO BOARD

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

The papers for this meeting can be found by following this [link](#) to the Committee page on the Trust website.

<b>Trust Board Meeting Date</b>	25 September 2025
<b>Committee Meeting Date</b>	05 August 2025
<b>Chair</b>	Bethan Evans

### KEY ESCALATION AND DISCUSSION POINTS

#### ALERT

(Alert the Board to areas of attention)

1. Following concerns raised at the last meeting, a refreshed **Putting Things Right & Legal Services Performance Organisational Recovery Plan** was developed collaboratively to address structural and staffing changes alongside system and process improvements aimed at restoring performance. Recent changes to the clinical model have increased the complexity of investigations and ongoing recruitment challenges have meant audit and investigation capacity has not increased as planned, further complicating the ability to manage complaints and coronial workloads effectively.
2. Some improvement actions have long lead in times and benefits are difficult to forecast, meaning timeliness related performance is expected to improve gradually over the coming year.
3. The Committee were not assured by the deliverability of the plan as outlined, not doubting the commitment or effort of staff, but expressing apprehension considering the pressures that the Trust is operating in, the complexity staff face, and the likelihood that complexity will increase with ongoing service diversification and transformation. Members emphasised the need to continually review staff support and training needs.
4. The Executive Director of Nursing & Quality noted that the Executive Leadership Team will closely monitor the plan over the coming months. – which was welcomed by Committee Members.
5. Members were assured that:
  - There is a prioritisation approach taken to actions based on what is achievable, with a focus on managing complexity from the Clinical Model Transformation and ensuring proportionate approaches to reported incidents.



GIG  
CYMRU  
NHS  
WALES

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

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

## ADVISE

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

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

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

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

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

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

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



8. The Committee received the **Operational Update for Q1 2025/26**, which members noted demonstrated a strong focus on quality and improving services for patients, and the level of change and transformation throughout. The report highlighted that handover delays are continuing a downward trend, which has resulted in reduced wait times for Amber response calls. Additionally, the Trust recently de-escalated to REAP level one, attributed in part to these improvements. related to investigations (concerns, coroner inquiries etc) include complexity in patient call flows involving multiple touchpoints has added significant lines of inquiry and investigation, making backlog resolution more challenging.
9. The **Annual Infection and Prevention Control Report 2024/25** was deferred.
10. Members' **reflections** included that the lighter agenda allowed for deeper focus on the Putting Things Right Report and the associated Recovery Plan, enabling more probing and challenging questions from Non-Executive Directors and robust scrutiny and assurance. Members praised the quality of reports, presentations and the strong Chairing was noted. Members' appreciated the transparency and early sight of strategic work, and acknowledged the significant risks being managed by the Trust.
11. The committee **met briefly in private** to approve the minutes of the May 2025 private session and receive a confidential risk report.

## ASSURE

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

12. The **Monthly Integrated Performance Report (MIQPR)** was received, setting out the metrics for June 2025. Members noted that the board will receive and discuss the MIQPR at its meeting in September 2025. Performance related to Putting Things Right is reported separately below. Of note:
  - The Trust lost 15,278 hours to hospital handover delays in June 2025, one of the lowest levels in four years but still a significant operational challenge impacting response capacity and as such, inevitably leading to incidents of avoidable harm.
  - The Trust reported eight National Reportable Incidents in June 2025. Complaint response times against national definition improved to 88%, compared to a two-year average of 57%. Notwithstanding this, a PTR recovery plan has been received for the overdue open complaints.
13. The committee received an update on the revised **Ambulance Performance Framework**, highlighting the introduction of new outcome focused metrics for cardiac arrest and high-risk calls, with distinct clinical indicators and response targets. The committee welcomed the focus on clinical outcomes, robust data analysis, and alignment with national standards. Members were pleased to hear that the launch went well on 1 July 2025, which was supported by cross directorate working, and that there are no known patient safety incidents directly attributed to the changes in call categorisations known at this stage. Work is underway to prepare for the go-live of Phase II of the framework for what is currently the amber and green categories.
14. Members received an update on the **Ministerial Advisory Group Wait 45 Taskforce**, highlighting the focus on system improvement and pathway improvement, with workshops scheduled for each Health Board and a meeting with the Cabinet Secretary on 15th September 2025; the outcome of which will be



GIG  
CYMRU  
NHS  
WALES

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

15. The **Putting Things Right (PTR) Report** for Q1 2025-26 was received. Members were assured on the learning, deep dives undertaken, the data driven insights and the intelligence being interpreted which are critical to assurance. Some of the areas of poor performance will be addressed in the PTR recovery plan above, but of note for the board:
- The increase in concerns related to patient waits and the increase in Non-Emergency Patient Care Service cancellations. Renal and Oncology patients are not affected.
  - The performance challenges associated with delays in PTR responses and inquest statements have led to the Trust being issued with five Schedule 5 notices from a regional Coroner's office for the first time.
  - The external backdrop is concerning and the delay in providing statements and evidence to the Coroner's office risks financial and reputational penalties.
  - The distressing impact for all patients and families awaiting investigation findings or inquests is acknowledged and the Trust extends apologies to all affected.
  - The Trust has received a Section 27 Public Services Ombudsman report. All recommendations have been accepted and completed and, the actions taken by the Trust to enhance future safety are outlined in the learning section of this report on high risk overdoses.
  - The Chair will provide an assurance report to the Audit, Risk & Assurance Committee (ARAC) regarding low harm and near misses, noting that the focus is currently on the incidents that have taken place and that have been reported and that this type of proactive reporting is being built through the Clinical Model Transformation.
16. The **Annual Safeguarding Report 2024/25** was approved. The Committee praised the report's clarity and evidence of strong partnership working and noted the increase in internal safeguarding allegations being reported were indicative of a positive cultural shift within the organisation.
17. The **Clinical Audit Plan and Action Tracker update for Q1 2025/26** was received with no escalations.
18. Members received a presentation on the **Clinical Plan for 2025-2030** redevelopment which includes an innovative, interactive format to enhance user engagement. Next steps will be engagement with the ELT considering prioritisation of digital work, consideration of the Welsh Language and alignment with other Trust documents.
19. The **Internal audit on Start of Shift Procedure** was presented. The audit assessed the effectiveness of the procedure for preparing vehicles and ensuring availability of key equipment and medicines at shift start within Emergency Medical Services (EMS) and Ambulance Care. The audit rated two objectives as reasonable assurance, three as limited, and one as substantial, with several medium and high priority recommendations raised. The actions will be monitored by this committee.



20. The **Emergency Communication Nurse System Implementation Internal Audit Report** was received. The audit highlighting significant audit backlogs, with over 400 audits pending, and issues with monitoring and compliance. Members were assured of the plans to address these concerns with additional auditors and improved processes.
21. An update was received on the **Audit tracker** with 63% (40% last quarter) of committee related internal audit actions due in quarter were closed in quarter. The committee was assured that appropriate plans were in place to address those actions overdue. There were 30% of external audit recommendations closed in quarter. 17 of 32 Welsh Risk Pool open recommendations relating to the backlog of investigations and concerns have had revised dates during this period.

## RISKS

### Risks Discussed:

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

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

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

### New Risks Identified:

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

## COMMITTEE AGENDA FOR MEETING

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



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	Communication Nurse System Implementation	Care Report Arrangement for Managing Demand – WAST (consent item)
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COMMITTEE ATTENDANCE					
NAME	9 MAY 2025	13 JUN 2025	5 AUG 2025	4 NOV 2025	3 FEB 2026
Bethan Evans (Chair)					
Ceri Jackson					
Rhiannon Beaumont-Woods					
Liam Williams					
Andy Swinburn			Jonathan Chippendale		
Lee Brooks	Peter Brown				
Rachel Marsh			Hugh Bennett		
Jonny Sammut	Keith Williams				
Trish Mills		Trish Mills			
Mark Marsden					
Hugh Parry					
Henry Garrard					

	Attended
	Deputy attended
	Apologies received
	No longer member

**WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST  
MINUTES OF THE EXTRAORDINARY OPEN MEETING OF THE  
QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE  
HELD ON 10 OCTOBER 2025 VIA TEAMS**

**MEMBERS PRESENT:**

Bethan Evans Non-Executive Director and Chair  
Rhiannon Beaumont-Wood Non-Executive Director

**PRESCRIBED ATTENDEES:**

Lee Brooks Executive Director of Operations  
Henry Garrard Trade Union Partner  
Rachel Marsh Executive Director of Strategy, Planning & Performance  
Hugh Parry Trade Union Partner  
Andy Swinburn Executive Director of Paramedicine  
Liam Williams Executive Director of Quality and Nursing

**ATTENDEES:**

Claire Appleton Assistant Director of Putting Things Right  
Jayne Beeslee Non-Executive Director  
Julie Boalch Assistant Director of Corporate Governance and Risk  
Hugh Bennett Assistant Director of Commissioning and Performance  
Kate Blackmore Assistant Director of Quality Governance  
Jonathan Chippendale Assistant Director of Clinical Development  
Colin Dennis Chair of the Trust Board  
Penny Durrant Deputy Director of Nursing, Quality and Governance  
Sarah Harland Corporate Governance Officer  
Alex Payne Corporate Governance Manager  
Emma Wood Chief Executive

**APOLOGIES:**

Ceri Jackson Non-Executive Director and Vice Chair of the Board  
Mark Marsden Trade Union Partner  
Trish Mills Director of Corporate Governance/Board Secretary  
Angela Mutlow Director of Operations, Llais  
Jonny Sammut Director of Digital Services

## **1. WELCOME AND APOLOGIES**

- 1.1 The Chair opened the extraordinary meeting of the Quality, Patient Experience and Safety Committee, convened to consider a single significant agenda item *Call Categorisation Phase Two*, and to review and endorse the Quality Impact Assessment and Equality Impact Assessment.
- 1.2 Apologies were duly noted and the Chair welcomed members, extending a warm welcome to Emma Wood, the newly appointed Chief Executive, as well as Colin Dennis and Jayne Beeslee, who do not ordinarily attend meetings of this Committee.
- 1.3 The Chair confirmed the meeting met quorum.

**The Committee RESOLVED to: Members were welcomed, apologies were duly noted and it was confirmed the meeting met quorum.**

## **2. DECLARATIONS OF INTEREST**

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

## **3. MINUTES FROM THE OPEN MEETING 5 AUGUST 2025**

- 3.1 The minutes from the meeting held on 5 August 2025 were received. Rhiannon Beaumont-Wood requested a minor amendment to Item 9.4, to read "in the emergency assessment unit despite *apparent* available beds". Subject to this amendment, the minutes were accepted as a correct record.

**The Committee RESOLVED to: Approve the minutes of the open meeting held on 5 August 2025, which were accepted as correct record, subject to a minor amendment to Item 9.4.**

## **4. CALL CATEGORISATION: PHASE TWO INCIDENT CODING (ORANGE/YELLOW/GREEN) ASSURANCE PACK – QUALITY IMPACT ASSESSMENT AND EQUALITY IMPACT ASSESSMENT**

- 4.1 Liam Williams explained that the Phase Two Performance Framework Quality Impact Assessment (QIA) builds on feedback from Phase One to enhance robustness and clarity, with the Remote Integrated Care Service as a key enabler. Liam credited colleagues for a thorough multi-professional review, describing extensive intelligence gathering and acknowledged ongoing refinement of measures based on Phase One data. Liam expressed confidence in the QIA's readiness for approval. Lee Brooks added that there was a robust discussion at the Finance and Performance Committee on the 16 September 2025, which considered the model's intent and design.

4.2 Key highlights from the ensuing discussion were as follows:

- 4.2.1 The Chair referenced previous discussions on Phase Two, noting both challenges and assurances on the QIA and Equality Impact Assessment (EqIA) documents, and requested clarification regarding minor amendments from the Clinical Quality Governance Group (CQGG). Liam confirmed the papers were submitted in advance and that CQGG's requested amendments were clarifications rather than substantive changes.
- 4.2.2 Rhiannon Beaumont-Wood commended the quality and thoroughness of the QIA, while raising concerns regarding the resilience of the remote clinical workforce and emphasising the need for ongoing staff development, robust audit capability and continuous data monitoring. In response, Liam outlined investments in training, education and audit functions, describing efforts to balance assurance with clinician autonomy, and highlighted ongoing work to use process data for continuous improvement and targeted education.
- 4.2.3 Andy Swinburn emphasised that moving to remote clinical practice requires shifting from process metrics to clinical indicators, with Phase Two continuing improvements having begun in Phase One. Andy stressed the need for embedding these changes and ongoing leadership for resilience.
- 4.2.4 Lee Brooks explained that the Clinical Model Transformation is separate from the Ambulance Performance Framework, but both share synergies and staff have already adapted to the new patient flow. Lee emphasised the need to review staff capacity and update modelling after implementation. Phase Two will require extra staff support due to new categories, with lessons from Phase One informing this. Support for clinicians will continue beyond the initial go-live period. Lee also highlighted plans to merge Clinical Support Desk (CSD) and 111 into the Remote Integrated Care Service (RICS), backed by investment in a new Computer Aided Dispatch (CAD) system, and ongoing efforts to strengthen team supervision, peer support and training, all expected to be in place before the CAD launch. These changes will help guide the model's future direction.
- 4.2.5 The Chair raised concerns regarding staff morale and burnout, with Hugh Parry and Henry Garrard emphasising the need for sustained support as winter approaches. Liam, Lee and Andy responded that remote care workflows and enhanced categorisation are expected to improve staff experience and patient prioritisation; and highlighted

ongoing engagement, training and leadership support, stressing that all decisions are guided by a commitment to safety for patients and staff.

- 4.2.6 The Chair recognised the safety driven approach and requested assurance on the clarity and timing of external communications for the upcoming changes. Members were assured that a suite of communication materials is being developed, including resources for health staff, stakeholders, and the public, with animations and other tools to explain the changes and address the risks associated with the rollout of Phase Two. Coordination with government is underway to align the communications with ministerial announcements regarding the progression to this next phase.
- 4.2.7 The Committee sought and received assurance that robust monitoring would be in place to detect any increase in patient safety incidents, rather than waiting for scheduled audits; which includes a rapid review of incidents and escalation of concerns. Specifically, the Committee were assured that the learning from Phase One had led to a more dynamic and responsive consideration following any concerns being raised.
- 4.2.8 The Chair sought assurance regarding how the new model would affect accessibility and quality of access for patients with complex needs, such as those with learning disabilities. Andy explained that, unlike previous algorithm-led models, the involvement of Clinical Navigators and senior clinicians early in the process now enables more bespoke interventions for individuals with unique needs, emphasising the link between the Clinical Model Transformation programme and core categorisation phases. Liam highlighted ongoing initiatives to support people with complex needs, including dementia, mental health and a learning disability register; with further advice to be provided at go live, all underpinned by broader clinical development efforts.
- 4.2.9 Jayne Beeslee commended the quality of the assessments and progress since the Finance and Performance Committee, and was assured on escalation processes for system pressures and expressed confidence in the Executives' oversight and delivery of the call categorisation changes
- 4.2.10 The Committee agreed to endorse and recommend for approval the Ambulance Performance Framework Phase 2 Quality Impact Assessment and the Emergency Response Workstream Equality Impact Assessment for Call Categorisation Phase Two to the Trust Board on 23 October 2025. Rachel Marsh confirmed that a paper will come to the Trust Board covering assurance around all aspects of the change, not just the QIA and EqIA, and noted a specific group chaired by Estelle

Hitchon which is working on internal and external communications.  
Rachel deferred to Liam and Lee for more recent updates.

**The Committee RESOLVED to:**

**Endorse and recommended for approval the Quality Impact Assessment and Equality Impact Assessment for Call Categorisation Phase Two to the Trust Board on 23 October 2025.**

**5. KEY MESSAGES FOR THE BOARD**

5.1 The Chair summarised the endorsement and recommendation as the key message for the Trust Board.

**6. REFLECTIONS AND SUMMARY OF DECISIONS/ACTIONS**

6.1 The Chair thanked all contributors for their work and open discussion, robust scrutiny and assurance process for the Call Categorisation Phase Two.

**7. ANY OTHER BUSINESS**

7.1 None declared.

**8. DATE OF THE NEXT MEETING**

8.1 The next meeting is scheduled for 04 November 2025.

**The meeting concluded at 5:10pm.**



## QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE HIGHLIGHT REPORT TO BOARD

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

The papers for this meeting can be found by following this [link](#) to the Committee page on the Trust website.

<b>Trust Board Meeting Date</b>	23 October 2025 Extraordinary Meeting
<b>Committee Meeting Date</b>	10 October 2025 Extraordinary Meeting
<b>Chair</b>	Bethan Evans

### KEY ESCALATION AND DISCUSSION POINTS

#### ALERT

(Alert the Board to areas of attention)

1. Committee received and endorsed the Quality Impact Assessment (QIA) and Equality Impact Assessment (EqIA) which are before the Board for approval.
2. These documents support the transition into Phase Two of the Ambulance Performance Framework, which was endorsed by the Finance & Performance Committee on the 16 September 2025. This phase will facilitate 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.
3. Typically, the QIA would clearly outline improvement measures and their trajectory; however, work is ongoing to refine measurement approaches, within the evaluation and efforts to identify the right measures at both corporate and clinical levels. It was noted that the QIA is completed in the context of the ongoing harm across the emergency care pathway and that the proposed changes and their impact were professionally judged to enable safer care.
4. A comprehensive discussion highlighted the change management strategy ensuring staff feel supported with visible clinical educational leadership in Clinical Contact Centres, ongoing supervision, advocacy and collaboration between education, development and operations teams. Nine engagement sessions are scheduled for integrated care staff to familiarise themselves with upcoming changes which are complemented by further training and familiarisation activities to enhance confidence and competence.
5. Committee received assurance that the impact from increased remote clinical management resulting from the categorisation changes in flow had been considered and that the Remote Integrated Care Service QIA would address how this is being operationally enacted through the remote clinical workforce.



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6. Members were assured that a suite of communication materials is being developed, including resources for health staff, stakeholders, and the public, with animations and other tools to explain the changes and address the risks associated with the rollout of phase two. Coordination with government is underway to align the communications with ministerial announcements regarding the progression to this next phase.
7. Committee sought and received assurance that robust monitoring would be in place to detect any increase in patient safety incidents, rather than waiting for scheduled audits, which includes a rapid review of incidents and escalation of concerns. Specifically, committee were assured that the learning from Phase I had led to a more dynamic and responsive consideration following any concerns being raised.
8. In relation to the accessibility and quality of access for patients with complex needs, such as those with learning disabilities, Members were assured that the new model introduces clinical navigators and senior clinicians early in the process. This allows for more nuanced, bespoke interventions for individuals who do not fit standard pathways, improving opportunities to address unique needs.
9. Colleagues were commended for their effective work in ensuring a high degree of scrutiny at a multi-professional and multi-directorate level for the QIA. Committee were assured regarding the intelligence gathering which was conducted through liaison with the Putting Things Right team and acute clinical leads to observe patient flow changes after call categorisation phase one, aiming to identify any learning that could be applied to the current phase. It was emphasised that these learnings were incorporated into the QIA in an evolutionary way from the original draft.
10. The Chair formally thanked all colleagues involved in preparing the papers and delivering the work, recognising the depth, challenges, and critical importance of the project for the Trust.

### ADVISE

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

11. The Chair extended a warm welcome to the meeting to our new Chief Executive, Emma Wood, the Trust Chair, Colin Dennis and Jayne Beeslee, Non-Executive Director.

### ASSURE

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

12. N/A

### RISKS

**Risks Discussed:** N/A

**New Risks Identified:** N/A

### COMMITTEE AGENDA FOR MEETING

Call Categorisation: Phase Two Incident Coding (Orange/Yellow/Green) Assurance Pack  
Quality Impact Assessment and Equality Impact Assessment



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COMMITTEE ATTENDANCE						
NAME	9 MAY 2025	13 JUN 2025	5 AUG 2025	23 OCT 2025 Extraordinary	4 NOV 2025	3 FEB 2026
Bethan Evans (Chair)						
Ceri Jackson						
Rhiannon Beaumont-Woods						
Liam Williams						
Andy Swinburn			Jonathan Chippendale			
Lee Brooks	Peter Brown					
Rachel Marsh			Hugh Bennett			
Jonny Sammut	Keith Williams					
Trish Mills		Trish Mills		Julie Boalch		
Mark Marsden						
Hugh Parry						
Henry Garrard						

	Attended
	Deputy attended
	Apologies received
	No longer member

**ACTION LOG - UPDATE  
QUEST COMMITTEE**

Minute Ref	Date	Agenda Item	Action Note	Responsible	Due Date	Progress/Comment	Status
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 QuEST November meeting.	Rachel Marsh	4 November 2025	<u>Update 15 October 2025</u> Analysis received from Mark Thomas that was conducted in July which shows handover and conveyances by age. It highlights that handover delays increase with the age of the patient and that people over 70 do wait longer than average outside hospital ED's and that these waits have been disproportionately higher in Swansea Bay HB. However, the data also shows that a significantly higher number of over 70's are conveyed to an ED than those in younger age groups, accounting for 55.3% of all conveyances over the 12-month period. This was circulated to members.	Complete
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.	Liam Williams	5 August 2025	<u>Update 29 July 2025</u> A meeting has been arranged on 4 September 2025 with Liam Williams, Ceri Jackson and David Hopkins to explore funding opportunities through the charity.	Complete
06-08/25	5 August 2025	Patient Story	Explore a co-production approach on future digital resources to enable improved engagement and experiences of those with learning disabilities.	Jonny Sammut	4 November 2025	<u>Update from Jonny Sammut 20 October 2025</u> The action relating to exploring co-production on future digital items can now be closed. 1. A Human-Centred Design Lead has been engaged and is currently delivering a programme of workshops with the Digital Team over the coming months to embed user-centred design principles in our approach. 2. Early engagement has commenced with the Purple Network to gather insight into what is and isn't working effectively within our current digital services. 3. The outcomes from both streams of work will inform the development of our Digital Transformation and Innovation Programme (DTIP) and the establishment of the Innovation Lab, both of which are planned for launch next year.	Complete
09-08/25	5 August 2025	Ministerial Advisory Group WAIT 45 Taskforce	Liam Williams 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.	Liam Williams	4 November 2025	<u>Update 18 August 2025</u> Following the ASM, this item has been included in the November 2025 meeting. Action proposed for closure.	Complete
13-08/25	5 August 2025	Clinical Audit Plan and Action Tracker Q1 (Update) 2024-2025	Bethan Evans noted a discrepancy in the reported audit numbers listed in the executive summary, Jonathan Chippendale agreed to review and correct.	Jonathan Chippendale	4 November 2025	<u>Update 11 August 2025</u> Jonathan Chippendale provided the corrected paper with the corrective narrative at section 11. Action proposed for closure.	Complete
14-08/25	5 August 2025	Clinical Plan Progress Update	Refer the prioritisation of the digital Clinical Plan project back to the Executive Leadership Team (ELT) for review, ensuring it aligns with current organisational priorities and resource capacity. (If technical or resource barriers arise, the content can be reformatted into a more traditional format).	Jonathan Chippendale	4 November 2025	<u>Update from Jonathan Chippendale 16 October 2025</u> Following stakeholder engagement and the developing requirement to reassess actions required to deliver against the new clinical performance framework, work is underway to set out the ongoing actions required as part of this project. This work will set the course of clinical development and delivery for subsequent years and create a series of targeted actions to drive clinical performance and outcomes.	Open



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## OPERATIONS DIRECTORATE QUARTERLY REPORT FOR COMMITTEES 2025-26 Q2 (July – September 2025)

### National Operations & Support

#### IMTP

#### **Manchester Arena Inquiry**

We continue to await a formal outcome following our August 2024 submission on the Manchester Arena Inquiry recommendations. We have continued to engage with commissioners and completed a fifth scrutiny session in September 2025 with Health Board colleagues and JCC to answer the outstanding queries on our submission. The timeline advised is to anticipate an outcome in December 2025.

#### General Update

#### **HART Drone**

Our HART drone is now being utilised regularly in a training environment to ensure pilots maintain regular flying hours. In August, the drone capability was successfully demonstrated to the Senior Leadership Team, with live streaming into the ODU. The drone group is working with Information Governance to finalise the draft SOP which should enter the governance approvals before Christmas.

#### **Volunteer Conference**

The Volunteer team delivered the annual Volunteer Conference in Swansea on 27<sup>th</sup> September, celebrating the achievements and contributions from our volunteers. The event was well attended with final numbers exceeding 175 volunteers, with Executive and Non-Executive colleagues in attendance. Speakers on the day covered an exciting agenda including Human Factors in Health Care, Oncology: The Patient Journey, Response Model update and WAST Charity with the event concluded with the WAST Volunteer Award Ceremony.

## **EPRR Testing and Exercising**

On 7th October, HART (Blue Watch) participated in *Exercise Tendley 2*, a multi-agency major incident scenario planned and delivered by South Wales Police. The exercise simulated a multi-vehicle road traffic collision involving a coach carrying high-risk football supporters and featured 40 live casualty actors, enhanced with realistic moulage provided by the BBC *Casualty* team. HART supported triage, treatment, and extrication of patients to the Casualty Collection Point (CCP), working closely with Fire and Rescue Service, Police, EMRTS, and Medserve colleagues to deliver high-quality care.

The HART Team Leader integrated effectively within the command structure, directing the team to prioritise tasks and patients. JESIP principles were actively maintained throughout—supporting shared situational awareness, coordinated decision-making, and effective joint working. JESIP is recognised nationally as best practice for interoperability between emergency services during major incidents.

Positive outcomes from the exercise included successful mobilisation and testing of SORT logistical capabilities, with SORT setting up tents for the Casualty Clearing Station in collaboration with EMRTS. The first crew on scene promptly initiated triage using ten second triage and, establishing a Forward Command Post (FCP). Debriefs on points of learning for the exercise will follow.

## **Resourcing, EMS Coordination and Quality**

### **General Update**

#### **EMS Coordination**

#### **IAED Mentor Courses**

In August, we commenced IAED Accredited Mentor courses for Call Supervisors and Senior EMDs across the three EMSC's, enhancing their skills and knowledge to better support our EMDs. Additionally, Managing Attendance at Work Training has been delivered to all Shift Managers and Call Supervisors, increasing their understanding and confidence in applying this policy, and supporting our people.

#### **Yorkshire Ambulance Service (YAS)**

Our support for Yorkshire Ambulance Service (YAS) concluded with WAST monitoring performance impacts daily. Since its inception in 7th April 2025, we have dealt with over twenty-two thousand calls. As a result of the monies generated from this process, alongside support of our colleagues in Yorkshire, we have been able to offer our staff overtime to support this mutual aid request. In addition, it has provided the financial means to send more staff to the Navigator conference and offer overtime so that we can facilitate the IAED mentor courses.

## **CMT – Clinical Model Transformation**

On the 1 July 2025, the first phase of the Clinical Model Transformation project was implemented. The existing Red Category in the Dispatch Cross Reference (DCR) table was split into three new categories: Purple Arrest, Red Emergency, and RCS0. Additional codes were added for Multi Agency Incident Transfer (MAIT) and 111, and amendments were made to Cymru High Acuity Response Unit (CHARU) suitable codes. Standard Operating Procedures were updated and face to face training was delivered to EMSC Staff. It is particularly pleasing that following a survey the implementation of phase 1 has received positive feedback from EMSC staff outlining that the rationale for the need to change was explained clearly and that colleagues felt supported in understanding and being prepared for the change.

## **Quality Assurance Framework**

A Quality Assurance Framework for Clinical Navigators has been approved. This framework will offer the monitoring, compliance and reporting processes that need to be in place to provide and assure a high-quality service. The cultural ethos and aim of audits and monitoring is to observe and applaud good practice and provide feedback for improvement where compliance and clinical advice has fallen below standards. The framework provides a shared understanding of what is required to be achieved and offers a two-way feedback mechanism to improve standards.

## **Operations Quality (OQ)**

### **Organisational Change**

A formal consultation process for expansion of the OQ department concluded on 05 September 2025. The department is now in the process of recruiting staff into new posts and teams which include CPSS Quality Audit, ECNS Quality Audit and Integrated Care concerns. A team of 10 CPSS auditors have been recruited and started on 01 October 2025. Training is ongoing and the department will be working with the International Academies of Emergency Dispatch (IAED) to scope out requirements to work towards Accredited Centre of Excellence status for CPSS. ECNS auditor recruitment will begin early January 2026.

### **Putting Things Right (PTR) Recovery Plan**

Operations Quality is working closely with the PTR team to improve the Trust's PTR position as part of the PTR recovery plan. Complaint reviews have been taking place to ensure investigation scopes are proportionate and to enable the investigation team to expedite overdue complaints. Temporary investment has been provided to increase the department's QA capacity and a trajectory of improvement is in development.

## **Resourcing**

Following a period of user acceptance testing, GRS live on premise has successfully been upgraded to v4.8 which is a prerequisite for transition to Cloud and the broader e-timesheet project. The timeline for Cloud Migration to happen in May 2026.

Resourcing have welcomed two newly appointed resourcing coordinators to the team during September, bringing us to coordinator establishment and a welcomed support to the Swansea based team as we progress preliminary work for the rostering of Integrated Care, 111 to GRS.

## **Emergency Medical Service**

### **IMTP**

## **EAP Training**

EAP training continues to progress well. There are further courses scheduled for 6 October & 11 November with both courses currently have 45 staff booked on. Therefore, by the end of the current calendar year a total of 378 staff (including EMT3) will have completed the training and qualified as EAPs, with 518 completed by the end of the financial year.

As a result of considerable staff release to support this training initiative the upcoming winter UHP position is a concern, and we will continue to manage this by targeting staff release strategically to avoid overburdening any single area. Our winter structures will elad the response across the period.

## **APP Roster Review**

The APP Roster Review is progressing, and a series of meetings have already been undertaken with Clinical colleagues and TUPs. There are many functional elements to build into new rotas which includes Primary Care, APP Navigators, Palliative Care and operational staff. Further modelling is underway to support rota build.

## **Improve Capacity in Rural Wales**

A Task and Finish Group has been established in partnership to develop an action plan that is actionable and sustainable, improve rural recruitment and retention alongside rural capacity and resilience.

## General Update

### **CHARU Recruitment**

CHARU Recruitment is transitioning to a quarterly cycle, with no immediate barriers or additional recruitment needs anticipated.

With the commencement of external training courses, it is expected that a high proportion of candidates will succeed. However, following the completion of the upcoming external training course we will be in a position to fully understand the true CHARU position and whether there remain any shortfalls.

If shortfalls remain following all the recruitment processes (internal & external), consideration will then be given to applying acceptable solutions to increase CHARU coverage similar to the Welshpool rotational model.

### **Overruns**

Conversations to reduce end-of-shift overruns are being advanced through ongoing collaboration with TUPs. The ambition is to operationalise the majority of identified strategies within October 2025, thereby safely improving operational efficiency and enhancing staff wellbeing.

## Ambulance Care

### Challenges

### **Transfer and Discharge Pressures**

Transfer and discharge has emerged as a pressure point for Ambulance Care. As Health Boards actively strive to reduce handover times outside Emergency Departments to achieve the W45 standards, there has been a noticeable increase in journey booking requests for Discharge & Transfer. Whilst every effort is being made to accommodate all journeys, there have been occasions when demand exceeds available capacity and some journeys have been delayed until the following day. The service is focused on engaging proactively with HBs and maximising the utilisation of our discharge and transfer resources.

### **Capacity Management Plan (CMP)**

The Capacity Management Plan continues to be a considerable challenge, with an average of 500 journeys across Wales cancelled each week. Although this figure is higher than desired, a whole systems approach has enabled a reduction in overall cancellations, particularly in areas of greatest need.

In AB and BCU Health Boards areas we have piloted initiatives to reduce CMP numbers, and these are delivering positive outcomes, including days without the CMP being activated. These initiatives include;

- Continued review of PAS improved provision to identify utilisation
- Operational oversight via OTL within control rooms.

We continue to raise awareness of these efforts both internally and externally, including with our commissioners.

Additionally, focused collaboration with PTR and PECL is ongoing to better support patients whose journeys are cancelled, and to enhance our responsiveness to concerns raised.

## IMTP

### **NEPTS Cleric System and Hywel Dda Patient Administration System Connectivity**

The link between the Cleric system and the Hywel Dda PAS is now complete and in operation. This connection facilitates cross checking of systems to identify patients who have transport booked, but are no longer attending their appointment due to cancellation, date/time change or a change in patient circumstances. In a week of operation, we have identified almost 50 journeys where a patient's healthcare appointment has changed, and they no longer require the transport that was booked. It is highly likely that a resource would have been dispatched to complete this journey without this information. Rollout to additional Health Board areas will be explored following completion of further refinement with Hywel Dda.

### **Roster Review Modelling**

Following the pause to the review, additional modelling has been provided and two new potential roster proposals have been developed. These have passed the first phase of testing and are currently being tested with real world data by our planning and operational management team. Upon completion of the testing and, providing a viable option is identified, working parties will recommence soon.

## General Update

### **Ambulance Care Roadshows**

Throughout September, we completed our inaugural set of six Ambulance Care roadshows. The roadshows provided an opportunity for the management team to engage with colleagues across the country, through three face-to-face and three online sessions. Key

topics included the future vision for Ambulance Care, the Capacity Management Plan, the Urgent Care Service, and Roster Reviews. Each session featured an interactive Q&A, sparking valuable discussions and prompting further consideration within the team.

Feedback was overwhelmingly positive, with staff highlighting the sessions as informative and welcoming the opportunity to engage directly with the senior leadership team. The NHS Staff Survey was also actively promoted during these events.

Key engagement metrics from the six sessions:

- 110 unique attendees, with face-to-face sessions attracting higher numbers
- 75 questions were received and answered
- 92 interactions were received on the future Ambulance Care Future Vision
- In addition to informing future years IMTP content, the feedback on the Ambulance Care Vision will be incorporated into next year's IMTP and the refresh of the Trust's long-term strategy.

Further engagement events will be held in the New Year.

## Integrated Care

### IMTP

#### **Senior Management OCP**

The process has now been completed and will reshape the Service Manager structure, moving our Service Managers into functional, pan Wales roles:

- Service Manager for Inbound Services.
- Service Managers leading Clinical Services.

In addition, we appointed a new Service Manager post with responsibility for service improvement. This role will oversee a wider portfolio, including the Directory of Service team and a Locality Manager.

### **Ambulance Performance Framework**

On 1 July 2025, the new Ambulance Performance Framework was launched and the introduction of RCS0 calls to Integrated Care. Another significant development was the establishment of the 'Rapid Assessment Queue,' dedicated to handling RCS0 and priority calls, with clinicians specifically assigned to these cases. Priority calls, identified by the Clinical Navigator, CSD Operations Manager, or Point of Contact, are clinically assessed as needing a faster call back. Since this queue began operating, the average time to assessment of 9 mins has been below the balancing measure of 15 mins.

### **Care Planning**

We are refining how we manage the Care Planning queue by dividing it into three categories: remote monitoring, falls, and extended response delays over six hours during periods of high escalation. The primary focus for care planning clinicians will be on remote monitoring, supporting patients to be safely managed in the community and reducing the need for transport to an Emergency Department. To achieve this, they will work closely with Advanced Paramedic Practitioners and Health Board community teams. A new AQM (Advanced Questioning Module) has been developed and will be implemented in October to improve the documentation and data collection on activity.

### **Video Consultation**

On the 8th of July video consultation was introduced to clinicians working on the 111 CAD system, joining those clinicians on the CSD CAD who already had access. Video consultation is designed to support the triaging process by enabling clinicians to visually assess a patient's condition. This visual interaction enhances clinical judgement and supports critical thinking, helping clinicians determine the most appropriate pathway. Since the launch, there have been 329 episodes of Video Consultation activations. Within CSD 754 video consultations were completed (this was the highest amount since records began in Sep 22). In total there were 1,083 Video consultations completed.

### **Simply Do Challenge**

The intergrated care team, were the first team to trial the use of the "Simply Do- WIN platform". This platform is an ideas generation platform, that allows teams to submit ideas around a specific challenge. A challenge was designed, focused on gathering ideas around improving the abandonment rate of 111 specific calls. A total of 17 ideas were submitted by Call Handling Coordinators, focused on the specific challenge. The team are collaborating with the Quality Improvement Team, within the Quality Directorate, to progress some ideas into small tests of change. This was presented at the annual Quality Conference.

## Pan Operations

### **Staff Survey**

Following the Quality and Support Day held in response to the NHS Wales Staff Survey 2024, all service areas have now developed and confirmed their action plans based on the feedback received. These action plans have been reviewed and approved through the Senior Operations Team (SOT) and are now ready for submission to the People & Culture team. This marks a key milestone in our commitment to addressing staff feedback and driving meaningful improvements across the Operations Directorate.

### **Quality and Support Days**

As part of our commitment to act on staff feedback and deliver meaningful improvements across the Operations Directorate, the good work carried out so far through the Quality and Support Days will be further built upon by holding the sessions monthly on one day across all service areas from October 2025. The dedicated sessions will provide a structured opportunity to prioritise staff wellbeing while addressing both organisation wide themes and local service specific priorities.

The content of each session will be scheduled in advance, drawing on service area action plans, staff feedback, compliance requirements, and lessons learned. Outcomes will be integrated into action plans where significant interventions are required, including actions linked to the NHS Wales Staff Survey 2024. Alongside these larger initiatives, a log of immediate local "Just Do It" improvements will be maintained to capture quick resolutions where appropriate.

While staff wellbeing will remain the central focus, the sessions will also provide a platform for timely operational priorities such as compliance, training, seasonal planning, and feedback on national programmes of work. In doing so, Quality and Support Days will ensure a consistent, visible, and meaningful approach to supporting staff and strengthening service delivery across the Directorate.



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Agenda Item No.

7

## REPORT TITLE

Monthly Integrated Quality Performance Report – August/September 2025

## MEETING

Name of meeting	QuEST
Date of meeting	4 November 2025
Public or Private	Public
If private - <a href="#">rationale</a>	Choose item from below

## REPORT SPONSOR

Executive sponsor	Rachel Marsh– Executive Director of Strategy, Planning & Performance
Author(s) of report	Hugh Bennett – Assistant Director Commissioning & Performance Mark Thomas - Commissioning & Performance Manager Melanie O'Connor - Senior Performance Analyst

## PURPOSE OF REPORT

<input type="checkbox"/> Approval	<input type="checkbox"/> Endorsement
<input checked="" type="checkbox"/> Assurance	<input checked="" type="checkbox"/> Discussion
<input 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]

1. The purpose of this report is to provide senior decision makers in the Trust with an integrated dashboard (Our Patients, Our People, Value and Partnerships/System Contribution) focused on the "vital few" key metrics. This report is for **August/September 2025**.
2. The report aims to provide an integrated view of quality and performance, so is made available to all three committees to give that overview, with more specific and detailed reports supplementing it. Whilst giving an integrated overview, each slide contains an icon denoting the lead committee for each set of indicators.
3. There are a few acknowledged data quality issues within the report e.g. APP data. There is a clear executive focus on Phase 2 of the Ambulance Performance Framework, so this is the current priority, but additional capacity is being sought for the Insight & Data Services function. Some additional capacity is already in place and further positions are due to be filled following interviews which took place in early September 2025. The pressures on IDS are being actively managed through a CMT workplan.
4. The new Purple Arrest and Red Emergency categories went live, as planned, on 01 July 2025 and data from the first three months of reporting is contained within this report.
5. The Trust saw 12,284 hours lost to handover during September 2025, compared to 20,693 lost hours in September 2024. This follows on from significant month-on-month reductions seen during June, July and August 2025 pan-Wales. Whilst this reduction is very welcome, it is by no means universal, and the ambition is for all health boards to reduce handover to levels which improve patient experience and outcomes, and which are sustainable.
6. 111 call handling performance has stabilised post-delivery of the new 111 CAS, but the service did not achieve the 5% abandonment rate in September 2025.
7. Ambulance Care, in particular, Non-Emergency Patient Transport Service's (NEPTS) performance is varied, with only oncology and renal journeys remaining above target in September 2025.
8. The Trust continues to focus on its people, with a range of actions in place to improve workplace experience including, for example, reducing shift overruns, whilst also continuing with the more strategic focus on the People and Culture Plan.



## RECOMMENDATION(S)

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

The QuEST Committee is requested to:

1. **Consider the August/September 2025** Integrated Quality and Performance Report and actions being taken and determine whether:
  - a. The report provides sufficient assurance.
  - b. Whether further information, scrutiny or assurance are required, or
  - c. Further remedial actions are to be undertaken through Executives.

## ADDITIONAL PAPER(S)

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

1. Annex 1 - Monthly Integrated Quality and Performance Dashboard

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

223 - The Trust's inability to reach patients in the community causing patient harm and death

224 - 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

160 - High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service



558 - Deterioration of staff health and wellbeing in the face of continued system pressures as a consequence of workplace experiences

100 - Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience

139 - Failure to deliver our Statutory Financial Duties in accordance with Legislation

## HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

Quality Domains (select all that apply) [ <a href="#">link to standards</a> ]		
<input checked="" type="checkbox"/> Safe	<input checked="" type="checkbox"/> Timely	<input checked="" type="checkbox"/> Effective
<input checked="" type="checkbox"/> Efficient	<input checked="" type="checkbox"/> Equitable	<input checked="" type="checkbox"/> Person Centred
Quality Enablers (select all that apply) [ <a href="#">link to standards</a> ]		
<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) [ <a href="#">link to goals</a> ]		
<input checked="" type="checkbox"/> A socially responsible 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 checked="" type="checkbox"/> No <input type="checkbox"/> Yes
If yes, what impact assessment is attached	

## APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
24 October 2025	Hugh Bennett – Assistant Director Commissioning & Performance



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## SITUATION

1. The purpose of this report is to provide senior decision-makers within the Trust with an integrated dashboard (Our Patients, Our People, Value and Partnerships/System Contribution) focused on the “vital few” key metrics. This report is for **August/September 2025**.
2. The report aims to provide an integrated view of quality and performance, so is made available to all three committees, to give that overview, with more specific and detailed reports supplementing it. Whilst giving an integrated overview, each slide contains an icon denoting the lead committee for each set of indicators:-



## BACKGROUND

3. This Integrated Quality and Performance Report contains information on key indicators at a highly summarised level, which aim to demonstrate how the Trust is performing across four integrated areas of focus:
  - Our Patients (Quality, Safety and Patient Experience).
  - Our People;
  - Finance and Value; and
  - Partnerships and System Contribution.
4. As previously agreed, the metrics which form part of this committee report are updated on an annual basis, to ensure that they continue to represent the best way of tracking progress against the Trust’s plans (IMTP) and strategies. A Board development session was held in April 2025 at which the annual review was undertaken. It was noted that there will be some changes to metrics during 2025/26, aligned to the new performance framework announced by the Cabinet Secretary. No other specific changes were requested, but the Board did discuss a number of areas where it was felt development and progress could be made in terms of the MIQPR and ‘what good looks like’ reporting. At other levels of the organisation, work continues in terms of developing appropriate metrics which can be used to measure quality and performance against our four domains.
5. Following more recent discussions with the Chair of this committee, and with others, a session will be convened later in the autumn (now arranged) to discuss with committee chairs the format of the MIQPR for the next financial year, as the organisation and its metrics evolve.



## ASSESSMENT

### Our Patients – Quality, Safety and Patient Experience

6. **Call answering** (safety): the speed at which the Trust is able to answer a 999 or 111 call is a key patient safety measure.
7. **999** call answering times during September 2025 saw the 95<sup>th</sup> percentile decreasing to 18 seconds, compared to 23 seconds in August 2025. However, the 65<sup>th</sup> percentile and median performance times remained consistently good. Work is currently being undertaken on demand and capacity analysis of 999 call demand.
8. **111 call answering performance has minimally decreased over recent weeks**, with the call abandonment rate for September 2025 being 10.4%, and therefore not achieving the 5% target. 111 demand in September 2025 did see a 1.4% increase compared to September 2024. In addition, the external rostering review suggests there is a demand and capacity gap within the current funded establishment, and the Trust is therefore unlikely to reach performance without an increase in its workforce (including efficiencies). The current position with commissioners is to focus on the 111 digital front end as a way of managing demand rather than investment in call handlers.
9. **111 Clinical response:** clinical ring back times for patients with the highest priority remained above target at 99.1%. Response times for lower priority calls showed a minimal decrease, reducing to 71.4% and 65.1% for P2CT and P3CT respectively.
10. **Ambulance Response** (safety / patient experience): on 1 July 2025, the Trust's new ambulance response model was implemented, and two new response categories replaced the previous (old) Red category. The new categories are Arrest (Purple), for cardiac and respiratory arrests, and Emergency (Red), for major trauma and other incidents where patients are at significant risk of cardiac or respiratory arrest if they do not receive a rapid response. In September 2025, there were 785 purple calls to the ambulance service, around 2.31% of all calls, and 4,453 (Emerg) red calls, around 13% of all calls. The median response times for purple and red calls were 7 minutes 15 seconds and 8 minutes 36 seconds respectively, which were both positive at this early stage.



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The Amber 1 median in September 2025 was 1 hour and 21 minutes and the Amber 1 95<sup>th</sup> percentile was 4 hours 52 minutes. The Clinical Safety Plan will protect Arrest and Emergency demand, but Amber is where the impact of handover lost hours is most felt i.e. there is a strong correlation. Amber 1 response times have seen a significant improvement in recent months, in line with the fall in the number of hours lost to handover. However, these response times still remain too high and have a known impact on avoidable patient harm. Amber will be replaced by the Orange (Now) and Yellow (Soon) categories in quarter three of this year. The changes are designed to improve patient safety and patient outcomes by better stratifying patient demand.

**11.** Traditionally, the main factors which affect response times are demand and capacity (recruitment and lost hours). EMS production has been good although it dropped below 90% in September, and handover lost hours have significantly improved; with this improvement particularly feeding through into the Amber categories' performance. Health Boards are implementing new actions in order to further reduce handover lost hours. The Trust's main focus is to continue to implement a material change in how it responds to patient demand by evolving its clinical model through the Clinical Model Transformation (CMT) programme. Areas of focus for 2025/26 include: -

- Further investment into remote clinical capacity;
- Further investment in APPs;
- Development of the remote integrated care service (111 clinicians and CSD clinicians);
- Continued focus on a range of responses that support non-conveyance, where it is clinically safe and appropriate to do so: Connected Support Cymru, mental health response pilot, Falls response etc.; and
- The transformation of the various clinical model categories as per the previous paragraph.

**12.** As above, the level of lost hours to **handover outside Emergency Departments** remains a critical component of long waiting times and patient safety incidents. 12,284 hours were lost during September 2025; a 40.6% reduction compared to September 2024 and is the lowest monthly figure since July 2021. This follows on from significant month-on-month reductions seen during June, July and August 2025 pan-Wales. Whilst this reduction is very welcome, it is by no means universal, with Betsi Cadwaladr health board remaining high, with 7,569 hours being lost within the health board during September 2025. The ambition is for all health boards to reduce handover to levels which improve patient experience and outcomes and which are sustainable. WG has re-iterated to health boards the critical importance of improvements in this area and the reduction of all over



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45-minute waits was a recommendation from the recent Ministerial Advisory Group on Performance and Productivity. The W45 initiative would see handover lost hours reduce to approximately what the EMS rosters are designed to cope with.

- 13. Ambulance Care (Patient Experience):** Oncology performance in September 2025 was 77.79%, achieving the 70% target. Renal performance increased slightly to above target, achieving 71.21% and advanced discharge and transfer journey performance also increased to 81% (95% target), with this primarily being an issue with capacity. Same day discharge and transfer journey performance was also below the 95% target at 94%. Overall demand for NEPTS continues to increase and is now above pre-pandemic levels. The Trust has a comprehensive health transport transformation workstream in place, which includes delivering a range of efficiencies and improvements. The Trust is currently re-rostering NEPTS transport which will better align available capacity with changing demand patterns (on target). This is proving complex and difficult but will be delivered.
- 14. National Reportable Incidents (NRIs) / Concerns Response:** the Trust reported three NRIs to NHS Wales Performance & Improvement in September 2025, remaining the same as August 2025, and two serious patient safety incidents were referred to health boards under the Joint Investigation Framework. In September 2025 complaint response times decreased to 56%, compared to the 60% recorded in August 2025, not achieving the 75% target. Data accuracy issues have been identified and addressed. However, a PTR recovery plan remains in place, recognising that cases continue to be complex.
- 15. Clinical outcomes:** The percentage of suspected stroke patients who are documented as receiving an appropriate stroke care bundle was 88.5% in September 2025, decreasing from the previous month (90.8%), and remains below the 95% performance target. Work is ongoing to improve reporting and compliance through the ePCR system, and this improvement is clearly being seen in most of the clinical indicators. The Return to Spontaneous Circulation (ROSC) compliance rate decreased to 23.7% in September compared to 27.4% in August 2025, which is a positive increase since the implementation of the new clinical response model.
- 16.** For September 2025, the Trust saw call to hospital door times of two hours and 9 minutes for stroke patients and two hours and forty-six minutes for STEMI. Clearly these times remain too long and are representative of the longer Amber response times, because of the pressures and issues outlined earlier within this report, notwithstanding recent improvements in hours lost to handover.



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**17.** In September 2025, 5,314 patients **cancelled** their ambulance (this figure excludes patients who refused treatment), which is a significant reduction on previous levels. This reduction is likely to be the impact of switching on RCS although caution is required at this stage, as a longer run of data is required in order to properly evaluate the changes made. The Trust changed its Clinical Safety Plan in December, removing the “can’t send” application, with the option remaining at the strategic commander’s discretion in the new plan.

#### Our People (workforce resourcing, experience, and safety)

**18. Hours Produced:** The Trust produced 115,981 Ambulance Response unit hours during September 2025 and delivered an emergency ambulance unit hours production (UHP) of 89%, remaining below the 95% target (This will be a product of abstractions being above benchmark and the current vacancy factor).

**19. Response Abstractions:** EMS abstraction levels decreased minimally to 32.71% during September 2025 but remained above the 30% benchmark figure. Response sickness abstractions stood at 7.39% (benchmark 5.99%).

**20. Trust sickness absence:** the Trust’s overall sickness percentage was 7.77% in September 2025, minimally down on the 7.91% recorded in August 2025, which is in line with seasonal factors. Actions within the IMTP concentrate on staff well-being with an aim to reduce this level to the IMTP ambition of 6%.

**21. Staff training and PADRs:** PADR rates did not achieve the 85% target in September 2025 and decrease slightly to 75.35%. Compliance for Statutory and Mandatory training also decreased slightly to 84.61% marginally failing to achieve the 85% target.

**22. People & Culture Plan:** the Trust launched its People & Culture Plan in April 2023 and workstreams are being delivered around behaviours, in particular, sexual safety, Freedom to Speak Up, 111 culture review, flexible working, and the introduction of a staff pulse survey tool. The Executive Leadership Team undertook a round of pan-Wales CEO Roadshows in mid-October 2025.

#### Finance & Value

**23. Financial Balance:** the reported outturn performance at Month 6 is a deficit of £0.186m with a forecast to the year-end of breakeven. The Trust is forecasting the achievement of both its External Financing Limit and its Capital Expenditure Limit.



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## Partnerships & System Contribution

24. The consult & close rate was 18.7% in September 2025, a slight decrease from the previous month but continuing to achieve the IMTP ambition (and Welsh Government target) of 17%.
25. Same Day Emergency Care (SDEC) centres continue to see only a low level of ambulance activity.

## **RECOMMENDATION**

The Recommendation is set out in the front cover above.

## **NEXT STEPS**

For 111, key next steps include preparing for winter (forecasting, recruitment/production, respiratory offer, digital offer) and acting on the findings from the roster practice review.

For the 999-emergency care pathway, similarly, the focus is now on winter, which will include the usual business as usual preparations, but also the planned major transformation change of moving to the new Orange (Now), Yellow (Soon) and Green (Planned) categories.

For Ambulance Care, the focus will be on ensuring sufficient capacity is available for the predicted increase in planned care i.e. supporting health boards with the required transport on this, the NEPTS re-roster and options for how the Trust can reduce cancellations as a result of the Capacity Management Plan.

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# Monthly Integrated Quality & Performance Report

August/September 2025

Annex 1 – Top Indicator Dashboard



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Annex 1 – Top Indicator Dashboard  
Version 1.0  
Released: October 2025

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by Commissioning & Performance Team

# Section 1: Monthly Indicators / Top Indicator Dashboard



Top Monthly Indicators		Target 2025/26	Aug-25	Sep-25	2 Year Average	RAG	Top Monthly Indicators		Target 2025/26	Aug-25	Sep-25	2 Year Average	RAG
<b>Our Patients</b>						<b>Health &amp; Well-being</b>							
<b>Timeliness Indicators</b>							Sickness Absence ( <i>all staff</i> )		6.0%	7.91%	7.77%	7.97%	R
NHS111 Call Handling Abandonment Rates	< 5%	10.8%	10.4%	9.7%	R	Mental Health Absence Rates		Reduction Trend	2.89%	2.96%	2.49%	R	
111 Clinical Triage Call Back Time (P1)	90%	98.8%	99.1%	97.6%	G	Staff Turnover Rate		Reduction Trend	8.15%	8.02%	8.48%	G	
999 Call Answer Times 95th Percentile	00:06	00:23	00:18	00:22	R	Statutory & Mandatory Training		>85%	84.95%	84.61%	83.65%	A	
Arrest (Purple) Median	6-8 Minutes	07:15	07:15	N/A	G	PADR/Medical Appraisal		>85%	75.53%	75.35%	74.54%	R	
Emerg. (Red) Median	6-8 Minutes	09:15	08:36	N/A	A	Number of Shift Overruns		Reduction Trend	3,501	3,292	3,810	G	
999 Amber 1 Median	00:18	01:25	01:21	01:36	R	<b>Inclusion &amp; Engagement / Culture</b>							
Oncology Journeys arriving within 45 mins and up to 15 minutes after appointment time	70%	77.0%	77.8%	74.5%	G	NEPTS % of Total Calls Answered in Welsh		Increasing Trend	2.00%	1.50%	1.9%	R	
Advanced Discharge & Transfer journeys collected less than 60 minutes after booked time (NEPTS)	90%	79.3%	80.6%	79.8%	R	<b>Value</b>							
<b>Clinical Outcomes / Quality Indicators</b>						Financial balance - annual expenditure YTD as % of budget expenditure YTD		100%	100%	100%	100%	G	
Return of Spontaneous Circulation (ROSC)	Increasing Trend	27.4%	23.7%	20.2%	G	EMS Utilisation Metric (CHARU)		Increasing Trend	25.5%	26.4%	28%	G	
Stroke Patients with Appropriate Care	95%	90.8%	88.5%	85.2%	A	Average Jobs per Shift (All Vehicles)		Increasing Trend	2.36	2.39	2.40	R	
Stroke Call to Hospital Door Times	Reduction Trend	02:27	02:09	02:24	A	NEPTS on the Day Cancellations		Reduction Trend	14.7%	14.3%	13%	G	
ST-Elevation Myocardial Infarction (STEMI) with Appropriate Care	95%	75.9%	67.5%	60.6%	R	<b>Partnerships / System Contribution</b>							
National Reportable Incidents reports (NRI)		3	3	4	TBD	<b>Inverting the Triangle</b>							
Can't Send & Cancelled by Patient Volumes	Reduction Trend	5,822	5,314	8,215	G	Successful Consult & Close Outcome		17.0%	19.1%	18.7%	15.7%	G	
Concerns Response within 30 Days	75%	60%	56%	57%	R	% Of Total Conveyances taken to a Service Other Than a Type One Emergency Department		Increasing Trend	9.55%	10.20%	11.1%	A	
Enactment of the Duty of Candour Total		0	4	5	TBD	Number of Handover Lost Hours		7,500	13,160	12,284	21,093	R	
<b>Our People</b>						<b>NHS111</b>							
<b>Capacity</b>						NHS111 Dental Calls		Increasing Trend	8,920	8,852	8,000	A	
Hours Produced for Emergency Ambulances	95-100%	90%	89%	93%	R	Consult & Close Volumes by NHS111		Increasing Trend	2,365	1,940	1,414	A	

### In-Month RAG Indicates =

Green: Performance is at or has exceeded the target (*Indicates no action is required*)

Amber: Performance is at or within 10% of target (*Indicates some issues/risks to performance (monitoring is required)*)

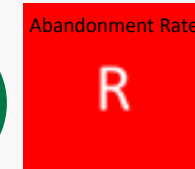
Red: Performance is less than 10% of target (*Indicates close monitoring or significant action is required*)

TBD: Status cannot be calculated (*To Be Determined*)

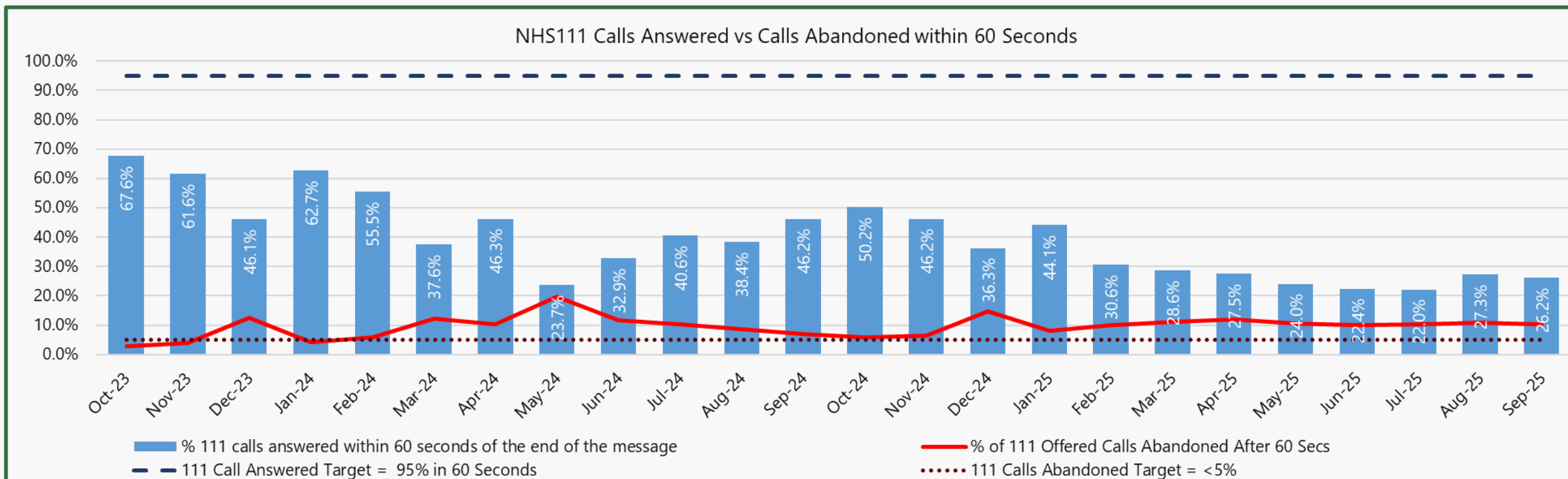
# Our Patients: Quality, Patient Safety & Experience

## 111 Call Answering/Abandoned Performance Indicators

(Responsible Officer: Lee Brooks)



### Influencing Factors – Demand and Call Handling Hours Produced



#### Analysis

The 111-call abandonment rate decreased slightly to 10.4% in September 2025 from 10.8% in August 2025. The percentage of 111 calls answered within 60 seconds decreased from 27.3% in August 2025 to 26.2% in September 2025 and continues to remain significantly below the 95% target and the levels seen during 2024.

This call answer rate of 26.2% in September 2025 is the fourth lowest seen in the past two years and is significantly below the 65.4% recorded in September 2023. This is at a time when UHP capacity for call handlers has increased slightly and is higher than the levels produced in September 2024.

However, the external rostering review suggests there is a demand and capacity gap within the current funded establishment, and the Trust is therefore unlikely to achieve the performance targets without an increased workforce.

#### Remedial Plans and Actions

Key actions include:

Actions have been undertaken to try and improve the call handling resourcing position through the summer; this includes an active recruitment plan.

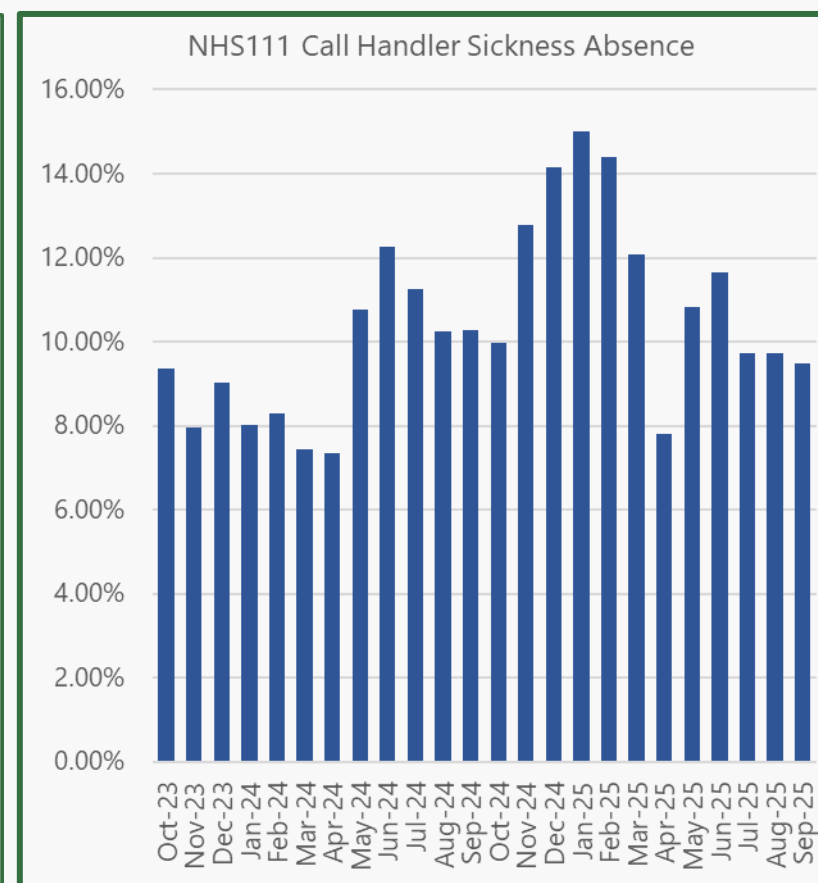
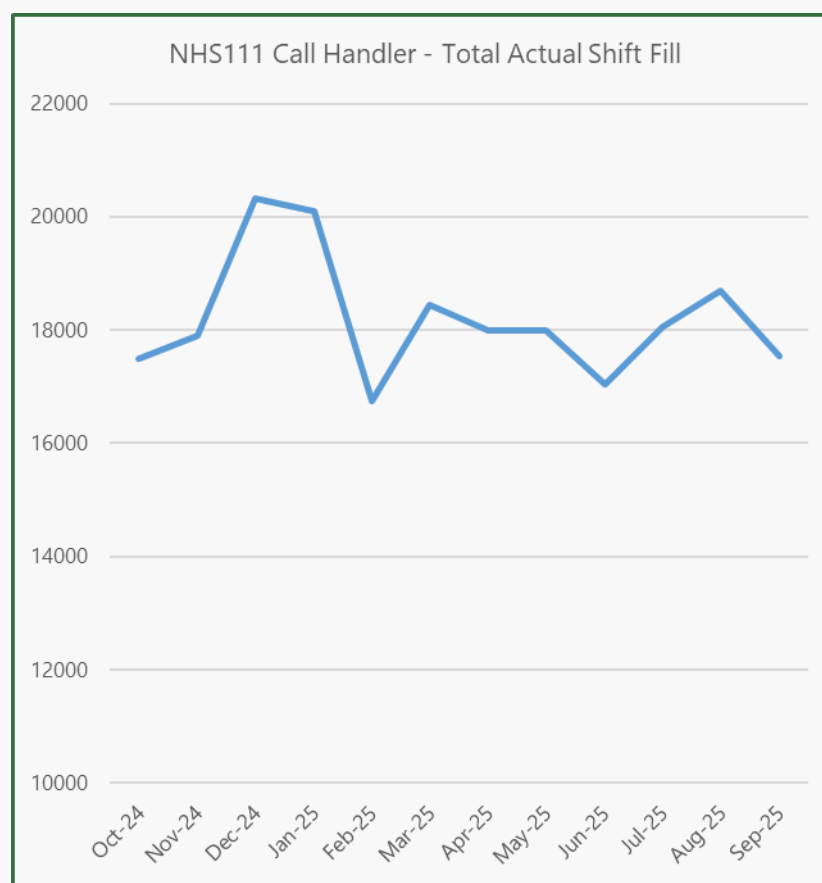
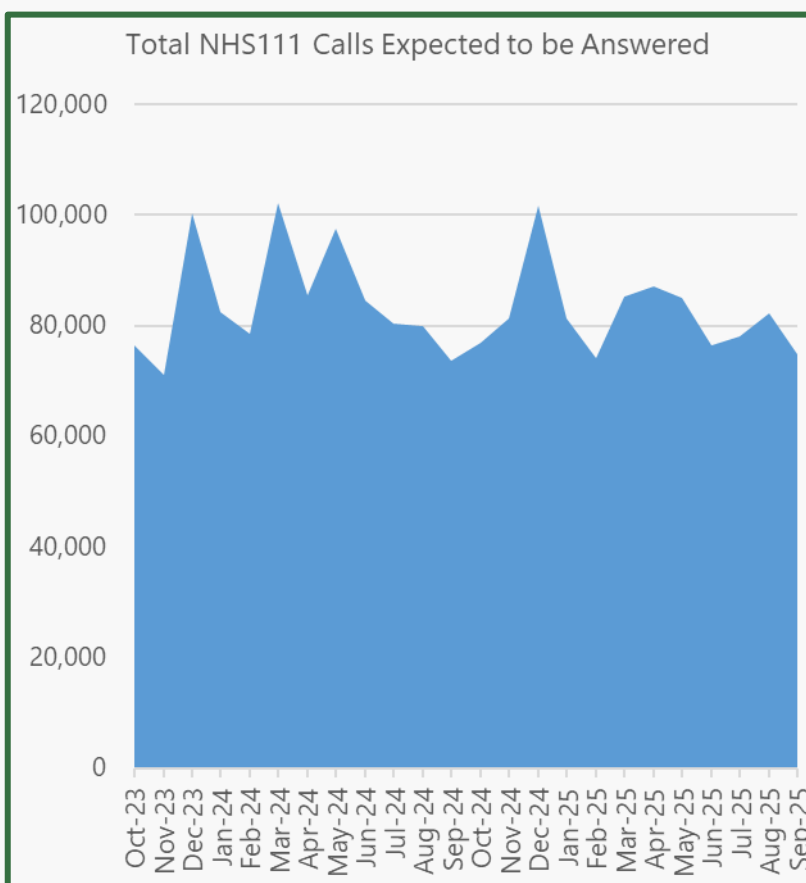
A 111-re-roster review, is underway, that takes account of the increased demand the Trust is seeing; what levels of performance commissioners want and the mix of capacity and efficiencies to achieve this.

The 111-re-roster project is also considered a key response to improving sickness levels i.e. more workable patterns.

Actions are underway to increase the utilisation of virtual queuing and review the way patients who are re-accessing for the same care episode could be managed differently.

#### Expected Performance Trajectory

We would expect to see performance levels improve slightly during the autumn if abstraction levels continue to fall.

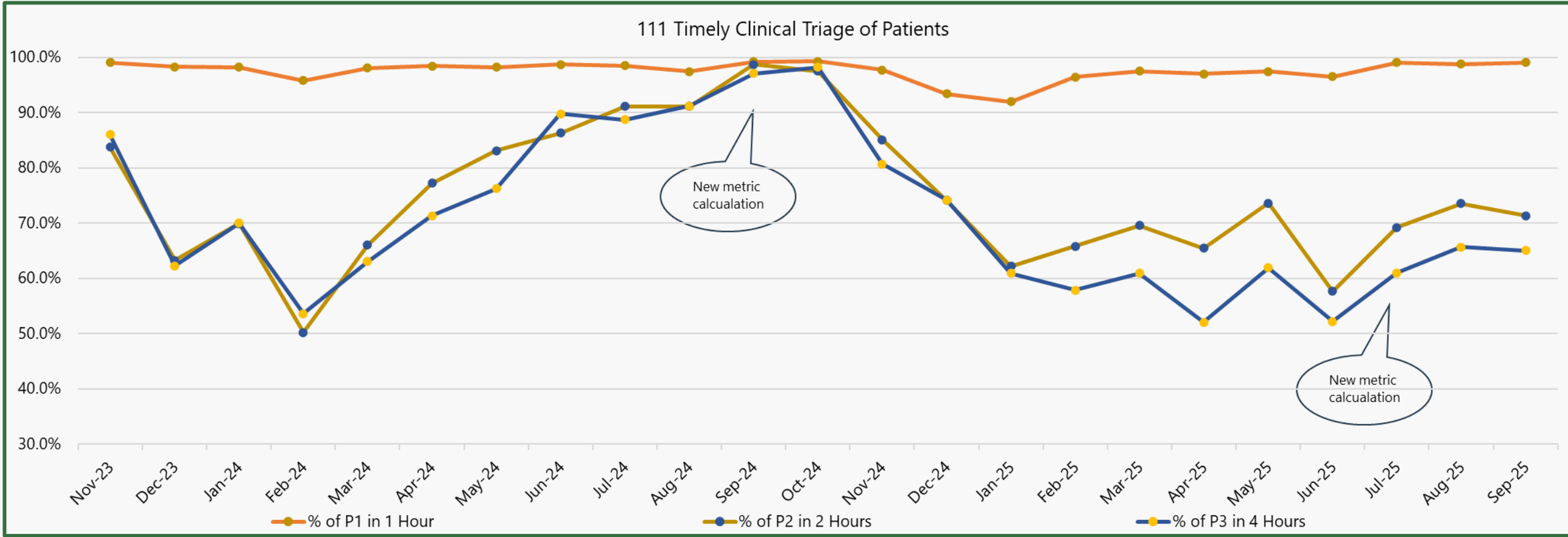
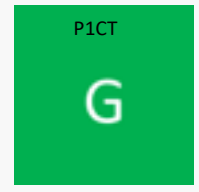


# Our Patients: Quality, Safety & Patient Experience

## 111 Clinical Assessment Start Time Performance Indicators

### Influencing Factors – Demand and Clinical Hours Produced

(Responsible Officer: Lee Brooks)



**Analysis**  
 The highest priority calls, P1CT, achieved the 90% target, recording 99.1% in September 2025.

Ring back times for lower category calls decreased slightly during September 2025, with P2CT calls at 71.4% and P3CT at 65.71%.

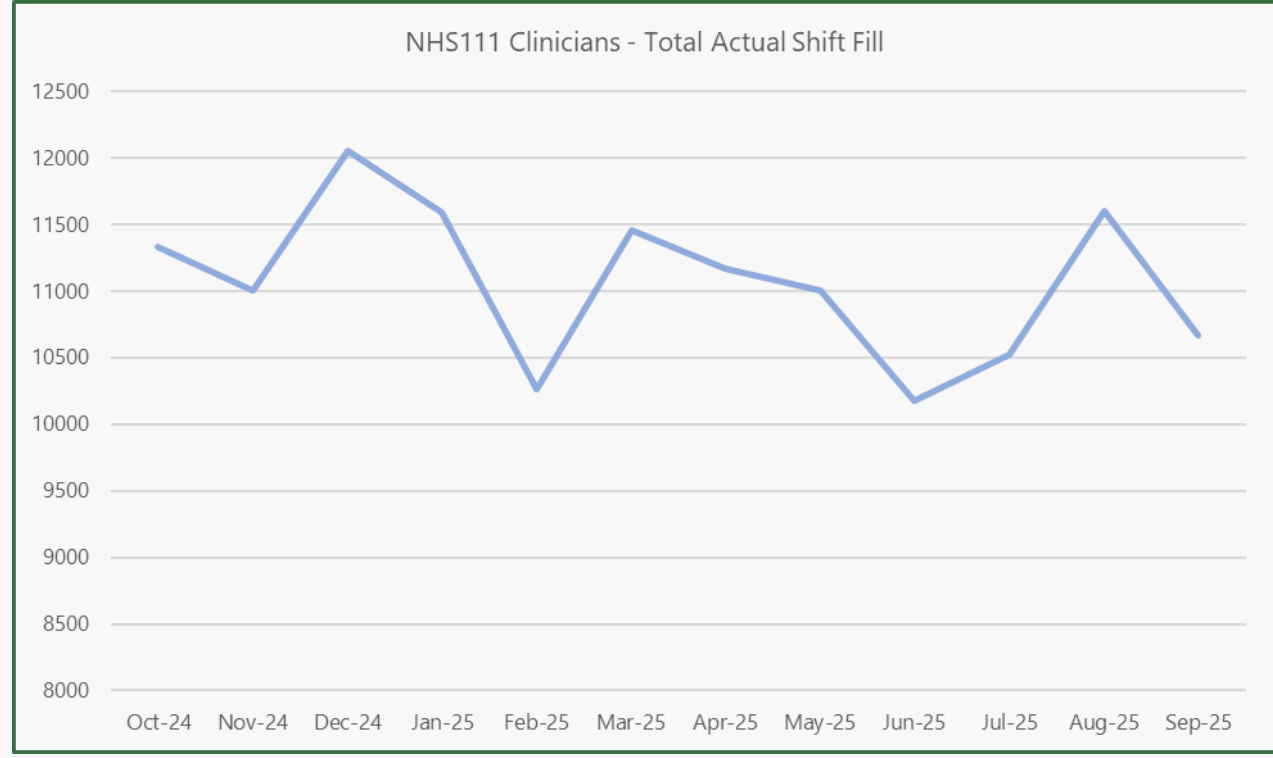
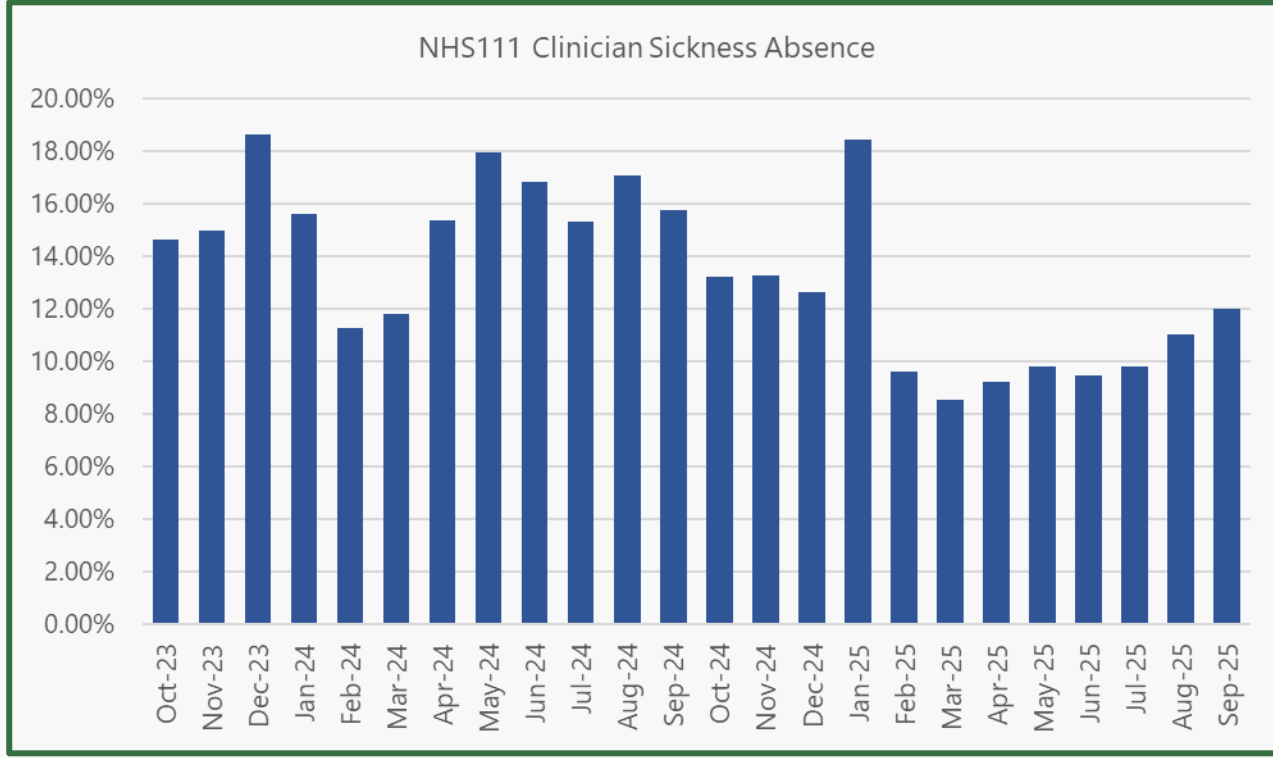
Number of clinician hours produced decreased during September 2025, falling from 11,604 hours in August 2025 to 10,670 hours in September 2025. This is against one less day in the month and they remain consistent with the figure produced for September 2024 (10,688).

**Remedial Plans and Actions**  
 The key actions include:  
 A focus on delivering the benefits of the new 111CAS. A review to determine appropriate levels of capacity to meet increasing demand, including rostering practice (review now live).

This review also considered key to improving clinician sickness absence along with exploring rotation, as part of the Strategic Workforce Plan.

The P1-P3 metric calculation has changed. Previously it was when the Trust called back, now it is when the patient answers.

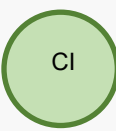
**Expected Performance Trajectory**  
 It is likely we will see performance levels improve slightly during the autumn however the external rostering review suggests there is a demand and capacity gap within the current funded establishment, and the Trust is therefore unlikely to reach performance without an increased workforce.



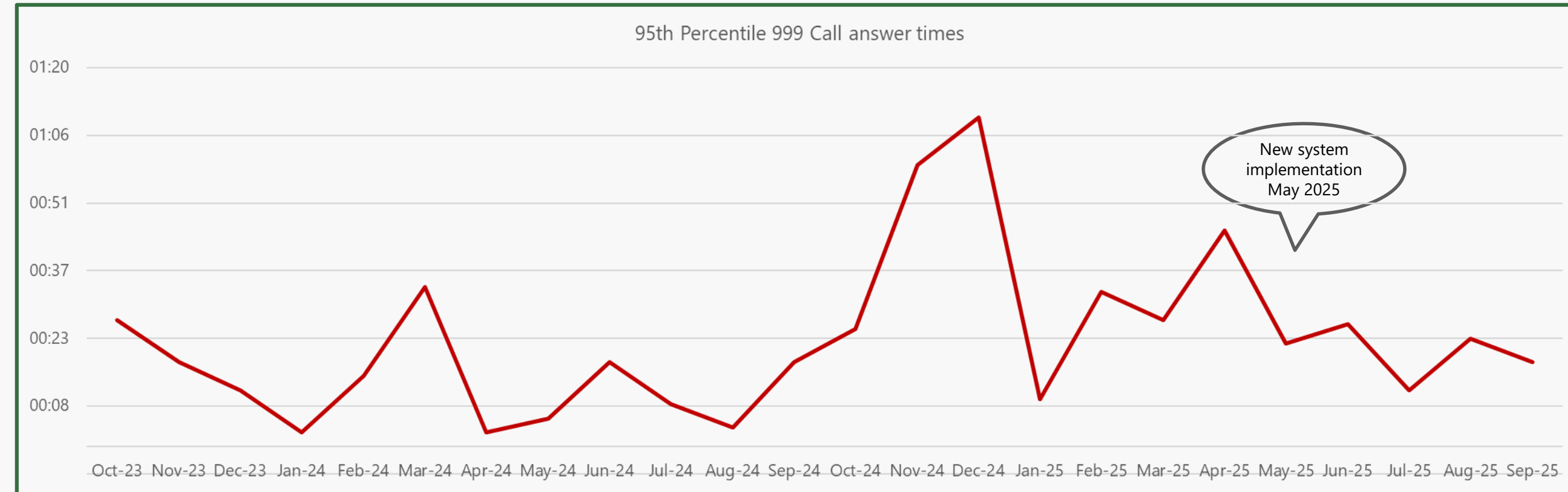
# Our Patients: Quality, Safety & Patient Experience

## 999 Call Performance Indicators

(Responsible Officer: Lee Brooks)



### Influencing Factors – Demand and Hours Produced



#### Analysis

The 95<sup>th</sup> percentile 999 call answering performance decreased to 18 seconds in September 2025 but remained above the 6 second target; however, the median call answer time for the 999-service has been consistently good at 1 second. The new system is now aligned with reporting and is signed off.

There was a decrease in demand during September 2025 to 44,720 calls from 46,955 in August 2025.

Call taker UHP for the month of September was at 88% and all EMSC sickness levels saw a decrease, from 12.14% in August 2025 to 9.07% in September 2025.

#### Remedial Plans and Actions

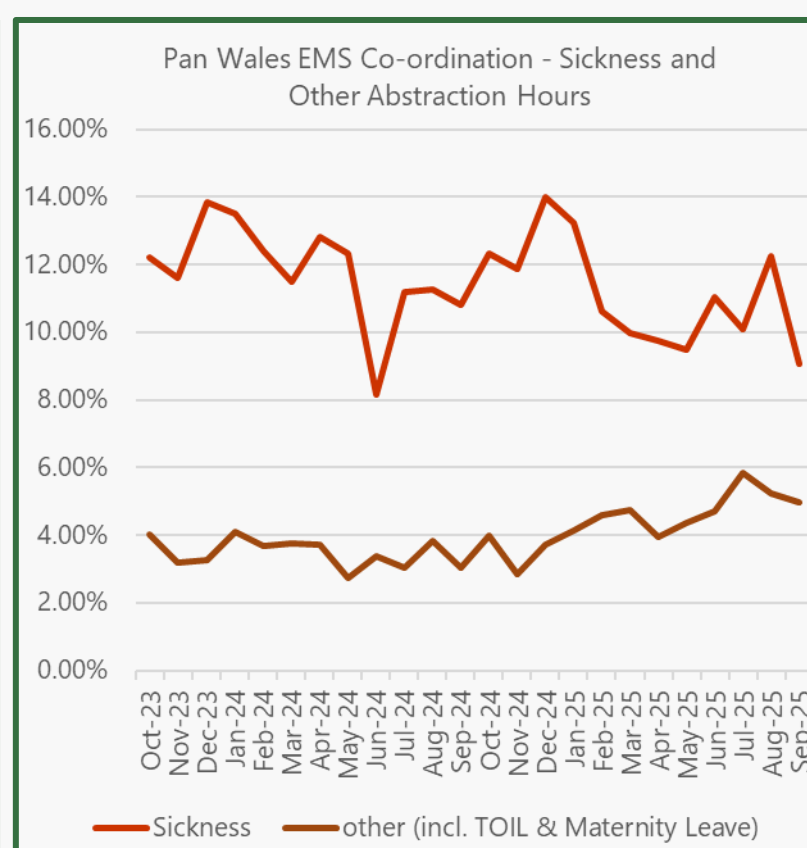
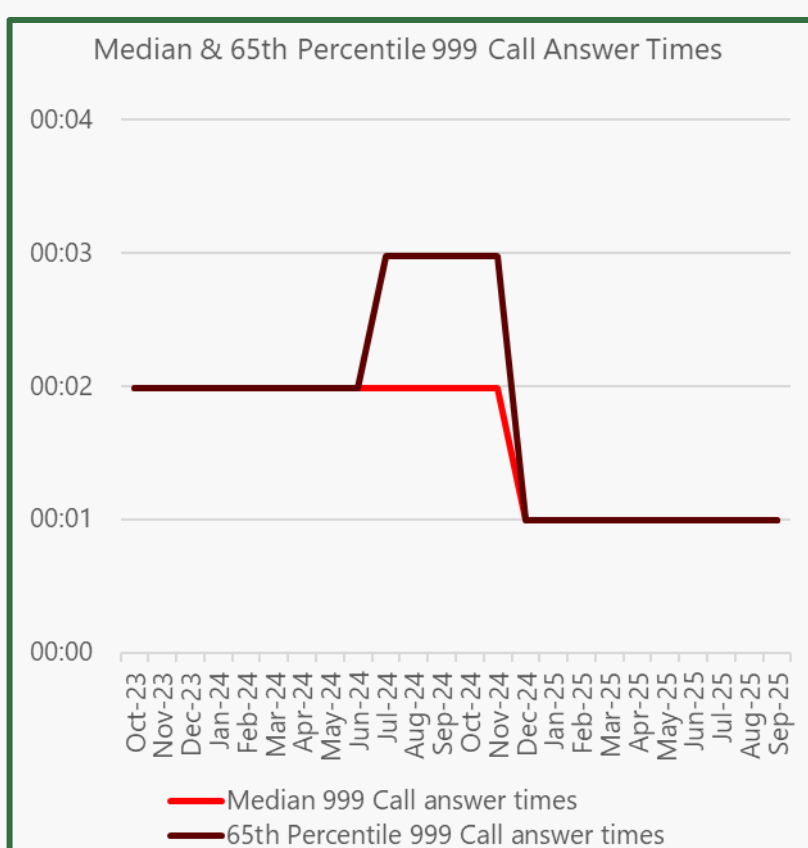
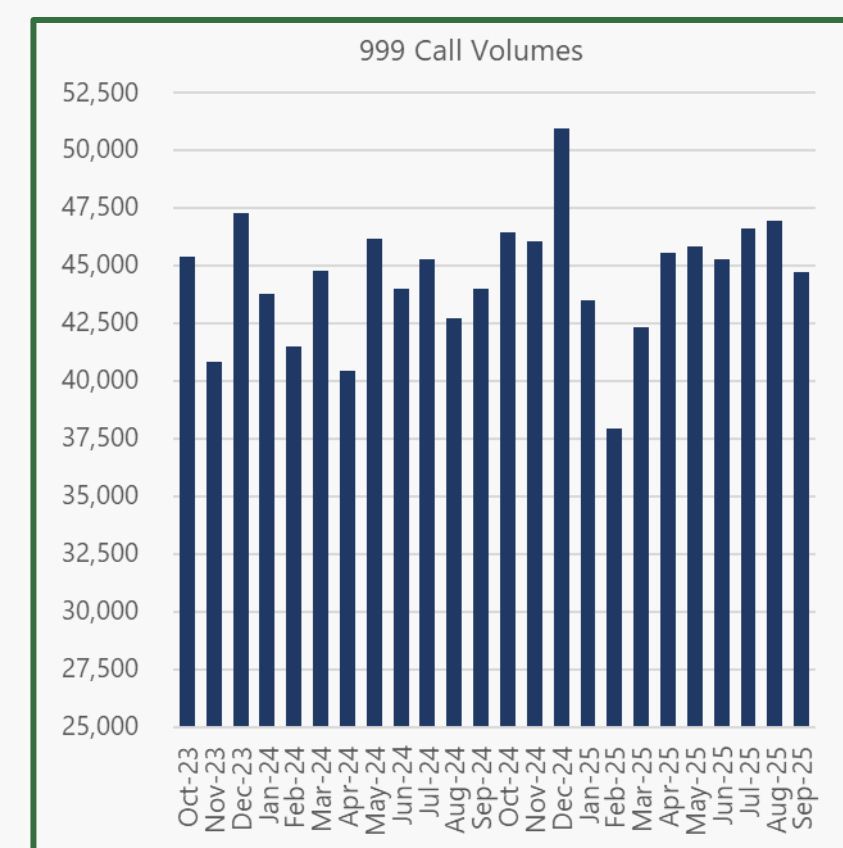
- Currently 2.88 above establishment with EMDs and Call Handlers at 91.88 WTE. A further training cohort will commence on November 3<sup>rd</sup> with two further courses in January and March.
- Work is ongoing to identify what is contributing to high sickness via the Managing Attendance at Work Policy and attrition via the recruitment and selection processes.

Whilst the EMSC transformation programme has concluded, there are various follow up actions:

- There is feedback from EMS that the new dispatch boundaries are adversely affecting performance, particularly within the South-East region. Further analysis of this issue is currently being undertaken.
- The Executive Director of Operations has asked for some additional modelling on EMD capacity. Capacity was not increased through the transformation programme but is an area of interest.
- There is a need to keep under review the consequences on allocators of changing/increasing resources e.g. APPs, Falls Resource etc.

#### Expected Performance Trajectory

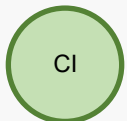
The median and 65<sup>th</sup> percentile are performing very well and are stable. Paper currently to be drafted on future resilience of EMSC i.e. winter demand v capacity (with efficiencies).



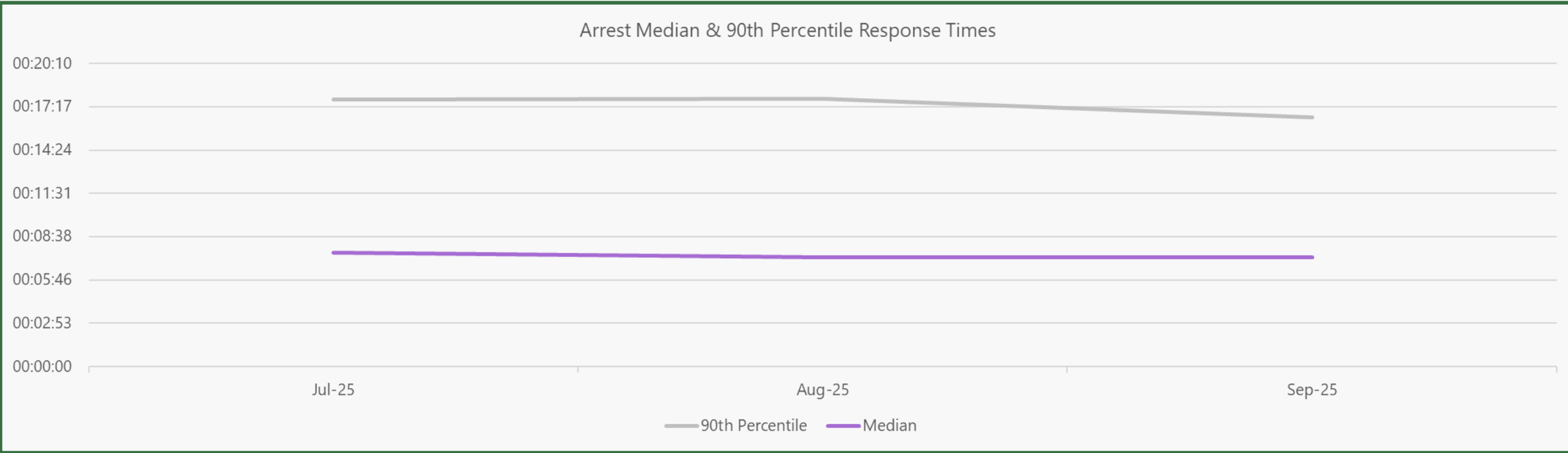
# Our Patients: Quality, Safety & Patient Experience

## Arrest Purple Performance Indicators

Influencing Factors – Demand, Hours Produced and Hours Lost



(Responsible Officer: Lee Brooks)



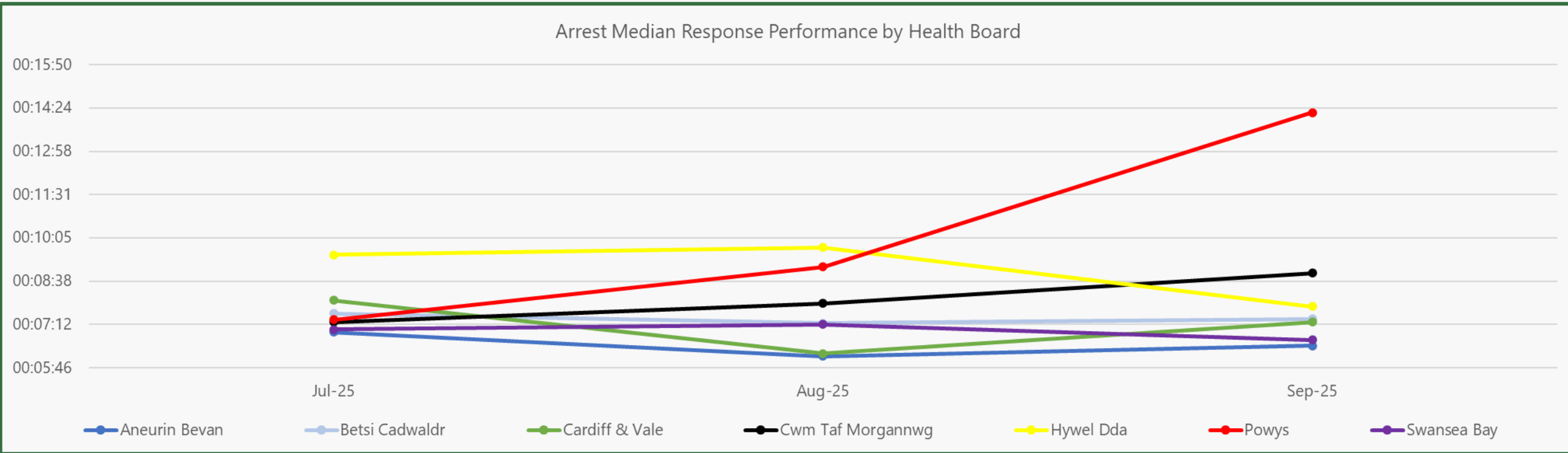
**Analysis**  
 On 1 July, our new ambulance response model was implemented, and two new response categories replaced the previous (old) Red category. The new categories are Arrest (Purple), for cardiac and respiratory arrests, and Emergency (Red), for major trauma and other incidents where patients are at significant risk of cardiac or respiratory arrest if they do not receive a rapid response.

In September there were 785 Arrest calls received, making up 2.31% of all calls.

The median response times for Arrest remained at 7 minutes 15 seconds. Aneurin Bevan had the lowest median time of 6 minutes and 30 seconds, and Powys had the highest at 14 minutes and 15 seconds, although this is against relatively low numbers and in quite rural locations.

The 90th percentile response time for Arrest calls was 16 minutes 35 seconds. Swansea Bay had the lowest time of 13 minutes and 11 seconds, and Powys had the highest at 26 minutes and 48 seconds.

For both Arrest and Emerg calls the median and 90th percentile response time targets are 6-8 minutes and 20 minutes, respectively.

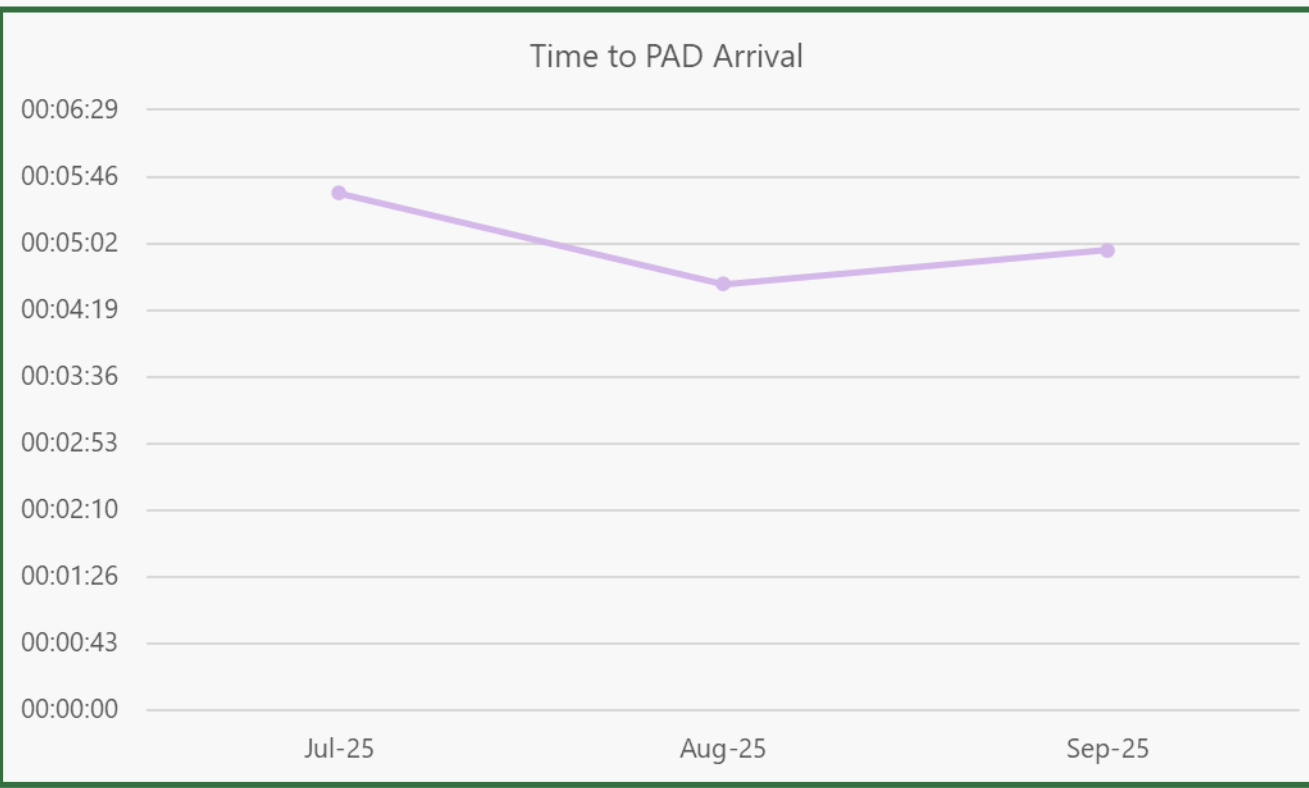
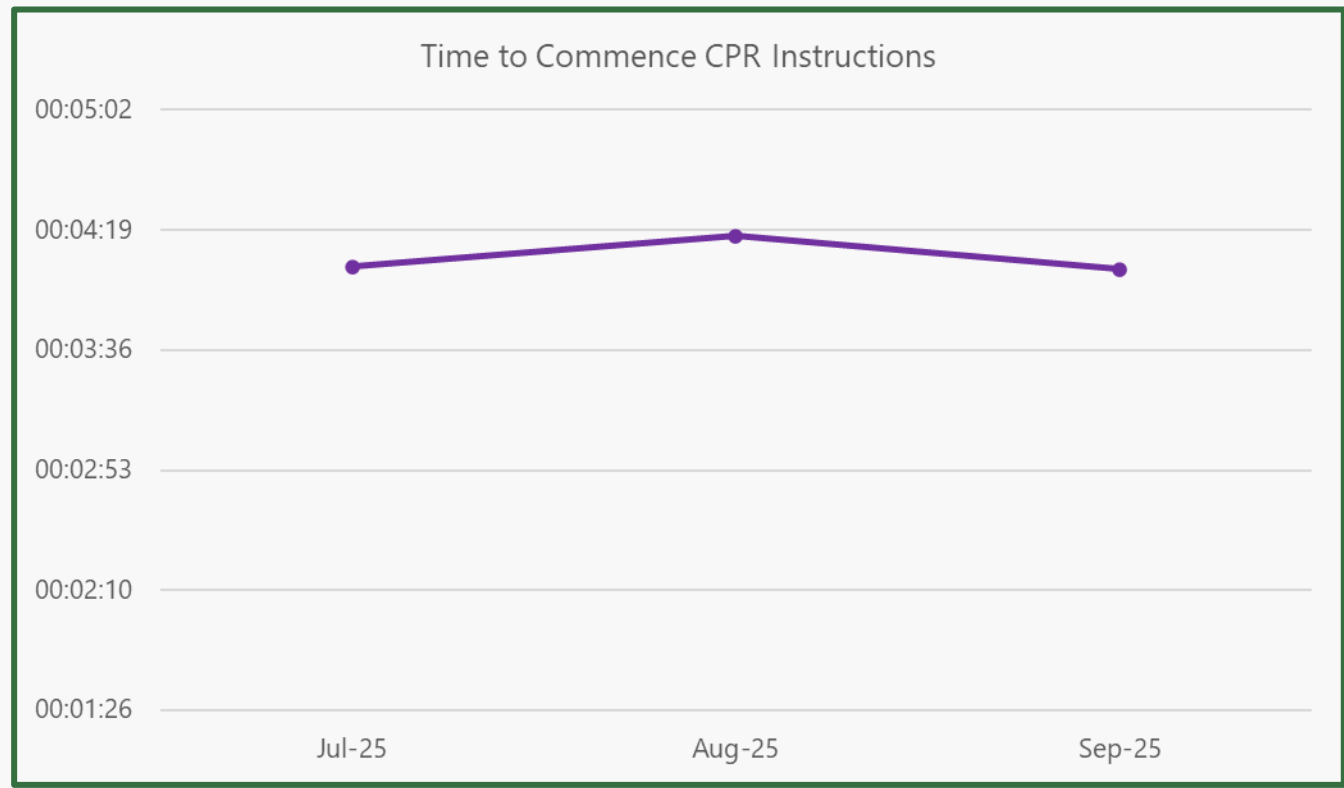
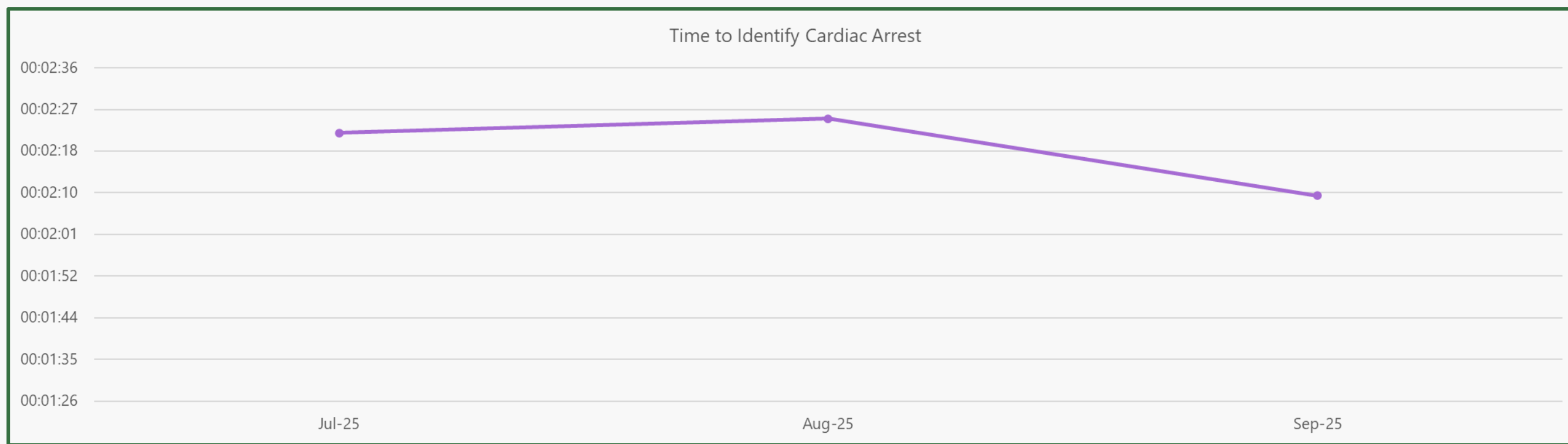
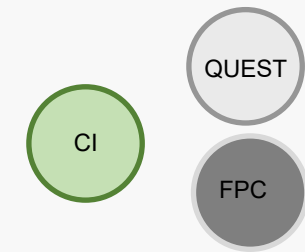


# Our Patients: Quality, Safety & Patient Experience

## Arrest Purple Performance Indicators

Influencing Factors – Demand, Hours Produced and Hours Lost

(Responsible Officer: Lee Brooks)



**Analysis**

As part of the go live on Arrest (Purple) more measures have been introduced to help better understand and manage the chain of survival.

In September 2025, the:  
Average Median time to identify cardiac arrest was 2 minutes and 9 seconds.

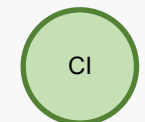
Average Median time to commence CPR instructions was 4 minutes and 5 seconds.

Average (Median) time for a defibrillator (PAD) arrival at scene was 4 minutes and 58 seconds. An improvement from August (5 minutes and 58 seconds).

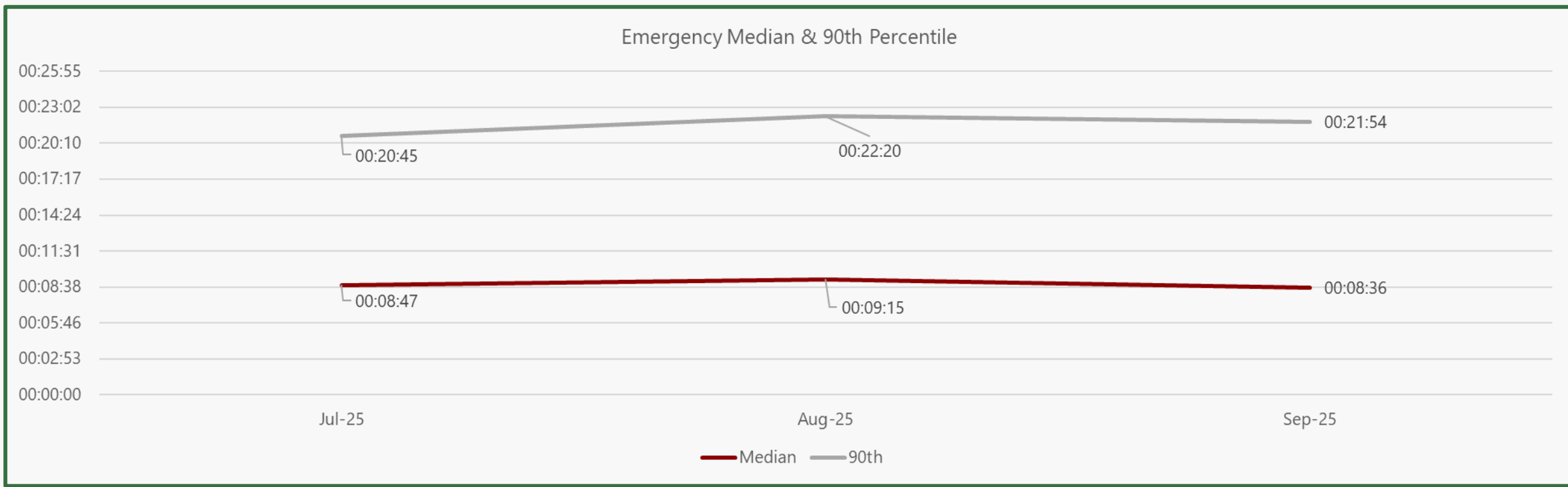
# Our Patients: Quality, Safety & Patient Experience

## RED EMERG Performance Indicators

Influencing Factors – Demand, Hours Produced and Hours Lost



(Responsible Officer: Lee Brooks)



**Analysis**

In September 2025 there were 4,453 Emerg (Red) calls, around 13.1% of all calls.

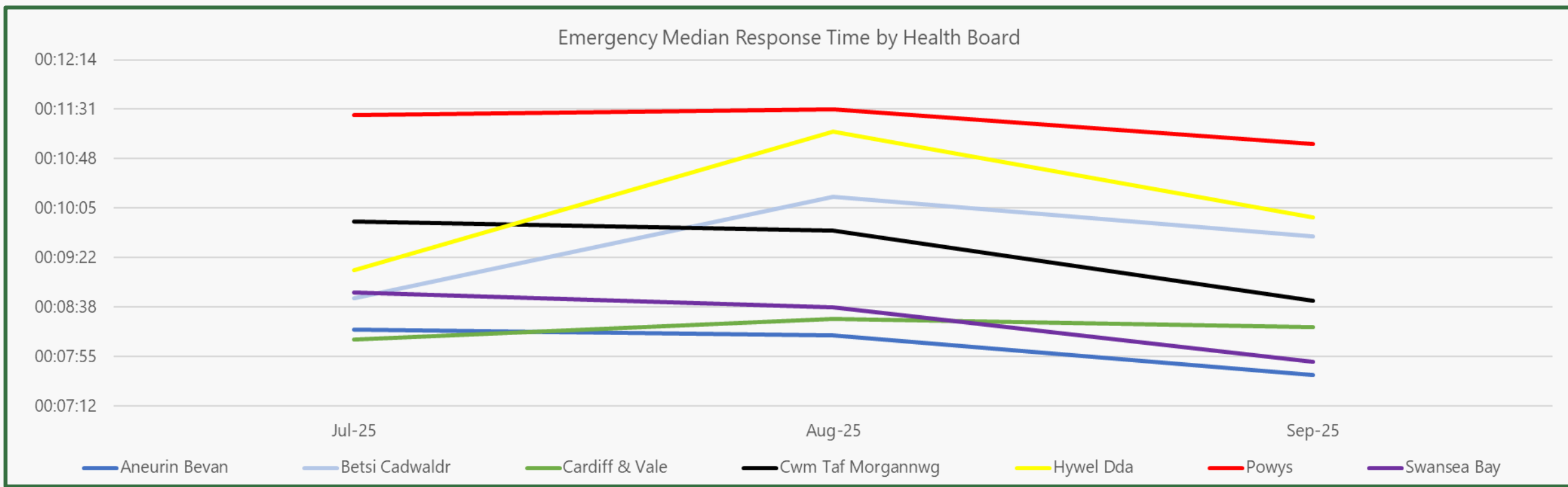
The median response time in September 2025 for Emerg incidents was 8 minutes 36 seconds. Aneurin Bevan health board had the lowest median time of 7 minutes and 39 seconds, and Powys had the highest at 11 minutes and 1 second.

For Emerg calls, the 90th percentile response time was 21 minutes 25 seconds. Swansea Bay had the lowest time of 16 minutes and 24 seconds, and Powys had the highest at 31 minutes and 21 seconds.

For both Arrest and Emerg calls the median and 90th percentile response time targets are 6-8 minutes and 20 minutes, respectively.

**Remedial Plans & Actions**

Arrest is performing better than the Trust modelled, but Emergency performance is worse than the Trust modelled. A small divergence between them was expected, but the divergence is bigger than expected. The Trust is currently undertaking a deep dive on its month one data to look at what may be causing this.



# Our Patients: Quality, Safety & Patient Experience

## Amber Performance Indicators

### Influencing Factors – Demand, Hours Produced and Hours Lost

(Responsible Officer: Lee Brooks)

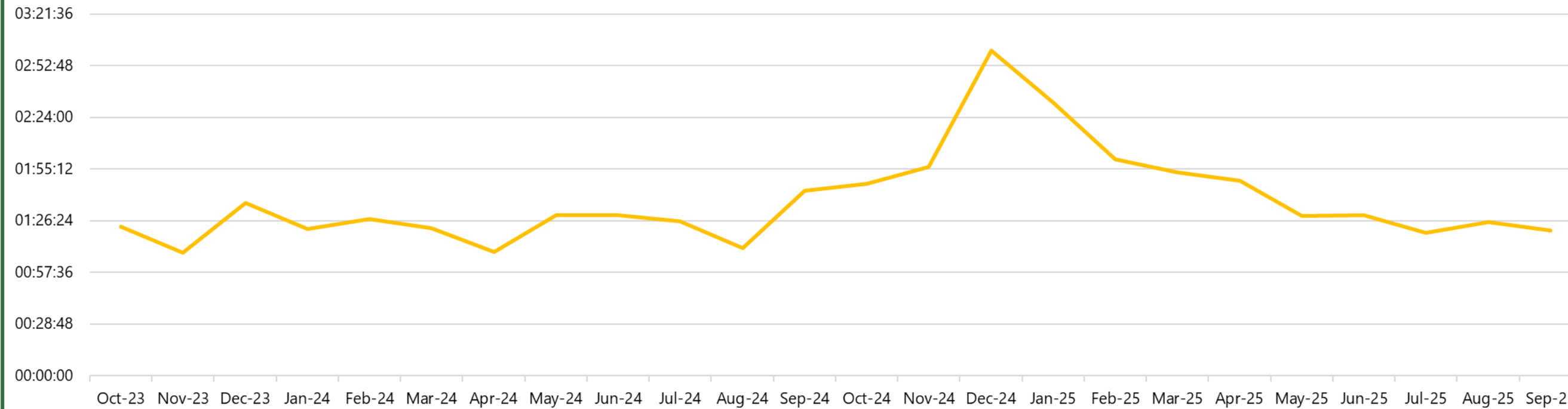
R

CI

FPC

QUEST

Amber 1 - Median



#### Analysis

The Amber 1 median performance time decreased during September 2025 to 1 hour and 21 minutes. The ideal Amber 1 median response time remains at 18 minutes.

The Amber 1 95<sup>th</sup> percentile also decreased during September 2025 to 4 hours 52 minutes, down from 5 hours 9 minutes in August 2025. This time remains below the 2-year average figure of 7 hours 3 minutes.

There is a strong correlation between Amber performance and lost hours due to handover delays, so if handover rates continue to remain below the 3-year average it would be expected that Amber 1 median response rates will continue to improve.

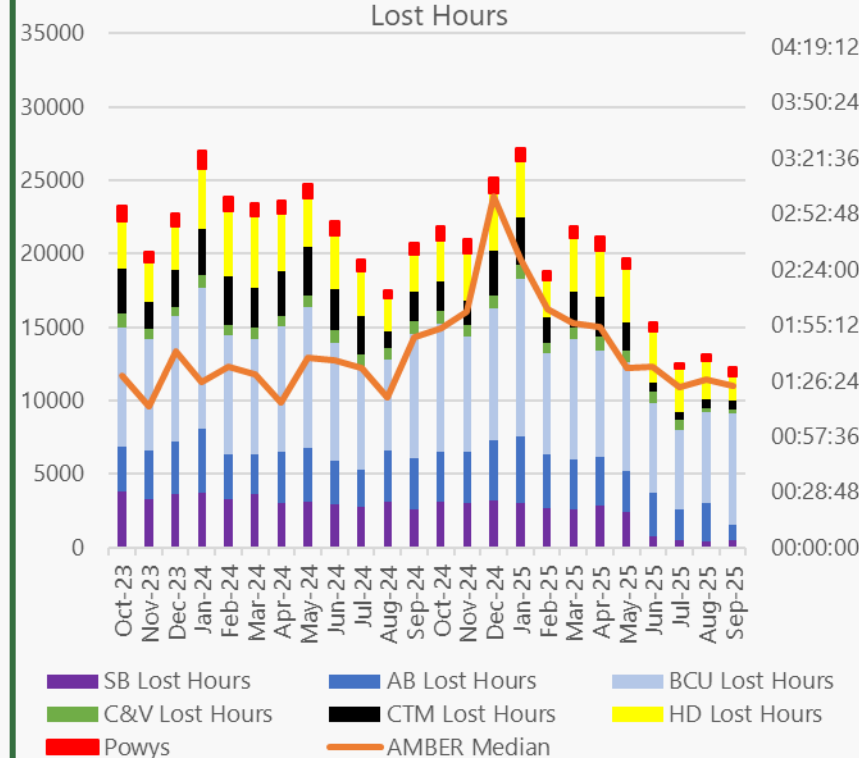
#### Remedial Plans and Actions

Welsh Government has recently announced further changes to the Ambulance Performance Framework that will affect the existing Amber category, which will be replaced by Orange (now) and Yellow (soon).

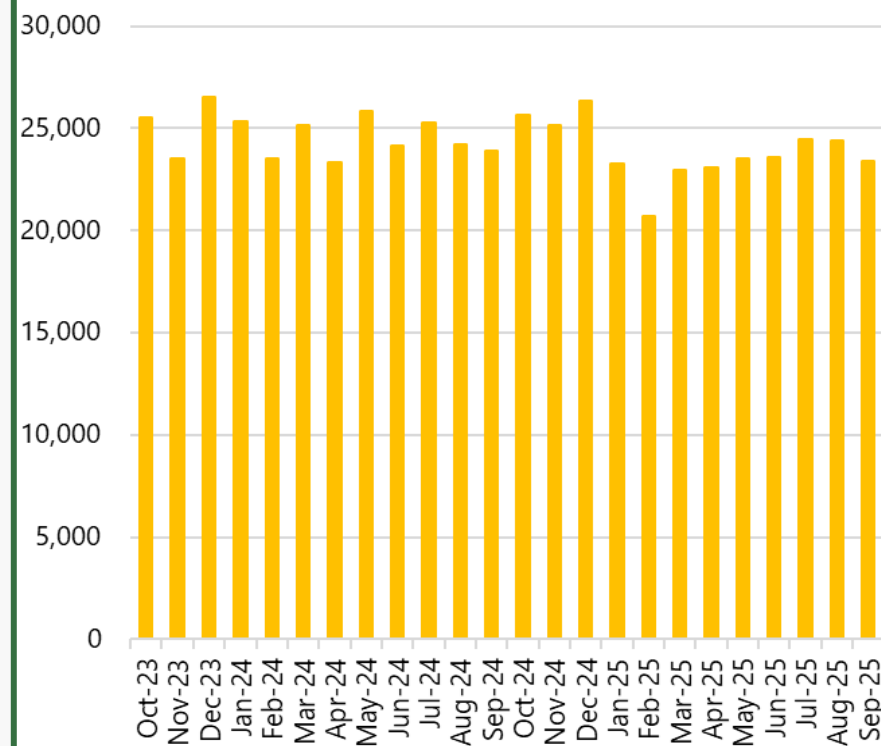
#### Expected Performance Trajectory

The Trust's commissioned level of production (its rosters) is designed to cope with 6,000 hours of handover lost hours. The Trust is now part of a WG led meeting on how handover can be reduced with a recommendation to reduce handover waits to 45 minutes. Reduced handover lost hours is a critical element of improving patient safety in this category.

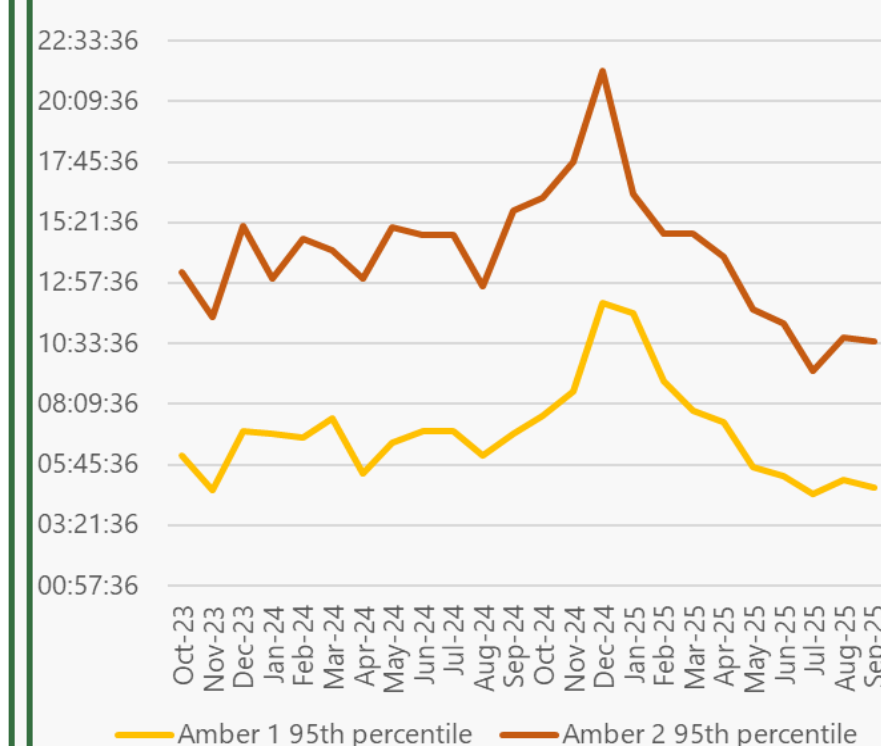
Amber Median Response Times against Handover Lost Hours



Amber Demand



Amber 1 & 2 - 95th Percentile



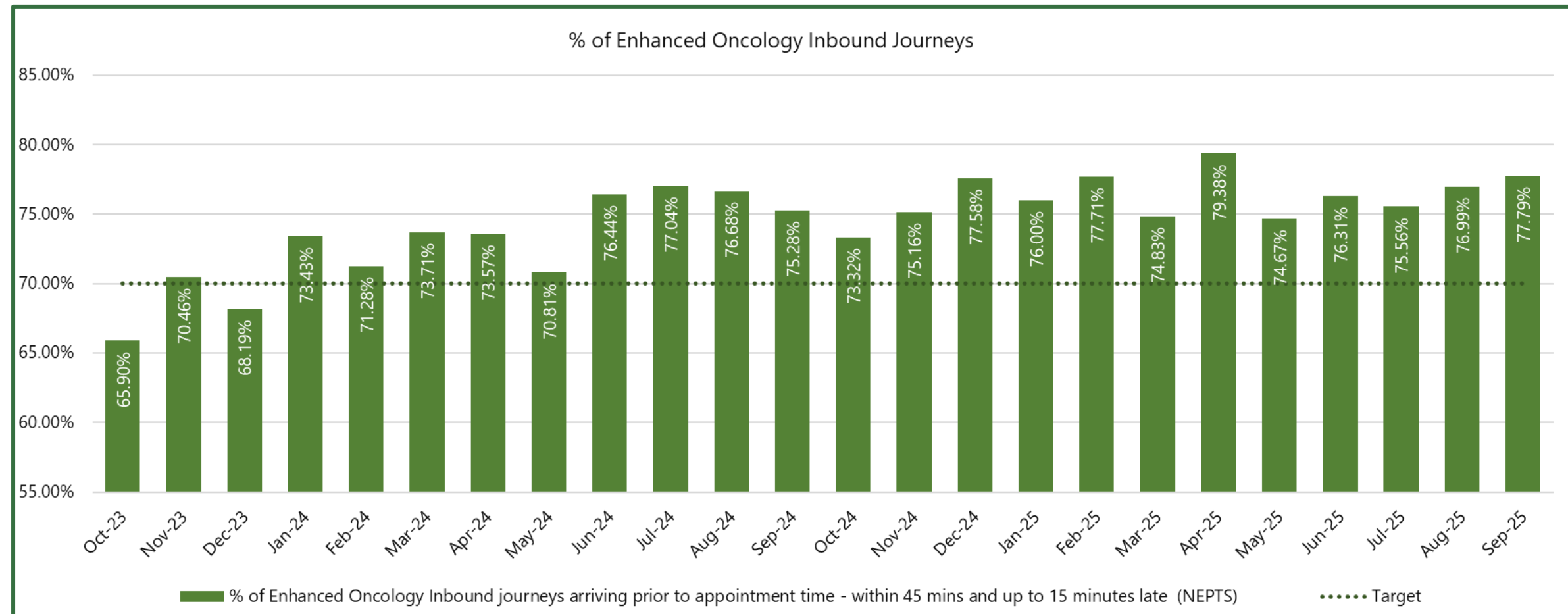
# Our Patients: Quality, Safety & Patient Experience

## Patient Experience – Influencing Ambulance Care Indicators

(Responsible Officer: Lee Brooks)

D&T	Oncology	Welsh Calls
R	G	R

FPC
CI



### Analysis

77.8% of enhanced Oncology journeys arrived within 45 minutes prior and up to 15 minutes late of their appointment time in September 2025, once again achieving the 70% target.

Discharge and Transfer journeys booked in advance and collected less than 60 minutes after their appointment increased in September 2025 to 81% and remain below the 95% target. Discharge and Transfer journeys booked on the same day achieved 94% in September 2025, remaining just below the target (95%).

Renal journeys arriving within 30 minutes prior to their appointment time increased from 69.21% in August 2025 to 71.21% in September 2025 and marginally achieved the agreed performance standard of 70%.

Call volumes answered increased to 14,869 calls during September 2025, from 14,629 in August 2025; but the average speed of call answering improved from 7 minutes 30 seconds to 3 minutes.

ACA1 sickness remains above the 5.99% target, at 12.12% and ACA2 sickness also remains above the 5.99% target at 6.88% in July 2025.

### Remedial Plans and Actions

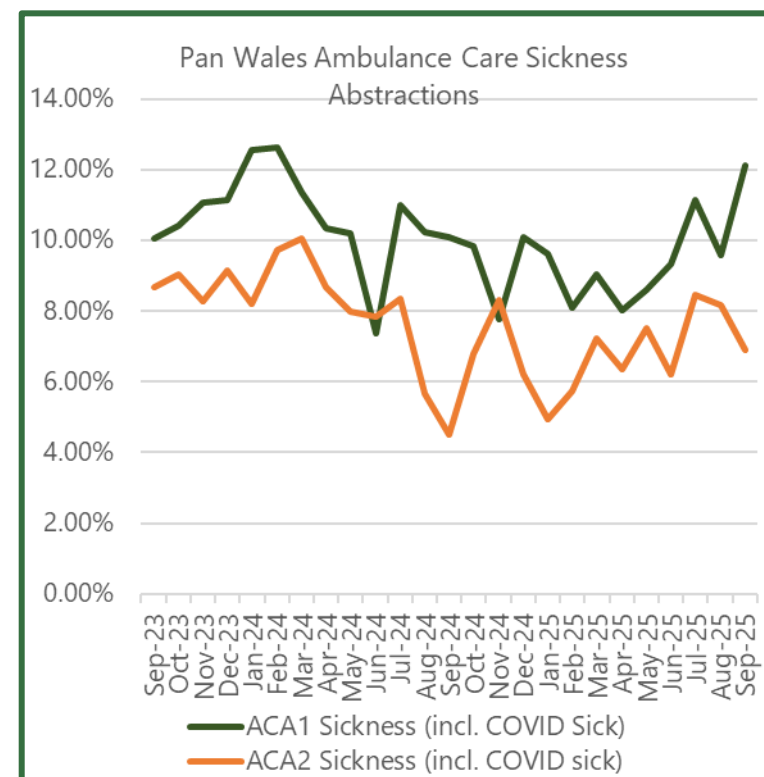
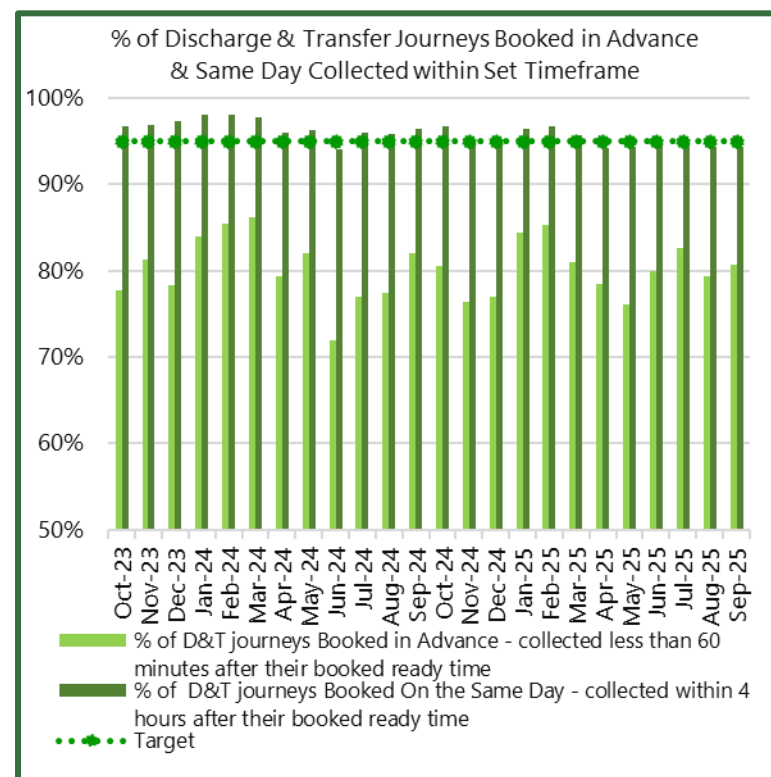
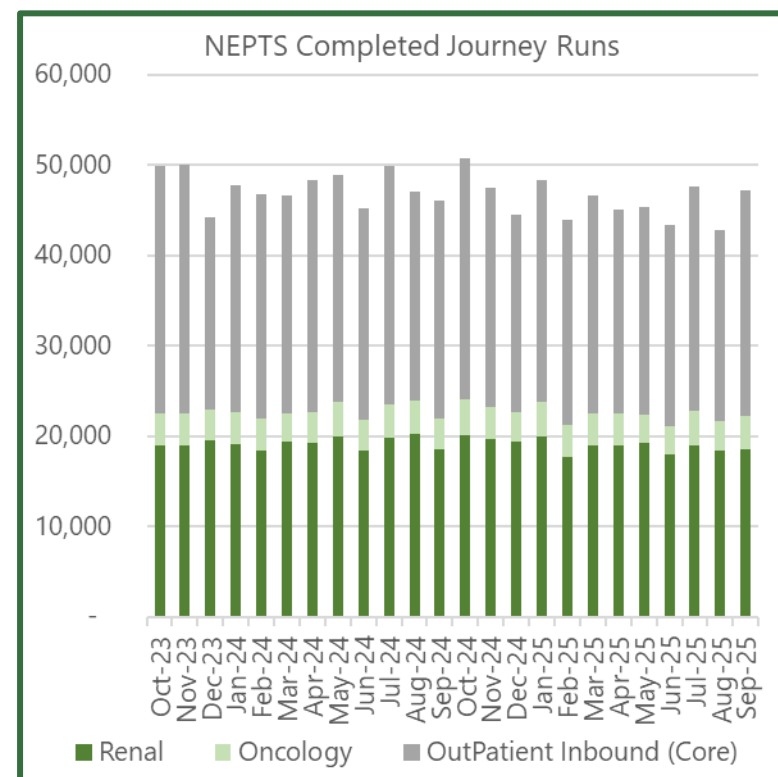
Oncology performance continues to be in excess of the service standards nationally, however there is some regional variation to this. Work continues in the areas where performance is lower to address the underlying reasons for this. The renal hub has now transitioned to also cover oncology journeys, and we anticipate that this will positively impact upon patient experience

Performance on advanced discharges and transfers has been challenged through the quarter. This has been addressed by the team and has begun to recover. It is important to note that this measure was always deemed aspirational and requires a shift in booking practice by Health Boards for this to be achieved.

Sickness levels have seen an increase trend during the quarter, with short term sickness proving most challenging. Actions have been put in place across the service areas to increase focus on this area.

### Expected Performance Trajectory

An improvement to sickness absence levels and advanced discharge and transfer is anticipated within the next quarter. Oncology performance is above the standard nationally and expected to sustain this.



# Our Patients: Quality, Safety & Patient Experience

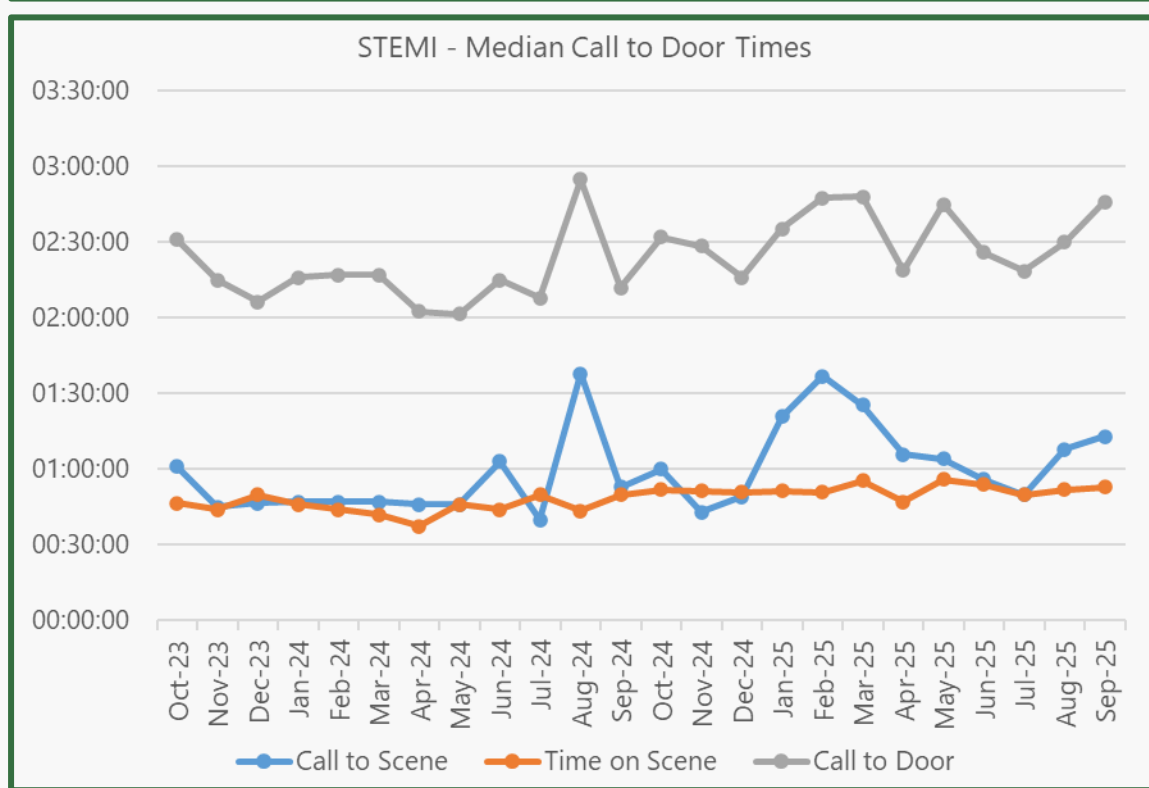
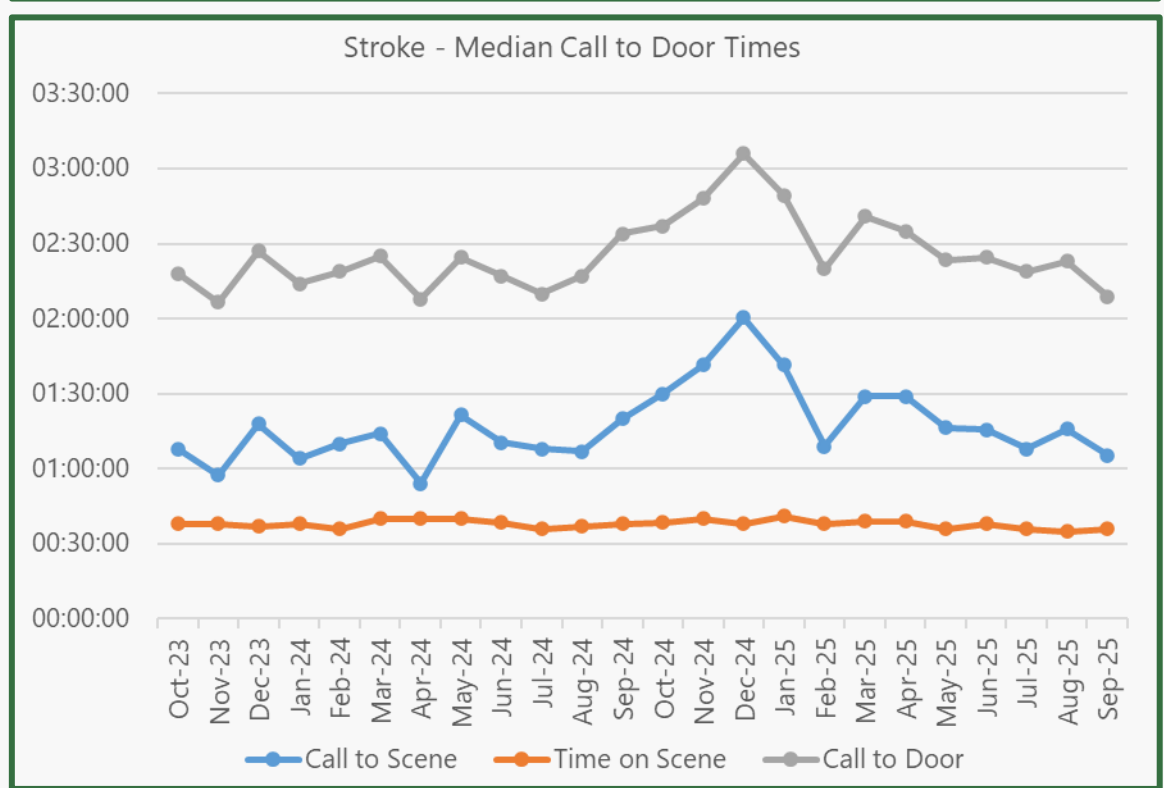
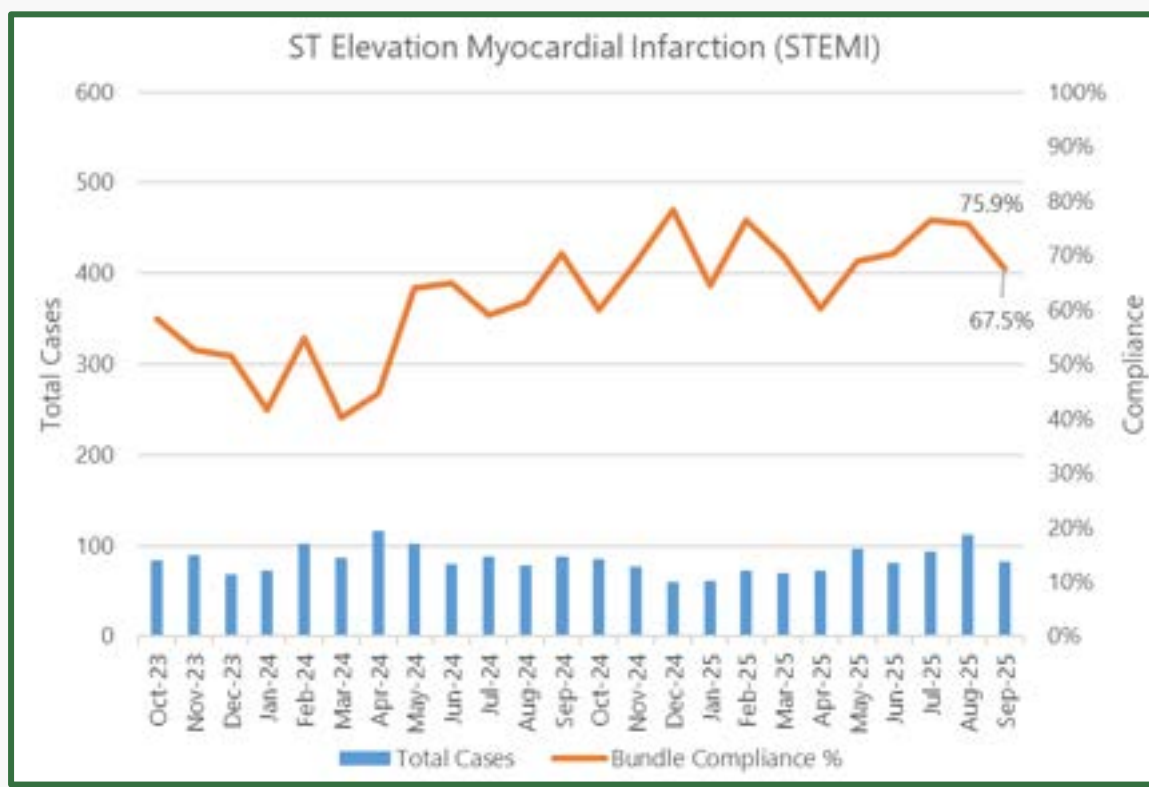
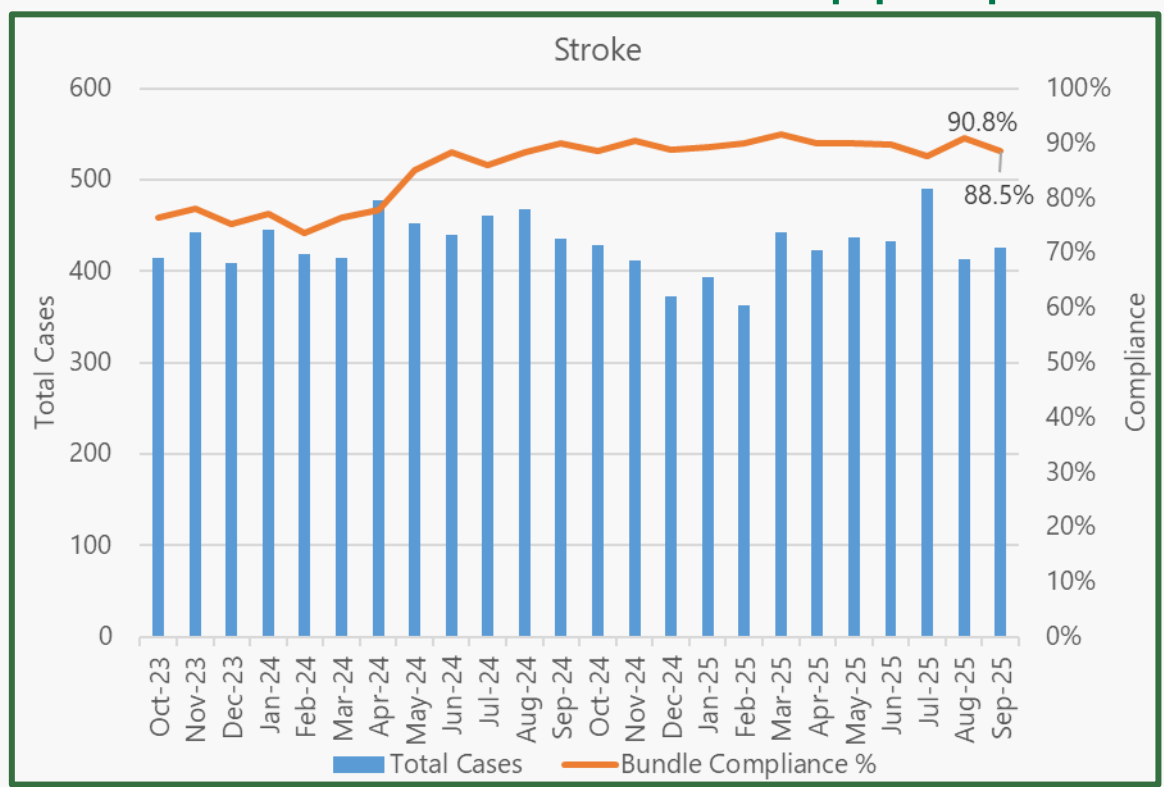
## Clinical Indicators

Suspected Stroke Patients with Appropriate Care, ST-elevation myocardial infarction (STEMI) with Appropriate Care and Time-Based metrics.

Stroke	Stroke Call to Door	STEMI	Self-Assessment: Strength of Internal Control: Moderate
A	A	R	

(Responsible Officer: Andy Swinburn)

QUEST



**Analysis:**  
The percentage of patients documented as receiving appropriate care bundles during September 2025 was:

**Stroke – 88.5% - performance has consistently remained at or above 85% since May 2024.** There is a close correlation between documenting FAST (a test to detect symptoms of stroke) and care bundle compliance.

**STEMI (heart attack) – 67.5%, a decrease from 75.9% in August 2025.** There has been a decrease in compliance across all elements of the care bundle. The number of cases remained low (83) therefore, increasing the volatility of the compliance data so this could be natural variance.

**Call to door times for Stroke** – call to door times decreased marginally for stroke in September (02:09:00). All three elements of the bundle have seen consistency on time.

**Call to door times for STEMI** – Call to door time has increased since last month, with this being driven by a rise in call to scene times (02:46:00).

**Remedial Plans and Actions**

- A recovery plan implemented from April – September 2024 and remains BAU monitored through CIAG to maintain the improvements:
- Continued focus on communication with clinicians to use the bespoke electronic Patient Clinical Record fields (in addition to the narrative).
- Provided weekly non-compliant data to support Senior Paramedics conversations with clinicians to improve compliance.
- Promoted Clinical Indicators, care bundles and electronic Patient Clinical Record completion at Health Board area focussed workshops.
- Review of the ePCR interface led by the Digital Directorate.
- Ongoing development of the Tennant Structure within ePCR to facilitate clinical feedback to clinicians.

**Expected Performance Trajectory**  
As a result of the work from the CI Recovery Group T&F group and the ongoing improvement interventions, a continued increase in compliance rates is expected and will be monitored by the Clinical Intelligence & Assurance Group.

# Our Patients: Quality, Safety & Patient Experience

## Clinical Indicators

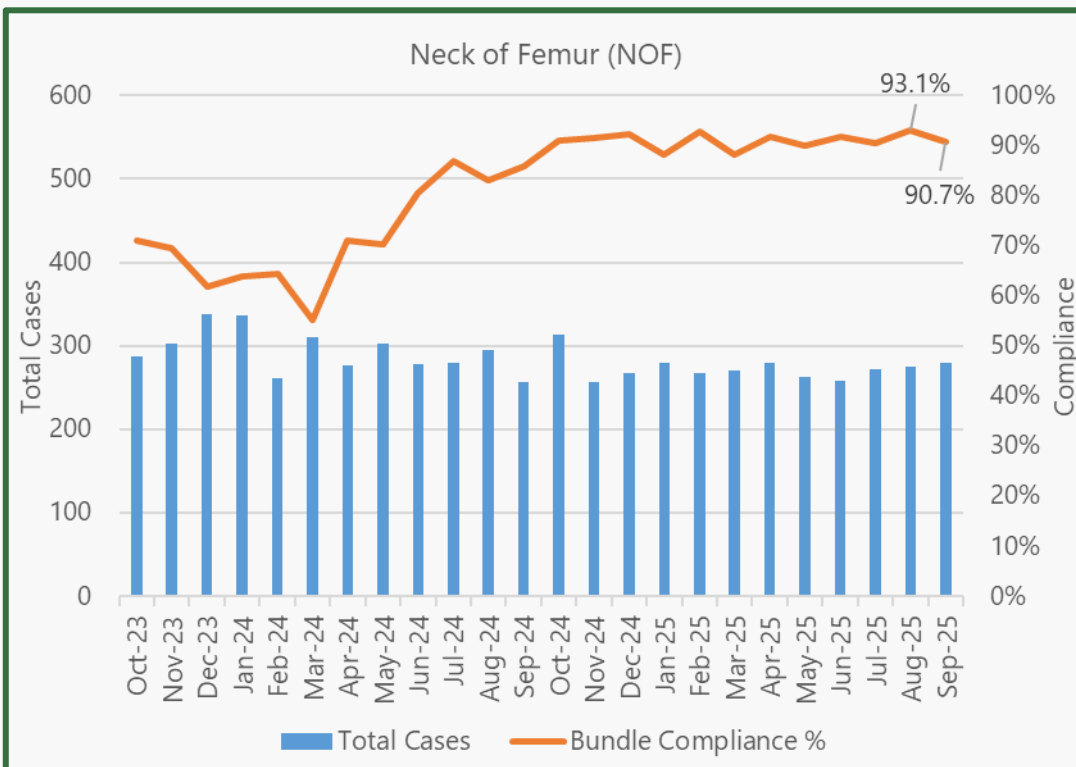
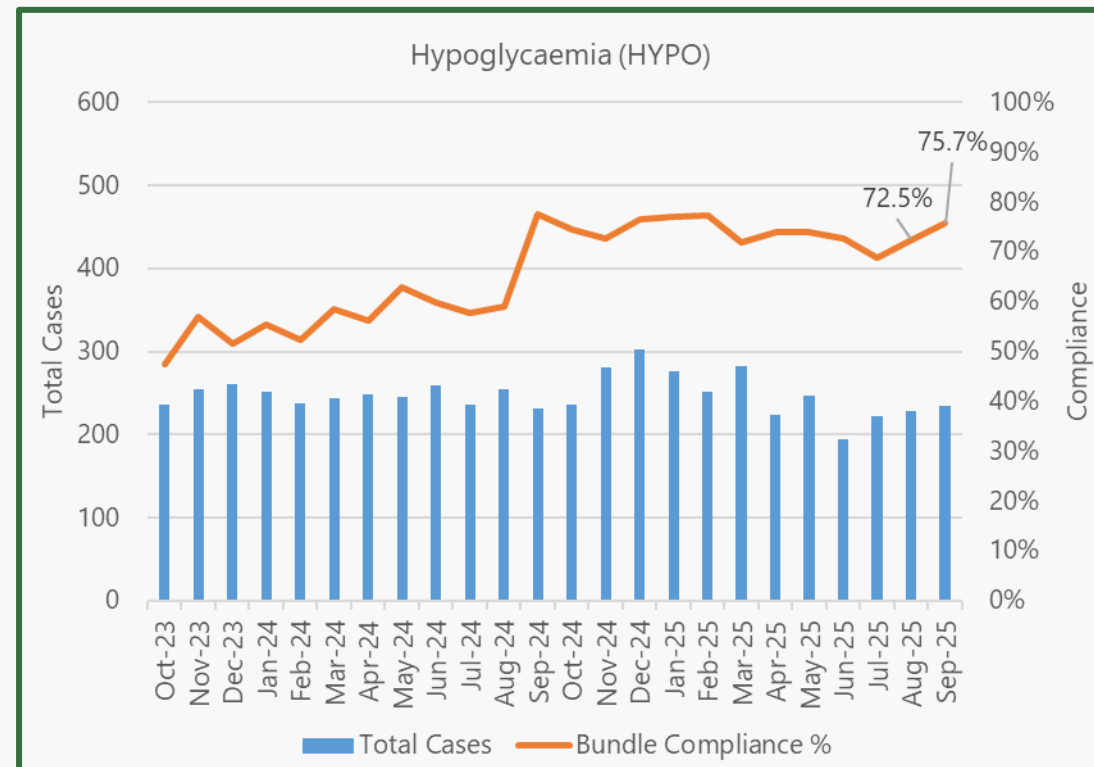
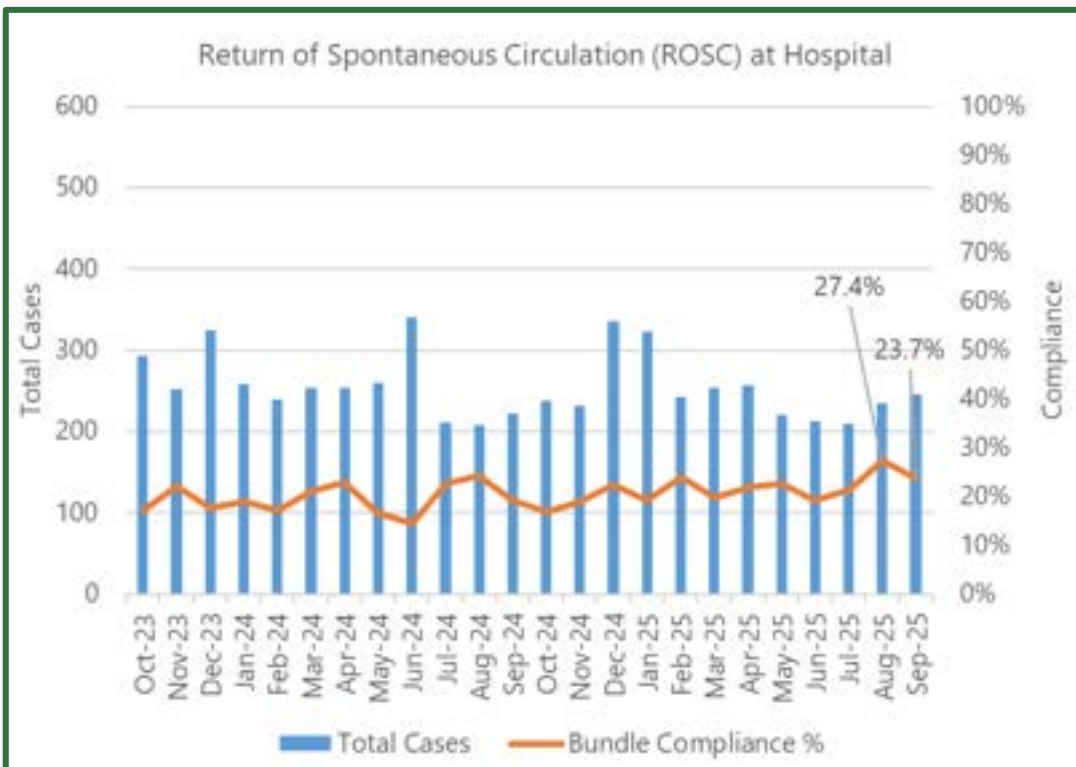
Return of Spontaneous Circulation, Hypoglycaemia, Fractured Neck of Femur (#NOF) and Time-Based metrics (#NOF)



Self-Assessment:  
Strength of Internal  
Control: Moderate



(Responsible Officer: Andy Swinburn)



#NOF Call 2 Door in development

**Analysis:**

The percentage of patients documented as receiving appropriate care bundles in September 2025 was:

**Return of Spontaneous Circulation at hospital (from cardiac arrest) – 23.7%, a decrease from 27.4% in August.** An update was made to the ROSC coding scripting which affected the data from July 2024. This resulted in a step change with August 2024 being the highest since ePCR was implemented. A 'nudge' to improve documentation for specific fields including outcome was implemented in October 2024. Low case numbers means a volatile percentage dataset.

**Hypoglycaemia (diabetic patients with low blood glucose) – 75.7%, an increase from last month (72.5%).** Compliance has remained consistency in compliance across the bundle though Q3.

**Fractured Neck of Femur (hip fracture) – 90.7%, a slight decrease in performance from August (93.1%).** Only a slight decrease in compliance which is evident across the care bundle.

**N.B.** Due to the nature of this metric, common cause variation occurs which can result in a marked reduction in performance from small numbers of unsuccessful resuscitations attempts. The factors that influence this are multifactorial and as such it is not possible to identify the specific element.

Following the switch to the electronic Patient Clinical Record, the way data is collected has changed. Automated Clinical Indicator reports are generated from data directly inputted by clinicians. As a result of the anticipated low compliance, risk 535 was generated with three key mitigations to work on:

- Design of the electronic Patient Clinical Record User Interface
- Clinician interaction with the electronic Patient Clinical Record
- Accuracy of the scripting to extract the data from the data warehouse to create the reports.

Further electronic Patient Clinical Record User Interface changes are planned for the next update, scheduled for Autumn / Winter 2025 - 2026.

# Our Patients: Quality, Safety & Patient Experience

## Patient National Reportable Incidents & Duty of Candour Responses Indicators

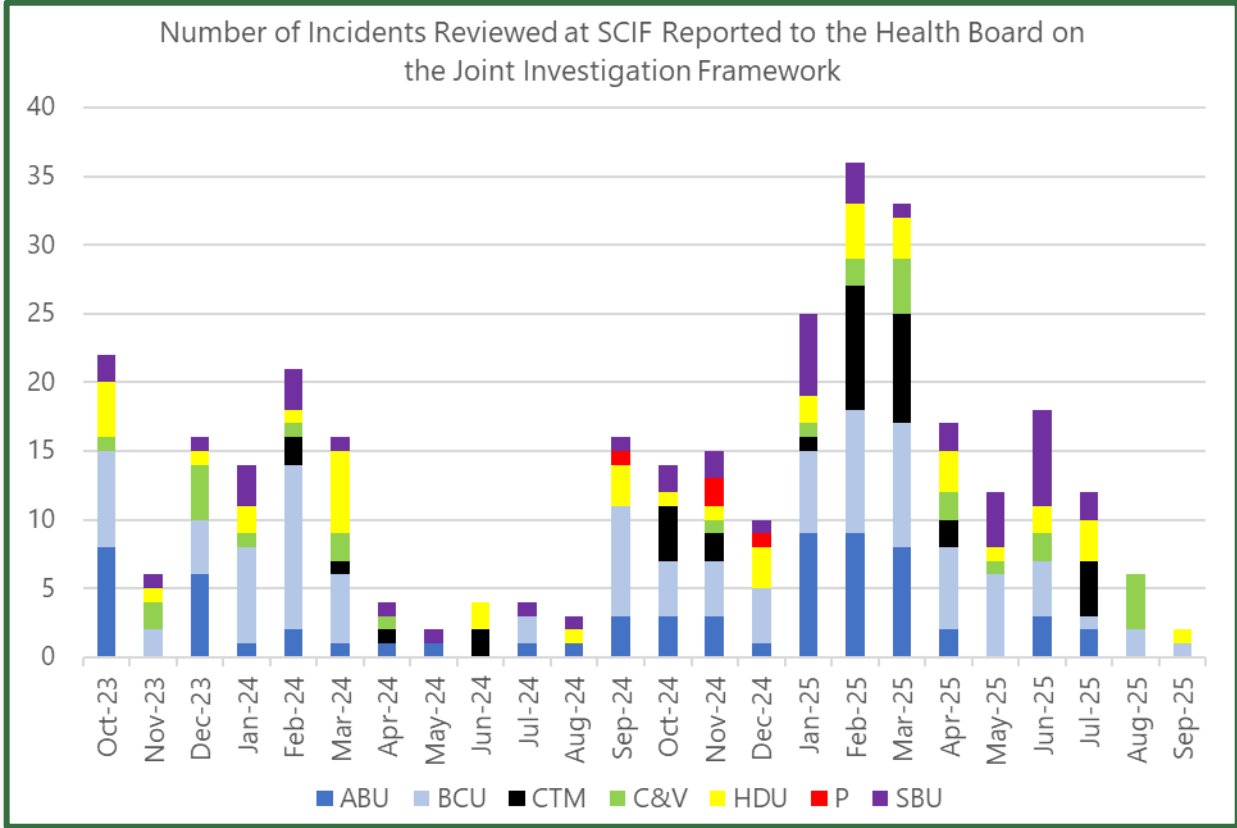
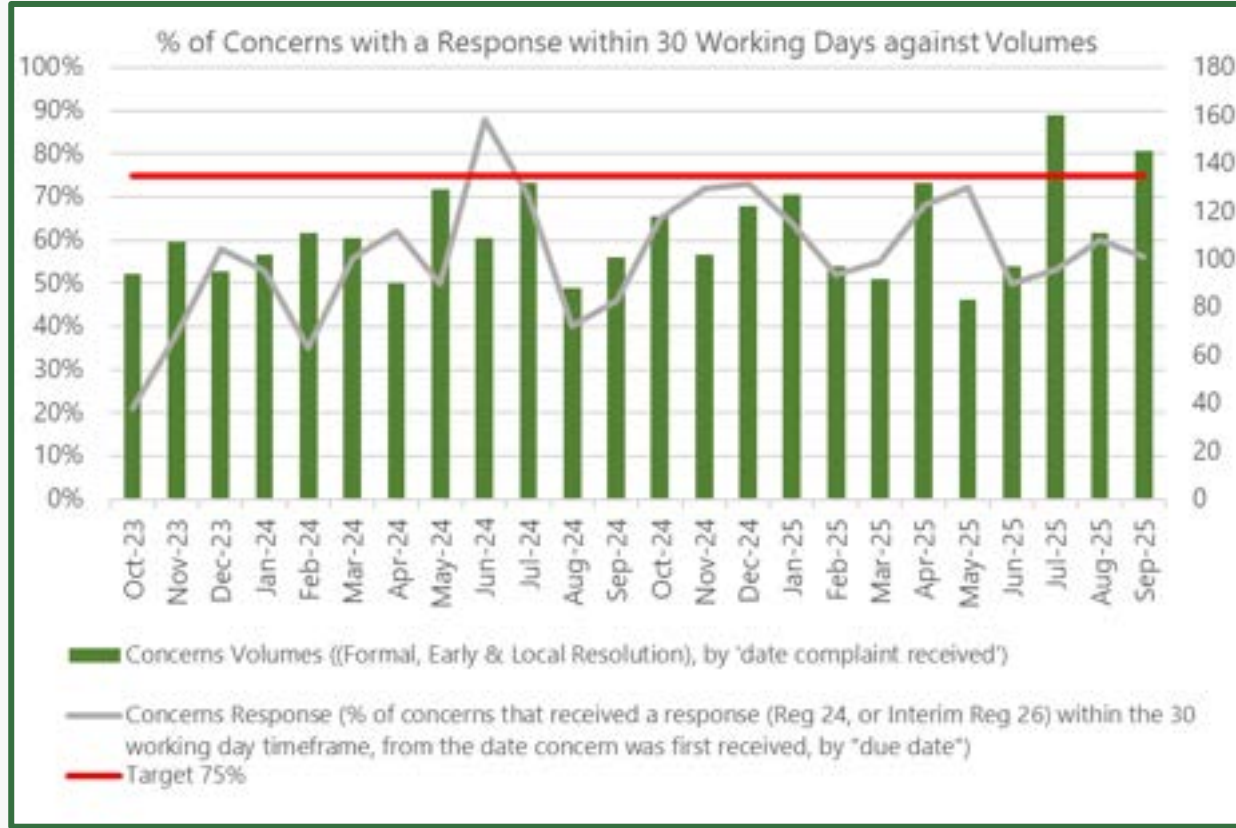
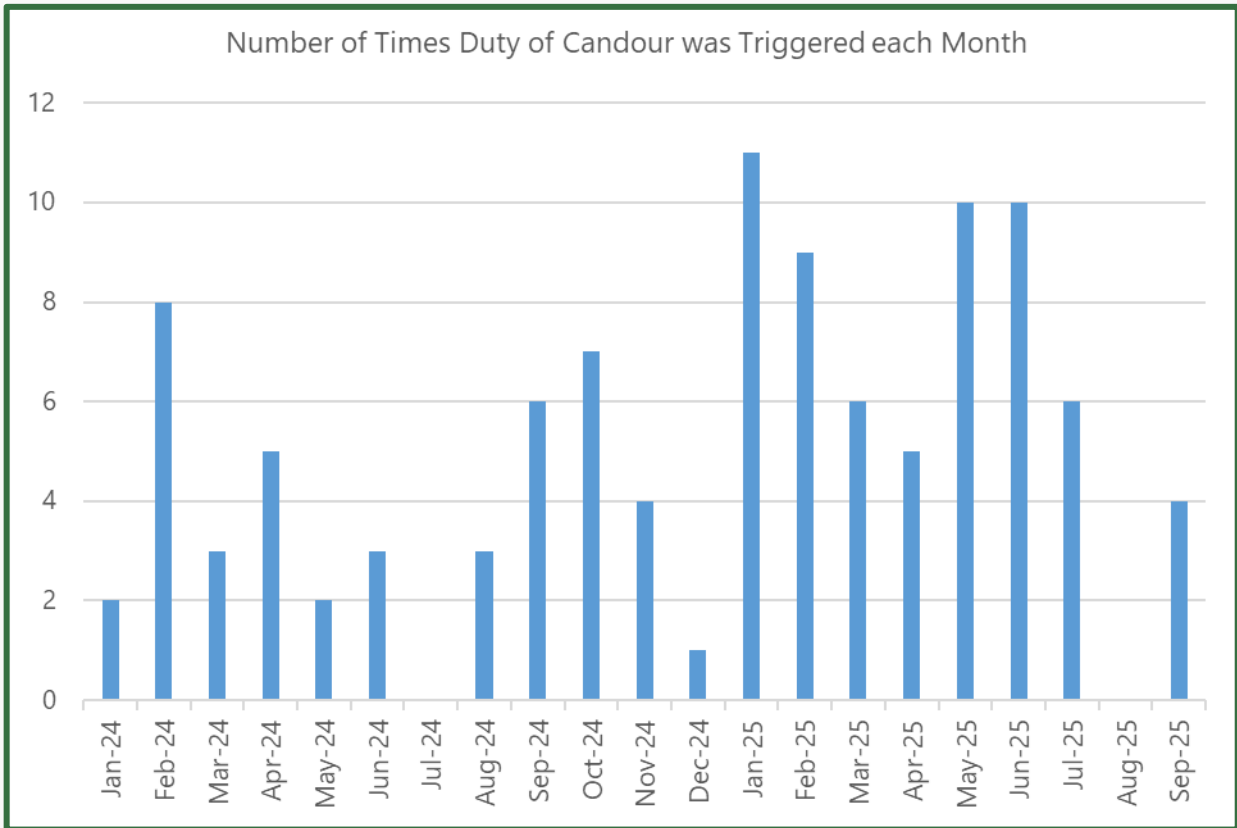
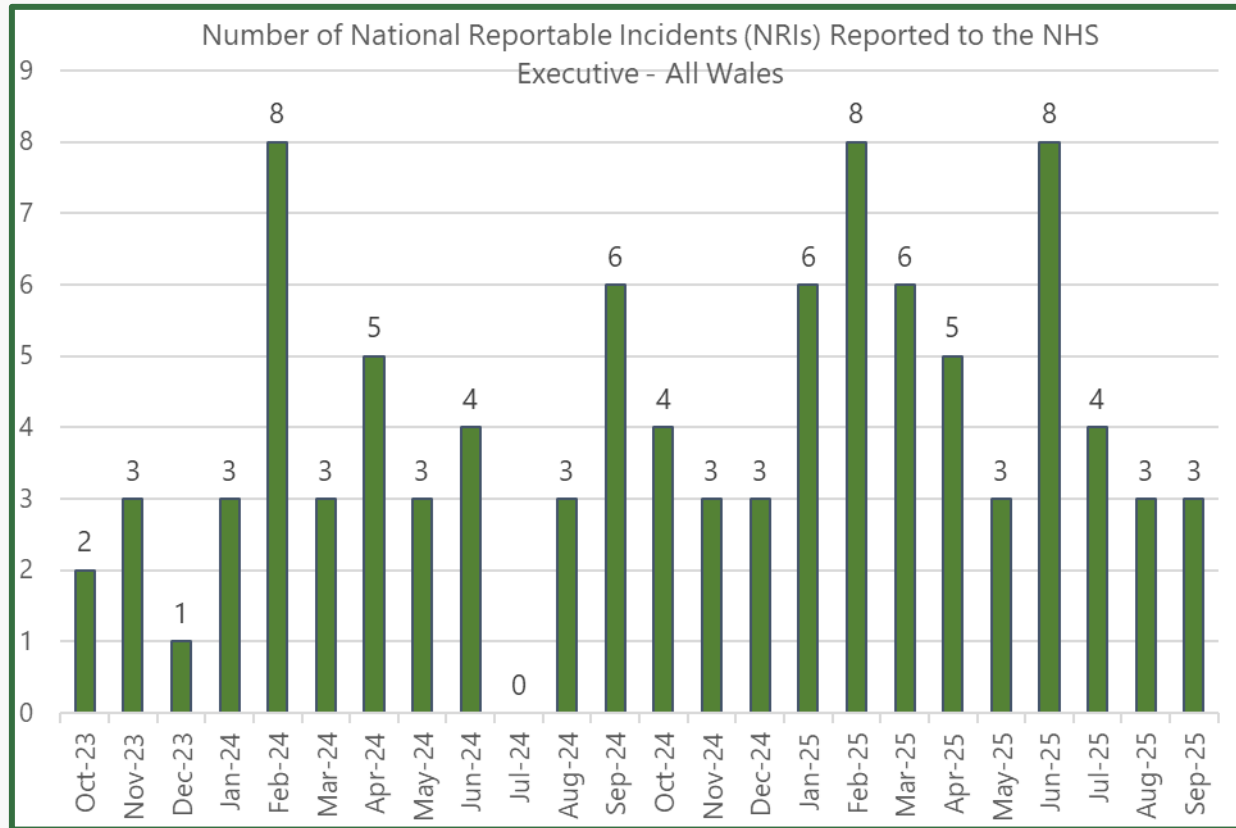
(Responsible Officer: Liam Williams)

Concerns. **R**

QUEST

Self-Assessment: Strength of Internal Control: **Moderate**

Health & Care Standard Health - Safe Care / Timely Care



**Analysis**  
 Complaint response times are of high concern with the organisation not having achieved the target in any of the previous 15 months reported. Whilst larger numbers of complaints have been closed in the last quarter, a much-improved position in reducing open overdue complaints will be required to provide acceptable performance.

A data reporting error identified with two sets of monthly data; June and August 30 working day compliance has been over-reported. The error was identified during the development of an automated business-intelligence product.

The number of complaints received by the Trust continues at historically high levels, this is being driven by an increased volume of complaints about Ambulance Care Services.

The Serious Case Incident Forum agreed for 3 incidents to be reported as NRIs, mostly relating to call management issues.

**Remedial Plans and Actions**  
 A Putting Things Right and Legal Services Recovery Plan has been developed to address the number of overdue concerns (complaints and incidents). This is being monitored through our internal governance structure. Additional non-recurrent investment is expected to deliver the required improved at increased pace.

This lays the foundations for the long-term objective of quality and safety data sources being available to meet user need and enable effective triangulation of all Trust information.

**Expected Performance Trajectory**  
 As service areas focus on reducing the number of open overdue complaints, it is expected that the 30-working day performance will decrease, depending on the success of Recovery Plan. Support from colleagues in terms of experiential emotional mapping, data visibility and the need to focus on 'on-the-spot' resolution is underway but does not yet appear to have impacted complaint volumes.

\*NB: Data correct on the date and time it was extracted; therefore, these figures are subject to change \*\*NB: 30 Day Compliance reported from Power BI and therefore data is not yet validated

# Our Patients: Quality, Safety & Patient Experience

## Patient & People Safety Indicators

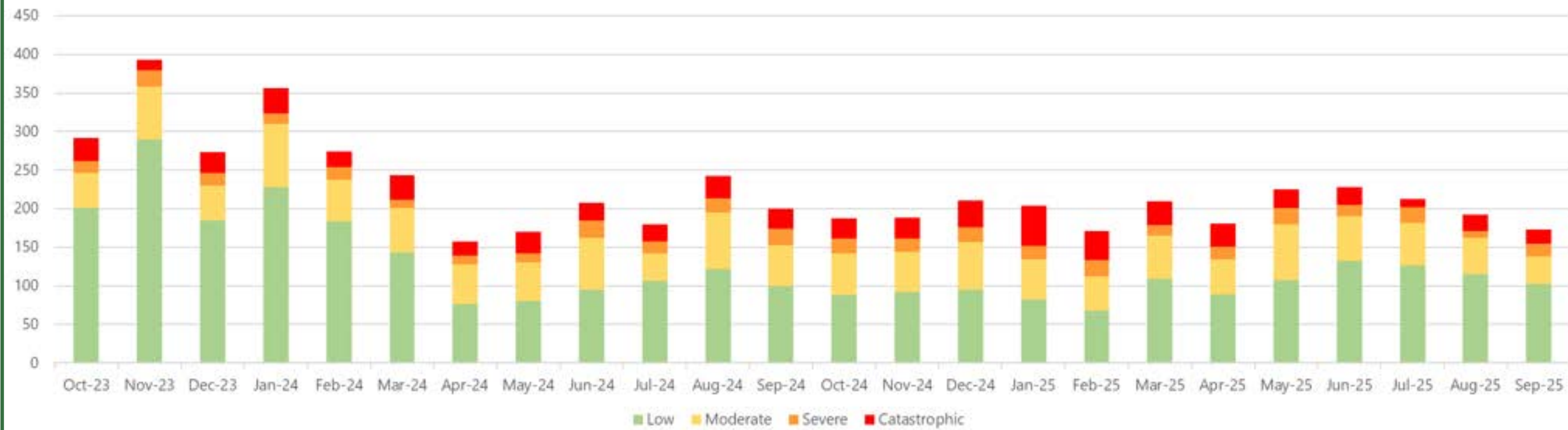
(Responsible Officer: Liam Williams)

Self-Assessment:  
Strength of  
Internal Control:  
Moderate

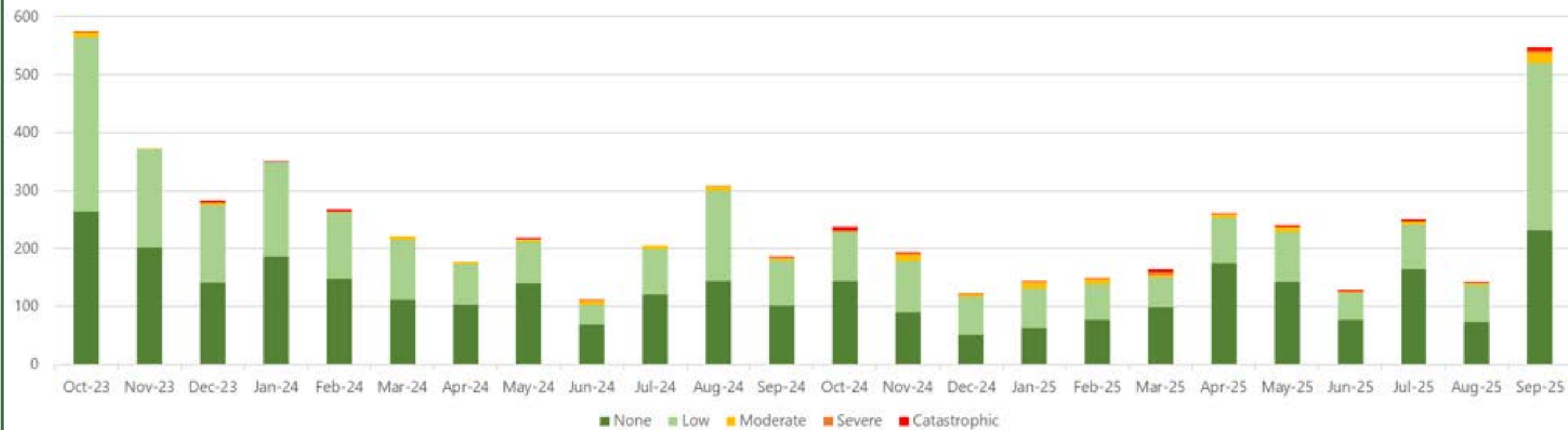
QUEST

Health & Care  
Standard  
Health – Safe Care

Number of Patient Safety Incidents Reported by Month by Initial Harm Assessment



Number of Patient Safety Incidents by Month Closed and by Post-investigation Harm Assessment



### Analysis

The number of investigations needing to be shared with other NHS Wales organisations has reduced in the last quarter. This appears in keeping with seasonal fluctuations however August and September have dropped beneath historical seasonal averages and there is optimism that the launch of the 'Wait 45' initiative is beginning to impact favourably on patient safety incidents caused by long community waits.

Incident reporting volumes remain stable, and the number of incidents being finalised and closed on the Datix system has increased markedly following a Senior Operations Team improvement drive in this area. Commitment to converting this to business-as-usual practice will be key to sustaining the improvements.

Closed incidents continue to demonstrate that validated levels of severe or catastrophic harm remain consistently low.

### Remedial Plans and Actions

Incident closures are being monitored through Quality Management Group.

### Expected Performance Trajectory

Incident volumes and harm levels are being closely monitored and triangulated with other sources of intelligence related to Clinical Model Transformation changes.

# Our Patients: Quality, Safety & Patient Experience

## Coroners, Mortality and Ombudsmen Indicators

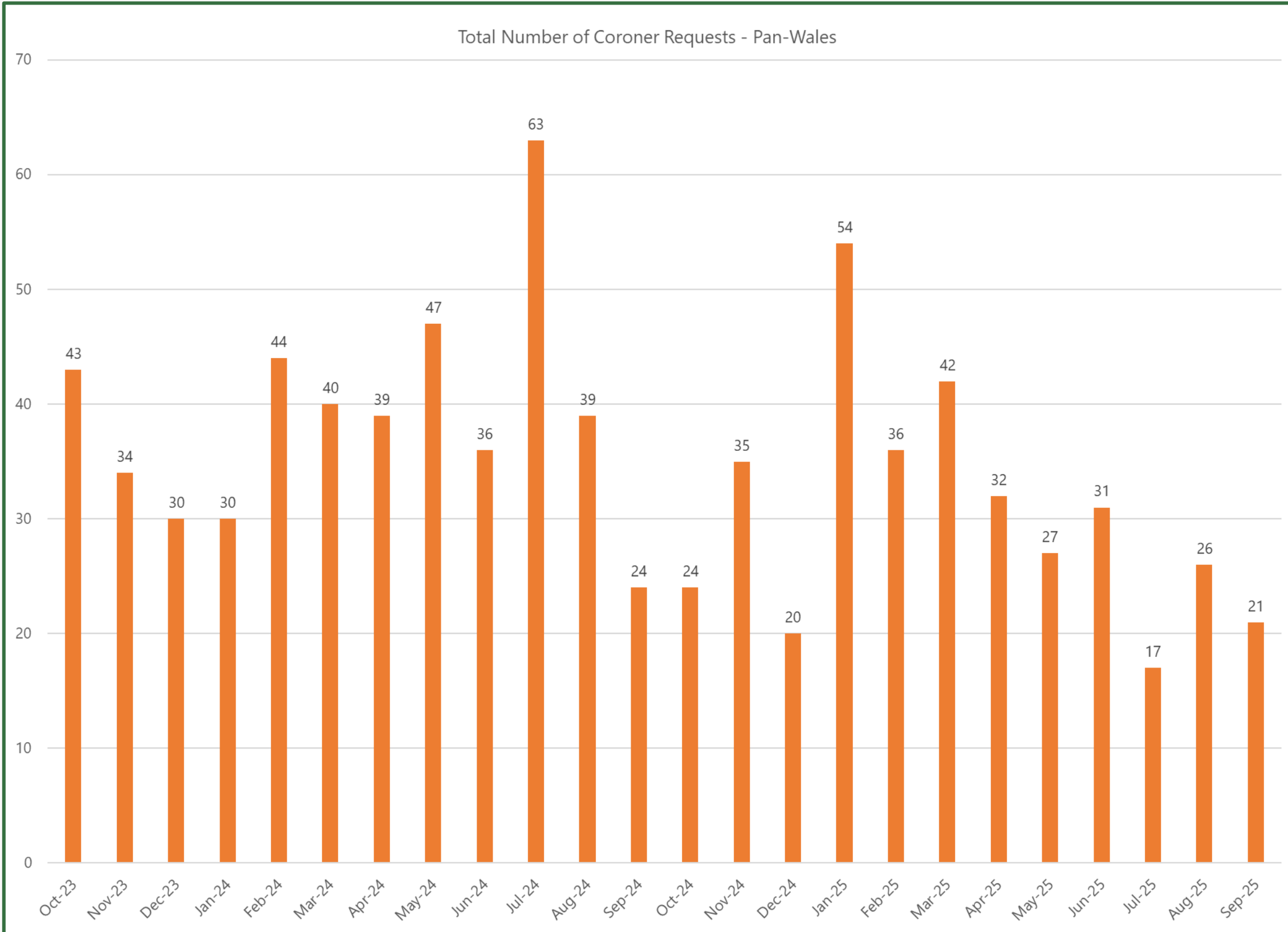
(Responsible Officer: Liam Williams)

Coroners  
Self-Assessment:  
Strength of  
Internal Control:  
Moderate

Mortality  
Self-Assessment:  
Strength of  
Internal Control:  
Moderate

QUEST

Health & Care  
Standard  
Health – Safe Care



**Analysis**  
There is a gradually improving picture in the organisational management of medical examiner reviews and coronial workloads. Inquest cases continue to present with increased complexity and large numbers of statements and witnesses being called. These factors combined makes this an area of continued pressure across Trust services and for the individual staff involved in representing the organisation.

Level 1 triage of Medical Examiner referrals proceeds at fortnightly intervals with all Q1 and Q2 cases. 143 referrals have been received from the Medical Examiner Services (MES) in the first two quarters of 2025/26. 27 cases have been triaged as requiring further review and investigation. Enhanced analytical opportunities and improved data capture reveal the vast majority of referrals being due to community delays and inability to provide 'Timely' care. Internal review of Q1 and Q2 referrals at Medical Examiner Learning Panel continues to identify learning relating to delays in attending in the community, alongside improvement opportunities for Advanced Care Planning and enhanced end of life care in the community.

**Remedial Plans and Actions**  
A Putting Things Right and Legal Services Recovery Plan has been developed to address the number of overdue concerns. This is being monitored through our internal governance structure and reported on in QuEst Committee. Additional non-recurrent investment is expected to deliver the required improved at increased pace, building on structural workforce changes and a shift to proportionate approaches that have already begun to demonstrate benefit.

- Expected Performance Trajectory**
- Coroner activity will continue to be monitored and delays in statement gathering escalated and prioritised internally as appropriate. Cross directorate teams continue to work together to ensure cases are prioritised, and the coroner is provided with estimated times of completion.
  - The ability to provide senior review of Medical Examiner feedback cases will depend on availability of the appropriate professional attendance at Learning Panel.

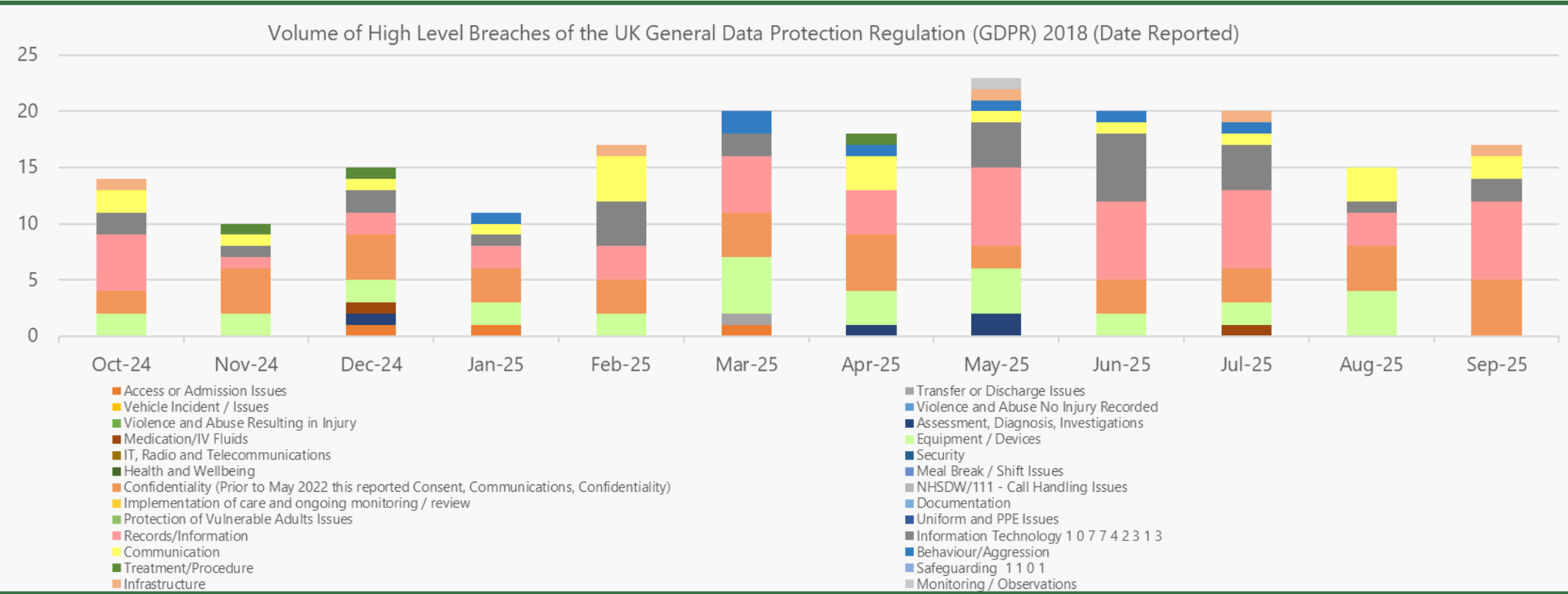
# Our Patients: Quality, Safety & Patient Experience Safeguarding, Data Governance & Public Engagement Indicators

(Responsible Officers: Jonny Sammut & Liam Williams)

Health & Care  
Standard  
Health – Safe Care

Self-Assessment:  
Strength of  
Internal Control:  
Strong

PCC



### Analysis

**Safeguarding:** In September 2025 WAST colleagues submitted a total of 212 Adult at Risk Reports, 93% of these were processed within 24 hours. Whilst the Trust does not report on Adult Need for Care & Support reports (wellbeing); 775 reports were shared with local authorities across Wales during this reporting period. There have been 249 Child Safeguarding Reports submitted in September 2025, 98% of these were processed within 24 hours.

**Data Governance:** In September 2025, there were 17 information governance (IG) related incidents reported on Datix Cymru categorised as an Information Governance (IG) breach. Of these 17 breaches, 7 related to Records/Information, 5 IG/Confidentiality, 2 Communication, 2 Information Technology, and 1 Infrastructure.

### Remedial Plans and Actions

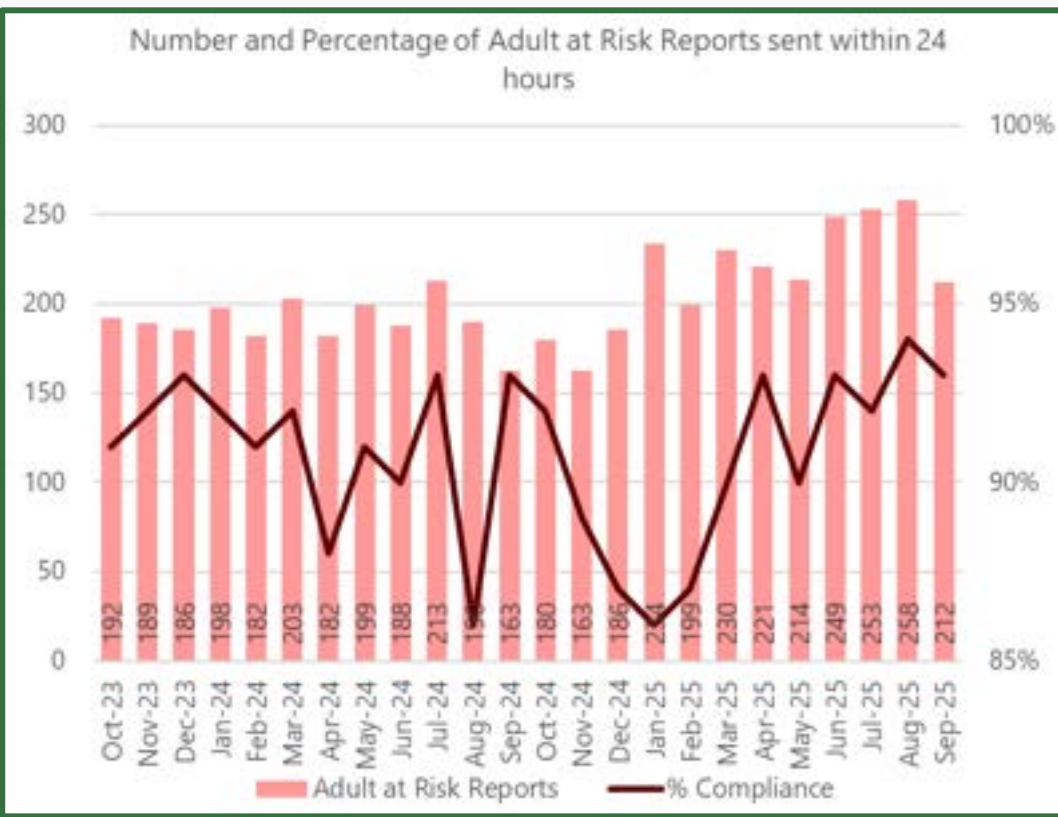
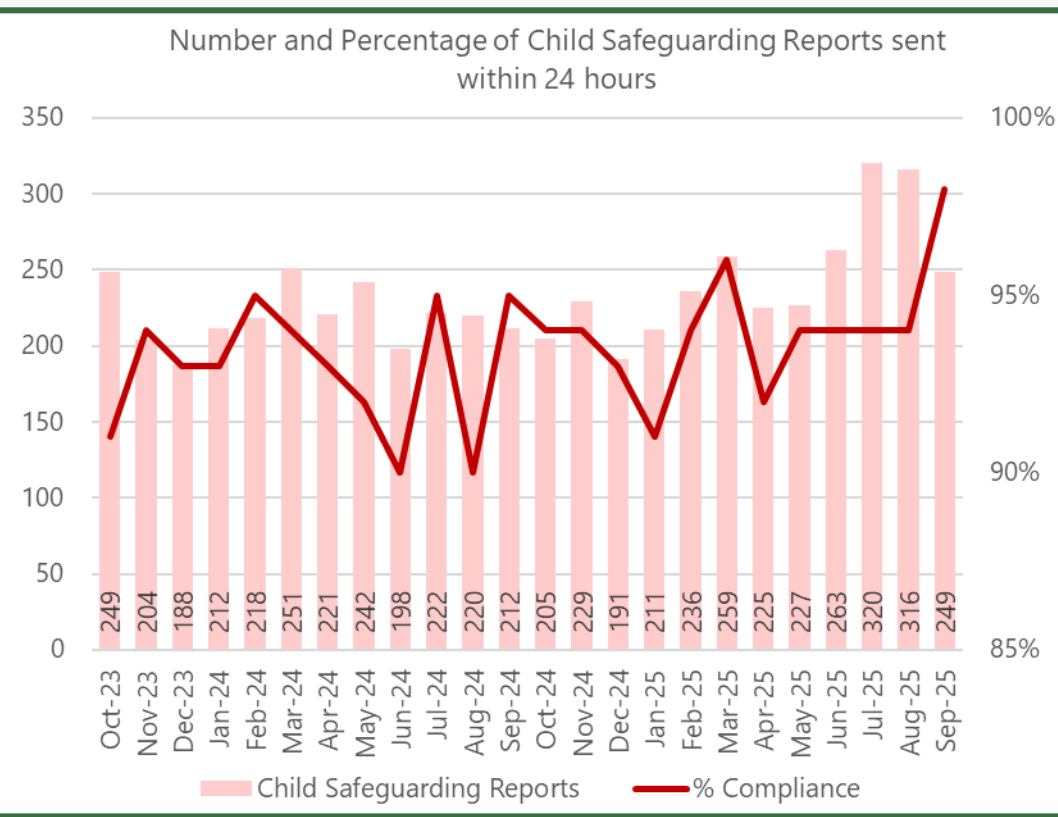
**Safeguarding:** The Trust manages all safeguarding reports digitally via Doc-works Scribe and regular monitoring of the system by the Safeguarding Team provides a means to identify any problems with delayed reports with appropriate action taken to support WAST colleagues with using the Doc-works Scribe system and liaising with local authorities when required. Only minimal paper safeguarding reports are now received; they are used as a back-up and are sent directly to the Safeguarding Team for actioning. The Safeguarding Team monitor any paper reports received and provide direct feedback to colleagues to improve practice.

**Data Governance:** During the reporting period, of the 17-information governance related incidents reported on Datix, 2 incidents were reported to the Information Commissioner's Office (ICO) as they met the risk threshold. Both incidents related to inappropriate recording and disclosure of personal data. The IG Team continues to monitor, and review reported incidents where applicable.

### Expected Performance Trajectory

**Safeguarding:** The Trust continues to aim to achieve 100% of Adult and Children at risk referrals within 24 hours.

**Data Governance:** The next iteration of the IG Toolkit has now opened for FY25/26 submissions.



\*NB: Data Governance Incidents are based on 'Date Reported' rather than 'Incident Date' as the process is currently manual until a dashboard is implemented and is therefore subject to change Safeguarding Data source: Doc Works

# Our Patients: Quality, Safety & Patient Experience

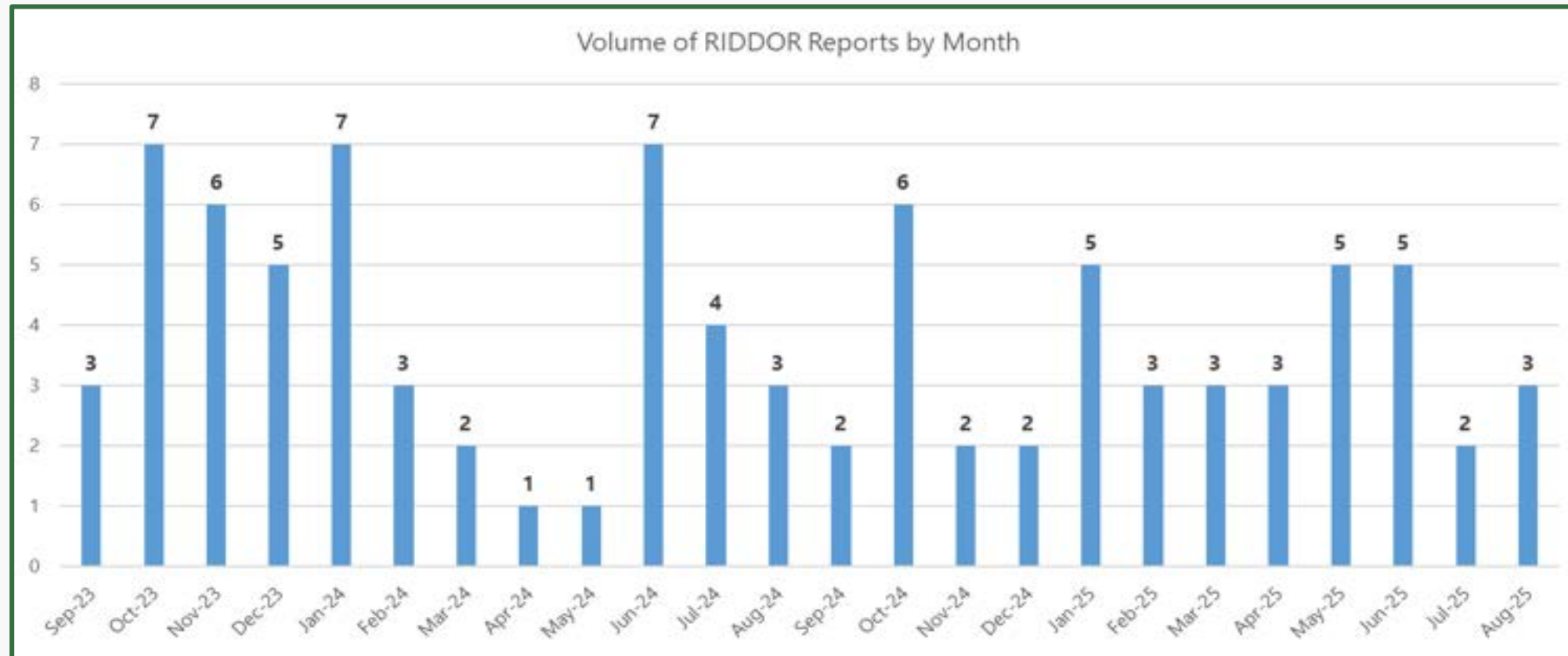
## Health & Safety (RIDDORS) Indicators

(Responsible Officer: Liam Williams)

Self-Assessment:  
Strength of  
Internal Control:  
Moderate

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Health & Care  
Standard  
Health – Safe Care



### Analysis

**RIDDOR:** There were 3 incidents requiring reporting under RIDDOR during August 2025 all were for an injuries requiring over 7 days of work.

- 33% of the RIDDOR's were submitted within the HSE reporting timelines, the main reason for not reporting in time was seen to be the late reporting of incidents onto Datix
- 3 RIDDORs reported during the month were as a result of manual handling incident whilst handling patients. 1 resulted from the use of a carry chair on the stairs of a patient's home and another happened when using a lift to load a patient onto a vehicle.

### Violence and Aggression:

- A total of 51 incidents have been reported of V&A in August
- There was an increase in the number of Aggressive/Threatening behaviour.
- 5 Physical Assault on staff was reported during the month with incidents of verbal assault that included swearing.

### Remedial Plans and Actions

**RIDDOR:** The weekly Datix incident meeting continues to be used to identify RIDDOR reportable incidents. A Safety Advisor is designated to assist with the investigation to find root cause and reporting to the HSE. Consistent effort to investigate incidents by line manager is making an improvements in causation and reporting to the HSE.

**Violence and Aggression:** The use of appropriate Hashtags to flag incidents of verbal aggression within the Trust call centres is being progressed to provide a greater understanding of the verbal abuse experienced by staff.

### Expected Performance Trajectory

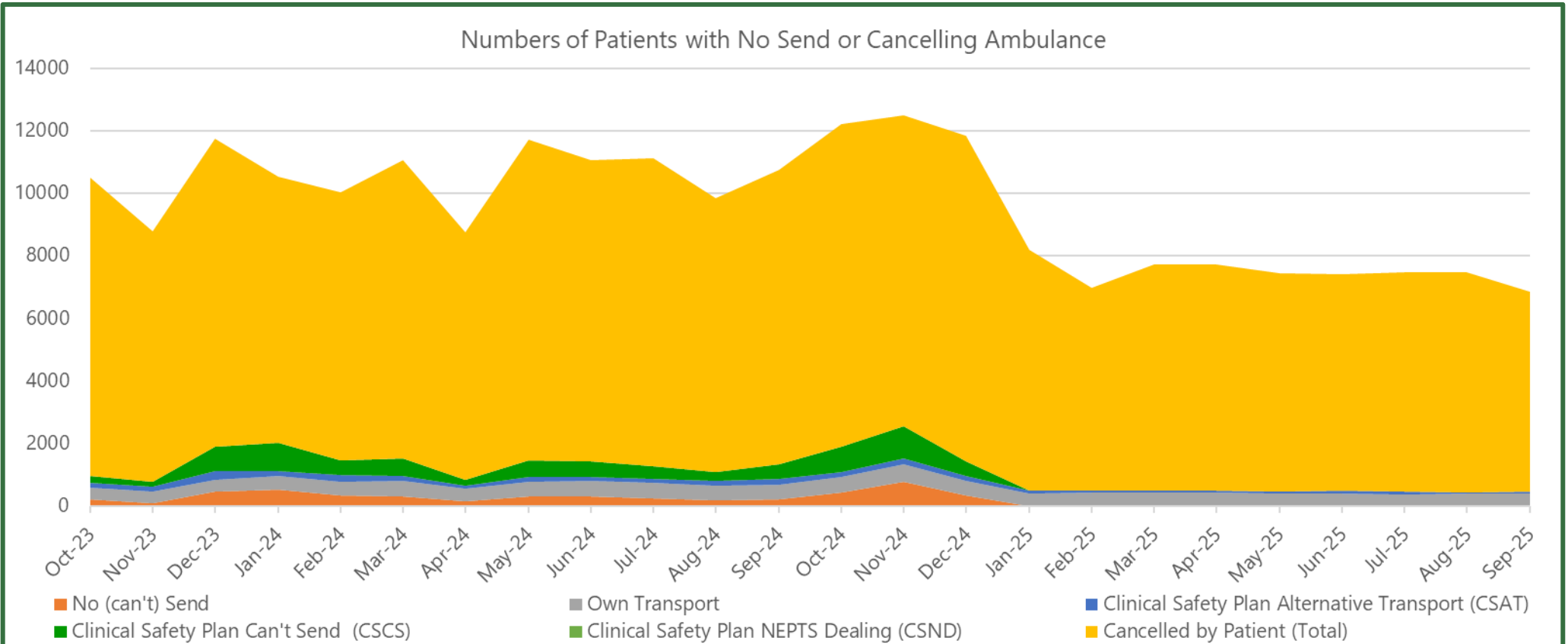
**RIDDOR:** The actions arising out of the recent deep dive into manual handling incidents aim to address the issues identified in the manual handling incidents this month.

**Violence and Aggression:** It is expected that the number of verbal V&A incidents will increase over the next few months as a result of increased awareness of reporting mechanisms within the call centre teams.

# Our Patients: Quality, Safety & Patient Experience

## Potential Patient Harm Indicators

(Responsible Officer: Andy Swinburn)



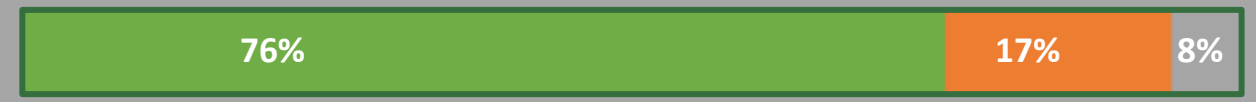
### Analysis

In September 2025, 71 ambulances were stopped due to Clinical Safety Plan alternative transport (CSPT). In addition, 6,381 ambulances were cancelled by patients (including patients refusing treatment at scene) a decrease from the 7,028 in August 2025. There has been a downward trend in patient cancellations since December 2024 which the Trust believes is connected to the implementation of Rapid Clinical Screening during the winter.

There were 426 requests made to Health Board EDs for immediate release of Arrest, Emergency or Amber 1 calls in September 2025. Of these 15 were accepted and released in the Arrest category, with none not being accepted, 87 were accepted in the Emerg category, with 4 not accepted and 86 ambulances were released to respond to Amber 1 calls, but 234 were not.

The graph in the bottom left shows the estimated level of patient harm during September 2025. Of the 3,484 patients who waited outside an ED for over an hour, to be handed over to the care of the hospital, the Trust could assume that 15% (523 patients) would experience no harm, 53% (1,847 patients) would experience low harm, 23% (801 patients) would experience moderate harm and 9% (314 patients) would experience severe harm.

In September 2025 CSP levels for the Trust were:

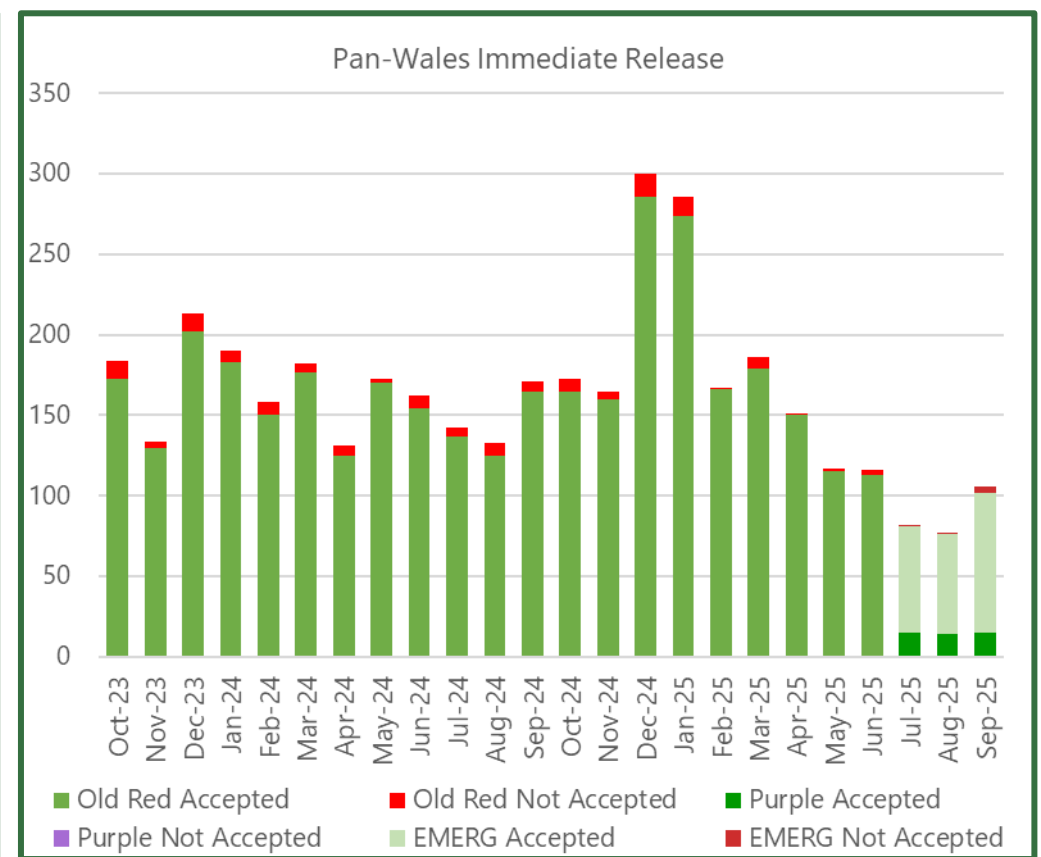
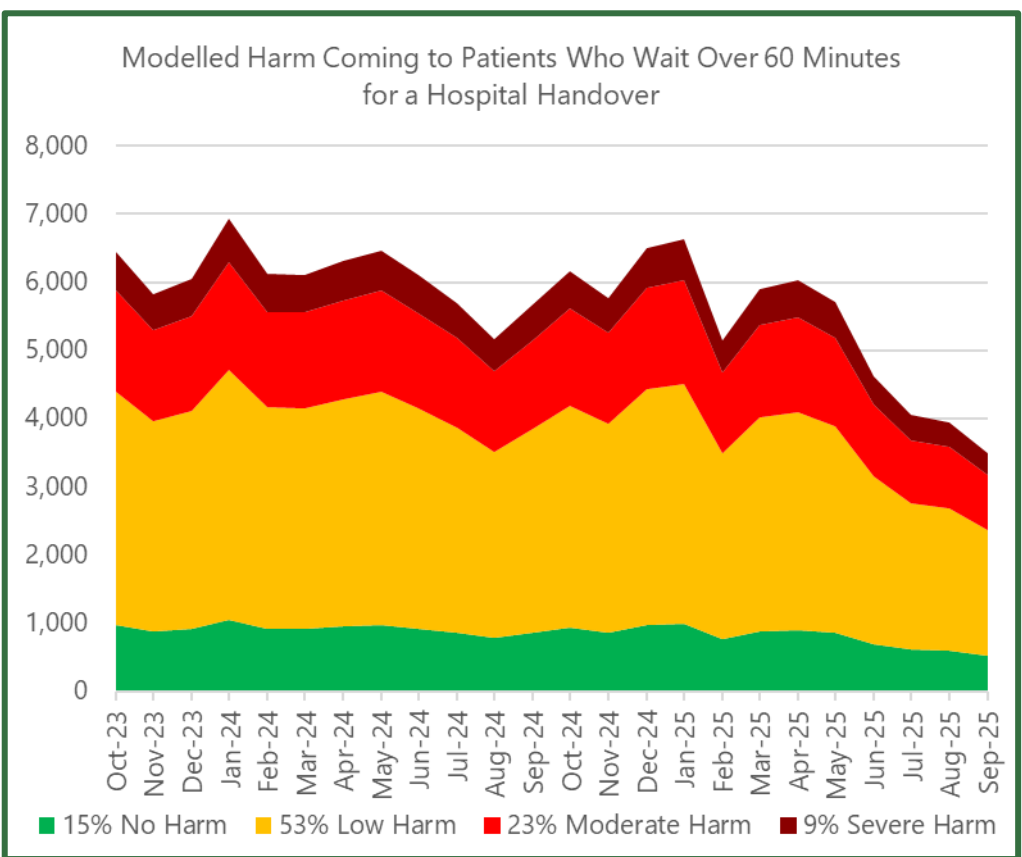


### Remedial Plans and Actions

Immediate release is monitored weekly by the Chief Executive and reported through to Health Board CEOs with the expectation that there are no declines for Arrest and Emerg Release from any of the 7 Health Boards. All health boards have agreed to this measure. Integrated Commissioning Action Plan (ICAP) meetings had been paused as the Trust moves into the new commissioning arrangements with new arrangements expected later this year. The WG target for 2025/26 has a target of no handovers of more than 45 minutes.

### Expected Performance Trajectory

The Trust continues to monitor CSP levels both daily through the ODU and weekly through the Weekly Operations Performance Meeting and mitigations are actioned to reduce the impact on the Trust's ability to respond to demand.



\*NB: Data correct on the date and time it was extracted; therefore, these figures are subject to change

# Our Patients: Quality, Safety & Patient Experience

## Patient Experience Surveys

(Responsible Officer: Liam Williams)

Self-Assessment:  
Strength of  
Internal Control:  
Moderate

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Health – Safe Care

August 2025		
<b>NEPTS</b> (221 responses)	Benchmark	Score
How long did you wait for your transport to take you home after your appointment.	85	87
Were you happy with the transport you received?	85	94
<b>999</b> (6 responses)	Benchmark	Score
The 999-call taker who answered your call was reassuring.	85	82
The 999-call taker who answered your call explained what was going to happen next.	85	100
The length of time I waited for an ambulance to arrive was acceptable.	85	70
<b>111</b> (13 responses)	Benchmark	Score
Do you feel your call to 111 Wales was helpful?	85	63
Did you follow the advice given to you by NHS 111 Wales?	85	75
Would you consider using NHS 111 Wales again?	85	57
<b>WAST Overall - Friends &amp; Family Test</b>	Ranked from very poor to very good.	
How was your overall experience with the service today?		
o Ambulance care	91.12% Good	5.33% Poor
o Integrated Care (NHS 111 Wales Telephone line only)	57.14% Good	42.86% Poor
o EMS (including CSD)	80.00% Good	0.00% Poor
o NHS 111 Wales Online	50.00% Good	18.18% Poor
	* Where totals above do not add up to 100%, this is because a 'Do Not Know' answer was given, these are excluded from overall total.	

### Analysis

During August 2025, PEI attended 13 community engagement opportunities, engaging with approximately 922 people.

Engagement this month included attending the Denbigh & Flint Show, offering an opportunity to engage with rural and farming communities and attending the National Eisteddfod in Wrexham, offering an opportunity to engage with young people - especially those who use Welsh as a first language.

We also continued to attend several sessions organised by Food Fun Wales school summer holiday enrichment programme where we visited schools in socially deprived areas of Cardiff and spoke to pupils attending about appropriate use of 999, what happens when you call 999 & demonstrated lifesaving skills that pupils can do while help is on its way.

Throughout August we continued to make available 4 patient experience surveys covering the Trust's main service delivery areas. Engagement and survey outcomes remain largely consistent and tell us that people continue to be very concerned about response times in the community and frustrated at hospital handover delays.

- 111 callers have told us that they experienced long waits for call backs.
- NEPTS users told us that overall, they continue to be happy with the transport they receive but experience delays when waiting for their transport home following their appointment.

### Remedial Plans and Actions

Work is underway to enact the findings of the service review in relation to public and patient engagement

The ICO responded to our DPIA with 7 recommendations which were presented to IGSG who gave permission to continue working on the recommendations.

### Expected Performance Trajectory

Vacancies and the work to enact the recommendations of the service review will have some impact on team capacity over the coming months.

# Our People Capacity - Ambulance Abstractions and Production Indicators

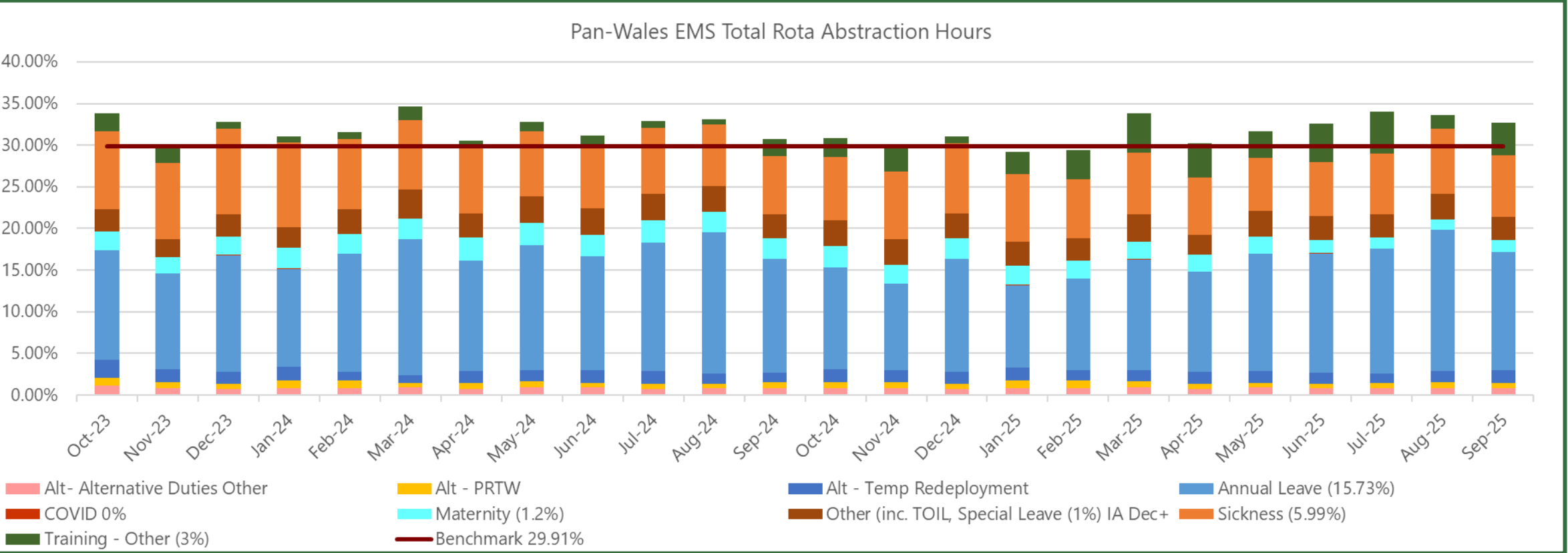
(Responsible Officer: Lee Brooks)

EA Production  
**R**

CI

PCC

FPC



### Analysis

Monthly abstractions from the rosters are key to managing the number of hours the Trust produces, as are the total number of staff in post. September 2025, saw total EMS abstractions (excluding Induction Training) of 32.71%. This was a minimal decrease on the 33.65% recorded in August 2025 and remains above the 29.91% benchmark. The highest proportion of abstractions was due to annual leave at 14.24% followed by sickness at 7.39%.

The total EMS hours produced is a key metric for patient safety. The Trust produced 115,981 hours during September 2025; a slight decrease compared to the 118,986 hours produced during September 2024. The Trust is still delivering good levels of production.

**Emergency Ambulance Unit Hours Production (UHP) achieved 89% in September 2025** which equated to 74,307 Actual Hours.

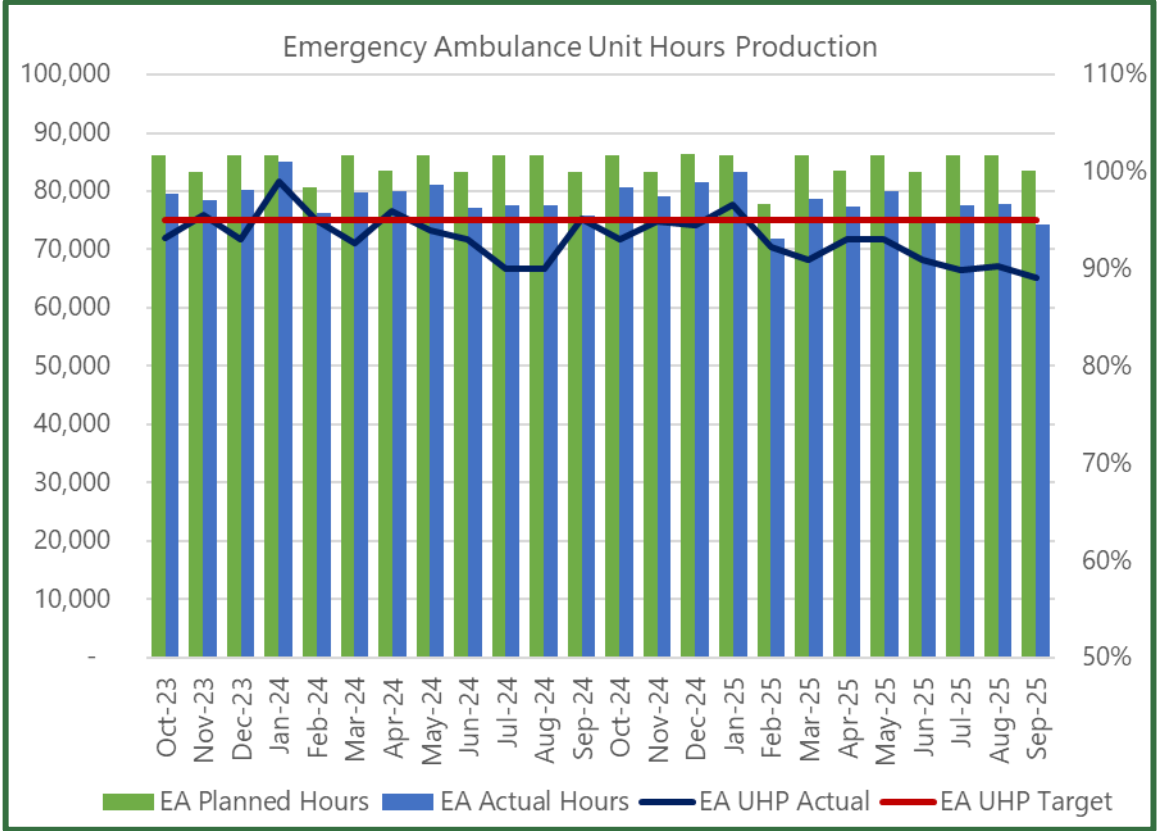
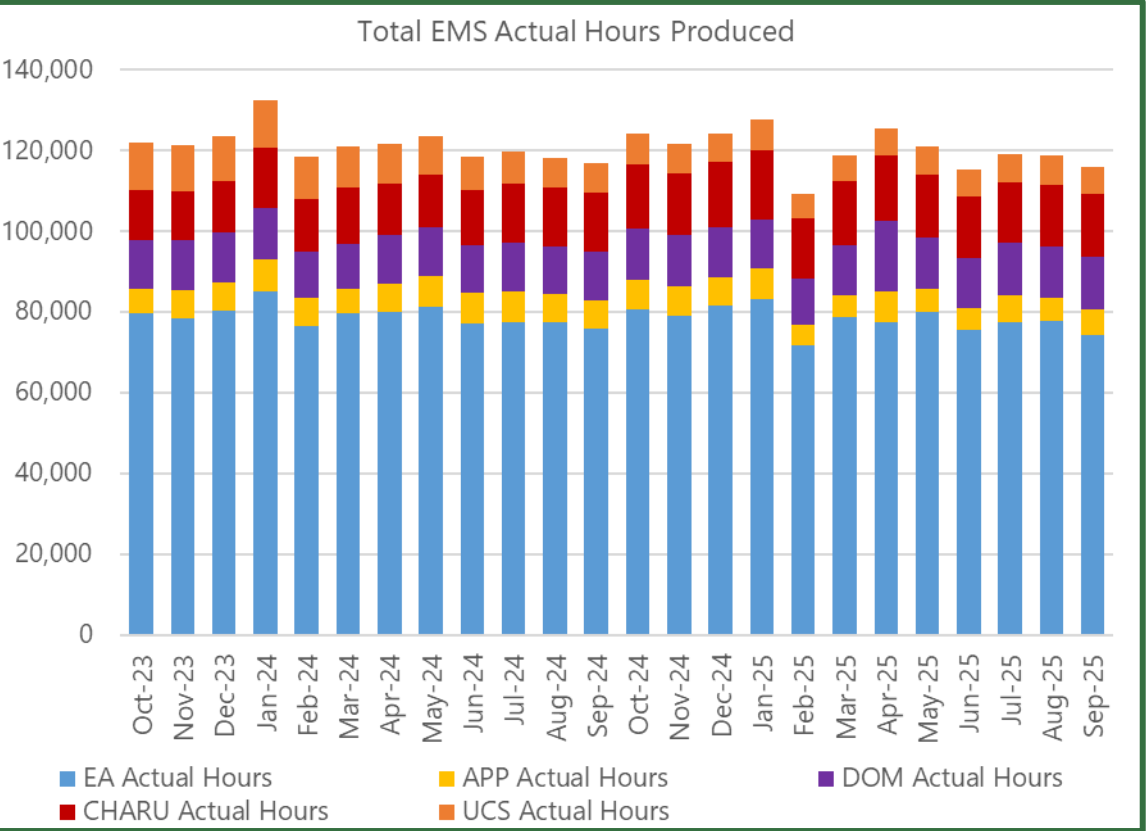
In September 2025 CHARU UHP was 88% against the full roll out requirement.

### Remedial Plans and Actions

- Continued focus on managing attendance across the Trust and managing abstractions from rosters.
- Full roll out of CHARUs.
- Continued focus on staff in post to establishment, aiming for 95% benchmark.
- Smoothing of staff between urban and rural areas.
- Focus on recruitment to reduce identified vacancy gap, in particular, EMTs and APPs.

### Expected Performance Trajectory

UHP estimates, based on recruitment levels, estimated abstractions and overtime have been provided to ELT. Production is just below target. The Trust maintains an ambition to reduce sickness to 6% and maintain abstractions to 30%. This has not yet been achieved for sickness, but the direction of travel is good, while the abstractions benchmark has been achieved a number of times this year.

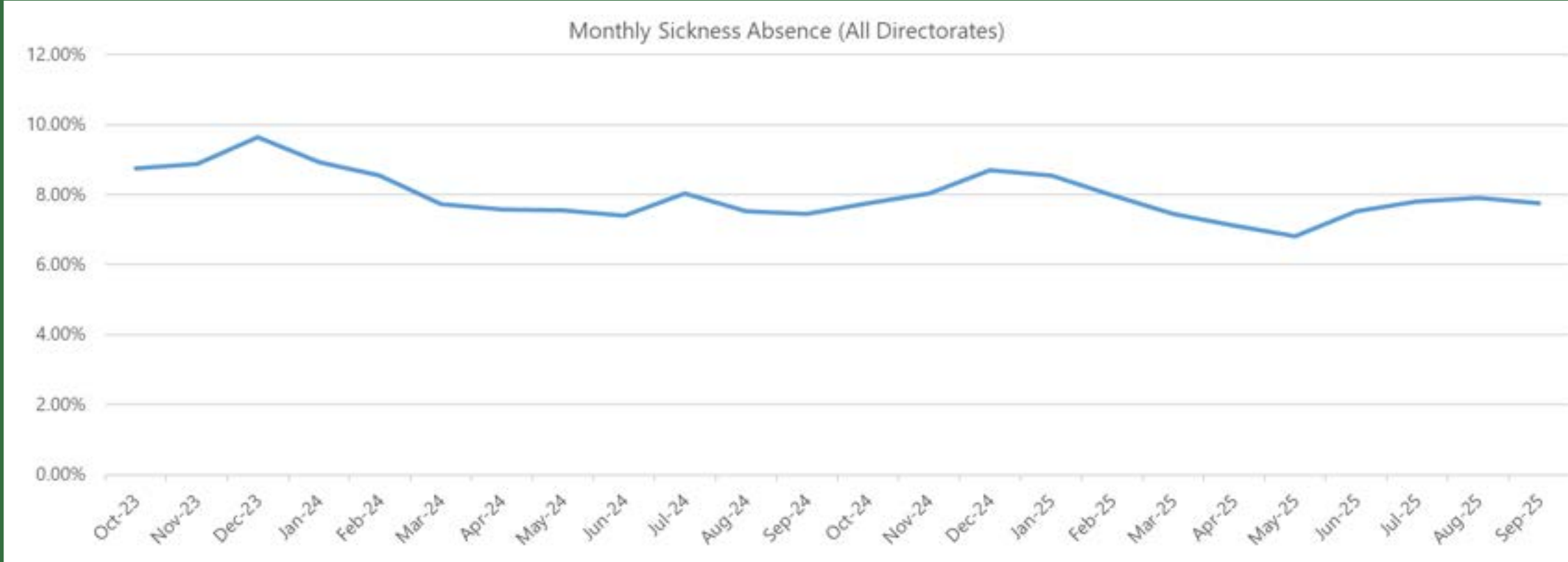


# Our People Capacity - Sickness Absence Indicators

(Responsible Officer: Carl Kneeshaw)

Sickness Mental Health  
R R

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**Analysis**

There was a slight decrease in overall sickness absence rates between August 2025 and September 2025, reducing from 7.91% to 7.77%. Long term absence decreased from 6.20% in August 2025 to 5.48% in September 2025, however short-term absence increased slightly to 2.28% (August 2025 - 1.71%).

The highest reasons for absence in September 2025 were Anxiety/ Stress/ Depression, other musculoskeletal problems, gastrointestinal problems and injury fracture. Absence due to Mental Health increased slightly from 2.89% in August 2025 to 2.96% in September 2025.

WAST Occupational Health continue to meet national KPIs set by the All-Wales Occupational Health standards and scope of practice, which states the 1st offered appointment date will be within 29 calendar days of the date referral received. The waiting time for a management referral in September was 10.4 days. We continue to use our external provider, Insight Health services, to help maintain KPIs and provide timely support to employees.

The team continue to triage all referrals and enquiries to ensure prioritisation of anything that requires urgent attention.

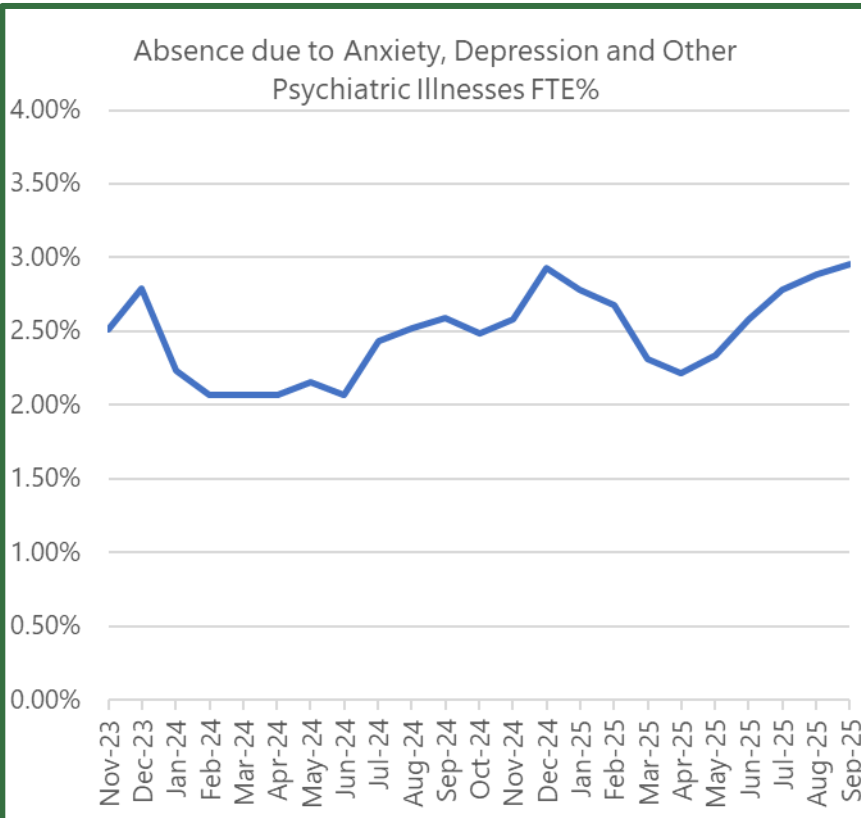
This year's flu campaign has begun and there are scheduled clinics for WAST and Public Health Wales staff.

**Remedial Plans and Actions**

- The Health and Wellbeing Plan for 2025-29 has been developed and implemented. The focus of the plan is on deliverables to improve workplace relationships, increase the trauma-awareness of the organisation and address health and wellbeing challenges.
- Team members from OH/Wellbeing/TRiM continue to promote our services via Siren, outstation visits and drop-in clinics. We regularly give presentations to newly recruited staff to highlight and promote the Occupational Health & Wellbeing service.
- The team continue to collect feedback and review services provided by our external partner organisations to help improve those services.

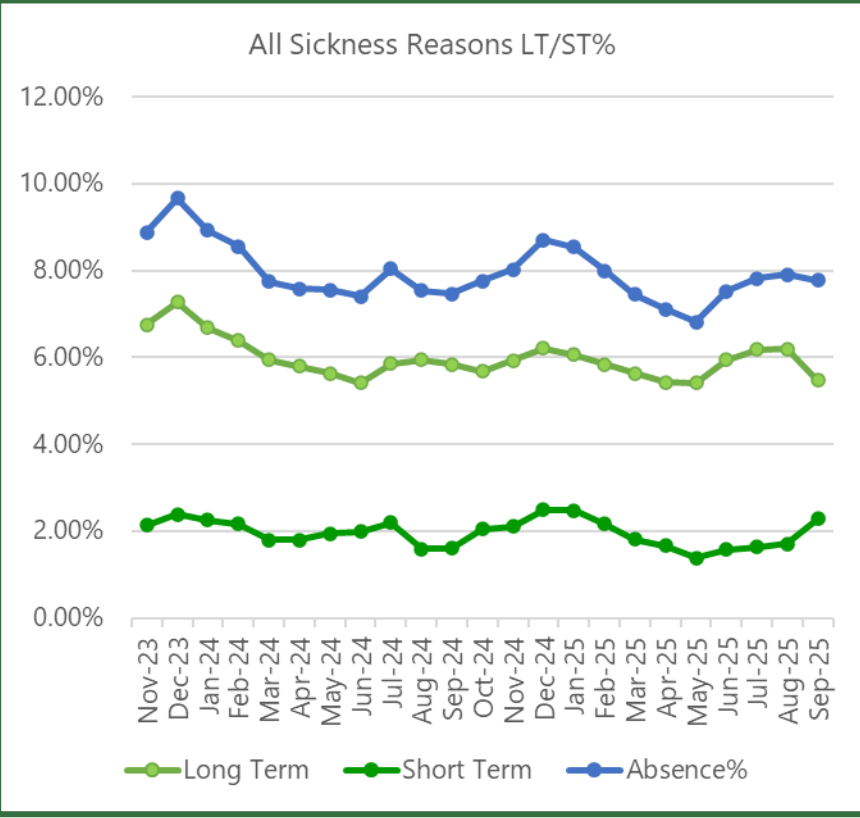
**Expected Performance Trajectory**

The Trust has indicated through its IMTP that sickness levels will fall in this financial year, but the Trust is unlikely to achieve the 6% target for the year.



Sep-25	
Average working days lost per FTE (Annual)	
17.76 days	
Single month Absence %	
7.77%	
Long Term	Short Term
5.48%	2.28%
Mental Health	Other MSK
(S10 Stress/Anxiety)	(excluding Back)
2.96%	0.80%

September 2025



\*NB: Sickness data will always be reported one month in arrears

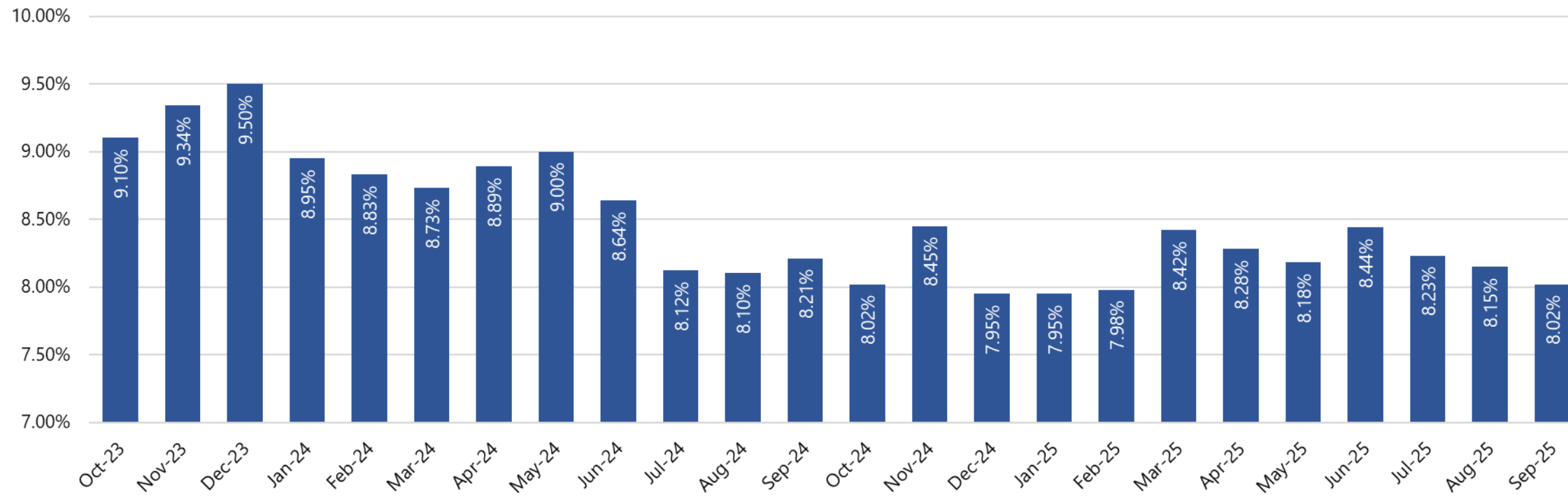
# Our People Capacity – Staff Turnover

(Responsible Officer: Carl Kneeshaw)

G

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Staff Turnover Rate FTE (% Employees leaving the Organisation) (12m)



## Analysis

The staff turnover rate in September 2025 was 8.02%, minimally decreasing from 8.15% in August 2025. September saw 32 leavers (26.54 FTE). Of those leaving, the greatest number were Operational and included;

- Ambulance Care Assistants/Patient Transport Drivers (8 people)
- Call Operators (5 people)
- Paramedics (4 people)
- Emergency Call Handlers (3 people)
- Technician (3 people)

Current trends are being monitored via the leaver's questionnaires; however, these are not mandatory.

In September, this was compensated by 85 joiners (83.70 FTE). A headcount of 79 people into Operational roles and 6 people into Corporate roles, the top including:

- Paramedic (28 people)
- Call Operators (22 people)
- Technicians (9 people)
- Emergency Call Handler (6 people)
- Non-Emergency Call Handler (4 people)

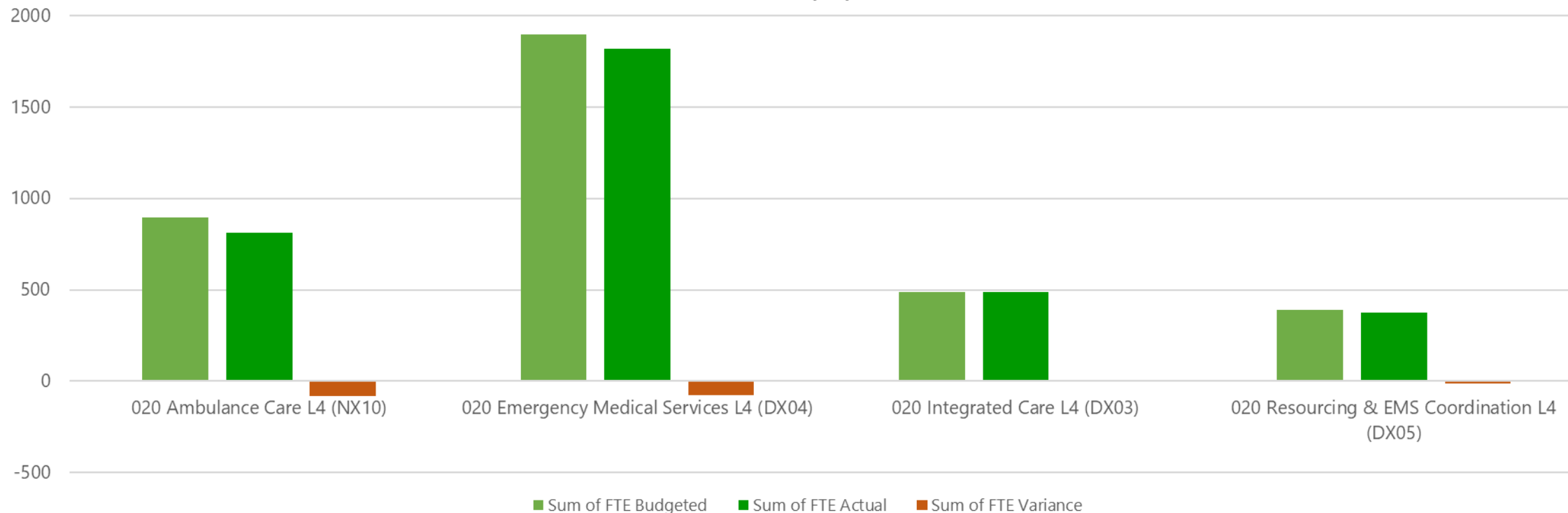
## Remedial Plans and Actions

- Discussions around the future skill mix of our EMS workforce are ongoing, this could have considerable impact on the EMS workforce going forward. However, sufficient training capacity has been planned during 2025-26 to enable the trust to recruit any staff into the organisation, regardless of what grade that may be.

## Expected Performance Trajectory

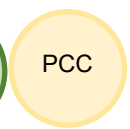
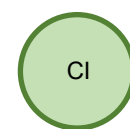
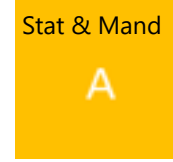
Turnover and FTE trends and themes are being monitored with plans adjusted accordingly.

FTE as of 31/09/2025



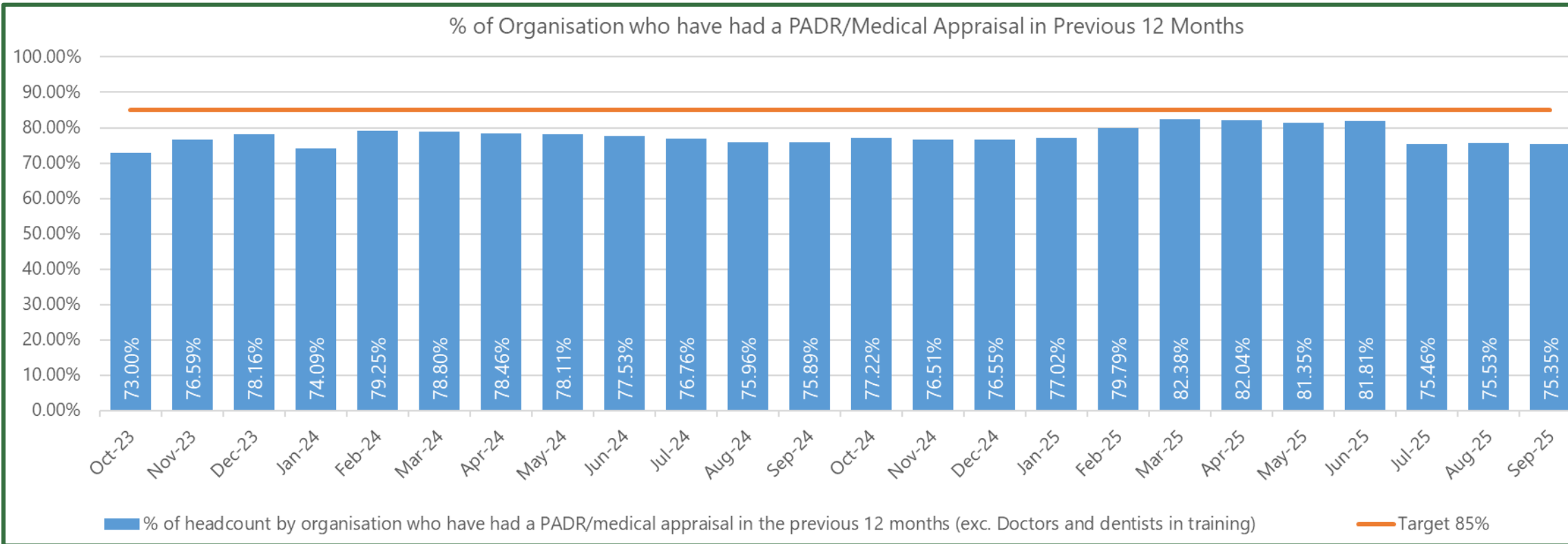
# Our People Capability - PADR and Training Rates Indicators

(Responsible Officer: Angela Lewis)



Health & Care Standard Health – Staff & Resources

Self-Assessment: Strength of Internal Control: Strong



### Analysis

PADR rates (excluding pay progression meetings) minimally decreased from 75.53% in August 2025 to 75.35% in September 2025 and remain below the 85% target. Over the reporting period this target has only been achieved once, in December 2022.

In September 2025 Statutory & Mandatory Training rates reported a combined compliance of 84.61% falling below the 85% target for the second consecutive month.

There are currently 20 Statutory and Mandatory courses that NHS employees must complete in their employment. These are listed in the table:

### Remedial Plans and Actions

Engagement in the PADR process serves as a key metric for evaluating team cultural health. By increasing engagement with the PADR process, our goal is to enhance employee development, support better communication between managers and employees and develop a culture of accountability and continual improvement.

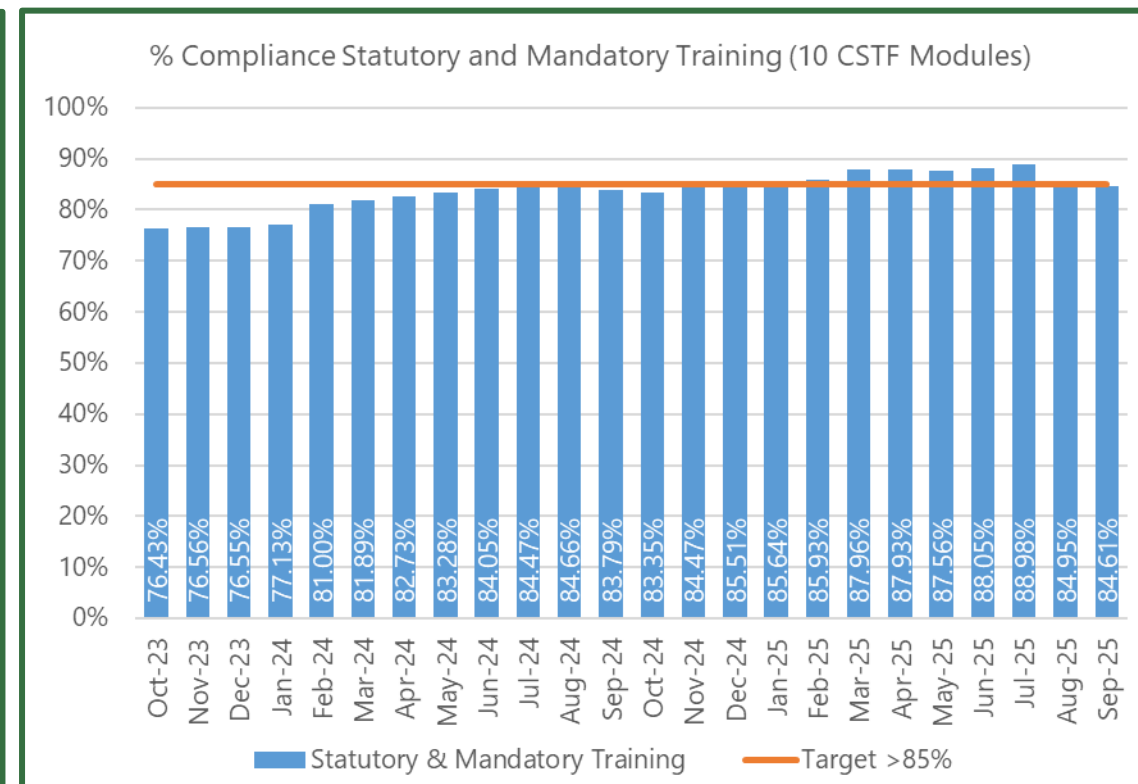
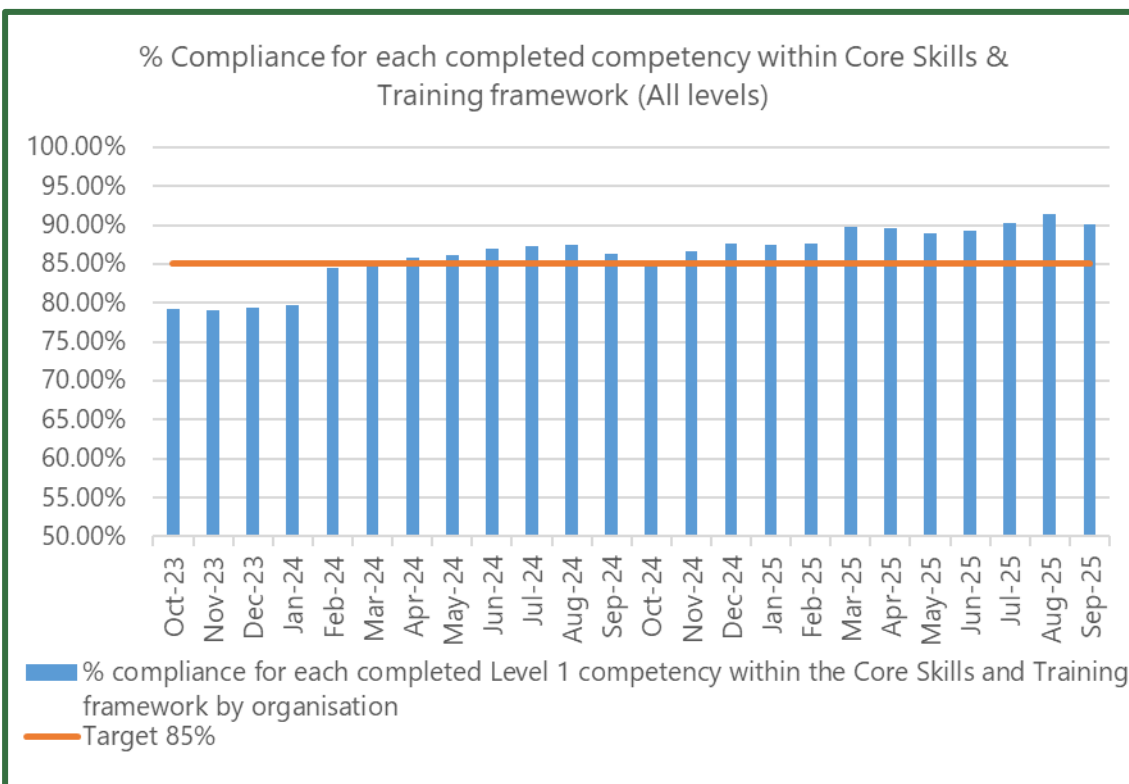
There has been a continuation of the climb toward achievement of the 85% target across the remainder of the Core Skills Training Framework competencies which is projected to continue to increase as more learning content is moved to the user friendly environment enabling easier access to these reportable competencies.

### Expected Performance Trajectory

Performance is improving as compliance has risen.

Skills & Training Framework	NHS Wales Minimum Renewal Standard
Equality, Diversity & Human Rights (Treat me Fairly)	3 years
Fire Safety	2 years
Health, Safety & Welfare	3 years
Infection, Prevention & Control Level 1	3 years
Information Governance (Wales)	2 years
Moving & Handling (Level1)	2 years
Resuscitation	Annually
Safeguarding Adults (Level 1)	3 years
Safeguarding Children (Level 1)	3 years
Violence & Aggression (Wales) Module A	No Renewal
Mandatory Courses	
Violence Against Women, Domestic Abuse and Sexual Violence	3 years
Dementia Awareness	No Renewal
Welsh Language Awareness	3 years
Paul Ridd (Learning Disability Awareness)	No Renewal
Environment, Waste & Energy (Admin & Clerical Staff Only)	Annually
Duty of Quality	3 years
Fraud Awareness	3 years
Prevent Course 1 - Awareness	No Renewal
Duty of Candour	3 years
Anti-Racism	3 years

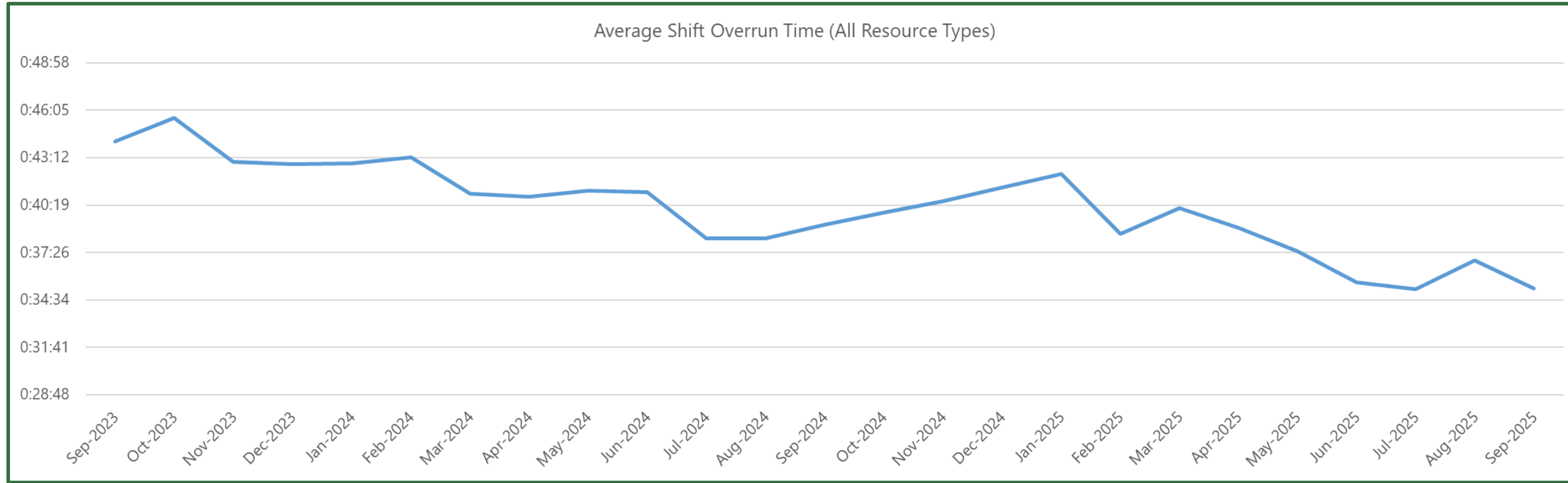
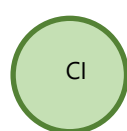
ESR Data correct at time of export. PADR data does not include pay progression.



# Our People

## Health and Well-being – Shift OVERRUNS

(Responsible Officer: Angela Lewis)



### Analysis

There were 3,292 shift overruns during September 2025.

The average overrun figure for September 2025 was 35 minutes and 16 seconds, a slight decrease from August 2025 (36 minutes 58 seconds). The trend continues to be downward over the past two years.

The highest volume of shift overruns occur within the 0 to 60-minute category, accounting for 76% of the total. 18.1% fall within the 61 to 120-minute category, 4.1% in the 121 to 180-minute category, 0.3% in the 181 to 240-minute category and 0.1% in the 241 minutes and over category.

### Remedial Plans and Actions

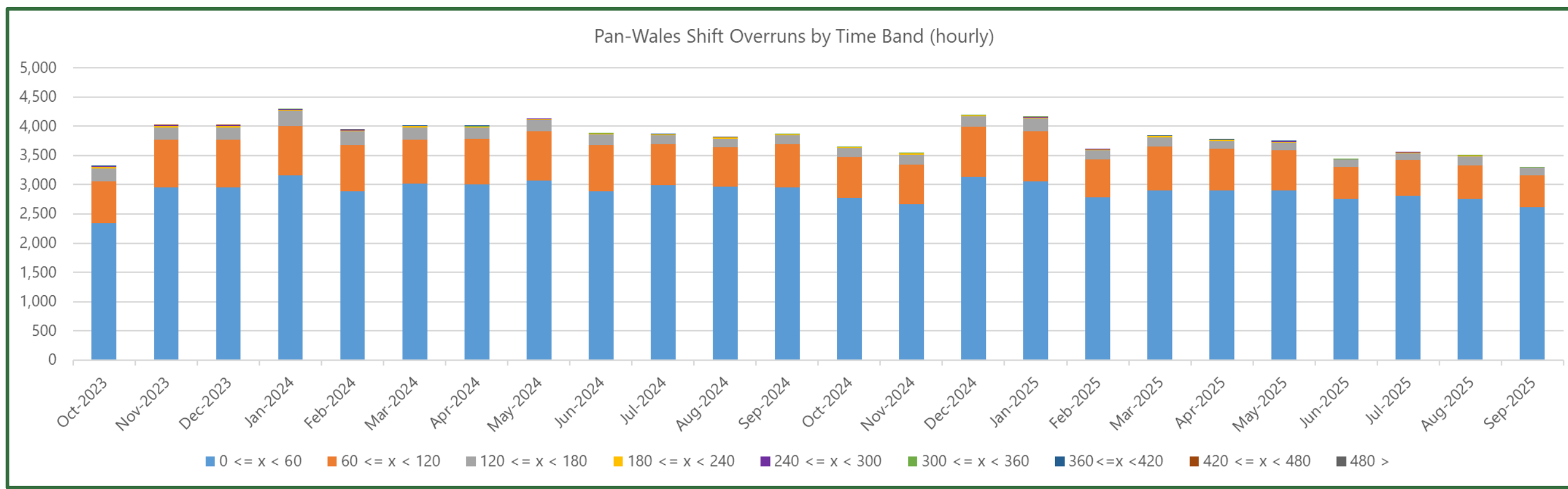
Shift overruns are a key element of staff wellbeing and work is ongoing to mitigate these in conjunction with handovers, as although not shown here there is a clear correlation.

Collaborative work is ongoing with our Trade Union Partners via a dedicated Task and Finish group to find ways to reduce overruns for our people.

Modelling on another option has just been completed and will be shared with TU partners.

### Expected Performance Trajectory

Overruns correlate with handover lost hours and may begin to decrease as handover times continue to reduce.

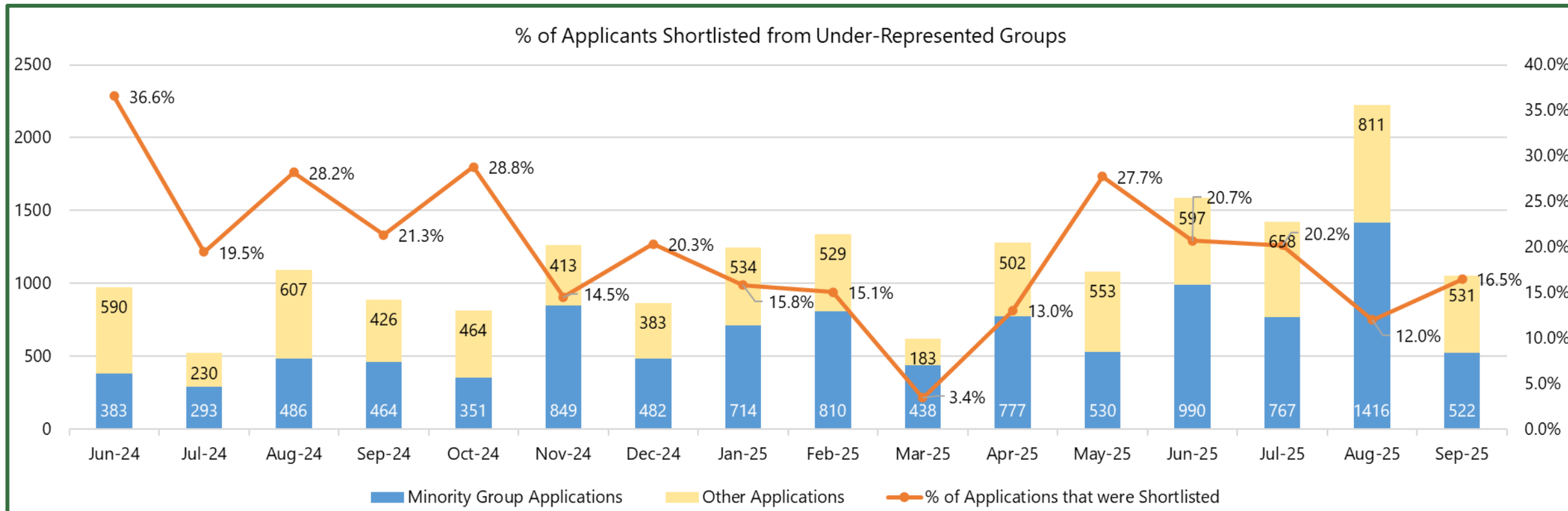
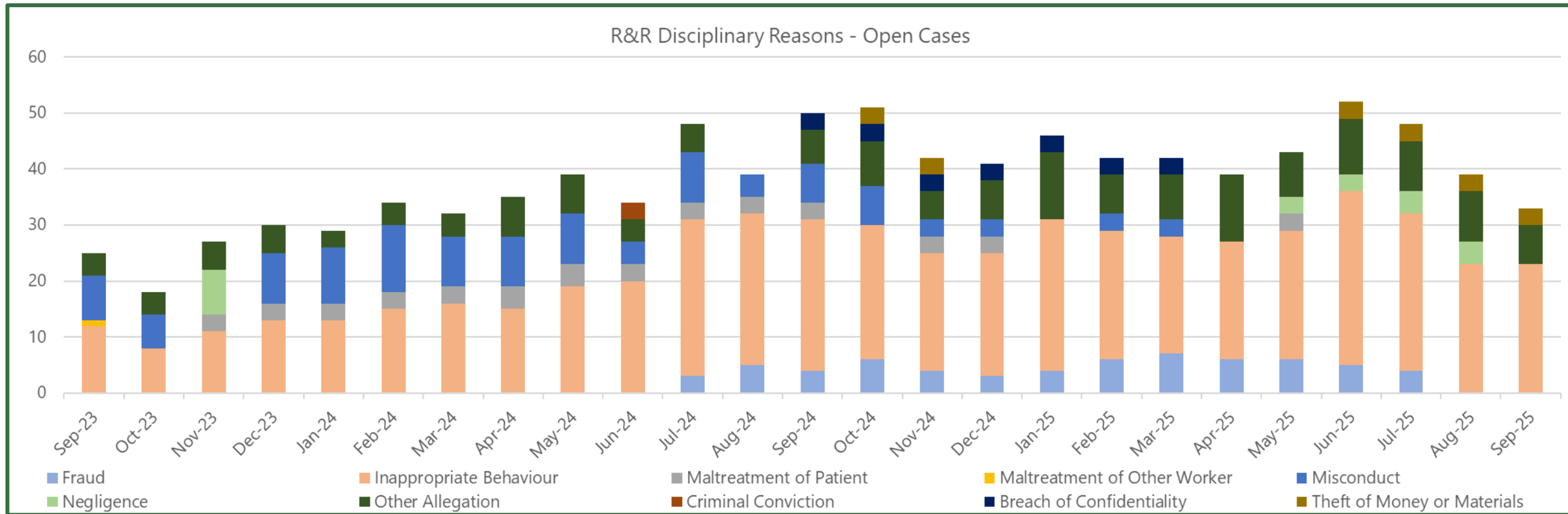


# Our People

## Culture – Number of R&R Disciplinary Hearings and Number of Applicants Shortlisted from Under-Represented Groups

(Responsible Officer: Angela Lewis)

Self-Assessment:  
Strength of Internal  
Control: Moderate



### Analysis

There were 41 open formal disciplinary cases recorded at the end of September 2025, compared to 42 in August 2025. Of these Disciplinary cases, 56% are due to allegations of inappropriate behaviour.

There were 12 open formal Respect and Resolution cases in September 2025, a slight decrease from 13 reported in August 2025. (Previous increase due to R&Rs in relation to Roster Reviews).

The bottom graph shows that in September 2025, 1,053 job applications were processed, and 204 interviews planned.

Of the 1,053 applications, a total of 522 were from under-represented groups with 322 in the category of Ethnicity, 115 within Disability and 85 identifying within Sexual Orientation.

In September 2025, 16.5% (n=86) of all applications from under-represented groups made it through shortlisting and were invited for interview. This was an increase from the 12% in August 2025.

### Remedial Plans and Actions

**R&R Formal Disciplinary Cases:** Continue to monitor. The Trust has a substantial programme of work in place, connected to behaviours.

**Applications:** Work continues with the digital directorate, and the ED&I team to host recruitment workshops for Black, Asian and Ethnically diverse applicants and unconscious bias training for those sitting on interviews panels. Mini multiple interviews are being undertaken more widely across the Trust following positive feedback from candidates and more consistent scoring from panels making the process fairer and less bias for all involved.

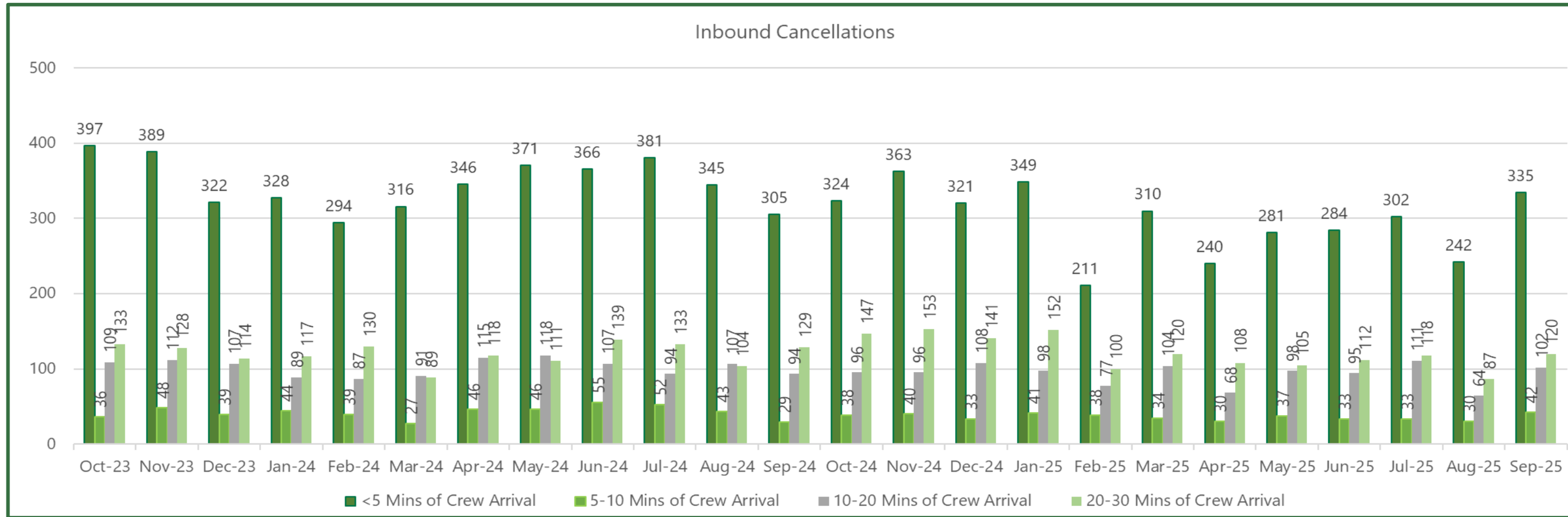
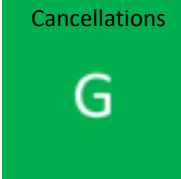
### Expected Performance Trajectory

Continue to monitor levels, no trajectory for this measure.

# Finance, Resources and Value

## Value: Ambulance Care Indicators

(Responsible Officer: Lee Brooks)



### Analysis

Inbound cancellations of 5 minutes or less of the crew arrival time saw an increase in September 2025 to 335, compared to 242 in August 2025. The total number of cancellations within 30 minutes also increased from 423 in August 2025 to 599 in September 2025.

Same day cancellations decreased slightly in September 2025 to 14.3% compared to August 2025 (14.7%).

Capacity Management Plan (CMP) cancellations decreased from 2,734 in August 2025 to 2,407 in September 2025.

### Remedial Plans and Actions

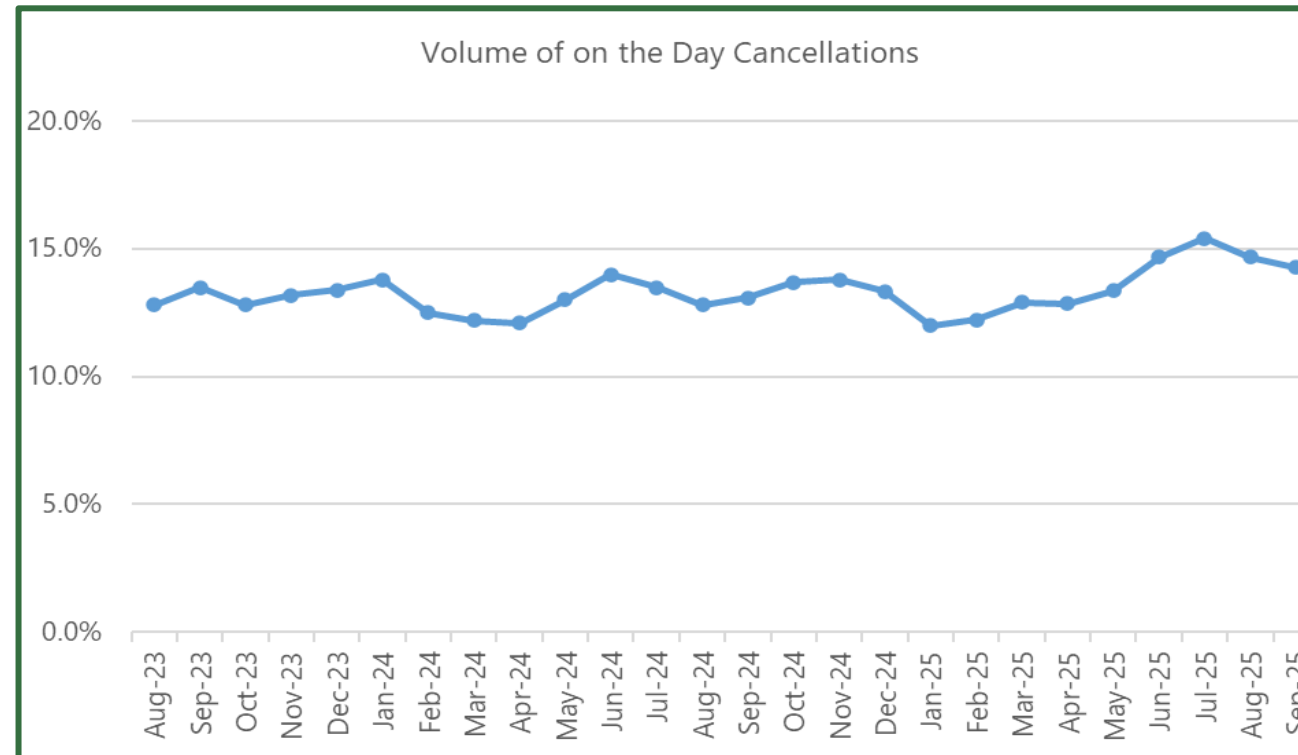
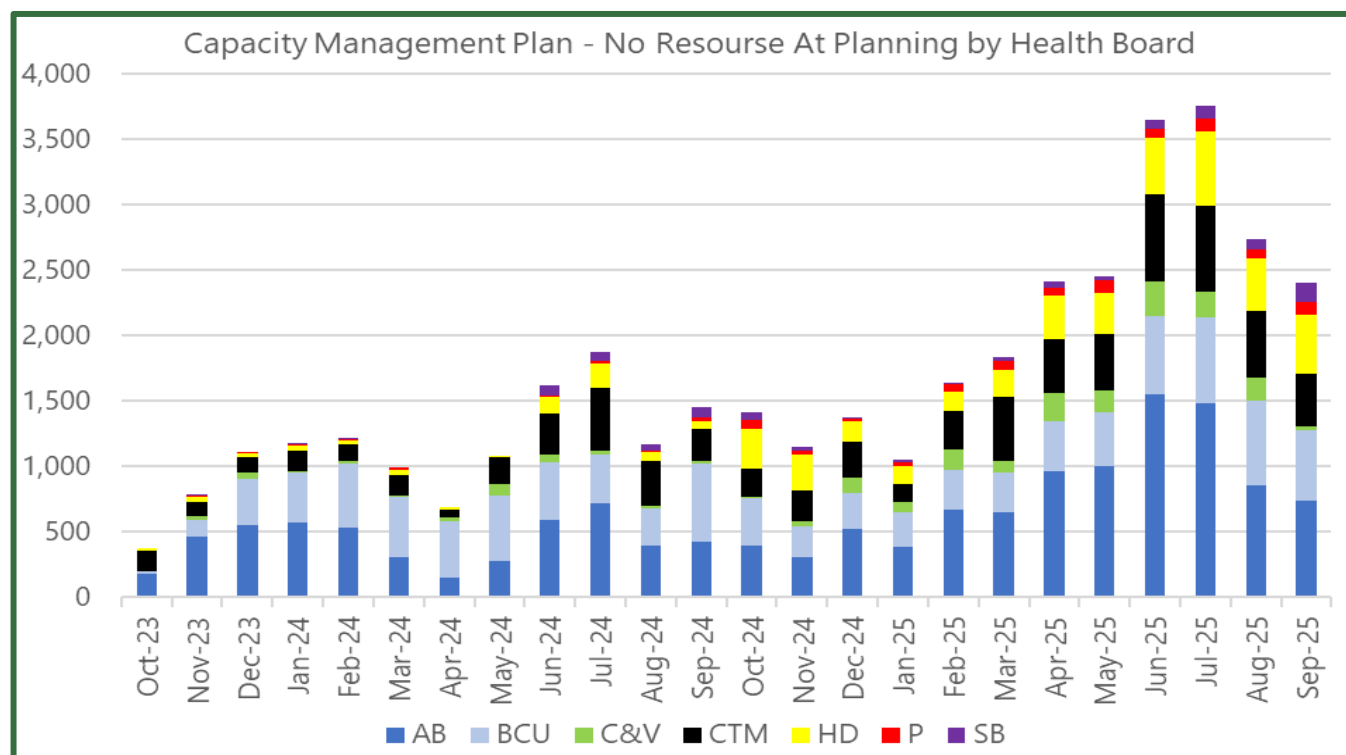
The work with Hywel Dda to connect patient management systems went live in August and is now in a BAU position. Although still in its infancy, a continued stream of avoided late notice cancellations has been observed.

The biggest challenge and risk to the service lies in the level of capacity management cancellations. Focused work has commenced in Aneurin Bevan and a significant decrease in cancellations has been observed. Similar work will commence in other areas through September.

### Expected Performance Trajectory

It is anticipated that CMP cancellations will continue to reduce in September.

*Please note that that figures may be lower than overall totals due to some records having no cancellation date.*



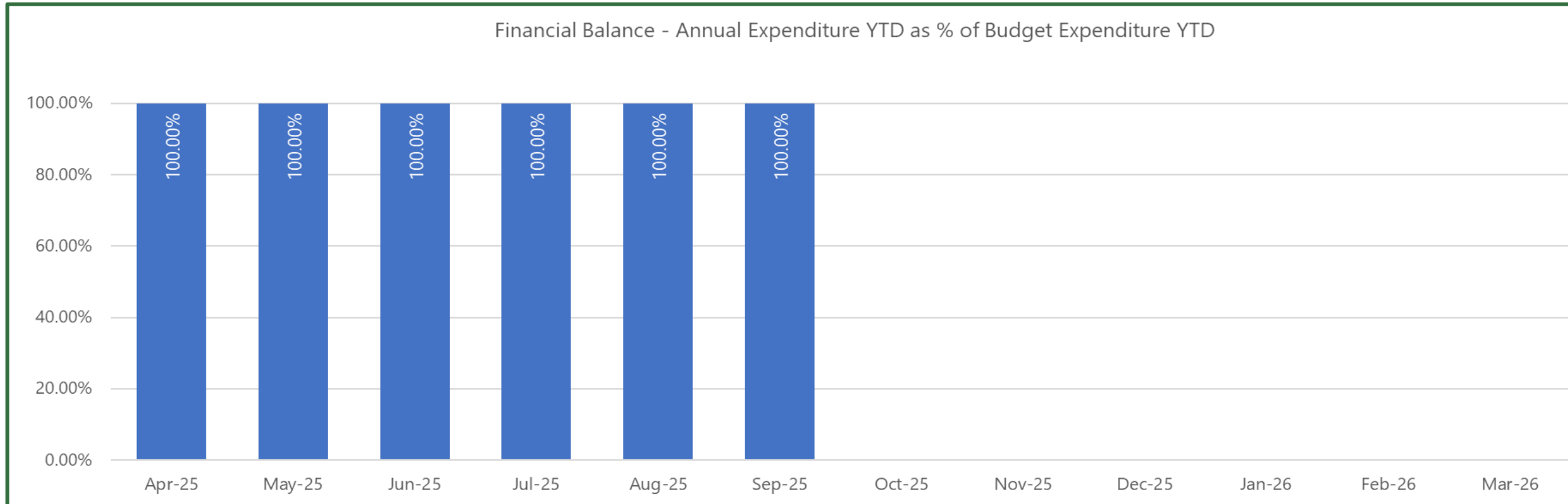
# Finance, Resources and Value

## Value - Finance Indicators

(Responsible Interim Officer: Ed Ringrose)

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### Analysis

The reported outturn performance at Month 6 is a deficit of £0.186m, with a forecast to the yearend of breakeven.

For Month 6 the Trust is reporting planned savings of £4.216m and actual savings of £4.260m (an achievement rate of 101.0%).

The Trust's cumulative performance against PSPP as at Month 6 is 98.8% against a target of 95%.

At Month 6 the Trust is forecasting achievement of both its External Financing Limit and its Capital Resource Limit.

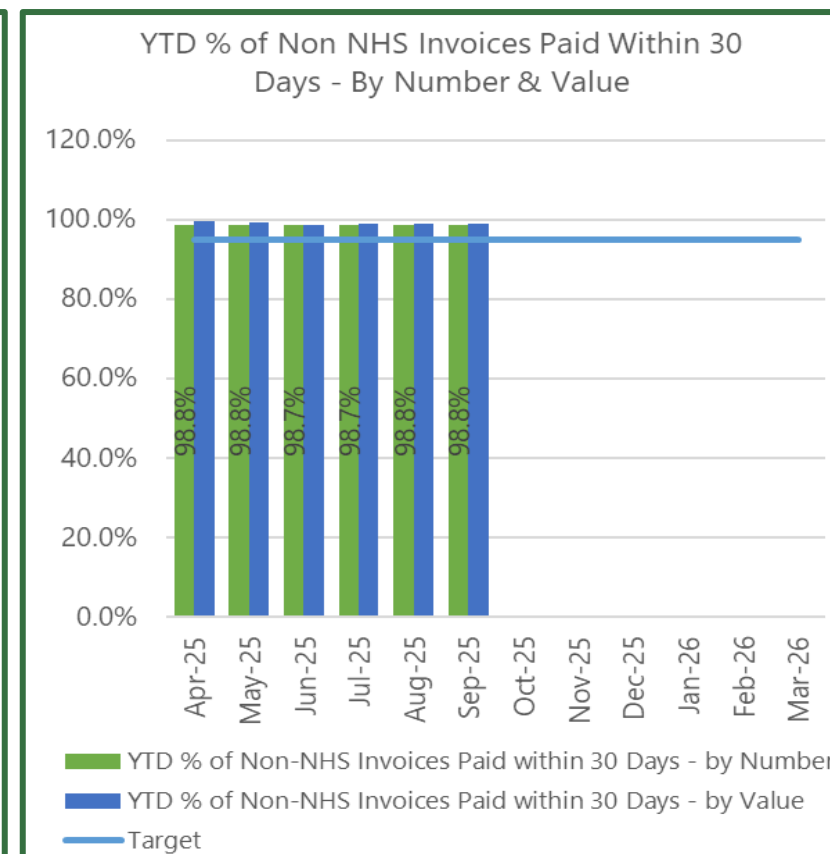
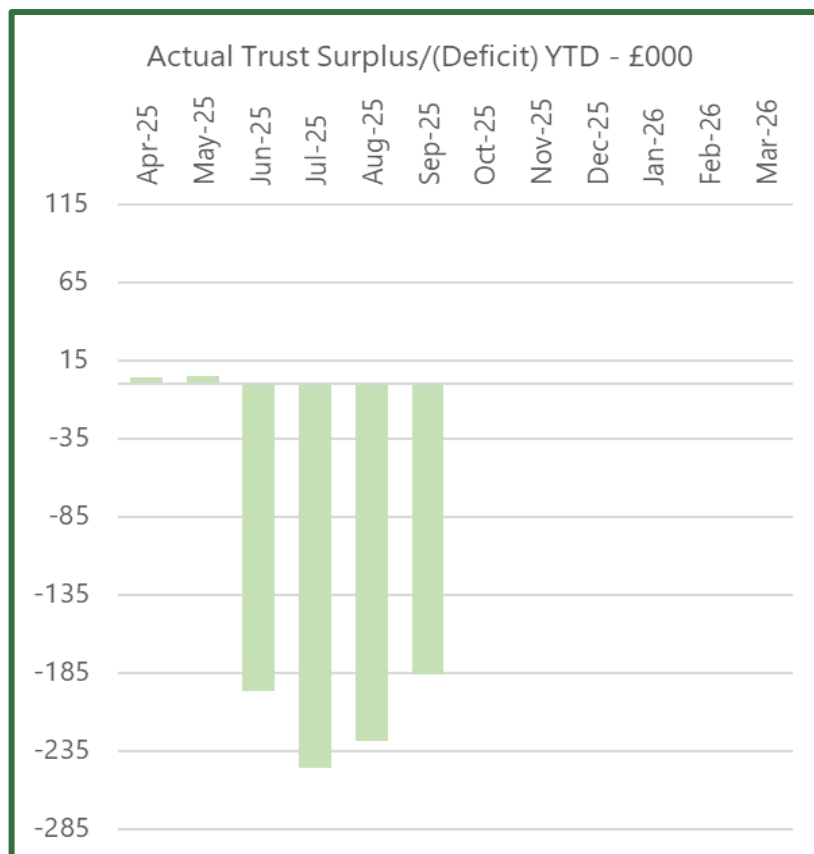
### Remedial Plans and Actions

There is no remedial plan required given the Trust is forecasting to breakeven; however, as the Trust moves into 2025/26 key areas of focus include:-

- Undertaking a review of commercial opportunities for income generation (once Head of Commercial Development is in post) .
- A continued focus on the Trust's financial sustainability programme.
- Improved governance for Value Based Health Care, with a particular focus on benchmarking; and
- An improved approach to benefits realisation

### Expected Performance Trajectory

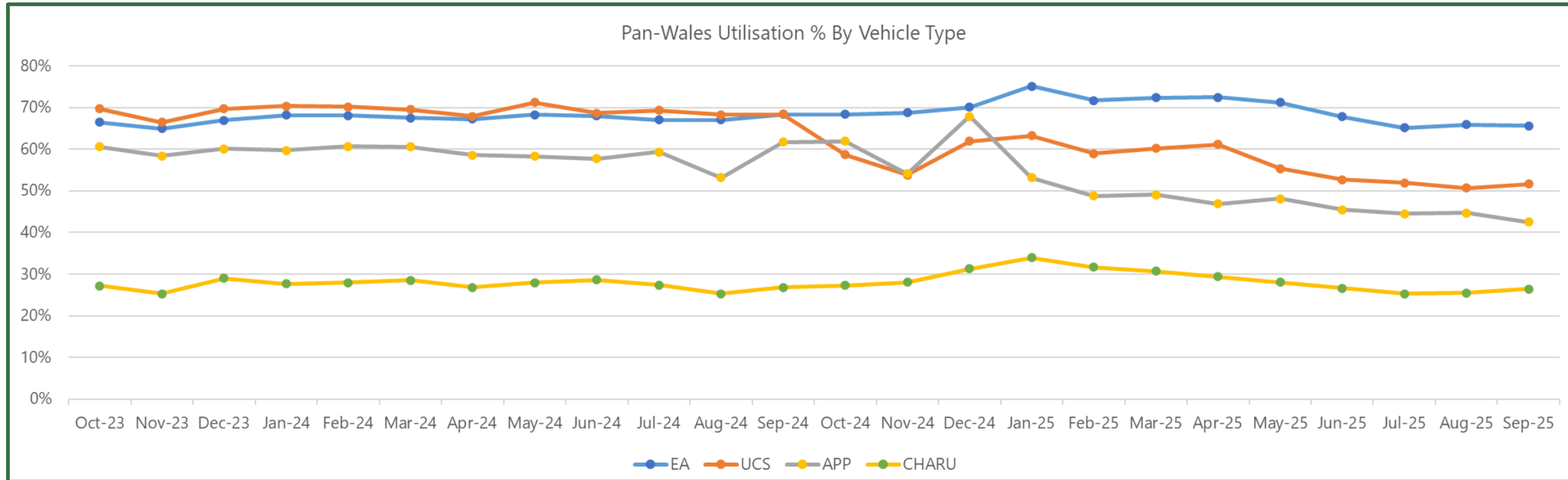
The expectation is that the Trust will continue to meet its statutory financial duties, as outlined in its IMTP for the 2025/26 financial year; however, it is expected that the Trust will continue to operate in a challenging financial environment and will need to deliver a planned level of savings in the 2025/26 financial year of c£8.5m.



# Finance, Resources and Value EMS Utilisation

(Responsible Officer: Lee Brooks)

*NB: Data quality issues have been identified within APP & CFR data. These are currently being addressed.*



### Analysis

**Pan Wales Utilisation metrics in September 2025 were 51.3% for all vehicles types, a minimal decrease from 51.7% in August 2025.** EA saw the highest rate during the month at 65.6%, a minimal decrease but returning to an upward trend for the beginning of the year. The optimal utilisation rate for EAs needs to be lower so that they are free to respond to incoming calls.

CFR data collation is under review due to the new Assemble system going live in June 2025. At present hours for which a CFR volunteers are entered manually by the individual, however, there is work ongoing to connect this to the current CAD system from which they are dispatched to appropriate call codes. From the data available, in September we can see that CFRs were allocated to 607 EMS incidents and responded to 369. In September 2025 80.5% Community First Responders attendances where they were the first response arriving at the scene.

### Remedial Plans and Actions

EA and UCS jobs per shift is fundamentally a product of handover delays.

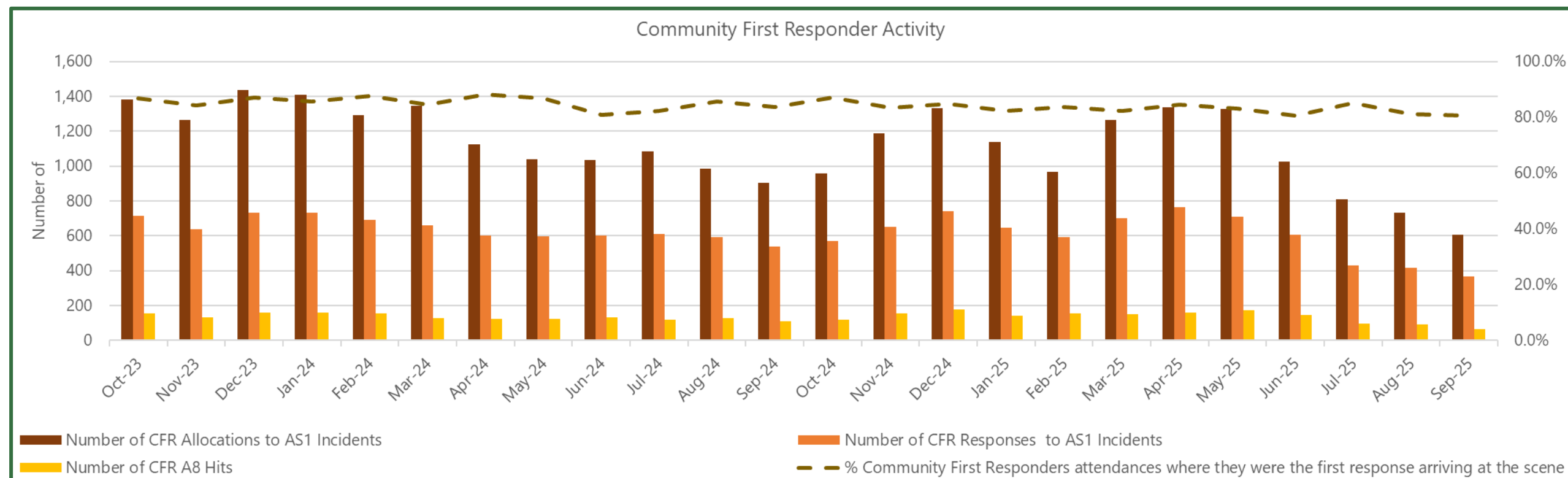
For APPs, the APP Recruitment Task & Finish Group will give a focus on further improvement, in particular, improved information and a re-roster.

CHARU is a particular area of focus. Analysis indicates that CHARU contribution to Red compares favourably with the previous resource: RRVs.

Work ongoing to connect Assemble and CAD for all CFR and Community Welfare Responders (CWR) hours.

### Expected Performance Trajectory

The Trust's ability to reduce the high utilisation rates for EAs and UCS is a product of handover, which it does not control. The Trust would expect an increase in CHARU utilisation and a decrease in EA utilisation during 2025/26 linked to the remedial actions identified above.



# Finance, Resources and Value

## Average Job/Shift Times

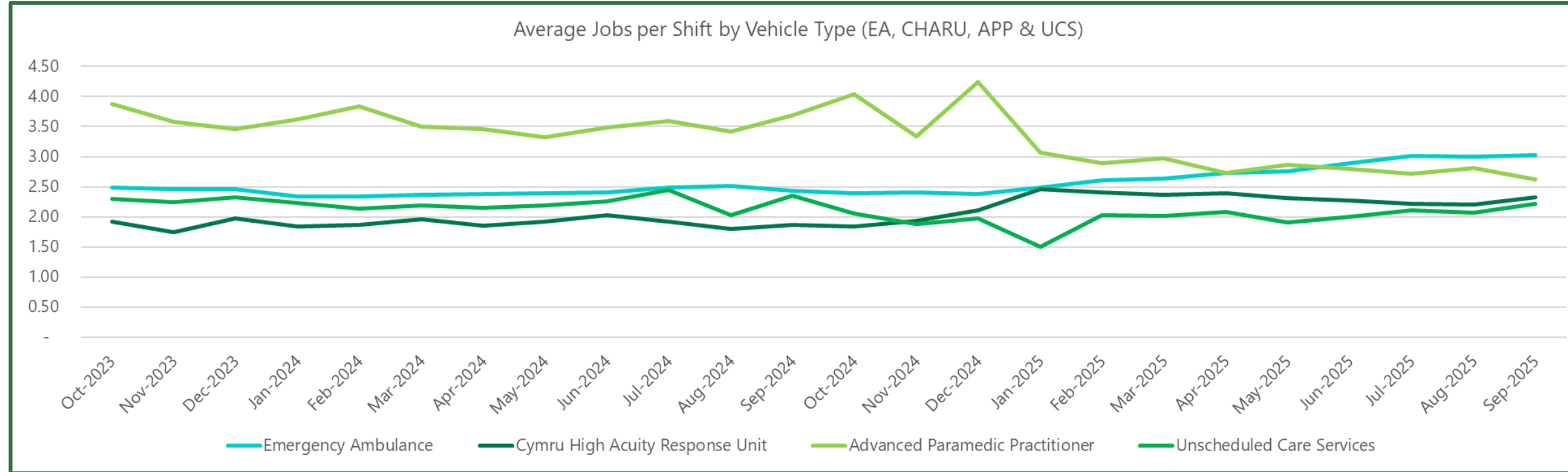
(Responsible Officer: Lee Brooks)

Jobs Per Shift

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*NB: Data quality issues have been identified within APP data. These are currently being addressed.*

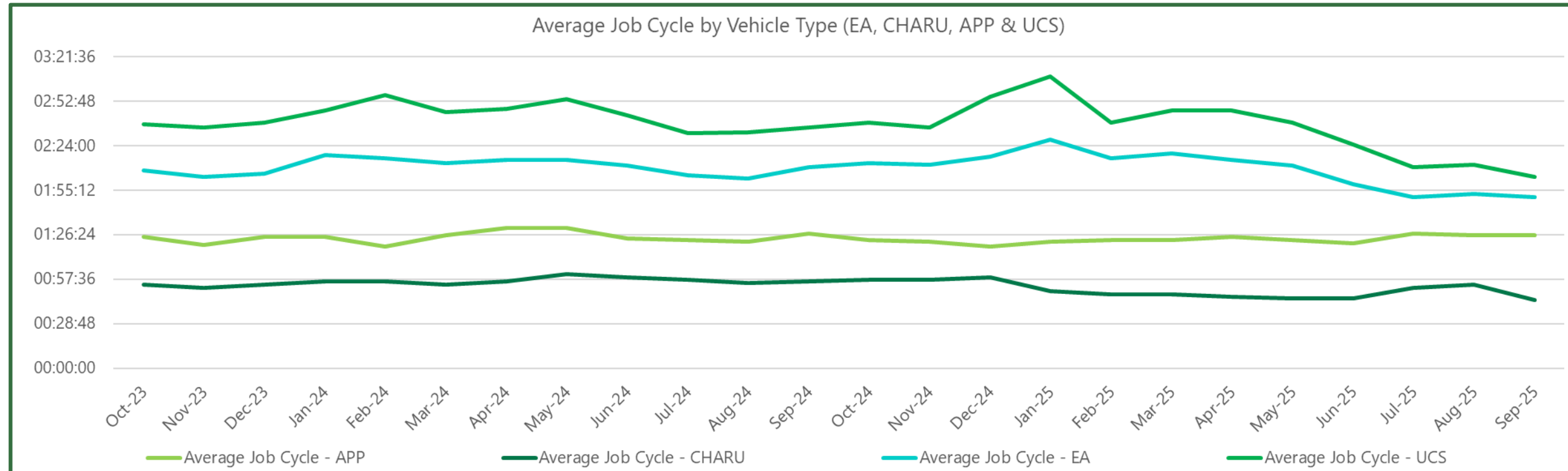


### Analysis

Overall average jobs per shift was 2.39 in September 2025, a slight increase from August 2025 (2.36). EAs averaged 3.03 jobs per shift and UCS crews 2.21. Discussions with ORH indicate that 3.03 jobs per shift for EAs is higher than might be expected with the current levels of handover, with a definite upward trend as handover lost hours have come down.

APPs attended on average 2.63 jobs per shift and CHARU's 2.32. However, both sets of data need to be reviewed. The current priority is phase 2 of the Ambulance Performance Framework, with further capacity being recruited into to support the Insight & Data Services function.

As demonstrated in the bottom graph, the average job cycle decreased slightly in September 2025 for EAs (1 hours 51 minutes) and UCS (2 hours 4 minutes) and CHARU (44 minutes). APPs (1 hour 26 minutes) remaining the same as the previous month.



# Partnerships / System Contribution

## NHS111 Hand Off Metrics and NHS111 Consult & Close Indicators

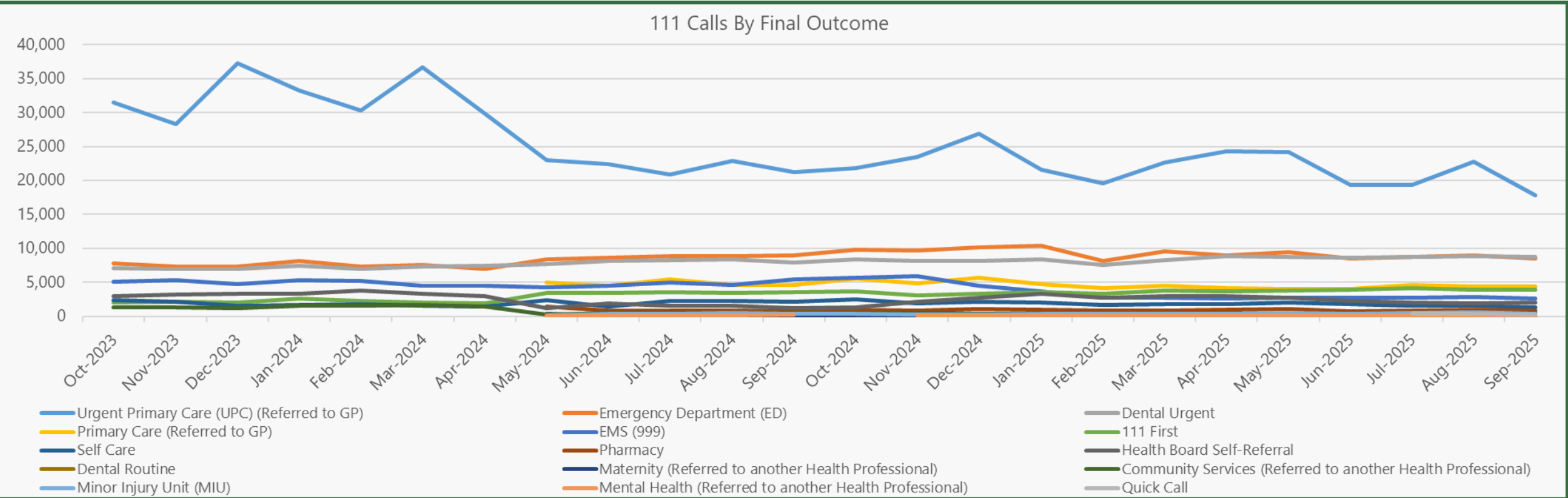
### Influencing Factors – Demand and Clinical Hours Produced

Dental  
A

C&C Volumes  
A

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(Responsible Officer: Lee Brooks)



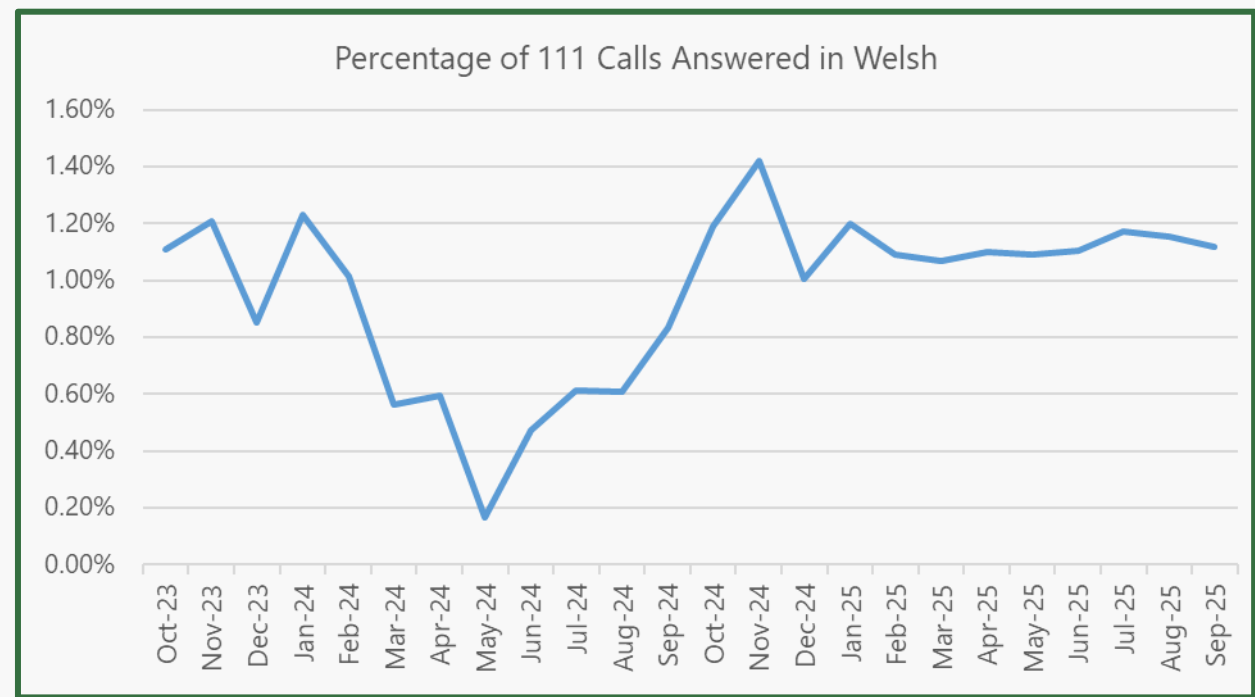
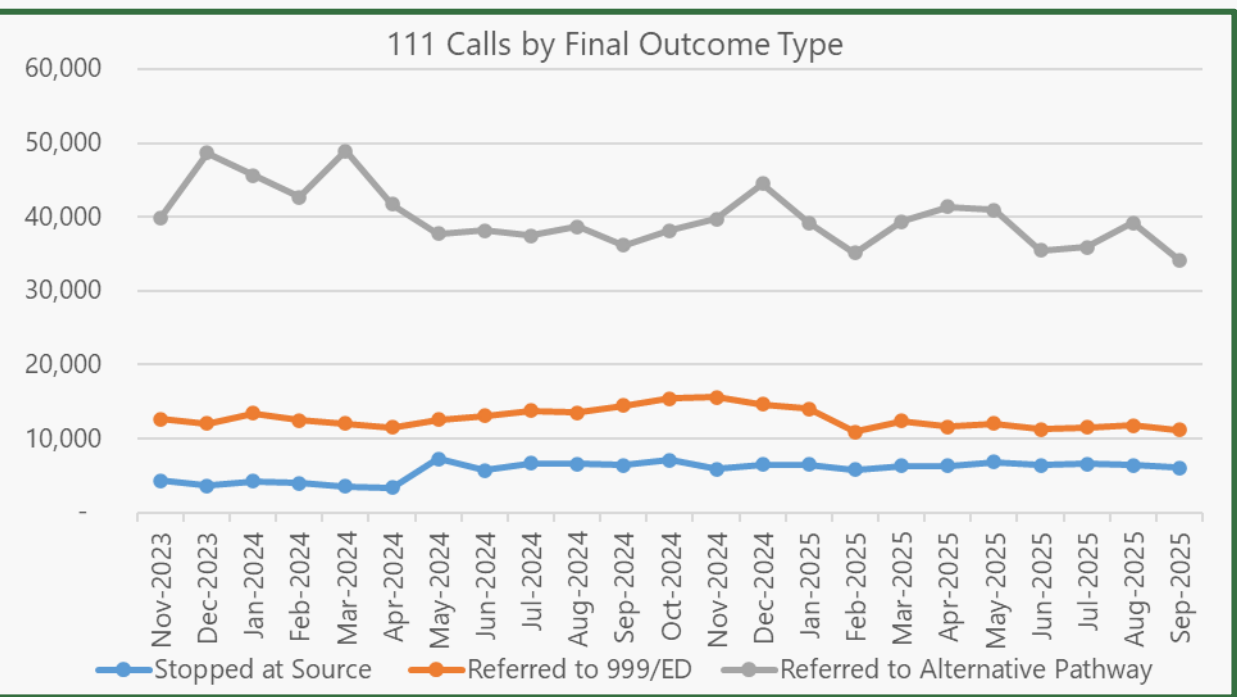
**Analysis**

During September 2025, 55,411 calls were allocated into the 14 categories displayed in the graph opposite; a decrease compared to the 57,446 seen during August 2025. However, data quality issues within 111 reporting have been addressed.

Calls Referred to a General Practitioner (handover of care) continued to be the top outcome for NHS111 accounting for 32.24% of all calls during September 2025, but there has been a material drop since the implementation of the new 111CAS system.

As the bottom left graph highlights, in September 2025, 6,029 calls were 'Stopped at Source', with no onward referral, a slight decrease from 6,427 in August 2025. 11,170 calls were referred to 999/ED in September 2025.

The percentage of 111 calls answered in Welsh decreased slightly from 1.15% in August 2025 to 1.12% in September 2025. This equated to 69.6% of all 111 calls being offered in Welsh being answered.



**Remedial Plans and Actions**

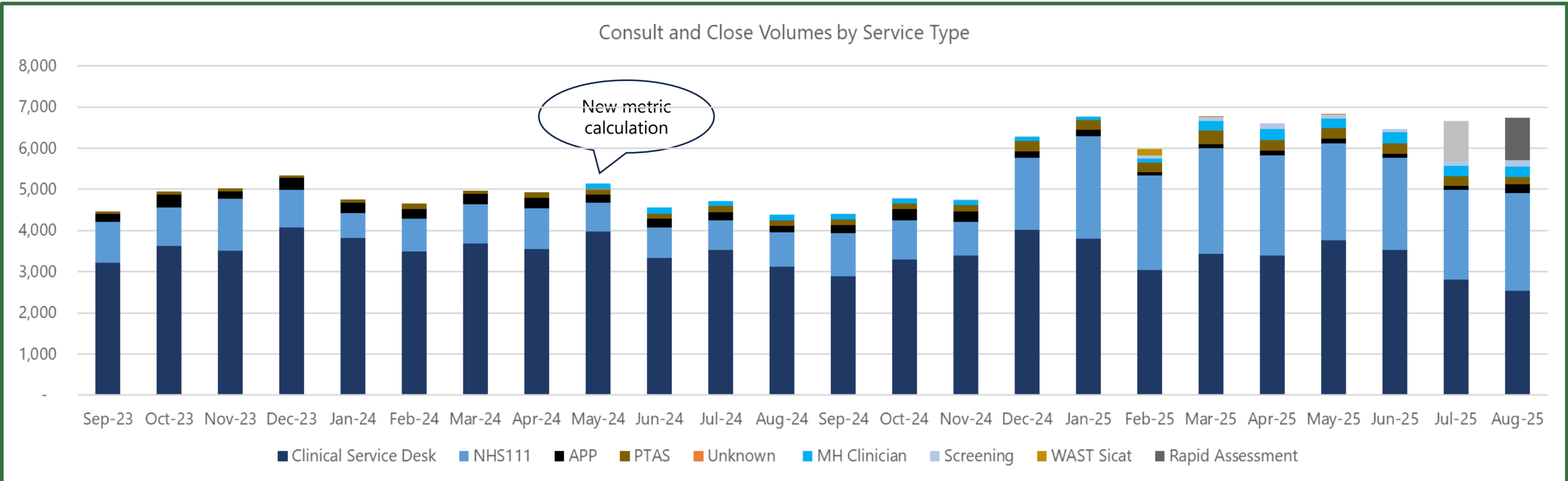
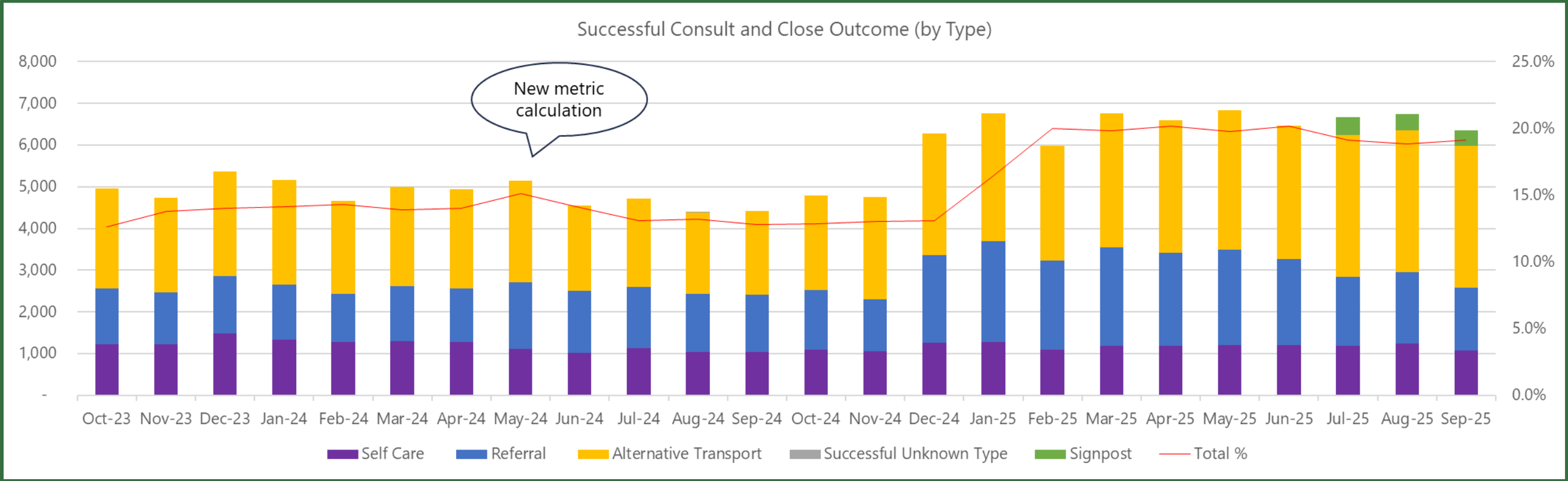
There is currently a 111 Measures Task and Finish Group. This is a collaborative meeting between WAST, Six Goals, commissioners and DHCW. The focus is the development of a nationally reportable 111 data set, similar to what is currently in place for Ambulance Service Indicators (ASIs). Part of this work involves looking at the reporting of disposition final outcomes.

**Expected Performance Trajectory**

No performance trajectory is set at this time, as the Trust develops its measures and systems around these metrics. Once developed there will be an opportunity to develop benchmarks. The focus remains to shift left, where it is clinically safe and appropriate to do so.

# Partnerships / System Contribution Consult & Close Indicators

(Responsible Officer: Lee Brooks)



## Analysis

The new **Consult and Close** definition was agreed by Commissioners in May 2025 with reporting recommencing in June 2025 after backdating data collation to May 2024.

Contributions from Clinical Service Desk (CSD) (8.10%), NHS111 (5.70%), WAST APP (0.60%), Health Boards using Physician Triage and Streaming Service (PTAS) (0.80%), Mental Health Clinician (0.80%), Screening (0.30%) and Rapid Assessment (2.40%) achieved 18.7% in September 2025, a minimal decrease compared to August 2025 (19.1%), but still achieving the 17% IMTP ambition for the eighth consecutive month. In September 2025, the number of 999 calls resulting in a Consult and Close outcome was 6,352, up from 4,412 in September 2024.

Of the calls successfully closed in September 2025, 62 patients received an outcome of self-care; 716 patients were referred to other services (including to Minor Injury Units and SDEC), 845 were advised to seek alternative transport services to acquire treatment and 317 were signposted.

## Remedial Plans and Actions

- Work underway reviewing processes, has yielded efficiencies in remote clinical support.
- Implementation of 15 recommendations from commissioner review.

## Expected Performance Trajectory

Further improvement is expected linked to CSD staff attendance (reduced abstractions and less vacancies) and the CMT model. The ambition remains 17%.

# Partnerships / System Contribution Conveyance to ED Indicators

(Responsible Officer: Andy Swinburn)

Conveyances

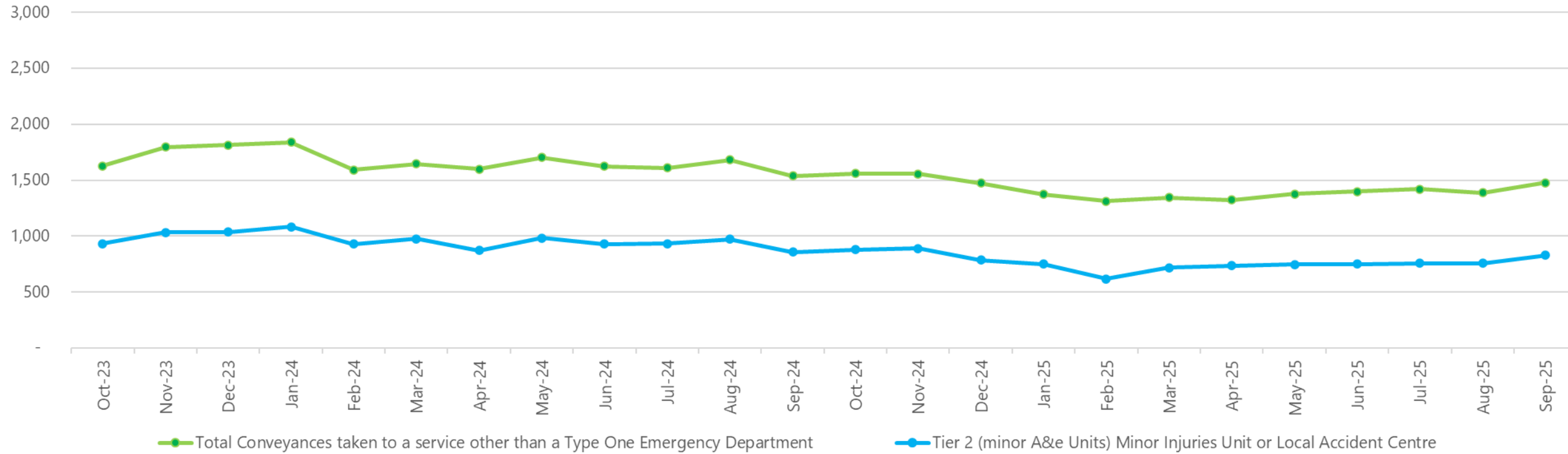
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Ministerial Measure

*NB: Data quality issues have been identified in APP data. These are currently being addressed.*

Total Conveyances taken to a Service other than a Type One Emergency Department vs Total Conveyances to a Minor Injury Unit



## Analysis

In September 2025 10.24% of patients (1,476) were conveyed to a service other than a Type One ED. 5.7% (829) were conveyed to a Tier two Minor Injuries Unit or Local Accident Centre while 38.15% of patients were conveyed to a major ED, as a percentage of verified incidents.

The combined number of incidents treated at scene or referred to alternate providers slightly increased, from 3,703 in August 2025 to 3,757 in September 2025.

Percentage of patients conveyed to SDEC units minimally increased in September 2025 to 0.5% from 0.44% the previous month.

Taxi conveyance has remained consistent for the past 12 months, averaging 842 per month to hospitals.

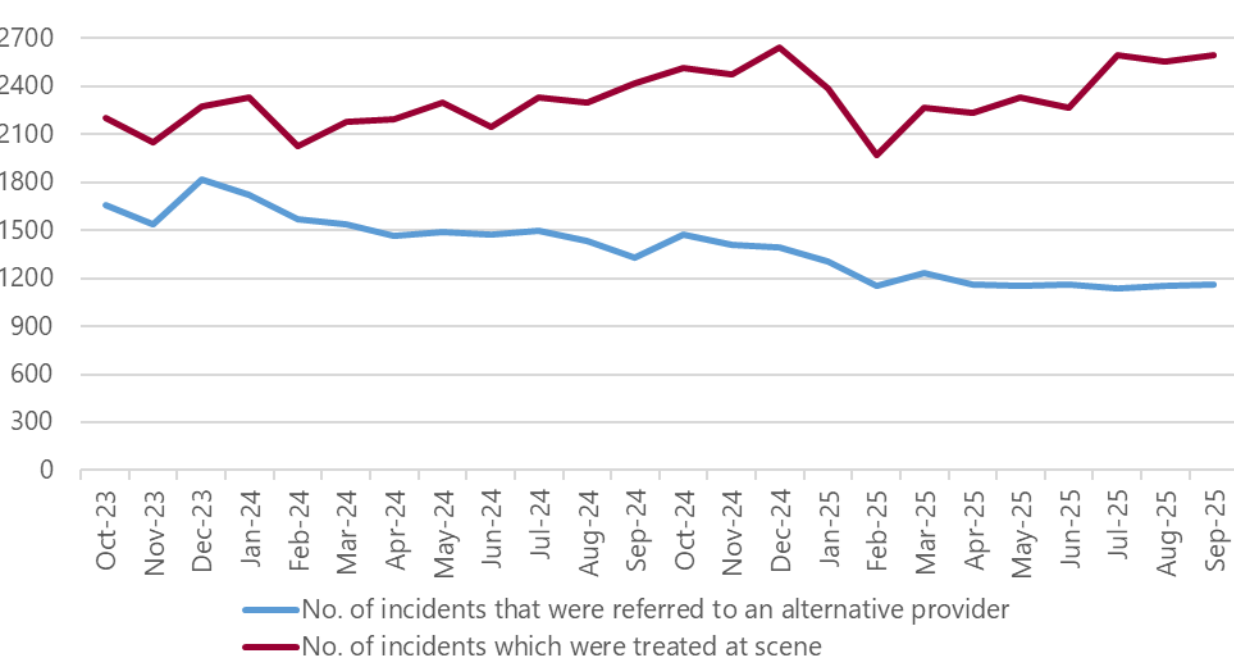
## Remedial Plans and Actions

- Further investment in the APP workforce.
- Formal education support and induction package for APPs agreed trust-wide.
- Embedding the Urgent Care response within the Clinical Model Transformation, tasking optimisation (alongside HB partners if available), scheduling care and APP development and workforce.
- Inclusion of specific Frailty and Falls workstream within Urgent Care Response Service with involvement in the review of the All-Wales Falls Response Framework alongside NHS Executive Colleagues.

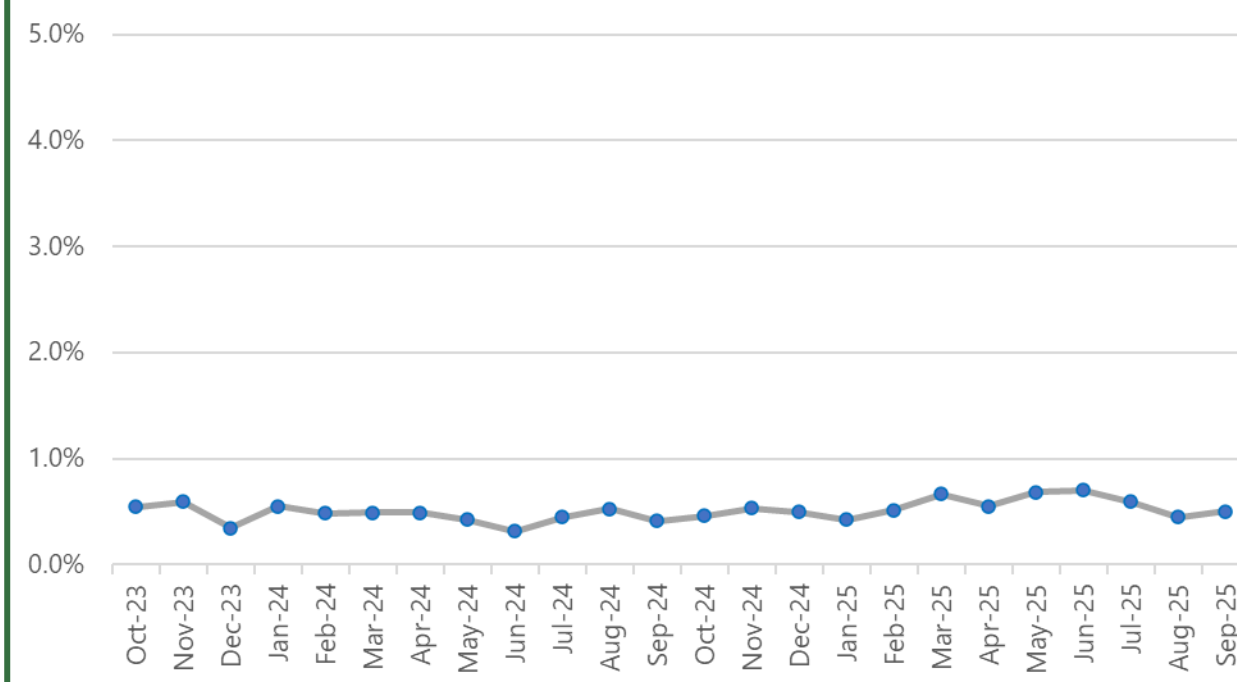
## Expected Performance Trajectory

The 2023 EMS Demand & Capacity Review (strategic) models various future states. The modelled scenarios indicate that the Trust will need to evolve its clinical model with health boards also significantly reducing handover e.g. 12,000 hours or 7,500 hours, alongside varying levels of investment. Seasonal modelling continues to be undertaken.

Incidents Treated at Scene VS Incidents Referred to Alternative Providers (Ambulances Stopped)



% Patients Conveyed to SDEC Units Pan-Wales



# Partnerships / System Contribution

## Handover Indicators

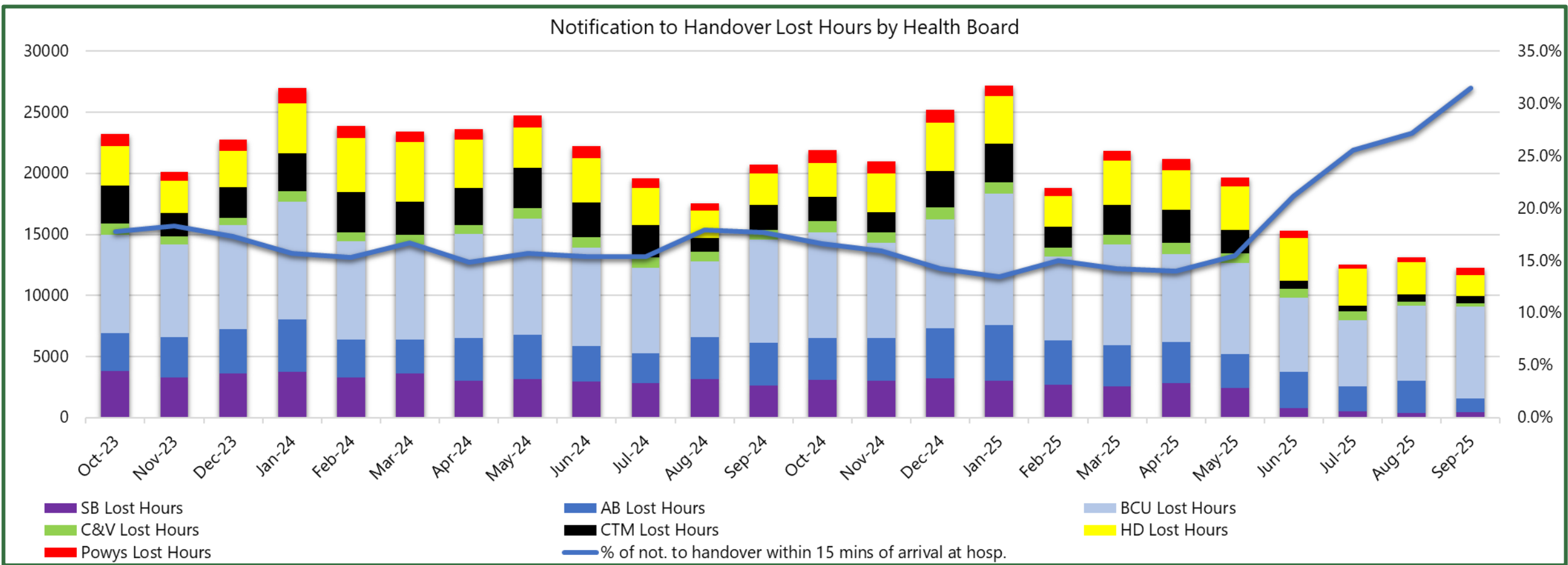
(Responsible Officer: Health Boards)

Lost Hours

R

CI

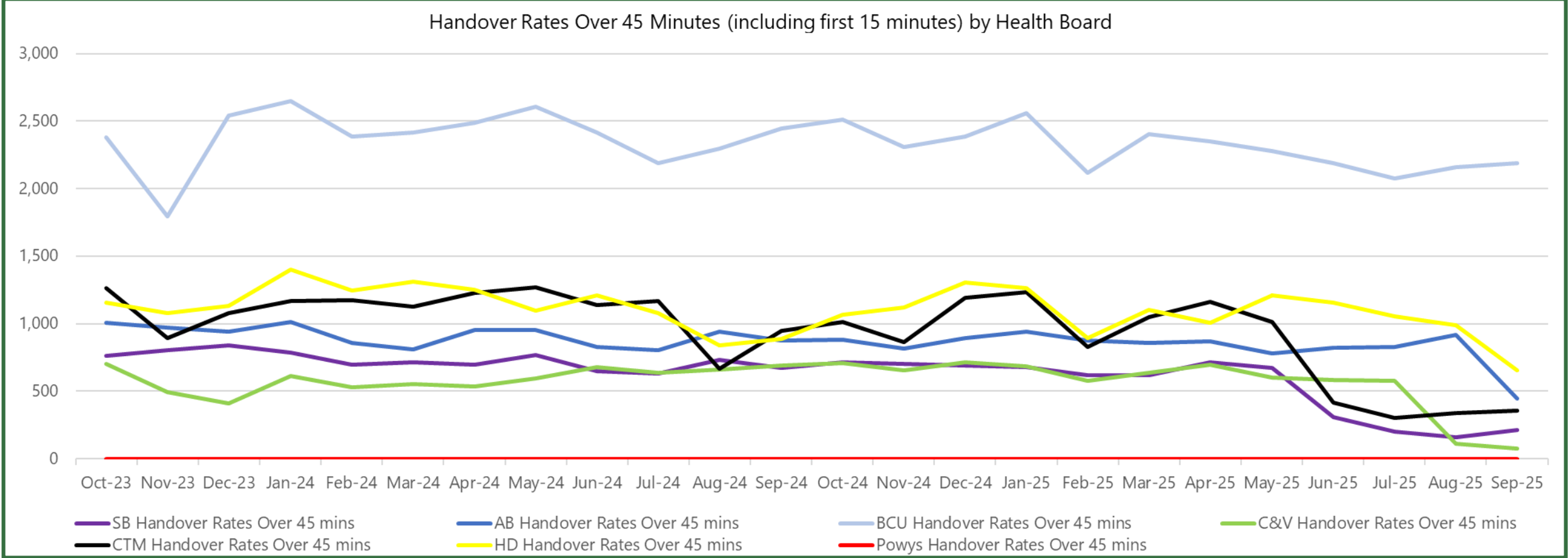
QUEST



**Analysis**  
**230,091 hours were lost to Notification to Handover, i.e. hospital handover delays, over the last 12 months (Oct-24 to Sep-25), compared to 268,832 hours over the same timeframe the previous year.** There were 12,284 hours lost in September 2025, which is 40.6% lower than the 20,693 hours lost during September 2024 and is the lowest monthly figure since July 2021. Three health boards have seen further reductions, compared to last month, particularly Aneurin Bevan (59.25%), Hywel Dda (35.28%) and Cardiff & Vale (16.46%).

The hospitals with the highest levels of handover delays during September 2025 were:

- Ysbyty Gwynedd Hospital (BCUHB) at 2,961 lost hours
- Ysbyty Maelor Hospital (BCUHB) at 2,514 lost hours
- Ysbyty Glan Clwyd (BCUHB) at 1,946 lost hours
- Grange University Hospital (ABUHB) at 1,056 lost hours
- Worthybush Hospital (HDUHB) at 776 lost hours



Notification to handover lost hours averaged 409 hours per day during September 2025 (30 days) compared to 424 hours per day (31 days) in August 2025.

In September 2025, the Trust could have responded to approximately 3,875 more patients if handovers were reduced, which highlights the impact these numbers are still having on the service.

**Remedial Plans and Actions**  
 Significant time has been spent by all Executives and non-Executives highlighting this patient safety issue to Commissioners, HBs and Welsh Government/Ministers, which have been listened to.

**Expected Performance Trajectory**  
 The likely expected ambition from Welsh Government is no waits over 45 minutes. W45 workshops have been facilitated with each health board by NHSWales Performance & Improvement (previously the NHS Executive).

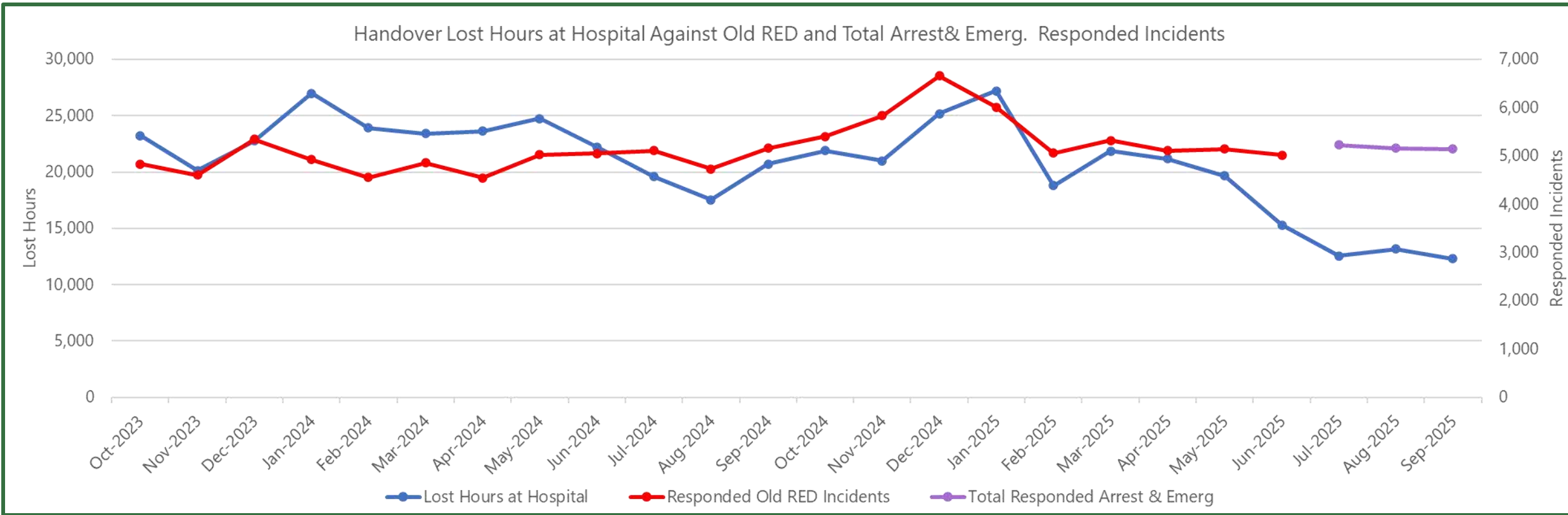
# Partnerships / System Contribution

## Handover Lost Hours Against Red & Amber 1 Responded Incidents

(Responsible Officer: Health Boards)

CI

QUEST



### Analysis

The top graph highlights that when handover lost hours have increased, so too do the number of Old Red, Arrest and Emerg incidents being responded to. This shows that when CSP is in periods of high demand and hospital handover increases, Red responses are protected, even during high pressure within the system.

The bottom right graph illustrates, that there is also a correlation between lost hours decreasing and Amber 1 incidents being responded to.

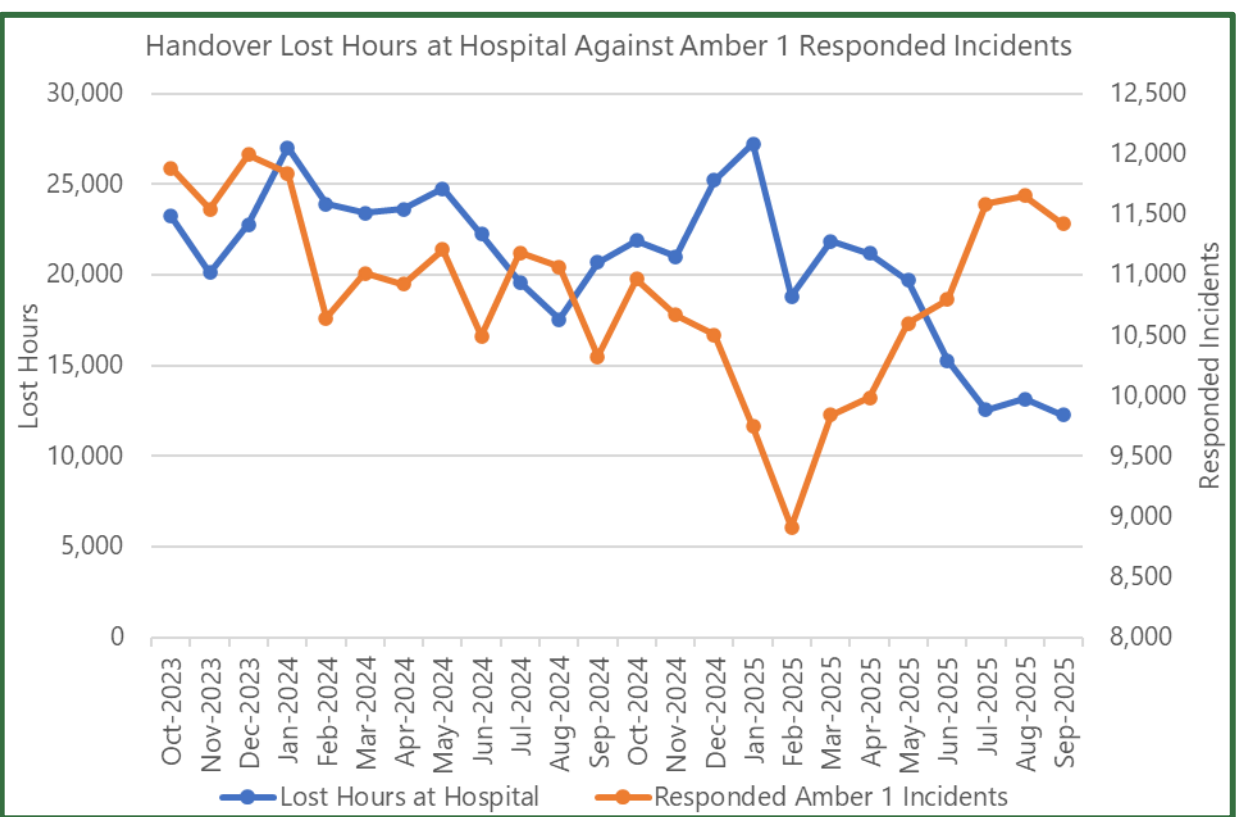
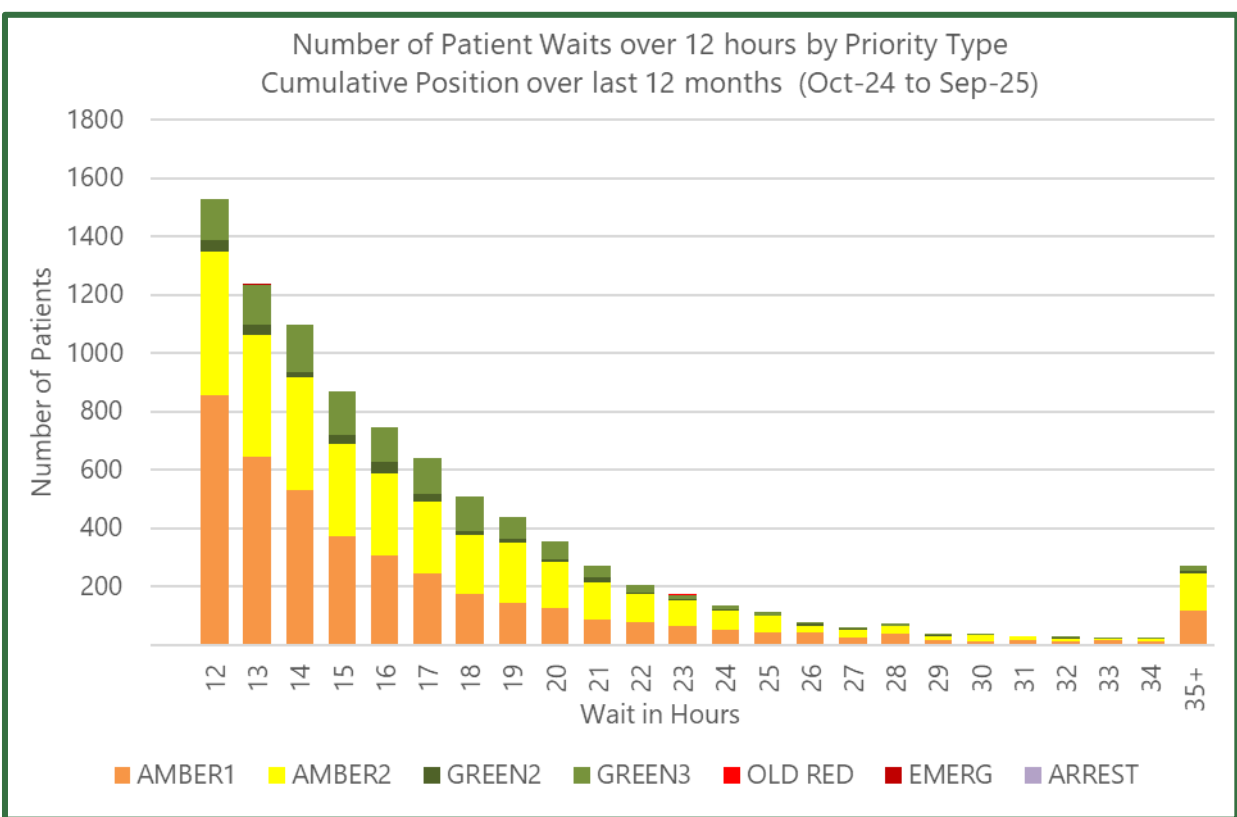
In September 2025, 323 patients waited over 12 hours for an ambulance response.

### Remedial Plans and Actions

NHSWales Performance & Improvement is currently leading on health board workshops on handover improvement, in line with the W45 ambition by by October 2025.

### Expected Performance Trajectory

The likely expected ambition from Welsh Government is no waits over 45 minutes.



\*NB: Data correct at time of abstraction

Term	Definition	Term	Definition	Term	Definition	Term	Definition	Term	Definition
AB / ABHB	Aneurin Bevan / Aneurin Bevan Health Board	CTM / CTMHB	Cwm Taf Morgannwg Health Board	HIW	Health Inspectorate Wales	NHSDW	National Health Service Direct Wales	ROSC	Return Of Spontaneous Circulation
AOM	Area Operations Manager	C&V / C&VHB	Cardiff & Vale / Cardiff & Vale Health Board	HI	Health Informatics	NPUC	National Programme for Unscheduled Care	RRV	Rapid Response Vehicle
APP	Advanced Paramedic Practitioner	DAG	Delivery & Assurance Group	H&W	Health & Wellbeing	NQPs	Newly Qualified Paramedic	SB / SBUHB	Swansea Bay / Swansea Bay Health Board
AQI	Ambulance Quality Indicator	D&T	Discharge & Transfer	HR	Human resources	NRI	Nationally Reportable Incident	SCIF	Serious Concerns Incident Forum
BCU / BCUHB	Betsi Cadwaladr / Betsi Cadwaladr university Health Board	DU	Delivery Unit	HSE	Health and Safety Executive	OBC	Outline Business Case	STEMI	ST segment Evaluation Myocardial Infarction
CASC	Chief Ambulance Services Commissioner	EAP	Emergency Ambulance Practitioner	IG	Information Governance	OD	Organisational Development	TPT	Tactical Pandemic Team
CCC	Clinical Contact Centre	ED	Emergency Department	IMTP	Integrated Medium Term Plan	ODU	Operational Delivery Unit	TU	Trade Union
CCP	Complex Case Panel	ELT	Executive Leadership Team	IPR	Integrated Performance Report	OH	Occupational Health	UCA	Unscheduled Care Assistant
CEO	Chief Executive Officer	EMD	Emergency Medical Department	JCC	Joint Commissioning Committee	P / PHB	Powys / Powys Health Board	UCS	Unscheduled Care System
CFR	Community First Responder	EMS	Emergency Medical services	KPI	Key Performance Indicator	PCR / PCRs	Patient Care Record(s)	UHP	Unit Hours Production
CI	Clinical Indicator	ePCR	Electronic Patient Care Record	LTS	Long Term Strategy	JRCALC	Joint Royal Colleges Ambulances Liaison Committee	U/A RTB	Unavailable – return to Base
CHARU	Cymru High Acuity Response Unit	FTE	Full Time Equivalent	MACA	Military Aid to the Civil Authority	PECI	Patient Engagement & community Involvement	VPH	Vantage Point House (Cwmbran)
COOs	Chief Operating Officers	GDPR	General Data Protection Regulations	MIU	Minor Injury Unit	POD	Patient Offload department	WAST	Welsh Ambulance Services University NHS Trust
COPD	Chronic Obstructive Pulmonary Disease	GPOOH	General Practitioner Out of Hours	MPDS	Medical Priority Dispatch System	PPLH	Post Production Lost Hours	WG	Welsh Government
COVID-19	Corona Virus Disease (2019)	GTN	Glyceryl Trinitrate	NCCU	National Collaborative Commissioning Unit	PSPP	Public Sector Purchase Programme	WIIN	WAST Improvement & Innovation Network
CMT	Clinical Model Transformation	HB	Health Board	NEPTS	Non-Emergency Patient Transport Services	QPSE	Quality, Patient Safety & Experience		
CSD	Clinical Service Desk	HCP	Health Care Professional	NEWS	National Early Warning Score	RCS	Rapid Clinical Screening		
CSP	Clinical Safety Plan	HD / HDHB	Hywel Dda / Hywel Dda Health Board	NHS	National Health Service	RICS	Remote Integrated Care Service		

# Definition of Indicators

Indicator	Definition	Indicator	Definition
<b>111 Abandoned Calls</b>	An offered call is one which has been through the Interactive Voice Response messages and has continued to speak to a Call Handler. There are several options for the caller to self-serve from the options presented in the IVR and a proportion of callers choose these options. An example is to guide the caller to 119 if they wish to speak to someone about a Coronavirus test. Once the caller is placed in the queue for the Call Handler if they hang up, they are counted as “abandoned” as we did not answer the call. The threshold starts at 60 seconds after being placed into the queue as this allows the callers to respond to the messages and options presented as it often takes a short while for the caller to react. Starting the count at 60 seconds provides a picture of abandonment where the caller has chosen not to wait, despite wanting to speak to a Call Handler	<b>Hours Produced for Emergency Ambulances</b>	Proportion of hours produced within the calendar month for Emergency Ambulance Vehicles (Target 95%).
<b>111 Patients Called back within 1 hours (P1)</b>	(Welsh Government performance target) which prescribes that 111 has up to 1 hour (longer for lower priory callers) for a 111 Clinician to call the patient to discuss their medical issue. These callers will already have been screened by Call Handlers and received an outcome which needs a conversation with a 111 Clinician. WAST operates a queue and call back method for all Clinical Calls.	<b>Sickness Absence (all staff)</b>	Staff sickness volumes as a percentage for all staff employed within the Welsh Ambulance Services NHS Trust.
<b>999 Call Answer Times 95<sup>th</sup> Percentile</b>	Time taken (in Minutes) to answer 999 emergency calls by call handlers. A percentile (or a centile) is a measure used in statistics indicating the value below which a given percentage of observations in a group of observations fall. For example, the 95th percentile is the value below which 95 percent of the observations may be found.	<b>Frontline COVID-19 Vaccination Rates</b>	Volume of frontline (patient facing and non-patient facing) who have received a second COVID-19 vaccination.
<b>999 Red Response within 8 Minutes</b>	Percentage of 999 incidents within the Red (immediately life-threatening) category which received an emergency response at scene within 8 minutes.	<b>Statutory and Mandatory Training</b>	Combined percentage of staff who are compliant with required statutory training undertaken by staff where a statutory body has dictated that an organisation must provide training based on legislation and mandatory training which relates to trade-specific training that the employer considers essential or compulsory for a specific job. (A detailed list of these can be found on slide 20).
<b>Red 95<sup>th</sup> Percentile</b>	Time taken (in minutes) for emergency response to arrive at scene for Red (immediately life-threatening) calls (NB: The 95th percentile is the value below which 95 percent of the observations may be found).	<b>PADR/Medical Appraisal</b>	Proportion of staff who have undertaken their annual Performance Appraisal & Development Review (PADR) or Medical Appraisal. This is a process of self-review supported by information gathered from an employees work to reflect on achievements and challenges and identify aspirations and learning needs. It is protected time once a year.
<b>999 Amber 1 95<sup>th</sup> Percentile</b>	Time taken (in minutes) for emergency response to arrive at scene for Amber 1 calls (other life-threatening emergencies – including cardiac chest pains or stroke). (NB: The 95th percentile is the value below which 95 percent of the observations may be found).	<b>Ambulance Response FTEs in Post</b>	Number of Emergency Medical Services, Full Time Equivalent (FTE) staff working for the Welsh Ambulance Services NHS Trust.
<b>Return of Spontaneous Circulation (ROSC)</b>	Percentage of patients for whom Return Of Spontaneous Circulation occurs. This refers to signs of restored circulation (more than occasional gasp, occasional fleeting pulse or arterial waveform) evidenced by breathing, a palpable pulse or a measurable blood pressure.	<b>Ambulance Care, Integrated Care, Resourcing &amp; EMS Coordination FTEs in Post</b>	Number of Ambulance Care, Integrated Care, Resourcing & EMS Coordination Full Time Equivalent (FTE) staff working for the Welsh Ambulance Services NHS Trust.
<b>Stroke Patients with Appropriate Care</b>	Proportion of suspected stroke patients who are documented as receiving an appropriate stroke care bundle (a bundle is a group of between three and five specific interventions or processes of care that have a greater effect on patient outcomes if done together in a time-limited way, rather than separately).	<b>Financial Balance – Annual Expenditure YTD as % of budget Expenditure</b>	Annual expenditure (Year to Date) as a proportion of budget expenditure.
<b>Acute Coronary Syndrome Patients with Appropriate Care</b>	Proportion of STEMI patients who receive appropriate care. ST segment elevation myocardial infarction - occurs when a coronary artery is totally occluded by a blood clot.	<b>Duty of Candour</b>	A notifiable adverse outcome is any incident whereby harm (moderate harm, severe harm and death) is caused, which is unintended or unexpected and that the provision of the health care was or may have been a factor in the service user suffering that outcome.
<b>Renal Journeys arriving within 30 minutes of their appointment (NEPTS)</b>	Proportion of renal journeys which arrive at hospital appointments within 30 minutes (+/-) of their appointment time.	<b>111 Consult and Close</b>	Consult and Close refers to the response to 999 callers where an alternative to a scene response has been provided. A cohort of 999 calls are passed to 111 where they are low acuity and the Clinicians in 111 may be able to help the caller with self-care, referral, etc. This is similar to the work of the Clinical Support Desk but for a lower acuity of caller. Where the outcome from the 111 clinical consultation ends in a Consult and Close outcome (self-care, referral, alternative transport) this is captured and forms part of the Trust’s Consult and Close reporting. Over 50% of calls passed to 111 in this way are successfully closed without an ambulance response.
<b>Discharge &amp; Transfer journeys collected less than 60 minutes after booked ready time (NEPTS)</b>	Proportion of journeys being discharged from and/or transferred between hospitals which were collected within 60 minutes of the hospital booked ready time.	<b>999 / 111 Hear and Treat</b>	Proportion of 999/111 calls which are successfully completed (closed) without dispatching an ambulance vehicle response. This may include advice, self-care or referral to other urgent care services.
<b>National reportable Incidents (NRI)</b>	Volume of patient safety incidents reported in the month which caused or contributed to the unexpected or avoidable death, or severe harm, of one or more patients, staff or members of the public, during NHS funded healthcare.	<b>% Incidents Conveyed to Major EDs</b>	Proportion of patients transported to a hospital Emergency Department following initial assessment at scene by a Welsh Ambulance Services NHS Trust Clinician, as a proportion of total verified incidents. (NB: An ED provides a wide range of acute in-patient and out-patient specialist services together with the necessary support systems, which allow emergency admissions, and which usually has an Accident and Emergency Department).
<b>Concerns Response within 30 Days</b>	Proportion of concerns responded to by the complaints team within 30 working days of receiving the concern.	<b>Number of Handover Lost hours</b>	Number of hours lost due to turnaround times at EDs taking more than 15 minutes. Transferring the care of a patient from an ambulance to an ED is expected to take no longer than 15 minutes, with a further 15 minutes for ambulance crews to make their vehicle ready for the next call.
<b>EMS Abstraction Rate</b>	The percentage of Emergency Medical Services (EMS) staff unavailable for rostered duties due to reasons, such as: annual leave, sickness, alternative duties, training, other and COVID-19.	<b>Immediate Release requests</b>	The number of requests submitted to Health Boards for the immediate release of vehicles at Emergency Departments to release them back into the community to respond to other urgent and life-threatening calls



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Agenda Item No. **8**

## REPORT TITLE

Strategic Quality Plan 2025-2028 Implementation Update

## MEETING

Name of meeting	Quality, Patient Experience & Safety Committee
Date of meeting	4 November 2025
Public or Private	Public
If private - <a href="#">rationale</a>	n/a

## REPORT SPONSOR

Executive sponsor	Liam Williams, Executive Director of Quality & Nursing
Author(s) of report	Kate Blackmore, Asst. Director of Quality Governance

## PURPOSE OF REPORT

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

## REPORT SUMMARY:

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

1. This paper outlines the approach taken to developing a detailed implementation plan for the Strategic Quality Plan 2025-28. It details the prioritisation of activities, alignment of timelines and the establishment of governance structures to monitor delivery.
2. The implementation of the Strategic Quality Plan 2025-28 is progressing in line with the prioritised timeline. Governance structures have been established to monitor delivery, and



early alignment with Digital, IMTP and Clinical Model Transformation programmes has been achieved. The paper provides partial assurance that the mechanisms for oversight and risk escalation are operational, with further assurance to be provided through quarterly progress dashboards

## RECOMMENDATION(S)

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

The QuEST Committee is requested to:

1. Receive assurance on the activity completed to undertake prioritisation of tasks and timelines associated with the Strategic Quality Plan 2025-28.
2. Support the development of an agreed cycle of business for progress updates relating to the Strategic Quality Plan 2025-28, as recommended by the Quality Governance Follow Up Review.
3. Receive assurance on the implementation approach, governance, and prioritisation of deliverables.

## ADDITIONAL PAPER(S)

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

N/A

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

N/A

## HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

<input type="checkbox"/> Safe	<input type="checkbox"/> Timely	<input checked="" type="checkbox"/> Effective
<input checked="" type="checkbox"/> Efficient	<input type="checkbox"/> Equitable	<input type="checkbox"/> Person Centred

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

<input checked="" type="checkbox"/> Leadership	<input type="checkbox"/> Workforce	<input type="checkbox"/> Culture
<input checked="" type="checkbox"/> Information	<input 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 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 checked="" type="checkbox"/> No <input type="checkbox"/> Yes
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If yes, what impact assessment is attached

## APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
21 October 2025	CQGG
04 November 2025	QuEST Committee



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## SITUATION

1. The Strategic Quality Plan 2025-28 was endorsed by the Quality, Patient Experience and Safety committee before onward approval by Trust Board in May 2025.
2. The purpose of this update is to provide early assurance that the mechanisms established since Board approval in May 2025 are embedding and to outline the dependencies and residual risks that may affect timely delivery.
3. During the endorsement process, committee members raised concerns about the resourcing and capacity to deliver the plan, given the level of transformation ongoing within the Trust.
4. Committee members requested that the next steps for the implementation plan, associated with prioritisation of tasks and aligning of timescales, were completed as a priority.
5. This paper provides an update on the work undertaken to prioritise activities and align timelines based on the priorities identified and the complementary timelines aligned with linked strategic plans.

## BACKGROUND

6. The Strategic Quality Plan was developed through extensive stakeholder engagement and aligns with statutory and regulatory responsibilities, as well as the Trust's long-term strategy.
7. The plan recognises the valuable contributions of other strategic plans through a lens of delivering the quality agenda aligned with the Health & Social Care (Quality and Engagement) Wales Act 2020.
8. The Integrated Medium-Term Plan identifies the need for a detailed implementation plan for delivery during 2025/26.
9. This implementation approach directly addresses Recommendation 2 of the Audit Wales Quality Governance Follow-Up Review (2024), which sought clearer milestones, accountability, and visibility of progress through the QuEst cycle of business.
10. A Strategic Quality Plan Implementation Task & Finish Group has been formed to support the oversight of progress against the key activities of the plan. This forum has developed a draft Terms of Reference and governance structures in order to monitor progress and provide assurance on the delivery of tasks identified.



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## ASSESSMENT

11. The Quality Strategy 2021-24 was supported by an implementation plan, however, the Quality Governance review 2022 recommended revision due to the lack of financial investment available to deliver objectives. Subsequently the Quality Governance follow up review in 2024 recommended providing timescales for expected delivery (previous plans included commencement dates but not delivery dates) and differentiating between the progress of actions vs strategic outputs.
12. The approach to strategic plans across the Trust has not been consistently accompanied by a specific and detailed implementation plan, instead activities developed within directorate level plans have been aligned with strategic plans and objectives. This has created a challenge when trying to align specific timelines to activities associated with quality focussed deliverables from other business areas.
13. The delivery of activities aligned with technology and innovation are dependent on resourcing and prioritisation. The deliverables identified are aligned with the Digital Plan and it is expected that the associated data strategy being developed will confirm timelines for dependencies, such as population health analytics.
14. The Strategic Quality Plan Implementation Task & Finish Group has met monthly since May 2025, chaired by the Assistant Director of Quality Governance. Terms of Reference have been agreed in draft and will align to the Quality and Performance Steering Group and CQGG for escalation. Key actions to date include mapping of all 149 deliverables, establishment of a prioritisation matrix, and identification of interdependencies across strategic plans. This prioritisation matrix may require further review in light of the agreed strategic priorities to be set out in the 2026/27 IMTP.
15. There are currently 149 tasks for completion and delivery during the cycle of the Strategic Quality Plan (2025-2028). Of these tasks 4% are identified as high priority deliverables (marked urgent in the implementation plan), the majority of these actions align to deliverables associated with the Clinical Model Transformation. A further 12% are identified as priority deliverables (marked important in the implementation plan), with a third of these also being associated with the Clinical Model Transformation.
16. All of the urgent or important tasks have been aligned with delivery dates commencing in this fiscal year (Apr 25- Mar 26).



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17. Assurance will be provided through a three-tier model:

**First line:** Directorate and programme leads report progress via RAG-rated dashboards at each Implementation Group meeting.

**Second line:** Quarterly oversight through CQGG and six-monthly assurance to QuEst, summarising progress, risks, and mitigations.

**Third line:** Internal Audit will review implementation maturity annually against Audit Wales Quality Governance recommendations.

This structure ensures continuous visibility, early escalation of delivery risks, and evidence-based assurance to Committee.

18. The majority of tasks associated with the Strategic Quality Plan have been identified as a medium priority. These tasks are aligned with commencement dates across the delivery cycle for the plan, with a third of the activities spanning more than one fiscal year. A number of these medium priority tasks (13%) are aligned across the entirety of the delivery cycle (3 years), a majority of which are associated with other strategic plans or programmes of delivery.

19. The governance arrangements for the Strategic Quality Plan Implementation Task & Finish includes standard agenda items for escalation of risks to delivery and the identification of items for re-prioritisation. As activity is completed it is the intention of the group to revisit medium term deliverables to undertake a re-prioritisation exercise for tasks to further focus capacity on priority and high-priority deliverables.

20. A risk to delivery of both the Strategic Quality Plan and the Integrated Medium Term Plan is the organisational capability and capacity to scope and deliver against objectives aligned to Population Health and Value Based Health Care. Recent appointments to support the Trust approach to financial sustainability and exploring commercial opportunities will enable progress in Value Based Healthcare. Working closely with the digital team in the creation of the data strategy, and as we move forward with the clinical transformation model, is expected to support the increased availability of population health analysis. Quality, Safety & Patient Experience colleagues will subsequently lead in building understanding and use of this data to inform population health improvement recommendations.



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21. On the basis of governance arrangements established and initial delivery progress, partial assurance can be provided to the QuEST Committee at this stage. This position will be reviewed following the first formal quarterly review of deliverables and confirmation of IMTP prioritisation / associated resourcing decisions.

## **RECOMMENDATION**

22. The recommendation(s) are as set out in the front cover above.



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Agenda Item No. 9

## REPORT TITLE

Putting Things Right Report - Quarter 2 2025/26 (July – September)

## MEETING

Name of meeting	Quality, Patient Experience & Safety Committee
Date of meeting	04 November 2025
Public or Private	Public
If private - <a href="#">rationale</a>	n/a

## REPORT SPONSOR

Executive sponsor	Liam Williams, Executive Director of Quality & Nursing
Author(s) of report	Wendy Herbert, Deputy Director of Quality and Putting Things Right Claire Appleton, Assistant Director of Putting Things Right

## PURPOSE OF REPORT

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

## REPORT SUMMARY:

1. This Report provides an update to the Quality, Patient Experience & Safety Committee (QuEst) on the key information covering the Putting Things Right (PTR) and Legal Services functions.



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In summary the Report for Quarter 2 2025/26 highlights:

- Early indications of reducing handover of care delays at Emergency Departments as demonstrated by a reduction in joint investigations.
- Continued high demand for Trust Non-Emergency Services and a consequentially high number of complaints relating to unmet patient need.
- Updates in respect of the organisational Putting Things Right and Legal Services Recovery Plan to address performance: early progress; risk materialisation; assurance of Executive commitment and allocation of non-recurrent investment to deliver the improvement required.
- Updates on overdue Learning from Events Reports submissions leading to an intensive support programme from Welsh Risk Pool.
- Learning around complex case management, impact of the Clinical Navigator introduction and an update on gender identity work
- Notification of a reporting error in June and August complaints compliance as reported on the MIQPR. This has been caused by reliance on manual extraction and calculation. The Directorate now has the technical capability to produce this metric in an automated way which will provide improved future confidence in the data reporting accuracy.
- Progress is being made at an intra-Directorate level in developing Datix-based business intelligence.

### RECOMMENDATION(S)

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

1. Receive the report for discussion
2. Identify any additional assurance requirements

### ADDITIONAL PAPER(S)

The Quality, Patient Experience & Safety Committee is requested to receive the following:

1. Annex 1 - PTR & Legal quarterly data
2. Annex 2 – October update of PTR Recovery and Improvement Plan



## STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

<input checked="" type="checkbox"/> SO1: Providing the right care or advice, in the right place, every time	<input type="checkbox"/> SO2: Enabling our people to be the best they can be
<input type="checkbox"/> SO3: Being at the forefront of innovation and technology	<input type="checkbox"/> SO4: Developing services in collaboration
<input checked="" type="checkbox"/> SO5: Being quality driven and clinically led	<input type="checkbox"/> SO6: Delivering exceptional value

## RISK(S) THIS REPORT MITIGATES

Where relevant note the local, directorate, corporate or BAF risk number
Risk ID IBC - <i>Inability to meet regulatory and statutory responsibilities related to Putting Things Right (Concerns Regulations), Ombudsman, Inquest management, Welsh Risk Procedures, Mortality Reviews</i>

## HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

Quality Domains		
<input checked="" type="checkbox"/> Safe	<input checked="" type="checkbox"/> Timely	<input checked="" type="checkbox"/> Effective
<input checked="" type="checkbox"/> Efficient	<input checked="" type="checkbox"/> Equitable	<input checked="" type="checkbox"/> Person Centred
Quality Enablers		
<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

<input type="checkbox"/> A socially responsible and inclusive employer	<input type="checkbox"/> An innovative and sustainable organisation	<input checked="" type="checkbox"/> A pro-active, accessible and equitable care provider
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## 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 checked="" type="checkbox"/> No <input type="checkbox"/> Yes
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## APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
21 October 2025	Clinical Quality Governance Group



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## SITUATION

1. This Putting Things Right Report covers the period from 1 July 2025 – 30 September 2025. This report covers the PTR functions which broadly include:
  - Patient Safety (proactive & reactive), including Low harm and Near-miss reporting
  - Complaints management and resolution
  - Ombudsman relationships, information sharing, reports, and responses
  - Coroner relationships, information sharing, reports, and responses
  - Redress management
  - Claims management, including Clinical Negligence, Personal Injury, Road Traffic Accident and Damage to property
  - Organisational learning (including Learning from Events and Welsh Risk Pool submissions)
  - The PTR and Legal Services Team also lead the learning from mortality agenda. This is covered in detail within the separate twice-yearly Learning from Mortality Report to this Committee.

## BACKGROUND

2. The Report consists of two consistent elements each quarter, with any additional annexes or appendices as and when required. The Report has been structured to provide a succinct overview of three core areas; Assurance, Performance and Learning.

The narrative is drawn from the data provided in Annex 1 as well as qualitative organisational intelligence flowing through the Trust's Quality and Safety Governance Groups.

Annex 2 PTR and Legal data reporting, includes a compliance heatmap (enabling focused attention on statutory requirements), assurance overview (a more detailed picture of statutory and regulatory functions), performance overview (indicative of potential risks to future assurance) and a thematic visual presentation of themes and learning (areas that are informing organisational development and improvement).



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## ASSESSMENT

### ASSURANCE

#### External Assurance

1. The Trust has not received any Public Services Ombudsman for Wales (PSOW) reports, Schedule 5 Inquest notifications nor Regulation 28 Prevention of Future Death Reports.
2. The Trust has been notified of the commencement of the Annual Welsh Risk Pool (WRP) Assessment Programme. System access has been provided and evidence collation has been commenced. Reporting against last year's improvement plan continues into Audit, Risk and Assurance Committee (ARAC).
3. The Trust has received no further information on the national assurance exercise being undertaken by NHS Wales Performance and Improvement Quality and Safety team relating to joint investigations and enactment of the Duty of Candour / NRI reporting. WAST previously provided data from January to June 2025.

#### Compliance heatmap

4. The overdue number of NRI investigations has remained reasonably static despite a high sickness absence rate in the Patient Safety Team. The team is currently being led by an Interim Deputy Head of Patient Safety and are commended on their commitment to maintaining performance in areas of business priority.
5. Staffing sickness absence has also heavily impacted the PTR administration function however complaint acknowledgement times have remained largely in line with Welsh Government targets, with only a very small number extended beyond the 5 working days by a small margin.
6. There has been a data reporting error identified with two sets of monthly data previously provided to Trust Board; June and August 30 working day compliance has been over-reported, with performance now confirmed as having been much lower. Data provided to NHS Performance and Improvement is believed to have been correct and the national 'Beacon' dashboard is unaffected.
7. The error was identified during the development of an automated business-intelligence product, with a subset of Annex 1 data visualisations also being produced in this way. This lays the foundations for the long-term objective of quality and safety data sources being available in the Trust data warehouse and a suite of business intelligence products to meet user need and enable effective triangulation of all Trust information. Capacity constraints in the Information and



Digital Services Directorate and competing organisational priorities limit the pace of progress towards these aspirations.

8. Complaint response times are of high concern with the organisation not having achieved the target in any of the previous 15 months reported. Whilst larger numbers of complaints have been closed in the last quarter, a much-improved position in reducing open overdue complaints will be required to provide acceptable performance against this key performance indicator.
9. Sickness absence in the Trust's Patient Safety team continues to have an impact on meeting the 5 five working day target for issuing Duty of Candour initial letters after the 'in-person' notification.
10. The Trust continues to achieve full compliance with National Patient Safety Alerts and Notices.
11. The Trust has received no Regulation 28 reports and requests for further information and assurance post-inquest have also reduced.
12. Compliance with Welsh Risk Pool Procedures has not yet been incorporated into the compliance heatmap due to analytical obstacles associated with the dataset however is a key objective prior to the next Committee to enhance transparency over performance in this area.
13. Last quarter's report detailed that six Learning from Events Reports related to Personal Injury Claims had been identified as being overdue. Continued assurance work has identified a further five Claims cases and two deferred Redress cases as also having breached Welsh Risk Pool procedural timeframes. Welsh Risk Pool have agreed to support the Trust on intensive intervention period, which will provide deadline extensions on all 13 cases identified as part of this recovery work. This will mitigate the financial risks identified in last quarter's report. This work is incorporated under the umbrella of the wider organisational PTR and Legal Services Recovery Plan.

### **Assurance profile**

14. The number of investigations needing to be shared with other NHS Wales organisations has reduced in the last quarter. This appears in keeping with seasonal fluctuations however August and September have dropped beneath historical seasonal averages and there is optimism that the launch of the 'Wait 45' initiative is beginning to impact favourably on patient safety incidents caused by long community waits.



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15. The number of incidents being finalised and closed on the Datix system has increased markedly following a Senior Operations Team improvement drive in this area. Commitment to converting this to business-as-usual practice will be key to sustaining the improvements.
16. The number of complaints received by the Trust continues at historically high levels. As commented on in last quarter's report, this is being driven by an increased volume of complaints about Ambulance Care Services. Support from QPSE to Ambulance Care colleagues in terms of experiential emotional mapping, data visibility and the need to focus on 'on-the-spot' resolution is underway but does not yet appear to have impacted complaint volumes.
17. The Trust acknowledges the increase in the number of referrals to the PSOW. This has been driven by the length of time being taken to complete complaint investigations and issue responses. The PSOW has directed to the Trust to issue one financial early settlement in recognition of the distress being caused by the delay in response.
18. The number of open Claims against the Trust continues to reduce at a pleasing rate. From a financial perspective it is important to explain that the reducing number of open cases is linked to a focus on data cleansing of unconfirmed cases and cases that have exceeded the statute of limitation rather than settled cases. Continuing work on this is planned however changes to staffing complement and planned absence in the Legal Services team mean this is a longer-term objective.

## **PERFORMANCE**

19. Organisational PTR and Legal Services Performance is subject to an organisational improvement plan. The October update report of this plan is included in Annex 2. Progress is being reported into the Clinical Quality and Governance Group and the Trust's Executive Leadership Team has approved a non-recurrent financial uplift of £155,000 until the end of Q4. This will be allocated largely in Operations to increase the pace of investigatory work and will also benefit from Project Manager resource for coordination and reporting responsibilities.
20. The additional investment is expected to deliver the required improved at increased pace, building on structural workforce changes and a shift to proportionate approaches that have already begun to demonstrate benefit. The additional investment should also mitigate risks to improvement delivery through winter and Phase 2 implementation of the Ambulance Performance Framework.



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21. The continuing increase in open overdue complaints is the performance metric of highest concern. This demonstrates that the situation is worsening rather than improving, although the length of time that complaints are overdue is improving in EMSC and Integrated Care, where the majority of more complex investigations occur. Ambulance Care is under considerable pressure due to the high volumes of complaints received over recent months. Compared to last quarter there are only slightly more open complaints (increase of 9) but a greater percentage of open complaints that are overdue (62% last report, 70% this report).
22. In addition to capacity constraints, the absence of regular monitoring and performance data at an operational level has been identified as a primary obstacle for managers in improving team performance for complaint resolution.
23. Incident management is also of organisational concern due to the number of unreviewed and uninvestigated incidents (1426), although notable progress has been made in incident closures as noted earlier in this report and there are now fewer open incidents overall.
24. Redress management has improved in respect of prioritising confirmed cases and improving efficiency of data collection. Further data on the timeliness of Redress case management is planned for next quarter's report.
25. There is a gradually improving picture in the organisational management of medical examiner reviews and coronial workloads.

## **LEARNING AND IMPROVEMENT**

### ***Gender Identity***

26. Acting on feedback received through complaints, changes will be made to the NHS 111 Wales Advanced Questionnaire Module (AQM) to improve clarity and consistency in questions about date of birth, sex assigned at birth and gender identity. These changes are based on public feedback and updated guidelines. Staff will receive educational content explaining the rationale behind each question, guidance on how to ask these questions confidently and respectfully, and a case study illustrating the importance of sensitive communication.

### ***Clinical Navigator Introduction and behavioural workforce shifts***

27. Learning from Rapid Incident Reviews and SCIF briefings, in addition to reviews of long waiting patients, has identified changes to the way in which response coordinators are allocating resource to certain calls. The introduction of the Rapid Clinical Screening Service saw Clinical Navigators recording 'ideal' and 'interim' response recommendations for resource allocation e.g Falls Responders, APP,



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Emergency Ambulance. Early learning suggests that educational efforts should focus on the importance of intelligent allocation as resources become available, aligned to any recommendations made where possible, ensuring allocation in time and priority order continues alongside clinically informed resource recommendations.

### ***PTR and Legal services: prioritising well-being and enhancing mental health competency***

28. The workforce impact of managing the sustained and significant volume of overdue complaints is recognised within corporate and operational teams. Feedback from last year's staff survey and dedicated debriefing sessions with staff have led to a bespoke well-being package being offered to the PTR and Legal teams. This has consisted of in-person group introductory sessions with follow-up 1:1 support for all staff who wish to access it. Support packs and 1:1 sessions are also being offered to staff on long-term sickness absence.
29. In response to an increasing number of highly distressed callers and members of the public who may present a risk to themselves, the Mental Health team in the Trust have provided Mental Health First Aid training to the PTR & Legal team. This was very well-received and will enhance staff skills in managing highly distressed and/or vulnerable callers.
30. At a national level, the increase in complex, distressing and contentious concerns is also recognised and a national work programme, which the Trust participated in, has culminated in the release of a Complex Case Management website and resources. Organisations are now expected to embed the nationally-endorsed approaches within their complaints management processes and the Trust will strengthen existing processes to achieve this. Shared responsibility is a key feature to reduce the effect on individuals, along with facilitating early access for psychological support for vicarious trauma, regular case supervision and clear risk assessments balancing compassionate complaint resolution with staff working conditions and exposure. Organisations are encouraged to have a low threshold for requesting national support, as well as seeking legal advice where harassment and defamation are present.

### ***Documentation***

31. Learning has been identified from complaint investigations for 111 Clinicians regarding the importance of documenting rationale for call downgrades made on the Clinical Advice Line. Reminders are being issued by the 111 Leadership team regarding professional responsibilities for accurate and contemporaneous documentation that clearly explains their decision-making.



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### **Joint investigations**

32. Themes following joint investigations remain the same with over-crowded Emergency Departments and wider system pressures resulting in high levels of escalation, lack of End-of-Life Care or ceilings of care planning and discharge delays.
33. Nationally-led evaluation of the Joint Investigation module Pilot within the Once for Wales Concerns Management System (OfWCMS), referred to as Datix Cymru, has proved valuable in identifying process gaps and strengthening governance around its use. National engagement on the module is now planned through the OfWCMS Steering Group and Programme Board.

### **National Reportable Incidents**

34. The incidents that have been reported as NRIs this quarter related to:
  - Call management - missed allocation opportunities, delay in attending due to incorrect incident address/location
  - Remote clinical care - inappropriate call downgrade, mental health consultation issue
  - Operational issues - abstractions and low staffing.

### **Horizon Scanning**

35. The Trust awaits confirmation of the revisions to the Concerns Regulations and the Putting Things Right Guidance. Organisational feedback has recently been provided on a draft guidance document. The implementation date for all revisions is expected to be April 2026.
36. Implementation planning will need to take place at pace and alongside Trust implementation of Phase 2 of the Ambulance Performance Framework. Additional senior capacity has been allocated to the Patient and Family Relations team where changes are most likely to be required. National delivery groups at both a strategic and operational level have been established.

### **RECOMMENDATION**

37. The recommendations are as set out in the front cover above.

### **NEXT STEPS**

38. Progress against the Trust PTR & Legal Services Performance Recovery Plan is being reported regularly into CQGG.
39. Recruitment against the non-recurrent spend is being progressed.

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# PTR & Legal Services – Quarterly data



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PTR & Legal Services – Quarterly data  
Version 1.0  
Released: July 2025

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by Claire Appleton  
Assistant Director of PTR & Legal Services

**Compliance Heatmap** - *how well are we meeting national legislation & regulation?*

**Assurance Profile** - *what does our PTR & Legal Services data tell us about quality and safety in the Trust?*

**Performance Profile** - *how effectively are we managing the Putting Things Right & Legal Services functions?*

Data contained within this report is accurate at the time of reporting.

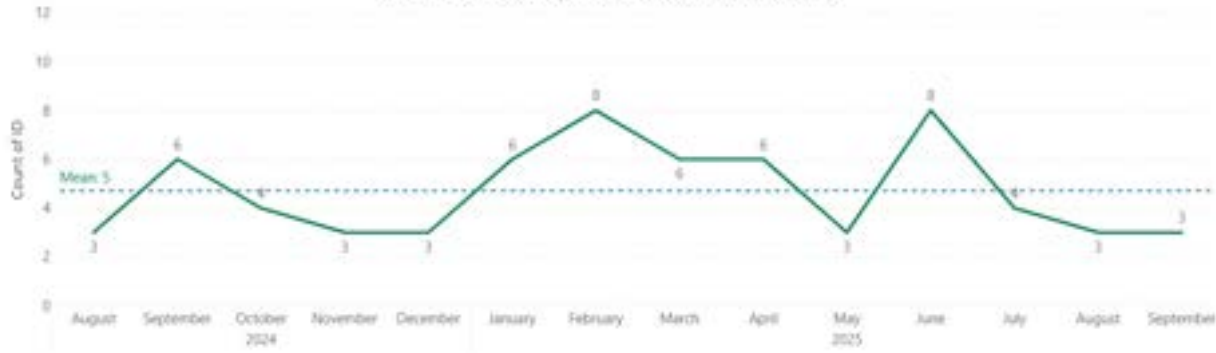
Data may be subject to change following validation, retrospective reviews and audits and ongoing clinical governance processes including regrading of incidents.

# Compliance heat map

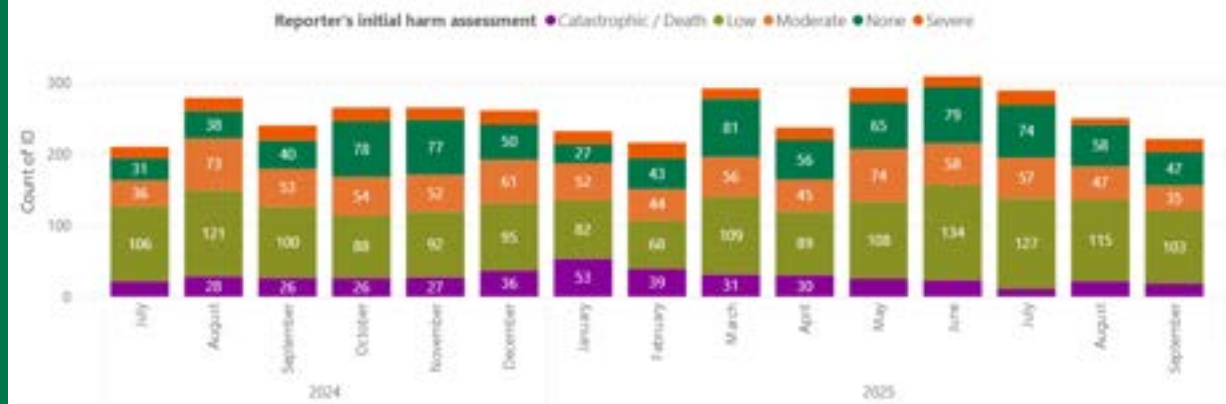
MEASURE	Scoring	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	June	July	Aug	Sept
Overdue NRIs	R: 10 A: 1 G: 0			40	34	29	30	28	29	29	30	32	34	38	32	34
Patient Safety Alerts/Notices overdue	R: 2 A: 1 G: 0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Complaints ack'd within 5 working days	R: 80% A: 90% G: 98%	100%	100%	100%	99%	95%	98%	99%	98%	100%	99%	89%	99%	99%	98%	100%
Complaints responded to within 30 working days	R: <65% A: 65% G: 75%	70%	40%	46%	65%	72%	73%	64%	52%	55%	68%	72%	50%	55%	60%	56%
Duty of Candour letters issued within 5 working days	R: NO G: YES	NO	YES	YES	NO	YES	YES	NO	YES	YES	YES	NO	NO	Yes	NO	NO
Regulation 28 PFD reports responded to on time	R: NO G: YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Public Interest reports published by the PSOW	R: >1 A: 1 G: 0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0

# Assurance Profile – Incidents & Duty of Candour

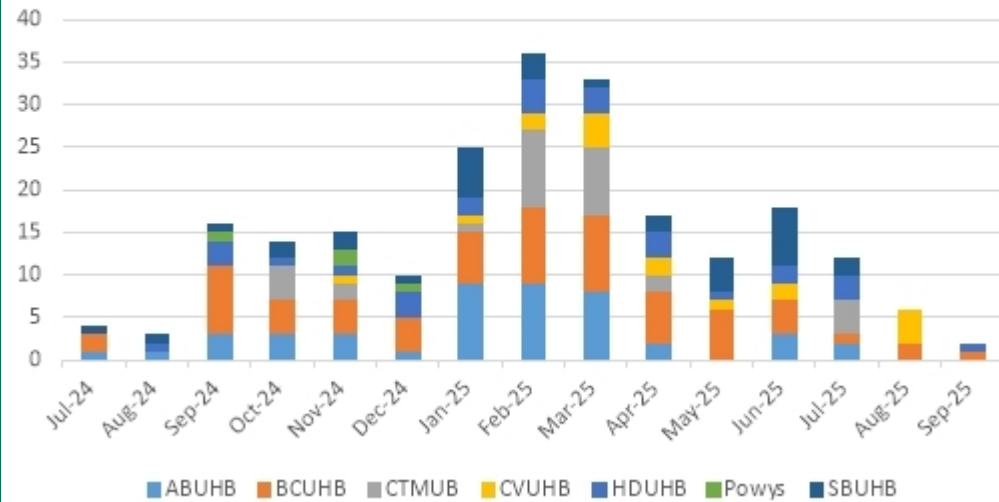
Number of NRIs reported to NHS Wales Executive



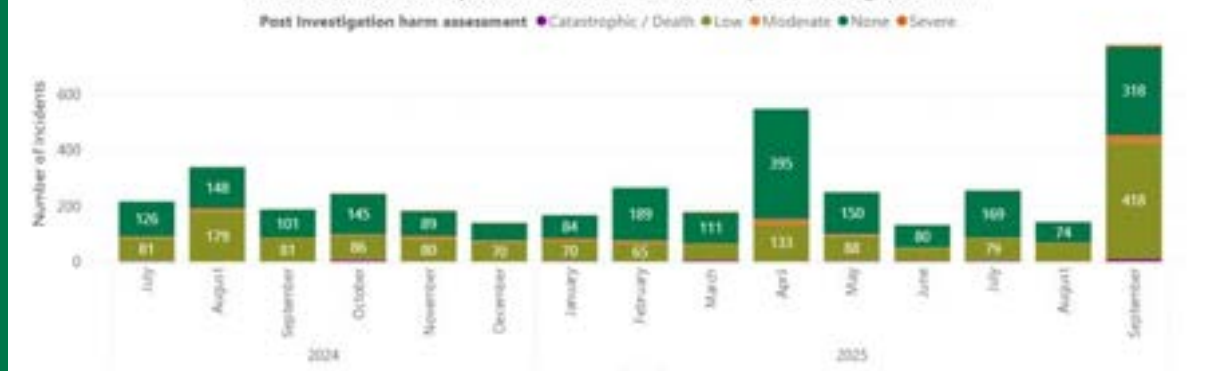
Number of Patient Safety Incidents Reported Each Month, by Reporter's Initial Harm Assessment



Number of incidents of moderate harm or above shared with Health Boards under the joint investigation process



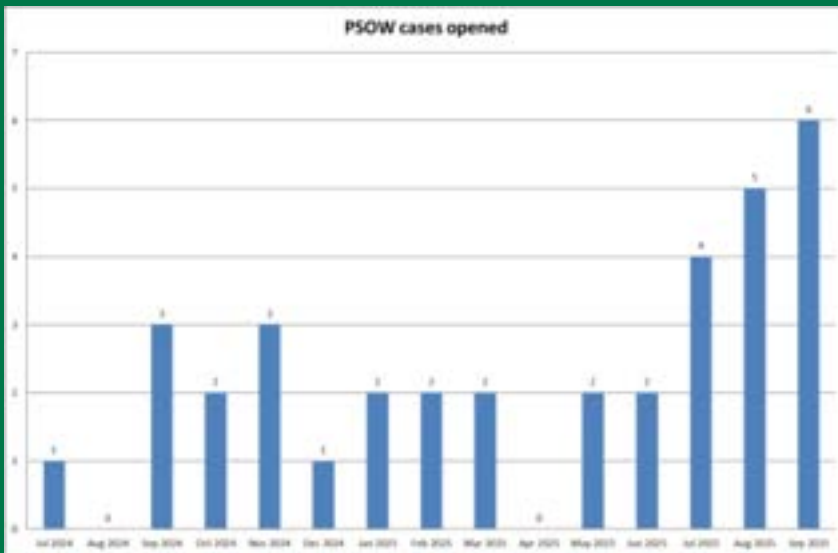
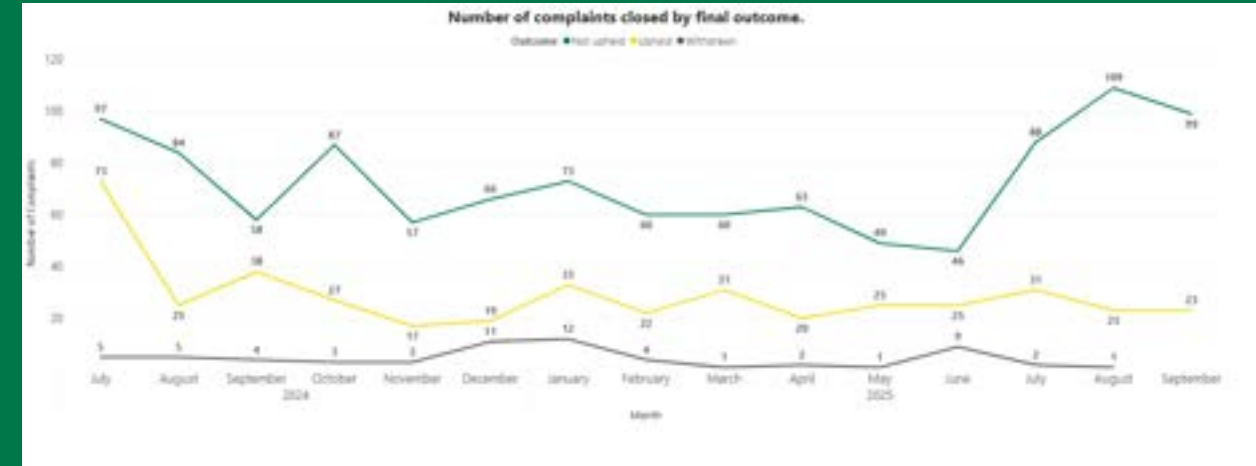
Number of Patient Safety Incidents Closed Each Month, by Post Investigation Harm Assessment



Number of times the Duty of Candour has been triggered



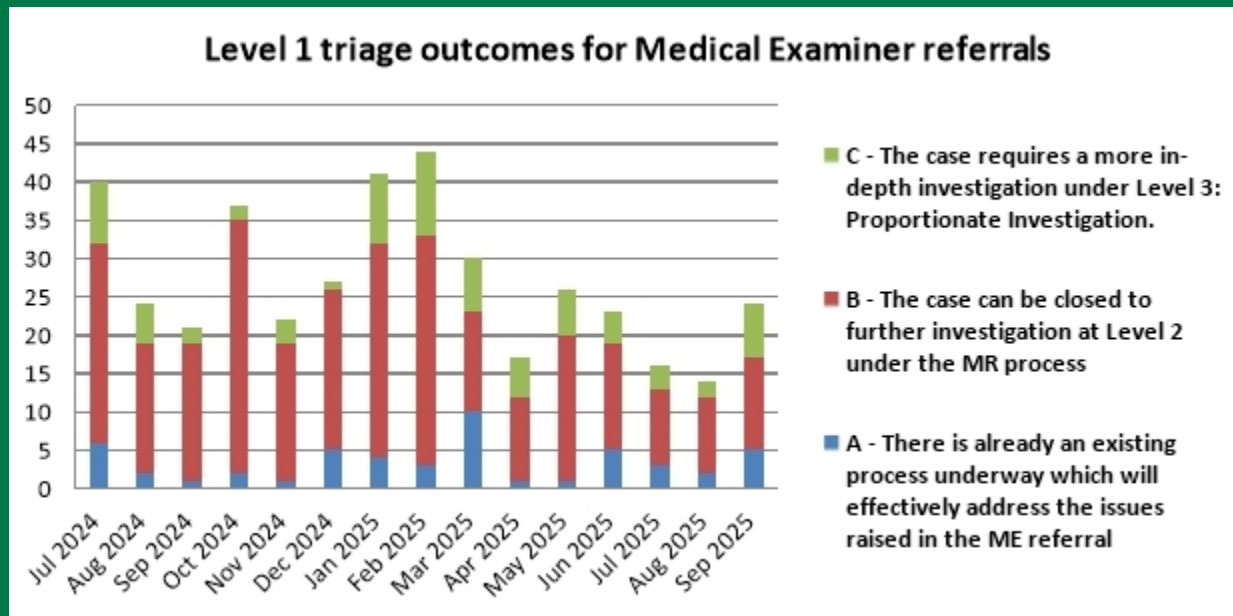
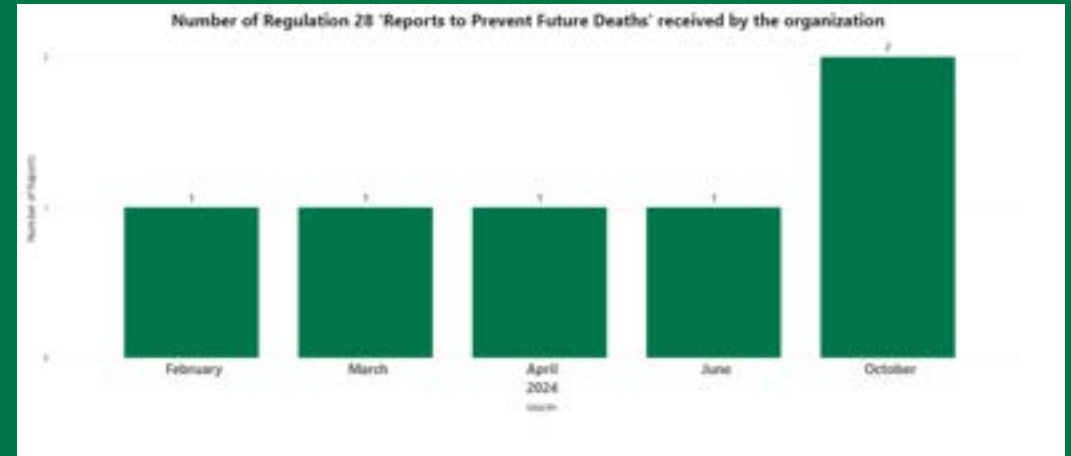
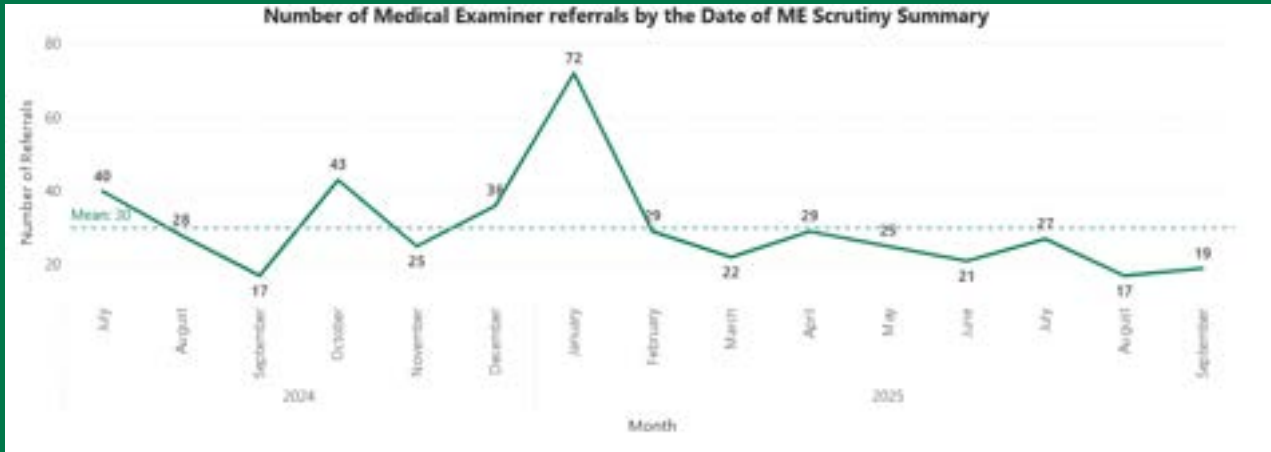
# Assurance Profile – Complaints, PSOW and LFER outcomes



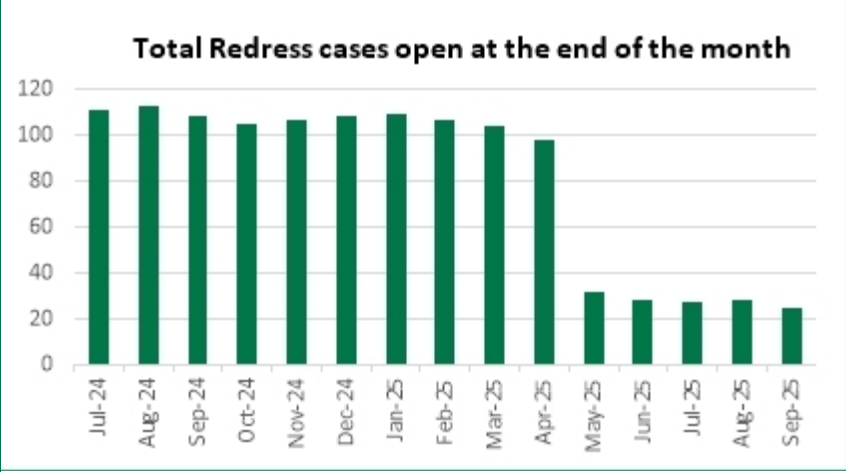
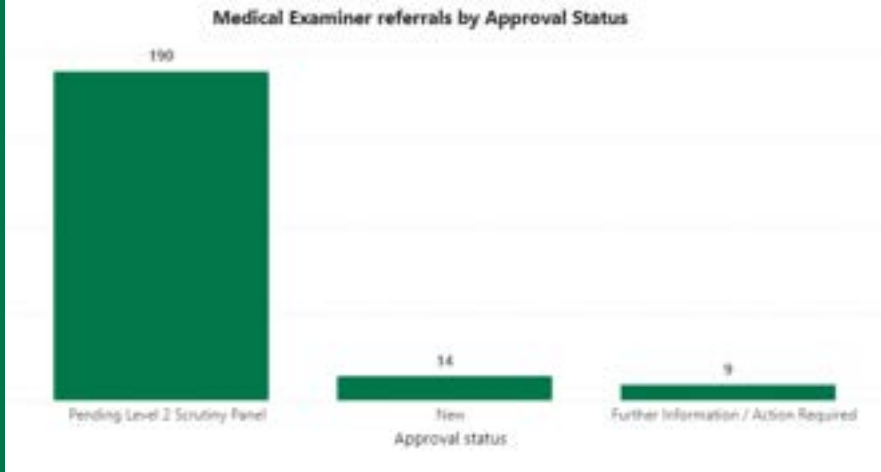
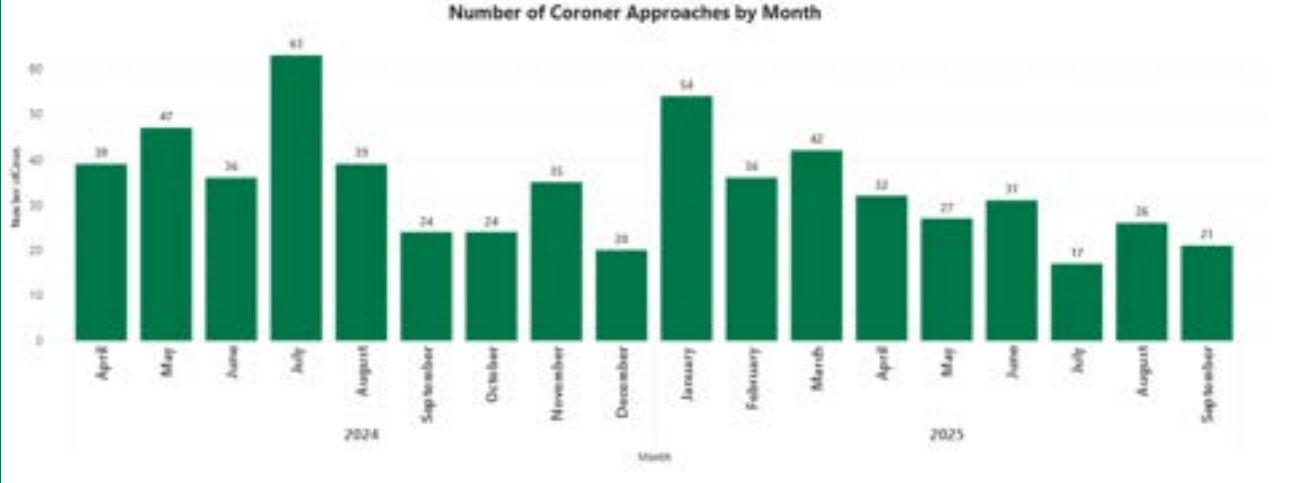
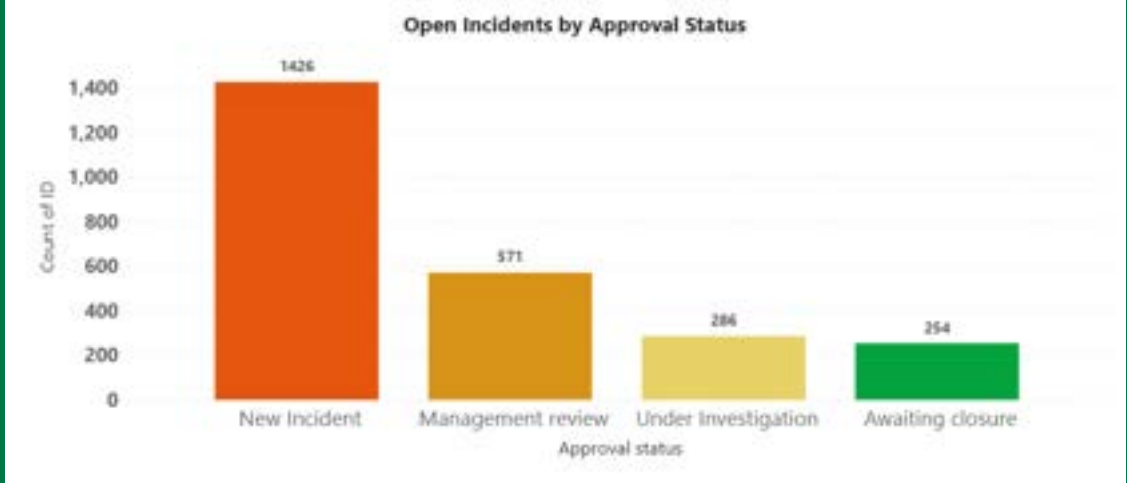
# Assurance Profile –Legal Services

		Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	June25	July-25	Aug-25	Sept-25
Claims opened	Personal Injury (PI)	1	2	0	3	1	2	4	2	2	5	1	3	2	0	0
	PI Road Traffic Accident	4	0	2	0	1	0	2	0	1	1	0	0	1	0	0
	Clinical Negligence	3	6	0	5	2	3	1	4	3	5	4	4	5	4	6
	Road Traffic Accident	14	30	14	26	16	14	23	11	19	21	17	28	22	19	10
	Damage to property	6	2	3	5	1	4	3	3	3	7	6	2	4	4	8
Claims closed	Personal Injury (PI)	0	0	2	0	6	8	9	2	0	--	30	9	3	2	8
	PI Road Traffic Accident	0	1	1	1	0	5	8	0	0	--	9	1	0	0	6
	Clinical Negligence	0	0	1	3	0	0	1	1	10	6	3	3	1	2	29
	Road Traffic Accident	18	29	43	30	27	9	12	27	11	--	39	58	51	12	22
	Damage to property	1	17	1	6	11	2	2	5	5	--	6	11	8	2	9
Claims open at the end of the month	Personal Injury (PI)	86	90	88	93	85	78	73	73	75	88	50	60	62	60	50
	PI Road Traffic Accident	68	67	68	67	56	51	45	45	46	46	37	44	46	46	39
	Clinical Negligence	175	181	180	182	184	186	186	189	178	174	176	177	181	183	161
	Road Traffic Accident	249	255	228	225	211	216	227	217	225	240	205	196	175	184	175
	Damage to property	37	22	24	23	13	14	15	18	16	19	13	10	9	12	11
		<b>615</b>	<b>615</b>	<b>588</b>	<b>590</b>	<b>549</b>	<b>545</b>	<b>546</b>	<b>542</b>	<b>540</b>	<b>567</b>	<b>486</b>	<b>487</b>	<b>473</b>	<b>485</b>	<b>436</b>

# Assurance Profile – Mortality Governance



# Performance Profile



# Putting Things Right & Legal Services Performance:

## Organisational Recovery Plan – Positional Update



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Welsh Ambulance Services  
University NHS Trust

September 2025

# PTR & Legal Services Performance

## Reasons

**Complexity** - more touchpoints, more services and more clinical care

**Volume** – seasonal demands and acceptance of system risks (removal of ‘no send’)

**Pace** of service development and delivery – posts not backfilled, audit & quality & safety responsibilities have not come online at same pace as service delivery

## Actions

Temporary additionality – non-recurrent funding

Structure/skill mix review, OCP and workflow efficiencies

Introduction of proportionate investigation, enhanced collaborative working and person-centred approaches

## Consequences

Poor PTR & Legal performance and assurance is undermining organisational credibility and political capital.

Impact on patients, families and staff – compound distress

Financial penalties (Ombudsman and Welsh Risk Pool)

Safety risks – lack of timely review & learning increases risk of unknown safety issues

## Risks & barriers

External factors – volume of work received, coronial timescales

Operational pressures and system demand

Lack of business intelligence for monitoring and oversight

Organisational capacity and commitment alongside Phase 2 CMT

## Performance challenges and risk

### Risk profile

- Some of the risk associated with these large volumes has already materialised, including increased contact from political representatives to our CEO regarding delayed complaint responses, and five Schedule 5 notices issued by Coroners.
- However some of the risk is as yet unrealised; complaints from families impacted by NRI and Coronial delays will continue until backlogs are cleared; given the lagging nature of the Tier 1 complaints performance target, performance will decline as we conclude overdue cases; timescale for PSOW referrals is up to 12 months following receipt of response.

### Risk consequences

- The compounded distress caused to patients and families who are awaiting delayed inquests, complaint responses or patient safety investigations.
- The impact on staff well-being of being frequently exposed to increasingly frustrated patients and families and erosion of working relationships built with external stakeholders such as Coroner.
- Reputational risks related to low compliance with Tier 1 PTR performance targets and externals among external stakeholders, including PSOW, Coroners and NHSWE. This risk is heightened in the context of CMT Programme where timely learning and recognition of safety risks is paramount to providing internal and external assurance.
- Patient Safety risks associated with delays in reviewing feedback, incidents and identifying issues and risks
- Potential financial impact of fines associated with non-compliance of Schedule 5 notices (Coroner) and PSOW awards due to unreasonable delays (PTR responses). If the Trust does not comply with LFER deadlines then this will also incur financial penalties and adversely impact how our financial contribution to Welsh Risk Pool scheme is calculated for future.



## Contributory factors

### Complexity

Increased service diversification: PTAS, APPs 111, RCS, EMSC, CSD, Mental Health, specialist desks – Care Planning & Winter Desk.

Reviewing call management and patient safety incidents now requires increased amount of technical and organisational structure expertise and enhanced cross-service collaboration. There are an increased number of interfaces & transfers between CAD systems and service areas and increased specialisation at both service and clinical levels mean investigations require input from multiple subject-matter experts.

The approach to call management investigations is increasingly less of a binary distinction based on audit findings but requires analysis of outcomes within complex socio-technical systems. Our patient safety profile is increasingly representative of the types of investigations undertaken in Clinical Directorate and other health organisations however these require an enhanced training and skillsets for which training needs analysis has yet to be completed.

### Volume

The seasonal demands of winter were exacerbated this past year by the number of circulating respiratory viruses. The Trust also noted an increased volume of incidents that may have arisen from planned changes in the Clinical Safety Plan that increased the Trust risk on behalf of the wider NHS system. This hasn't resulted in significant amounts of externally generated activity, with most of the increase being felt through internal patient safety incident reporting.

In our efforts to maintain and manage wider system risks, there have been an increased number of touchpoints for patients who are awaiting a response in order to detect clinical deterioration, provide risk reduction advice whilst waiting and ensure all other alternative pathways are explored. This means however that for each investigation, more contacts have to be located in C3 Radius and each reviewed, which has led to increased numbers of call audit requests.

### Service provision & development

As our Rapid Clinical Screening function was introduced and foundations laid to take the Trust towards provision of remote integrated care, experienced staff were realigned to lead new service development, leaving gaps that haven't been able to be filled in a like-for-like way, particularly with the Clinical Service Desk.

These service developments whilst needed at pace to mitigate risks during the winter period required recruitment of additional staff to support audit of the different interventions now in place across the Clinical Contact Centres; Clinical Navigators within Emergency Medical Service (EMS) and Emergency Communication Nurse System (ECNS) within 111 Wales Integrated Care.

Within specific service areas, sickness, vacancies and the impact of teams being redeployed during business continuity arrangements during CSP escalations and whilst at REAP 4 were also experienced.



# Assurance from previous QPSE PTR & Legal Services investment

Benefit realisation	
The investment into the PTR & Legal teams last year has provided organisational benefits with performance having previously shown incremental improvements prior to the winter period.	✓
Registration of concerns is being undertaken in a timely way and contact with patients and families maintained. This has not been possible in previous years due to under-resourcing of the central QPSE teams.	✓
Compliance with providing acknowledgement letters to complainants has improved significantly since April 2024.	✓
The majority of Duty of Candour written notification letters have been undertaken in a consistently timely way	✓
Letters to update complainants on why their responses are delayed are provided regularly along with telephone contact where desired	✓
Relationships with external stakeholders such as the Ombudsman and Coroners offices and other NHS Wales organisations are being maintained as best as possible.	✓
The transfer of portfolios between teams has provide effective, with there being increased resilience regarding knowledge and management of PSOW cases and improvement in LFER completion and approvals.	✓
Attendance and representation at national quality, safety and experience workstreams such as the Once for Wales Programme workstreams and Safety & Learning networks is much improved, enabling the Trust to contribute and influence more effectively in these national spaces.	✓



# National Policy and Regulations – Statutory, Regulatory & Mandatory requirements

## **The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011**

- Acknowledgement to formal complaints must be provided within 5 working days
- Early Resolutions (no harm/non-complex) resolved within 2 working days
- Formal complaints (possible harm/complex) are responded to within 30 working days
- Formal complaints must reach a conclusion on qualifying liability when under £25k

## **NHS Wales National Incident Management Policy**

- Nationally reportable Incidents (reported within 7 days, investigation completed in 90 days)
- Yorkshire Contributory Factors Framework

## **Coroners and Justice Act 2009**

- Responsibility to investigate deaths that are violent, unnatural, of unknown cause, or occur in state detention.

## **The Health and Social Care (Quality and Engagement) (Wales) Act 2020 – Duty of Candour**

- Moderate harm and above, where healthcare may have been a factor
- In person contact (face to face, telephone, video call)
- Written notification letters following initial contact must be provided within 5 working days

## **Medical Examiners (Wales) Regulations 2024 and All Wales Learning from Mortality Reviews Model Framework 2024**

- Independent review of the causes of deaths not investigated by a coroner
- Organisations must have arrangements in place to discharge all 5 levels of the Mortality Review Framework

## **Welsh Risk Pool Reimbursement Procedures 2023**

- Learning From Events Reports must be submitted within 4 months, and fully approved within 12 months.
- Claims Management Reports must be approved within 12 months
- Financial Penalties apply



# PTR & Legal Services Performance Organisational Recovery Plan

## Core objectives

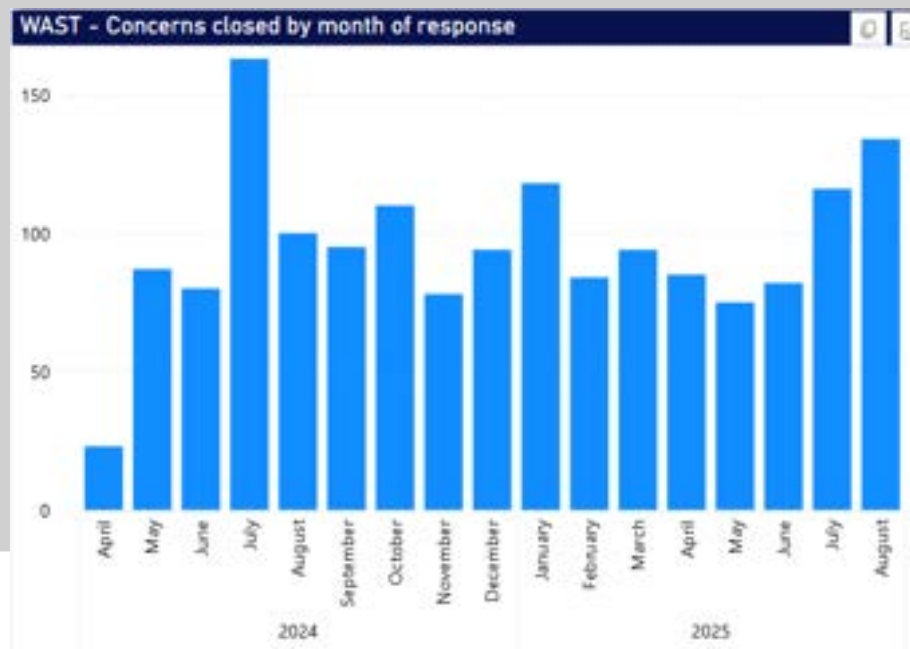
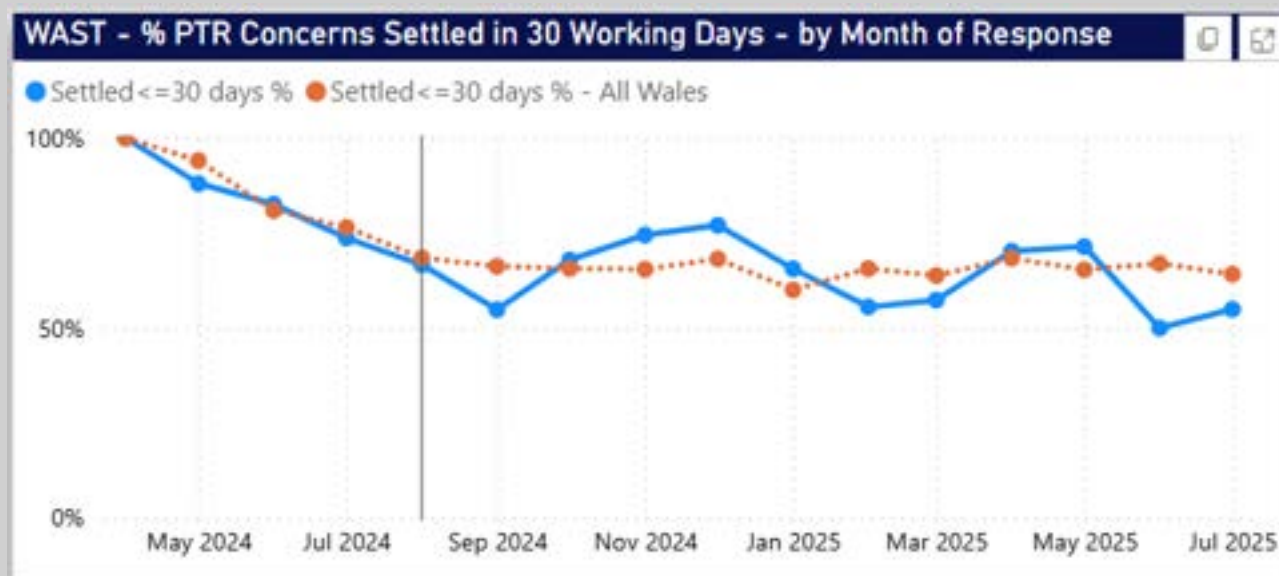
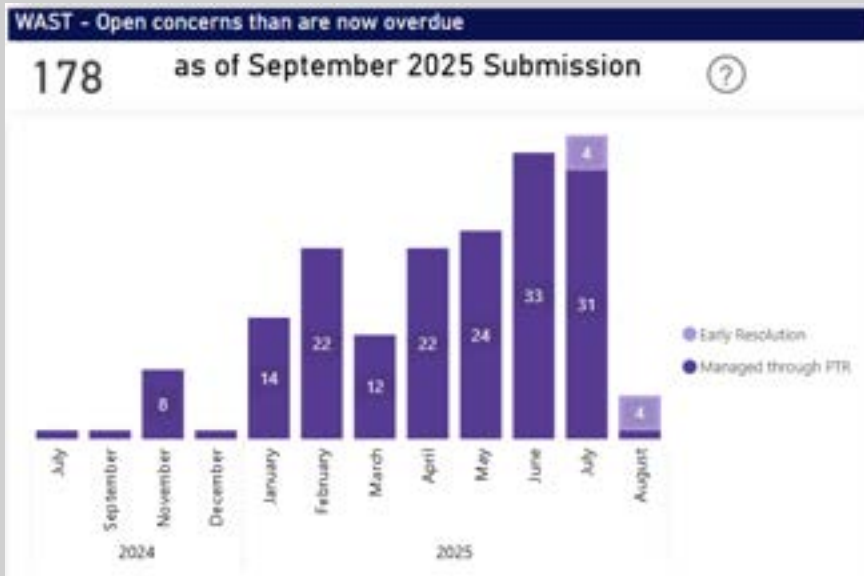
OBJECTIVE	MEASURE	TARGET	CURRENT POSITION	TREND
Timely investigation and response to complaints	Of all complaints closed in month, what percentage were closed within 30 wd	75%	56%	
Timely investigation and response to complaints	Number of open overdue complaints	0	178	
Timely completion of NRI investigations	Total NRIs that remain open 90 working days or more	0	37	
Improved incident management	Number of Datix Cymru Incidents in 'New' incident status	0	2180	
Improved incident management	Incidents open over 30 days	<25% of open incidents	Support needed with data provision	--
Timely learning from Medical Examiner referrals	Number of referrals awaiting Level 2 Learning Panel	99		
Timely and compliant submission of Learning from Events Reports	Number of LFER cases overdue submission deadline	0	11 cases	
Timely provision of evidence for HMC inquests	Overdue statement requests	0	Support needed with data provision	--

## Key enablers

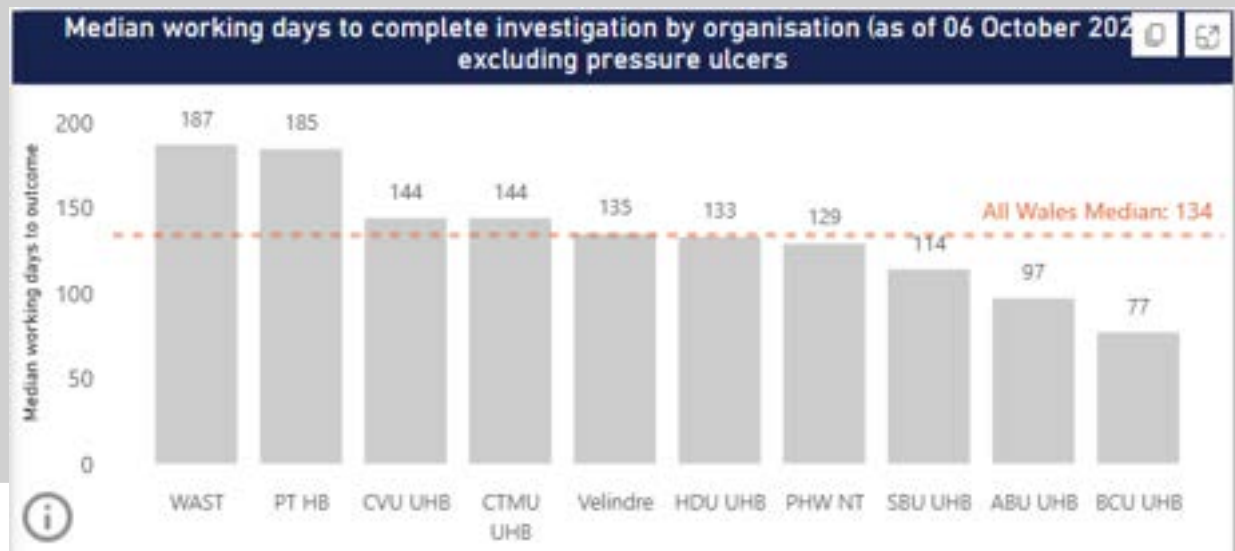
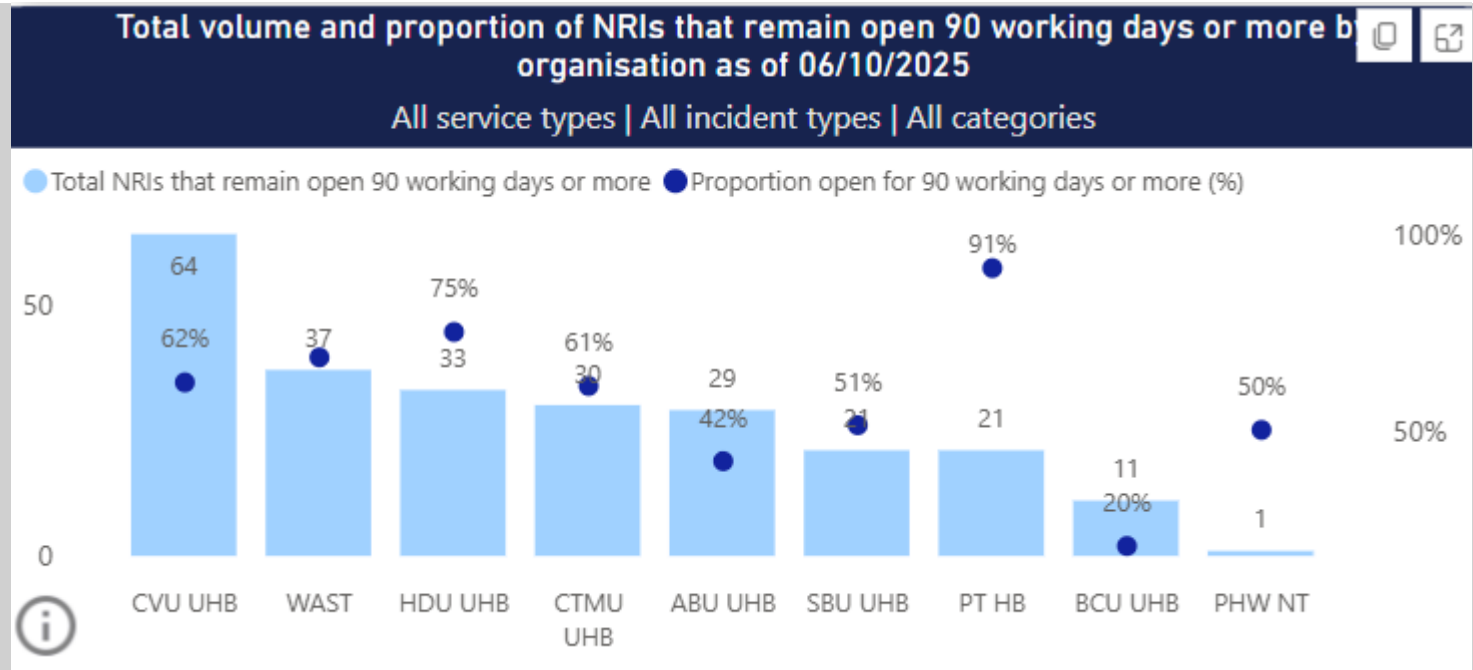
- Temporary additional resource - £155k released, majority into Operations. Recruitment progressing at pace.
- Proportionate investigation approaches- multi-professional Rapid Incident Review meeting successful in reducing call audit requests, multi- professional complaints triage has downgraded large volume of complaints. Informal resolution approaches being extended to Grade 1 and Grade 2 complaints in trialled and controlled way
- Data visibility, business intelligence for progress tracking – Datix semantic environment due to be released by end of November 2025 which will enable QPSE to develop some business intelligence products if capacity allows..
- The lack of operational-level data about concerns management remains one of the biggest obstacles to managers being able to effectively monitor performance, offer targeted support and drive improvement.
- Operations Quality OCP – completed. Workflow efficiency opportunities are now being identified.



# Current position – Complaints (data source Beacon)



# Current position – NRIs (data source Beacon)

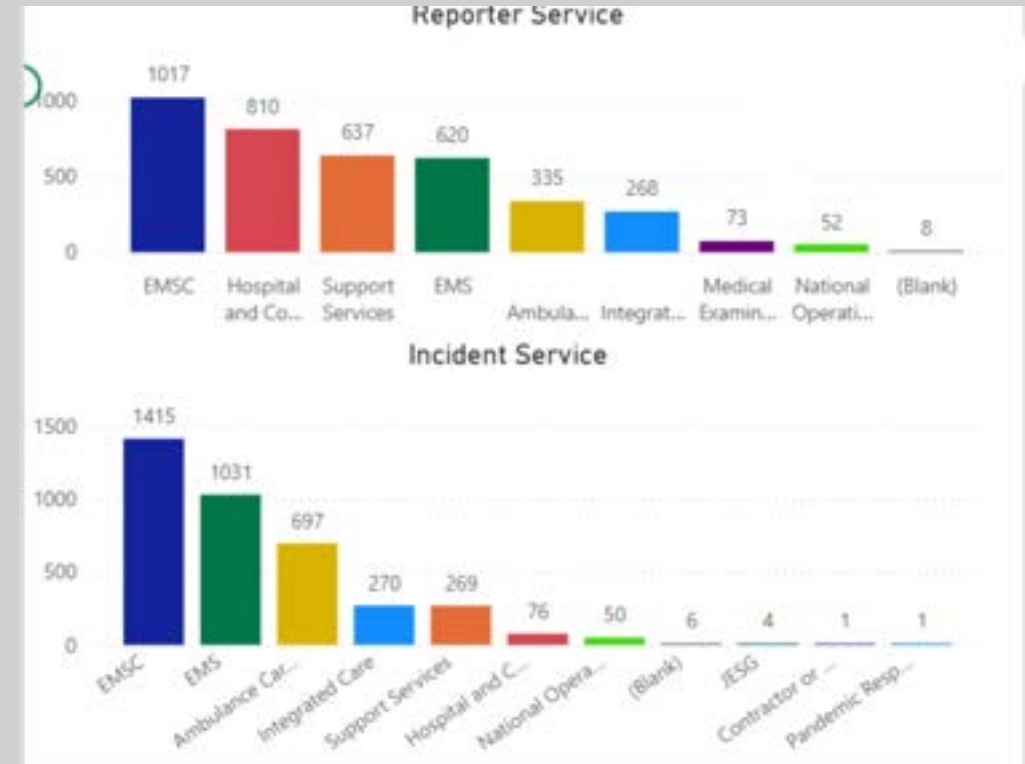
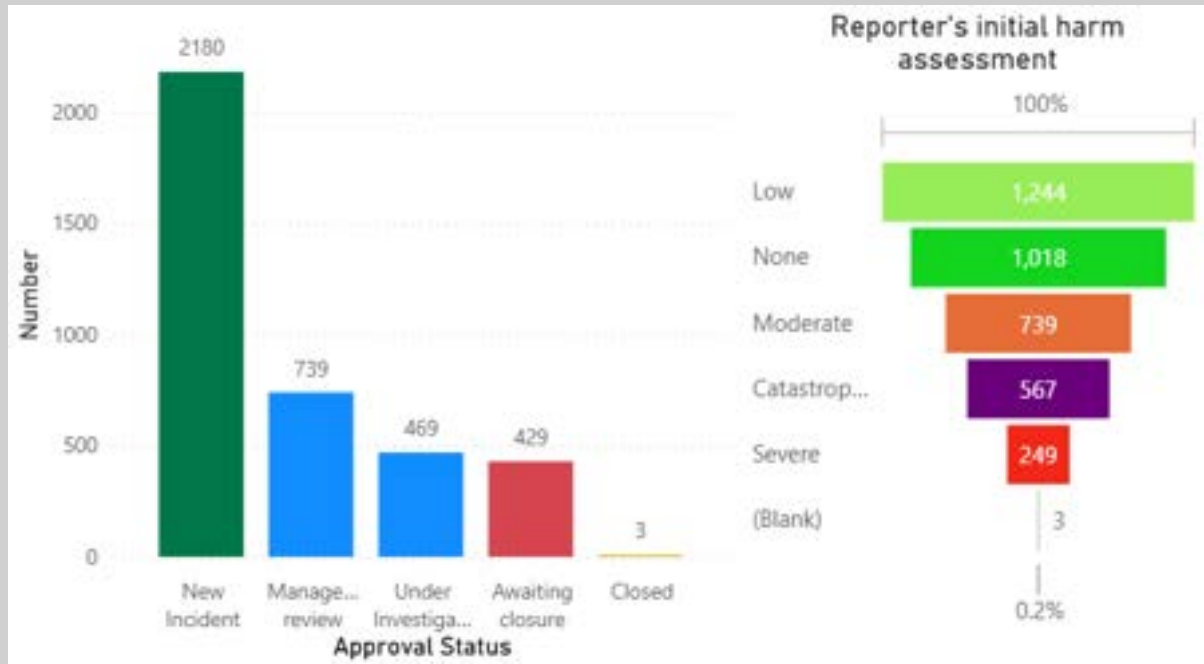




# Current position – Incident management (Data source – internal Q&S dashboard)

15.10.2025

*This data is NOT to be used for reporting purposes or shared externally outside of the TRUST.*





# Operations Improvement Trajectories\*

## Ambulance Care

	Starting Position	End November	End December	End January	End February	End March
Overdue Concerns	52	40	30	20	10	0
Longest Delay	5 months	3 months	2 months	2 months	2 months	1 month

\*All trajectories assume reporting rates of concerns at current volumes

## Integrated Care

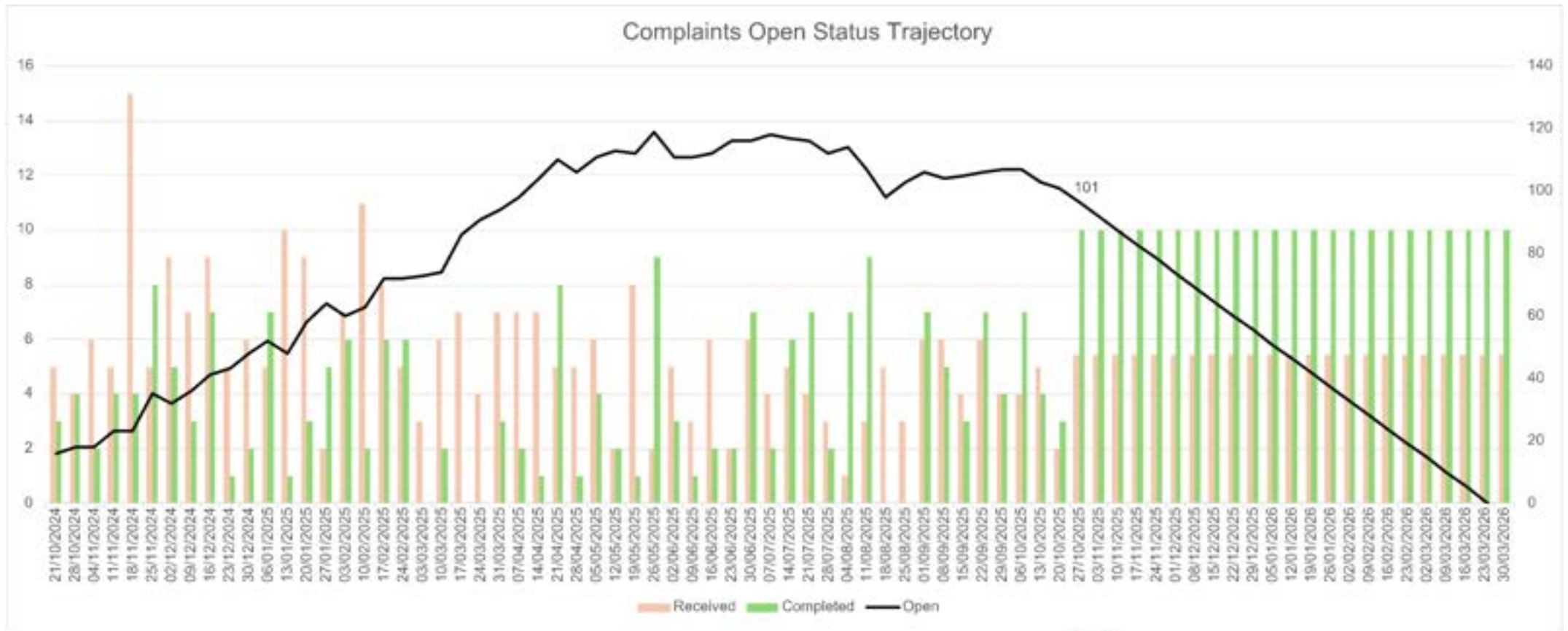
		Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
<b>Complaints</b>	Volume Overdue	16	14	12	10	8	8
	Longest Delay	3 Months	2 Months	2 Months	2 Months	2 Months	1 Month
<b>Coronial &amp; NRI Investigations</b>	Volume Overdue	2	0	0	1	1	0
	Longest Delay	2 Months	0	0	1 Month	1 Month	0
<b>LFERs</b>	Volume Overdue	2	0	0	0	0	0
	Longest Delay	1	0	0	0	0	0
<b>DATIX</b>	Volume of incidents in new incident status	25	20	25	25	20	15
	<i>Increasing % of DATIXs which are closed as a % of total</i>	90.30%	92%	90%	90%	92%	93%



# Operations Improvement Trajectories\*

## Operations Quality

Month	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Received	15	22	27	22	22	27
Completed	17	40	50	40	40	50
Open Complaints	101	83	60	42	24	1





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**AUDIT, RISK AND ASSURANCE COMMITTEE  
HIGHLIGHT REPORT TO THE QUALITY, PATIENT EXPERIENCE AND SAFETY  
COMMITTEE (QuEST)**

<b>Audit, Risk and Assurance Committee Date</b>	02 September 2025
<b>QuEST Committee Date</b>	04 November 2025
<b>Chair of the Audit, Risk and Assurance Committee</b>	Peter Curran

**KEY ESCALATION AND DISCUSSION POINTS**

**ALERT**

(Alert the Board to areas of attention)

1. The Audit, Risk and Assurance Committee (ARAC) received your annual assurance report regarding the framework supporting the **near miss and low harm intelligence reporting** in the Trust at its meeting on the 02 September 2025. The ARAC recognises that oversight of near miss and low harm intelligence reporting sits with the Quality, Patient Experience and Safety Committee (QuEST) and that this annual report is given to ARAC to provide assurance on the arrangements regarding the recording and management of near miss and low harm incidents.
2. The ARAC noted that this report provided only limited assurance, citing ongoing challenges within the Putting Things Right (PTR) Team to progress cultural work necessary to improve near miss reporting. Specifically, the PTR Team are dealing with continued high levels of demand resulting from system pressures and increased investigation complexity. At the ARAC on 02 September 2025 the Executive Director of Quality and Nursing indicated that the immediate priority is the PTR Recovery Plan to improve statutory and regulatory compliance.
3. As a result of the Trust's focus on the PTR Recovery Plan, the ARAC heard that improvements in near miss and low harm reporting may not be forthcoming in the short term. To ensure continued monitoring from ARAC due to the assurances it must receive, it has been asked that QuEST provide an interim update to the meeting of ARAC in March 2026 (in addition to the next annual report in September 2026). This is to ensure that the issue remains under active review; even if the update at that time is that the position remains unchanged.

**ADVISE**

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

n/a

**ASSURE**

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

n/a

**RISK MANAGEMENT**

n/a



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University NHS Trust

Agenda Item No.

11

## REPORT TITLE

Mental Health Annual Report

## MEETING

Name of meeting	QUEST
Date of meeting	4 November 2025
Public or Private	Public
If private - <a href="#">rationale</a>	Choose item from below

## REPORT SPONSOR

Executive sponsor	Liam Williams
Author(s) of report	Justine Cosby

## PURPOSE OF REPORT

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

## REPORT SUMMARY:

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

Mental health within WAST encompasses a broad range of specialisms commissioned by Welsh Government, including dementia, learning disabilities, substance misuse, neurodiversity, child and adolescent mental health (CAMHS), older people's mental health, post-natal mental health, and adult mental health.



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The Welsh Ambulance Services University NHS is undergoing a profound strategic transformation in its approach to mental health care. This annual report demonstrates how the Trust is moving beyond incremental improvements to deliver a step change in service quality, equity, and responsiveness which are directly aligned with priorities for governance, assurance, and strategic leadership.

WAST's transformation is anchored in a clear, ambitious vision: to create a comprehensive, integrated, and accessible mental health response system for Wales. This signals a shift from reactive crisis management to proactive, system wide mental health support reducing pressure on emergency departments and delivering value-based care. Aligning with the new Strategies for Mental Health and Suicide and Self harm from Welsh Government.

Equity is a guiding principle for WAST. The Trust is actively addressing geographical disparities, particularly in rural areas, and working to ensure mental health care is as prioritised and accessible as physical health care. Quality improvement is embedded in service delivery, with robust evaluation mechanisms, patient reported outcome measures, and a culture of continuous learning.

The focus on workforce development including advanced training, specialist roles, and leadership programmes ensures that WAST is building a skilled, compassionate, and future-ready workforce.

Recent leadership changes have brought renewed strategic focus and expertise to mental health, fostering collaboration across departments and with external partners. The involvement of stakeholders including health boards, police, third sector organisations, and lived experience ensures that services are co-produced, relevant, and aligned with national priorities.

The report acknowledges ongoing challenges, including workforce shortages, limited hours of specialist services, and the need for improved data and evaluation. WAST is addressing these through targeted recruitment, enhanced training, investment in technology, and continuous service evaluation.

The next steps outlined expanding services, implementing new outcome measures, and strengthening data capture position the Trust to build on its achievements and further improve mental health outcomes across Wales.

Ultimately, WAST's strategic transformation is about delivering measurable, positive change for individuals experiencing mental health crises. By prioritising equity, quality, and innovation—and by fostering strong leadership and stakeholder collaboration the Trust is creating a mental health service that is fit for the future. For board members, this represents a robust, evidence-based approach to governance, assurance, and strategic delivery ensuring that WAST continues to make a meaningful difference in the lives of those it serves.



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## RECOMMENDATION(S)

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

The QUEST forum is requested to:

1. To discuss and note the delivery assurance report.
2. To acknowledge that continued focus is recommended on:
  - Scaling successful pilots like MHRV and remote Triage;
  - Enhancing workforce development and recruitment; · Strengthening partnerships with Health Boards and third sector organisations;
  - Advancing digital innovation and data driven evaluation;
  - Ensuring equitable access and consistent quality of care across all regions.

## ADDITIONAL PAPER(S)

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

The QUEST Forum is requested to receive the following:

1. Mental Health Annual Report 2024 -2025

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

N/A

## HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

<input checked="" type="checkbox"/> Safe	<input type="checkbox"/> Timely	<input checked="" type="checkbox"/> Effective
<input type="checkbox"/> Efficient	<input checked="" type="checkbox"/> Equitable	<input checked="" type="checkbox"/> Person Centred

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

<input type="checkbox"/> Leadership	<input type="checkbox"/> Workforce	<input 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 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 checked="" type="checkbox"/> No <input type="checkbox"/> Yes
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If yes, what impact assessment is attached

## APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
21 October 2025	CQGG



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## SITUATION

1. This report provides assurance on the delivery of mental health and dementia priorities for 2024/25 within Welsh Ambulance Service NHS Trust (WAST). It confirms progress against strategic objectives, supported by robust oversight and evaluation. WAST remains on track to meet commitments, focusing on continuous improvement and high-quality, accessible care. Stakeholders can be confident that initiatives align with Welsh Government strategies for Mental Health and Wellbeing and Suicide and Self-Harm (April 2025).

## BACKGROUND

2. Mental health within WAST encompasses a broad range of specialisms commissioned by Welsh Government, including dementia, learning disabilities, substance misuse, neurodiversity, child and adolescent mental health (CAMHS), older people's mental health, post-natal mental health, and adult mental health. Over recent years, WAST has invested significantly in transforming services across 999 and NHS111 Wales, aiming to position itself as a leader in crisis care and community-based support. Leadership changes have strengthened this transformation. The appointment of a Deputy Director of Remote Clinical Care (April 2025) provides strategic oversight for integrating remote mental health services and enhancing the Mental Health Response Vehicle (MHRV) offer. Similarly, the recruitment of a Consultant Clinician for Mental Health and Dementia (October 2024) has driven improvements in clinical capability and strategic partnerships. These roles underpin WAST's commitment to integration, efficiency, and specialist service development.

## ASSESSMENT

3. Progress demonstrates significant achievements and alignment with strategic goals:

- **Leadership and Governance:** New appointments have enhanced operational performance measurement and programme management, ensuring delivery assurance across mental health initiatives.
- **Service Expansion:** The MHRV pilot in Gwent has shown positive outcomes in crisis response. Plans for phased roll-out across urban areas aim to achieve full 24/7 coverage, reducing reliance on emergency departments and improving patient experience.
- **Specialist Development:** Introduction of a Learning Disability Specialist Clinician and continued workforce development initiatives strengthen care for vulnerable populations. Collaborative research, such as the CAMHbalance study, reflects WAST's commitment to innovation.



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- **Inclusive Care:** Services now address diverse needs, including dementia-friendly pathways and support for neurodiverse individuals, post-natal mental health, and substance misuse.
- **Training and Workforce:** Advanced training programmes ensure staff are equipped with evidence-based skills in learning disabilities, CAMHS, and substance misuse, promoting resilience and high-quality care delivery.

Challenges remain in scaling services and sustaining workforce capacity, but strategic planning and investment indicate readiness to overcome these barriers.

## RECOMMENDATION

4. The recommendations are set out in the front cover above.

## NEXT STEPS

5. To maintain momentum and deliver on 2024/25 commitments, WAST should:
1. **MHRV Roll-Out:** Explore phased implementation across Wales to improve timely access to crisis care and reduce emergency department pressures.
  2. **Expanding 24/7 Practitioner Coverage:** Assess feasibility of round-the-clock mental health support to enhance responsiveness and patient outcomes.
  3. **Strengthen Dementia Pathways:** Develop clear, accessible routes for individuals and carers, integrating health and social care systems.
  4. **Embed Workforce Development:** Continue specialist training in dementia, learning disability, neurodiversity, CAMHS, and substance misuse, alongside practical modules for all staff.
  5. **Enhance Partnership Working:** Foster collaboration with Health Boards and community organisations to ensure integrated, person-centred care.
  6. **Monitor and Evaluate:** Maintain rigorous performance measurement and delivery assurance to track progress and inform future service development.

By implementing these recommendations, WAST will consolidate its position as a leader in mental health crisis care, delivering compassionate, expert support across Wales. These efforts will contribute significantly to the broader health and social care landscape, ensuring quality, accessibility, and sustainability in mental health provision



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# Mental Health Annual Report



2024-2025

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Version 1.0

04 October 2025

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Welsh Ambulance Services University NHS Trust is undergoing significant transformation in its Mental Health delivery. This report provides assurance for 2024/2025, highlighting strategic initiatives, leadership changes and service developments aimed at improving mental health crisis response across Wales.

### The Mental Health Team



The term "Mental Health" is employed as an overarching concept encompassing a range of specialisations. These specialisations include:

Dementia

Child and Adolescent Mental Health

Neurodivergence

Learning Disability

Post Natal Mental Health

Adult Mental Health

Substance use

Older People Mental Health

**"Supporting Mental Health"**

Support is not limited to remote care, but includes a wide portfolio of activities to advance our response to those with diverse needs. This holistic approach ensures individuals receive comprehensive care that addresses their unique circumstances. By integrating various modes of support, we can better meet the mental health needs of our community, offering both immediate assistance and long-term solutions.

Welsh Ambulance Services University NHS Trust

## Background

1. WAST has a significant role in responding to mental health crises, handling over 30,000 mental health-related contacts annually through the 999 service. This highlights the critical need for open access mental health support and the essential role WAST plays in providing it. The growing demand for mental health support through the NHS111 Wales service and the Non-Emergency Patient Transport Service (NEPTS) underscores the importance of these services.
2. Over the past five years, WAST has made significant investments to enhance the care experience for individuals living with mental health conditions and address broader mental health challenges in Wales. These have including expansion of services, workforce development, strategic partnerships, advancing specialist areas and research and innovation.

3. The development of the remote integrated care service, which brings together NHS 111 and 999 clinical teams, is a promising step towards more cohesive and efficient care. Additionally, the ongoing demand for emergency support from 111 press 2 partners within the health boards indicates the necessity of strong collaboration and integration across services. These efforts are crucial for ensuring that individuals in mental health crises receive timely and effective support.

4. Our future vision for WAST's mental health service is one of ambitious transformation. The focus on scaling successful pilot initiatives and embracing cutting-edge practices is a promising approach to building a comprehensive, 24/7 mental health response infrastructure. This transformation aims to improve patient outcomes, reduce the pressure on emergency services and ensure equitable care for this patient group.

5. Mental health support is not limited to remote care, it encompasses a wide range of services designed to cater to diverse needs. While remote care offers convenience and accessibility, it is crucial to highlight the importance of in-person and community-based mental health services. These services provide a holistic approach, ensuring individuals receive comprehensive care that addresses their unique circumstances. By integrating various modes of support, we can better meet the mental health needs of our community, offering both immediate assistance and long-term solutions.

## **Key Strategic Drivers, Vision, Leadership and Developments**

### Strategic programme for Mental Health

6. The Strategic Programme for Mental Health in Wales, established in October 2023, aims to provide system leadership and improve safety and outcomes by reducing unwarranted service variation.

### National Dementia Plan and Pathway of Standards

7. The creation of a new National Dementia plan in Wales through 2026/27 will provide an opportunity to ensure our dementia plans are in line with national and regional work programmes. The Trust's Dementia priorities continue to be connected

with national priorities including optimal environments for our patients, dementia friendly pathways and processes, and a high-quality training offer for our workforce.

### Six goals of Urgent and Emergency care

8. The Welsh Ambulance Services University NHS Trust (WAST) is deeply committed to improving mental health services and aligning with the Six Goals for Urgent and Emergency Care in Wales. Examples include:

- Coordination, Planning and Support: WAST's mental health initiatives ensure coordinated care for individuals at greater risk of need urgent or emergency care.
- Signposted to the Right Place, First time. The Senior Mental Clinicians in remote integrated care and MHRV help direct patients to the most appropriate care setting, reducing unnecessary hospital admissions.
- Access to clinically safe alternatives: by treating patients at scene, MHRV provide safe alternatives to hospital admission.
- Rapid response in a crisis: WAST's initiatives ensure a rapid response to mental health crisis improving patient outcomes.
- Optimal Hospital care following admission: streamlined handover processes at the appropriate facility for mental health patients ensuring they receive timely and appropriate care.
- Home first approach: WAST supports a home first approach, aiming to reduce the risk of readmission by providing or ensuring care can be provided in the community for our mental health patient group.

9. These efforts highlight WAST's commitment to delivering high quality mental health services and aligning with the strategic goals for urgent and emergency care in Wales that is equitable, effective and sustainable.

### Strategic Mental Health Workforce Plan for Health and Social Care.

10. WAST is actively involved in the Strategic Mental Health Workforce Plan for Health and Social Care in Wales.

11. We are focused on developing a skilled and motivated workforce to improve mental health services. This includes training and professional development for all staff.

12. The plan included the introduction of specialist roles, such as a Learning Disabilities practitioner to address specific needs and enhance care delivery.

13. Efforts are made to ensure all patients have access to high quality mental health care, addressing disparities and prompting equity in care delivery.

14. WAST aligns its initiatives with the strategic goals outlined on the plan, focusing on improving safety, outcomes and service variation. This is designed to create a more inclusive, engaged, sustainable and flexible workforce.

#### Conveyance Review Joint Commission Collaborative

15. The Mental Health Service in WAST was actively involved in the conveyance review as part of the membership of the Joint Commission Collaborative. There is collaboration with health boards and local authorities to enhance conveyance processes and ensure a coordinated approach to patient care. This also emphasises accountability and transparency in how conveyance services are managed and delivered across Wales. This is currently paused and has moved to sit under a different department within the JCC going forward.

#### Equity and Parity

16. Working towards equity and parity between physical and mental health services, ensuring that mental health care is as accessible and prioritised as physical health care.

#### Transformation of Acute and Crisis Care

17. Addressing national challenges in acute and crisis care mental health services by developing new service models informed by the latest research and evidence. This included the Mental health service in WAST attending and being vocal in the Accelerated Design Event to assist and support the development of mental health care for the future.

#### Stakeholder Collaboration

18. Engaging with health boards and other stakeholders to steer plans and ensure alignment with Ministerial priorities. This included the development of referral pathways and joint collaborations.

19. Greater integration of WAST services with Health Board teams will enhance the coordination and delivery of mental health care. This includes developing pathways for all regions of Wales.

#### Value Based Health Care

20. Value based mental health care in WAST focusses on delivering high quality, patient centred care that improves outcomes while being cost effective. Outcomes are prioritised that matter most to patients such as improved mental health and quality of life.

21. There are some challenges within mental health of measuring outcomes. Mental health lacks universally accepted metrics. Psychologically wellbeing is individual and multifaceted, making it difficult to quantify improvements in certain conditions. Mental health treatments often require long term engagement, making it challenging to determine when success has been achieved. Progress can occur over years rather than weeks.

22. WAST is developing ways of defining vales and successes by integrating both quantitative and qualitative measures.

#### Leadership

23. Over the period, significant leadership and personnel changes, the Trust has been shaping the future direction of mental health services. To align with our strategic goals, we appointed a new Deputy Director of Remote Clinical Care to strengthen oversight, particularly regarding the integration of mental health services across Trust service areas, and to foster deeper relationships with Health Board partners. The mental health team, funded by Welsh Government, now falls under this role's portfolio, enhancing leadership focus on mental health and remote care initiatives.

24. Under this leadership, alongside the recently established Consultant Practitioner for mental health, we are also focused on developing specialist expertise in areas such as substance misuse, learning disabilities and child and adolescent mental health (CAMHS). We currently are recruiting for a Learning Disability specialist clinician post following support from Welsh Government to utilise our allocation to achieve this. The Trust has also supported a CAMHbulance study led by a Cardiff University academic, following support from the Chief Nursing Officer for Wales.

25. The Consultant Practitioner for Mental health has been accepted and started the Advanced Clinical Leadership Programme with Health Education Improvement Wales. They are the first individual from WAST to have undertaken this course. This programme aims to develop senior clinicians compassionate and inclusive leadership, as well as emphasising interprofessional collaboration, and enhancing coordination and integration of services across the healthcare system.

26. These leadership changes are positioning the Trust to deliver more integrated and robust mental health services, with a clear focus on collaboration, expertise development and enhanced care for patients in crisis. With these changes, we are confident in our ability to fully utilise allocated funding and deliver on our strategic objectives.

27. Further attention is being directed towards enhancing performance and quality management within our clinical and operational settings. Additional considerations have been applied to program management to provide greater accountability for delivery assurance. We are positioning ourselves to better meet its strategic objectives and improve mental health crisis response.

### Workforce Development: Education and Training

28. It is essential to underscore the critical role of expert mental health clinicians in addressing the multifaceted nature of mental health cases. "Complexity"—the diversity and intricacy of each person's challenges, such as co-occurring conditions, symptom severity, and need for tailored interventions—truly demands advanced expertise.

29. During mental health crises, especially when urgent support is required at unpredictable times, the involvement of skilled clinicians becomes even more crucial. Crisis intervention is often needed during evenings and overnight, periods when routine care is unavailable. These out-of-hours presentations frequently involve individuals with more severe or overlapping conditions, requiring immediate, specialized responses. Only clinicians with deep experienced advanced training are equipped to navigate these high-stakes situations, ensuring both the safety of those in crisis and the delivery of effective, individualised care.

30. Continuing to develop staff skills through mental health modules and practical training in dementia awareness, learning Disability, Neurodiversity, Post natal mental health, Child and Adolescent mental health and substance misuse will ensure long-term resilience and high-quality care.

#### Enhancing and Advancing Clinical Practice, Education and Training

31. Recent experience has demonstrated that WAST is best placed concentrating on the development of education and training packages that support remote clinical decision making, while developing Level 7 mental health module within this . The mental health team will continue developing and delivering CPD sessions for colleagues across the Trust and offering support to those seeking access to HEIW funded education.

32. By investing in enabling staff to provide enhanced, advanced, and consultant-level mental health practice, WAST is widening its expertise and specialist support. This includes better care for individuals with learning disabilities, substance misuse issues and young people requiring specialist support. Additionally, building a range of learning opportunities based on practical skills and whole mental health awareness will ensure that the workforce is well-equipped to meet diverse needs. These efforts are crucial for ensuring long-term resilience and high-quality mental health right care, right person, right place open access care. There is a focus on moving our current modules from onclick to LMS365 as well as developing education on post-natal, health, eating disorder and communication skills.

## Education and Training

The Team has expanded its education initiatives, offering dementia-focused training for Paramedics, Call Handlers and staff across Non-Emergency Services.



This training includes webinars, podcasts and role-specific courses to enhance the ability of staff to care for individuals with dementia or mental health issues. The voice of those living with dementia is central to these learning opportunities.

Whilst training has been positively received, there are fresh attempts to make the content engaging and captivating, particularly in light of the Trust's strategic ambition to care for more patients through remote means.

A major focus has been on training staff across various service areas, such as 999 Call Handlers, to better support people experiencing mental health crises.

Welsh Ambulance Services University NHS Trust

### Innovation and Technology

33. Exploring digital health technologies and refining service delivery models will further enhance mental health triage, assessment, and support. Developing tools like the Patient Activity Toolkit (PAT) will provide valuable distraction and occupation activities for distressed or confused patients. There has also been a protocol developed and endorsed for use by Priority Solutions Inc. (international ECNS system used by clinicians in the remote triage space).

34. By addressing these challenges and advancing strategic initiatives, WAST is poised to lead a future where mental health care is equitable, responsive, and effective for all.

## Our 2024/25 Delivery

**Key Achievements**



**MENTAL HEALTH RESPONSE VEHICLE**

Coverage expanded in SE Wales. The Gwent pilot demonstrated a 74% non-conveyance rate, significantly reducing ED pressures.



**REMOTE CLINICAL TRIAGE**

Over 3,000 calls managed, with a 70.6% closure rate, highlighting the effectiveness of remote mental health clinicians.



**SENSORY FRIENDLY ENVIRONMENTS**

A consultation on our environments from a sensory viewpoint was conducted and an outcome paper was written to identify improvements and inform future fleet design.



**LEADERSHIP AND WORKFORCE**

Strategic direction and clinical capability strengthened through appointment of a Deputy Director for Remote Clinical Care and a Consultant Practitioner for Mental Health.



**RIGHT CARE, RIGHT PERSON**

Core partner in national implementation, with protocols and escalation pathways developed in collaboration with all four Welsh police forces.



**INNOVATION AND TECHNOLOGY**

Bespoke ECNS protocols for mental health triage and the development of a Patient Activity Toolkit are improving care quality and data capture.

35. Expanding the Mental Health Response Vehicles (MHRV) across Wales is a significant ambition moving forward. Building on the current coverage in the South-East region (since November 2024), and the current plan to operate response vehicles in every Health Board, especially in urban areas with high demand, will greatly enhance the capacity to respond to mental health crises swiftly. This expansion aims to provide on-the-spot therapeutic interventions, improving the quality of care and reducing the need for hospital conveyance where remote clinical support is not going to offer the support required. The ongoing work to establish pathways in the South-West and other regions of Wales demonstrates a commitment to comprehensive coverage and support. These efforts are poised to make a substantial impact on mental health care delivery across Wales and align with both the very recent Suicide and Self-Harm Strategy and the Welsh Government Mental Health and Wellbeing Strategy.

36. 24/7 Mental Health Practitioner Coverage: Extending the operating hours of Mental Health Practitioners (MHPs) to 24/7 is a crucial step in ensuring that individuals in mental health crises receive timely, expert care at any time. This initiative will significantly reduce the strain on emergency resources during out-of-hours periods and enhance the overall efficiency of the healthcare system. As a

national service provider, WAST's clinical contact centres will continue to play a vital role in ensuring that patients across Wales can access specialist care when they are in crisis. As part of the implementation plan for the Mental Health and Wellbeing Strategy WAST will be a key partner to supporting the design of future services that utilise digital and remote capabilities to support people not only when in crisis, but proactively to reduce the risk of crisis occurring.

### Mental Health Response Vehicle (MHRV)

37. The Business Case produced in May 2024 for the Welsh Ambulance Trust (WAST) outlined several key points.

- Development of Dedicated Mental Health Response: The need for a dedicated mental health response within WAST's existing service provision. This initiative aims to address the gaps where patients with mental health needs may fall between services, especially following changes to joint emergency response models like Right Care Right Person (RCRP).
- Equitable Response to Mental Health Callers: Recognising that 10% of callers are recorded as mental health-related, the Trust's ambitions to deliver a dedicated 24/7 hear and treat mental health triage. This service aims to reduce conveyance and avoidable waits for mental health patients in emergency departments. These efforts are designed to ensure that individuals experiencing mental health crises receive timely, expert care, reducing the strain on emergency services and improving patient outcomes. This also incorporated seamless pathways which are in development between WAST and Mental Health services within health boards to ensure the patient journey is holistic.
- The joint pilot between the Welsh Ambulance Services University NHS Trust (WAST) and Aneurin Bevan University Health Board (ABUHB) indeed showed promising results. The Mental Health Response Vehicle (MHRV) operated in the Gwent area from January to March 2024. The key outcomes included a significant reduction of conveyance to ED compared to non-specific mental health vehicles. It highlighted that 74 % were treated and closed, highlighting the effectiveness of the MHRV in managing Mental Health Crises without needing ED intervention.

- The comparison data highlights significant improvements in managing mental health-related calls over the years: 2019: 88% of calls resulted in conveyance to Emergency Departments (ED), with only 12% closed at the scene. 2022: After implementing Mental Health Clinicians within the Clinical Support Desk, the closure rate increased to 41.5%, with fewer calls needing conveyance to ED. Currently the closure rate for the remote clinical triage is on average 70.6% in 2024 of calls when the MHC are dealing with the mental health specific ones.

38. Given these improvements, an options appraisal was conducted to further develop the service provision through Mental Health Response Vehicles (MHRVs). The appraisal considered various options, ranging from doing nothing to providing 24/7 coverage across all areas of Wales. Ultimately, a three-phase approach to service delivery was developed.

39. In comparison, data from 2019 showed 88% of mental health-related calls resulted in conveyance to ED, compared with 12% closed. This closure rate increased to 41.5% closed or referred onwards following implementation of Mental Health Practitioners within Clinical Support Desk setting in 2022.

#### MHRV Operational Plan

40. The options appraisal for the Mental Health Response Vehicles (MHRVs) led to a comprehensive three-phase operational plan, currently being implemented by a Task & Finish Group under the leadership of the Service Manager for south-east Wales. The implementation is split into three phases:

41. **Phase One:** Start Date: 4th November 2024: Coverage: One MHRV in south-east Wales, specifically parts of Cardiff & Vale, Aneurin Bevan, and Cwm Taf Morgannwg University Health Boards (UHBs); Reason for Location: High number of mental health presentations and optimal response times within a twenty-mile radius covering Cardiff, Bridgend and Newport. Phase Two: Timeline: To be confirmed in 2025: Expansion: Service extended to urban areas in south-central, north, and west Wales based on evaluation, utilisation, efficiency release and expected demand prevalence.

42. **Phases Two, Three :** Timeline: To be considered and confirmed in 2026 subject to funding, evaluation, utilisation, efficiency release and expected demand prevalence.

43. **Full Implementation:** Dependant on completion of evaluation but consideration should be made to 24/7 service covering all areas of Wales;

44. **Operational Details:** Crew Model: Each vehicle will operate with a two-crew model consisting of one Emergency Medical Technician (EMT) and one mental health practitioner Shift Times: Initial model operates during peak demand times from 18:00 to 01:00, with twelve-hour shifts from 13:00 to 01:00.

45. This phased approach aims to enhance mental health crisis management across Wales, ensuring timely and appropriate care while reducing the burden on emergency department

46. **Metrics and Evaluation:** Key metrics used within the evaluation of the pilot have been applied to the Phase 1 implementation.

47. Since 4 November 2024 to 27 March 2025, the MHC in remote clinical triage answered 3085 calls the majority being Amber 2, age range typically rises in numbers from 13 - 60. The patient gender being 50:50 for these calls.

48. Calls are received from 60 -98 years, but these are fewer in number. The calls are highest on a Monday, with Thursdays being, on average, the day with less calls. Call from Betsi Cadwaladr account for over 1/3 more than other health board, with Powys having the least. Of these calls 11% triaged are conveyed to ED.

49. From the above calls the MHC will identify those call that need to be seen for a mental health assessment in person within the south-east area and the MHRV will attend to assess the patient in person.

50. Within the same timeframe the MHRV has attended 393 incidents, the majority being Amber 2, age ranges from 14 – 76, the oldest being 88. The patient gender being 525 female, 48% male for these calls.

51. The highest volume of MHRV attendance is on a Tuesday, with Thursday being the lowest. Aneurin Bevan (AB) area has the most responses followed by Cardiff & Vale (C&V) then Cwm Taf Morgannwg (CTM). The MHRV has conveyed 8 % of responses to Health Board Mental health services for assessment.

## Right Care Right Person (RCRP)

52. The Right Care Right Person (RCRP) initiative in Wales is a collaborative approach involving the police and other emergency services to ensure that individuals receive the most appropriate care from the right professionals. All police forces in Wales have implemented stages 1 and 2. South Wales Police is the only police force to have implemented all four stages, this occurred on 10.03.2025. Gwent has implemented stages 1, 2 and 4 the later stage initiated on 01.04.2025.

53. **Partnerships:** WAST'S mental health team has been engaging and working closely with all 4 police forces on this initiative. There is more intense collaboration happening with South Wales and Gwent at present due to their implementation dates. A number of partner events have occurred. This collaboration helps in providing timely and effective care.

54. **National Partnership Group:** In Wales, a National Partnership Group has been formed, including various stakeholders, to oversee the implementation of the RCRP initiative and ensure its success. These efforts are designed to improve the response to mental health crises and ensure that individuals receive the care they need from the most appropriate service. The involvement of WAST's mental health service, as a core member, highlights the significance of its role in influencing and ensuring individuals receive appropriate care during mental health crises.

55. The Right Care, Right Person (RCRP) initiative includes an escalation process to address situations where there are significant delays or issues in the system. This process ensure that individuals receive timely and appropriate care from the correct service, rather than being inappropriately managed by the police.

56. WAST Mental Health Service has been involved in developing local protocols which are very similar for all police forces in Wales, to ensure escalation is timely and appropriate. It is also ensuring a strong partnership between police forces, local health boards and local authorities to effectively implement and manage the escalation process. This process has not run as smoothly as it should. There remains to be confusing in understanding between the MCA (Mental Capacity Act) and the MHA (Mental health Act). Since March these conversations have become more complex as the phases have been introduced, the finer details of this will be covered off in the 6 month report at the end of October 2025.

57. MAIT (Multi Agency Incident Transfer) is a technology specifically intended to help emergency services share information with each other. It is a common standard for the sharing of electronic incident information between emergency services control rooms. This information is presented in the form of defined fields and values, containing both personal and incident-specific data. This system is due to be implemented in May / June for both Gwent and South Wales Police. We are unsure of the impact on RCRP that this may have.

58. Success in WAST's mental health initiatives will be measured through several key metrics and methods:

- Patient Outcomes: Tracking improvements in patient health and wellbeing, including reduced distress and better management of mental health conditions;
- Service Utilisation: Monitoring the reduction in emergency department visits and the increased use of community-based mental health services;
- Response Times: Measuring the speed and efficiency of crisis response, including the time taken for Mental Health Response Vehicles (MHRVs) to reach patients;
- Patient Satisfaction: Conducting surveys and feedback sessions to assess patient satisfaction with the care received;
- Clinical Performance: Evaluating the effectiveness of clinical interventions and the quality of care provided by mental health practitioners;
- Workforce Development: Assessing the impact of training and education programs on the skills and confidence of mental health professionals as well as the impact of the mental health education on the clinicians in WAST;
- Innovation and Research: Measuring the success of new technologies and research initiatives in improving mental health triage, assessment and support.

59. These metrics will help ensure that the initiatives are meeting their goals and making a meaningful impact on mental health care in Wales.

## Innovation through Technology and Research

60. When WAST adopted ECNS from MTS, it became evident that the Protocols or Algorithms for Mental Health/Crisis presentations were inadequate, leading to the need to exit the protocol or use the 'miscellaneous' route. The Emergency Communication Nurse System (ECNS) uses a protocol model that provides standardisation, risk reduction, and increases confidence in the practices of a hear and treat service. ECNS includes several mental health-specific protocols covering various conditions and presentations. However, due to their primary function of reductionist triage, none are suitable for use by specialist MHPs.

61. Following discussions with Priority Dispatch and the ECNS Quality Assurance Lead, a bespoke protocol was developed for use by WAST Mental Health Clinicians within the ECNS software. The benefits of adopting the protocol include protecting the organisation and ensuring the individual user feels professionally protected, potentially attracting and supporting future recruitment into SMHC posts. Additionally, the Mental Health protocol on ECNS will enable the organisation to gather more detailed data on assessments and outcomes conducted by clinicians using the protocol, leading to improved training, supervision, and key performance targets.

62. We will undertake further work to refine our service delivery models, testing in both remote and face-to-face contexts. In addition, we plan to explore the use of digital health technologies to further enhance mental health triage, assessment and support, reducing the need for patients to attend urgent and emergency care settings, where appropriate. Develop a Patient Activity Toolkit (PAT) to offer distraction and occupation activities to a range of patient groups who may be distressed or confused within our environments (Including Children, Mental Health, Dementia, Neuro diversity and Learning disabilities).

## Dementia Programme 2024/25 Highlights

63. Dementia is poised to become one of the most significant healthcare challenges of the 21st century. We are committed to enhancing the experience for individuals living with dementia who utilise our services, while also addressing the impact it will have on our workforce.

64. We are dedicated to addressing both the clinical and emotional needs of individuals living with dementia, as well as their carers and families. By increasing dementia awareness, we aim to enhance the skills and knowledge of our workforce. Our goal is to provide higher-quality services and improve the experiences and outcomes for those affected by dementia as they navigate our services. Our dementia programme is grounded in co-production, fostering innovative improvements such as the creation of dementia and sensory-friendly environments. Additionally, we collaborate with various health, social care, and third sector partners to deliver our initiatives in partnership.

65. Our workforce is essential to the development of our programme, and we are creating a network of staff champions and influencers who can encourage local engagement and good practice.

#### Engaging with dementia communities

66. We actively engage with various dementia groups and communities across Wales to educate them about our work and discuss the range of services we offer. We provide familiarisation opportunities, allowing individuals to explore our vehicles and understand our environments. This helps us identify challenges faced by people with dementia when using our services. Feedback from these communities has driven numerous improvements.

67. Our dementia programme is built on co-production, which drives innovative improvements, including the development of dementia and sensory-friendly environments.

#### Developing dementia-friendly environments

68. Feedback from dementia communities has prompted numerous enhancements to our vehicles. We have updated the flooring and seat colours and added pictures and imagery to the windows and blinds in the back of the vehicles. These features are now standard in all new non-emergency transport vehicles.

69. A project in Ceredigion aims to enhance ambulance transport by incorporating pictures of local scenic areas, genre-specific music and activity booklets to support patients. This initiative has been co-designed with the local dementia community, who have been involved from the start and will be evaluated in winter 2025.

## Using reminiscence therapy with people living with dementia

70. We are offering reminiscence therapy to dementia patients, supporting people who may become stressed and anxious in our environments, through a RITA tablet. We receive safety reports, staff and patient feedback where our environments including vehicles, processes, and staff interactions have an impact on experiences and outcomes of people living with dementia when in our care. A lack of communication, reassurance and support, particularly in an emergency, can be distressing confusing and cause anxiety.

71. Reminiscence Interactive Therapy Activities (RITA) is a digital solution using evidence-based therapies to develop more meaningful interactions with dementia patients. We currently have 25 RITA tablets in use across Wales and are working with regional partners to secure a small number of tablets to support local work in CTM and C&V Health Board areas.

72. Learning from this work has led to the development of a Dementia Activity Toolkit to be built in-house by the Dementia Team and will offer a range of solutions at no cost to the Trust.



### Dementia Care Enhancements

Dementia remains a critical challenge, with over 50,000 individuals in Wales affected.

In line with the Dementia Action Plan for Wales, WAST has worked to improve dementia care, particularly through innovative projects like the introduction of RITA (Reminiscence Interactive Therapy Activities) tablets.

These tablets have been used in Pilot Projects over the year to demonstrate their success in being used to calm agitated dementia patients.

Although it has been identified that cost constraints limit a widespread rollout, the Project has generated alternative approaches, such as the creation of a Patient Activity Toolkit, which is being developed to support patients more widely.

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## Dementia Concern Referral

73. We support many individuals living with dementia, from the early signs and symptoms to more advanced stages. We are collaborating with Alzheimer's Society Cymru on a referral process into their 'Dementia Concern' Service. This service provides bilingual telephone support to anyone living with dementia, as well as their carers and family members, on any dementia-related issues. Our staff can refer individuals to this service if they have concerns about memory loss, confusion, or dementia. A formal diagnosis of dementia is not required for a referral.

74. Within the first year of this project, we have supported over 150 referrals from a range of staff across the service, and across Wales. We are working with Alzheimer's Society Cymru on the value and effectiveness of the referrals.

## Improving emergency admission processes

75 Partnerships are being formed with different regional dementia networks to map the emergency admission process for dementia patients and their carers/families. Work began in Cardiff & Vale as part of a Bevan Exemplar programme and is now being moved into other areas including Aneurin Bevan and Betsi Cadwaladr. Some themes from this work includes:

- Maximise opportunities for co-production through projects, ensuring the dementia voice leads the work;
- Use of community initiatives such as biographical tools to maximise learning about people affected by dementia to support the care process;
- Exploring handover delays;
- Ensuring effective handovers between staff to maximise patient/carer wellbeing, safety and best interest decisions;
- Improving physical spaces and environments to make them more dementia-friendly;
- Working with care homes to improve patient journeys between services;
- Exploring existing feedback mechanisms for patients and staff, and audit tools which would aid improvement;
- Using current data sets to identify good practice and hotspot areas that require attention;
- Consider joint learning opportunities between services.

## Challenges and Opportunities

76. Addressing the current gaps in mental health support across Wales is crucial for achieving consistent and equitable.

- **Limited Hours and Scale:** While Mental Health Response Vehicles (MHRVs) and Mental Health Clinicians (MHCs) have been transformative, their limited hours and small-scale operation constrain their full potential. Consideration of expanding these services to operate 24/7 and increasing their availability across all Health Boards would enhance the opportunity to better support patients experiencing a mental health crisis.
- **Geographical Inequalities:** Significant disparities exist in mental health service provision, particularly in rural areas. Addressing these inequalities requires targeted efforts to ensure equitable access to care across different regions.
- **Finite Workforce:** The limited number of mental health practitioners in Wales poses a challenge. National efforts to attract and retain professionals in the mental health field, including those with expertise in learning difficulties, neurodiversity, substance misuse, and CAMHS, are essential. Integrating WAST services with Health Board mental health teams can provide attractive career opportunities and benefit clinician skills and development, aligning this with the HEIW Strategic Mental Health Workforce Plan.



## Key Challenges

**The current Mental Health Team faces several challenges that hinder its ability to meet the Trust's growing objectives:**

<p><b>Under-resourced Team</b></p> <p>Despite an increasing workload and high strategic ambitions, team headcount has declined, leaving critical gaps in expertise and operational support.</p>	<p><b>Specialist Expertise</b></p> <p>Additional roles in specialist areas such as Learning Disabilities, Substance Use, and CAMHS are needed to address complex needs of patients and ensure Mental Health Clinicians have access to specialist support.</p>	<p><b>Lack of Succession Planning</b></p> <p>The existing structure does not provide clear pathways for progression, limiting the potential for skill development within the team.</p>	<p><b>Integration with system partners</b></p> <p>Enhanced capacity and focus are required to ensure effective partnership with NHS Wales Mental Health Services.</p>	<p><b>Paucity of Data</b></p> <p>Inconsistent data capture across systems, limited access to key platforms like Datix, gaps in patient feedback mechanisms, and governance issues hinder effective evaluation and service improvement.</p>
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**Strategic Alignment**      The team requires greater participation in work supporting our long-term goals and Strategy.

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### 2025/2026: Next steps

## Challenges and Mitigation

<p style="text-align: center;"><b>Workforce Constraints</b></p> <p>Recruitment and retention remain a challenge. WAST is aligning with the HEIW Strategic Mental Health Workforce Plan to address this.</p>	<p style="text-align: center;"><b>Geographical Inequities</b></p> <p>Targeted expansion of services in rural areas is underway to ensure equitable access.</p>	<p style="text-align: center;"><b>Service Integration</b></p> <p>Continued collaboration with Health Boards is essential to streamline pathways and improve patient journeys.</p>
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**Looking Ahead**

WAST is committed to scaling successful pilots, embedding value-based care, and enhancing performance assurance. Our focus remains on delivering the right care, at the right time, by the right person—ensuring that mental health and dementia services are responsive, inclusive, and sustainable.

75. In our mental health delivery plan for 2025-2026, we aim to achieve several key milestones:

- **Comprehensive Mental Health Offer:** We will develop and share a detailed mental health offer that addresses diverse needs within our community. This offer will include a range of services, both remote and in-person, to ensure accessibility and holistic care.
- **Outcome Measures (PROMs and PREMs):** We will implement Patient-Reported Outcome Measures (PROMs) and Patient-Reported Experience Measures (PREMs) to continuously evaluate and improve our mental health services. These metrics will help us understand the impact of our interventions from the patients' perspectives.
- **Substance Misuse Support:** We will enhance our support services for individuals dealing with substance misuse. This includes providing identification of key areas or prioritisation, targeted interventions and resources to help them achieve recovery and maintain long-term sobriety.
- **Learning Disability Services:** We will expand our services for individuals with learning disabilities, ensuring they receive tailored support that addresses their unique needs. This will include both medical and community-based interventions. This included identification of key areas of Prioritisation.
- **Further MHRV Evaluation:** Building on our commitment to continuous improvement, we will conduct an in-depth evaluation of the Mental Health Review Visit (MHRV) process. This assessment will focus on identifying best practices, as well as any gaps or challenges encountered during previous reviews. By gathering and analysing feedback from both service users and staff, we aim to refine our approach, ensure high standards of care, and drive meaningful improvements in outcomes for those accessing mental health support.
- **Recruitment and Training of SMHCs:** To strengthen our mental health services, we will support recruitment and comprehensive training of Mental Health Clinicians (SMHCs). This initiative will ensure we have a skilled workforce equipped to deliver compassionate, evidence-based support.
- **Provision of Training and Education:** Recognising the importance of knowledge and professional development, we will enhance the provision of

training and education for all staff involved in mental health care. This will include ongoing learning opportunities, workshops, and access to the latest research and best practices. By fostering a culture of continuous development, we aim to maintain high standards of care and support staff in their roles, ultimately improving outcomes for the community we serve

76. Additionally, we have identified several areas of concern that we will address:

- Data and Metrics: We will improve our data collection and analysis processes to ensure we have accurate and up-to-date information on the mental health needs of our community. This will enable us to make informed decisions and allocate resources effectively.
- Incident Reporting (Datix): We will enhance our incident reporting system (Datix) to ensure all mental health-related incidents are accurately recorded and addressed. This will help us identify patterns, prevent future incidents, and improve overall safety and care quality.

77. By focusing on these areas, we aim to provide comprehensive mental health support that meets the immediate and long-term needs of our community catering to diverse needs through both remote and in-person services. Through continuous evaluation and improvement, we will ensure our services remain effective, accessible, and responsive to the unique circumstances of individuals within our community.



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## Strategic Outlook for 2025/26

The MHD Team will build on past successes, prioritising collaboration, evidence-based practice and innovative solutions to enhance care for individuals with mental health issues across Wales, through the next Mental Health, Learning disability, Substance Misuse & Dementia strategies.

Utilisation of the dedicated funding for Mental Health Services through employment of additional resources will be crucial to achieve the Trust ambitions.

The Mental Health Team has been realigned into the new Remote Clinical Care arm of the QSPE Directorate.



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Agenda Item No.

12

## REPORT TITLE

Learning from Deaths (Mortality Reviews) Report Quarters 1 and 2 2025/2026 (April – Sep)

## MEETING

Name of meeting	Quality, Patient Experience & Safety Committee
Date of meeting	4 November 2025
Public or Private	Public
If private - <a href="#">rationale</a>	n/a

## REPORT SPONSOR

Executive sponsor	Liam Williams, Executive Director of Quality and Nursing
Author(s) of report	Wendy Herbert, Deputy Director of Quality & Putting Things Right Claire Appleton, Assistant Director of Putting Things Right

## PURPOSE OF REPORT

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



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## REPORT SUMMARY:

1. This report provides an update to the Committee on the current position and progress since the last report in May 2025 in respect of the Mortality Review process and learning from deaths.
2. Level 1 triage of Medical Examiner referrals proceeds at fortnightly intervals with all Q1 and Q2 cases triaged. Progress is being made in reducing delays in reviewing cases at Level 2 Learning Panel with 96 cases still awaiting review.
3. 143 referrals have been received from the Medical Examiner Services (MES) in the first two quarters of 2025/26. 27 cases have been triaged as requiring further review and investigation.
4. Thematic analysis about case referral reasons and categorisation against the Health and Care Quality Standards has been facilitated by nationally-led enhancements in the Once for Wales Concerns Management System (Datix Cymru) and enhanced data capture by the Putting Things Right administration team.
5. The new analytical opportunities reveal the vast majority of referrals being due to community delays and inability to provide 'Timely' care.
6. Internal review of Q1 and Q2 referrals at Medical Examiner Learning Panel continues to identify learning relating to delays in attending in the community, alongside improvement opportunities for Advanced Care Planning and enhanced end of life care in the community to guide family expectations, avoid admission where not indicated and provide dignified and personalised care.
7. Updates are provided on the steady progress of the Regional Integrated Intelligence Review, with data analysis now taking place.
8. Assurance is given about the Trust's response to the David Fuller Inquiry Phase 2 Report.

## RECOMMENDATION(S)

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

1. Receive the report for discussion
2. Identify any additional assurance requirements

## ADDITIONAL PAPER(S)

N/A



### STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

<input checked="" type="checkbox"/> SO1: Providing the right care or advice, in the right place, every time	<input type="checkbox"/> SO2: Enabling our people to be the best they can be
<input type="checkbox"/> SO3: Being at the forefront of innovation and technology	<input type="checkbox"/> SO4: Developing services in collaboration
<input checked="" type="checkbox"/> SO5: Being quality driven and clinically led	<input type="checkbox"/> SO6: Delivering exceptional value

### RISK(S) THIS REPORT MITIGATES

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

N/A

### HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

Quality Domains		
<input checked="" type="checkbox"/> Safe	<input checked="" type="checkbox"/> Timely	<input checked="" type="checkbox"/> Effective
<input checked="" type="checkbox"/> Efficient	<input checked="" type="checkbox"/> Equitable	<input checked="" type="checkbox"/> Person Centred
Quality Enablers		
<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

<input type="checkbox"/> A socially responsible and inclusive employer	<input type="checkbox"/> An innovative and sustainable organisation	<input checked="" type="checkbox"/> A pro-active, accessible and equitable care provider
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### 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 checked="" type="checkbox"/> No <input type="checkbox"/> Yes
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### APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
21 October 2025	Clinical Quality Governance Group



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## SITUATION

1. This Learning from Deaths Report covers the period from 1 April 2025 – 30 September 2025.  
This Report covers:
  - Medical Examiner scrutiny feedback and implementation of the All Wales Learning from Mortality Reviews Model Framework (Second Edition)
  - Prevention of Future Death Reports
  - Organisational learning captured and responded to in the Trust's 'Learning from Death Forum'
  - Bereavement learning and improvement
2. Please note that the data contained within this Report is accurate at the time of reporting. Data may be subject to change following the Level 2 Panel Review of Medical Examiner cases.

## BACKGROUND

3. The critical importance of good governance and data analysis in respect of Mortality Review Processes have been highlighted in a number of high-profile NHS Independent Inquiries and Reviews. Learning from Deaths is broad and includes capturing good practice, improvement opportunities, any patterns, themes and trends including early warning signals, whilst considering potential inequalities in access to care or experience.
4. Following the publication in May 2024 of the All Wales Learning from Mortality Reviews Model Framework (Second Edition) (the Framework), the Trust has established an effective clinical governance structure to discharge all 5 levels of the Framework.
5. The Trust's Learning from Deaths Forum continues to develop its Work Programme, encompassing mortality learning from across the organisation, coronial work, clinical audit, patient experience and concerns management. The Forum has a clear remit to drive increased access, visibility and triangulation of mortality intelligence through digital and data insights.
6. The Learning from Death Forum also oversees external learning sources from Prevention of Future Death reporting, National Clinical Audit, National Learning Reports and National Inquiries and these are also drawn through in this Report.



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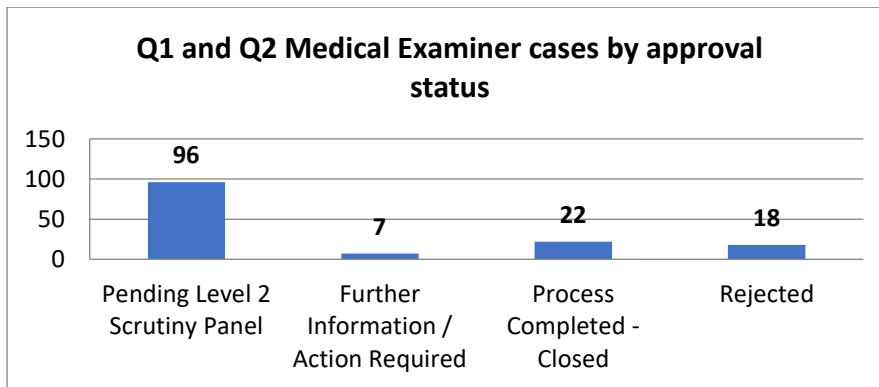
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## ASSESSMENT

### Learning from Medical Examiner Service Referrals

7. 143 Referrals were received from the ME Service in Q1 and Q2. The current approval status of those referrals as of 11 October 2025 is shown in Graph 1. It should be noted that this is a snapshot of the current stage at the time of extraction and will have progressed by the time this Report is received.

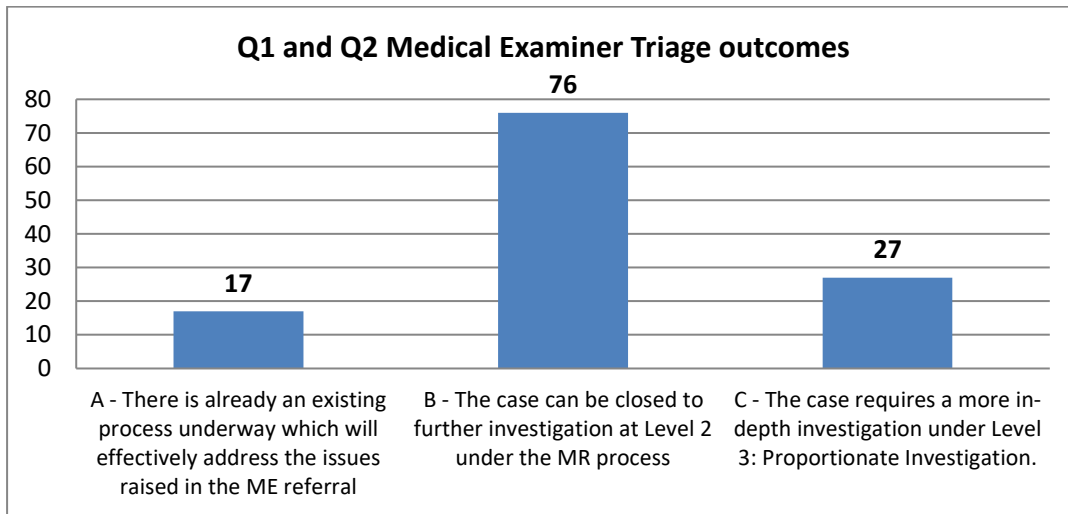
Graph 1



8. Level 2 Multi-Professional Medical Examiner Learning Panels have been scheduled at increased frequency to address the number of cases awaiting review. There are currently 96 cases awaiting presentation at the Medical Examiner Learning Panel, down from 172 in the previous bi-annual Learning from Death report.
9. Graph 2 demonstrates 27 of the cases received progressing straight to Level 3 and undergoing a proportionate investigation. This is 19% of all cases received in Q1 and Q2. Whilst recognising the importance of seeking external review and feedback, the Trust's long-term objective in this space is to improve internal assurance and promote earlier identification of cases through our internal incident reporting mechanisms. This would manifest as an increasing rate of cases categorised under A (existing processes underway) and a decreasing rate of cases categorised as C (proportionate investigation required)



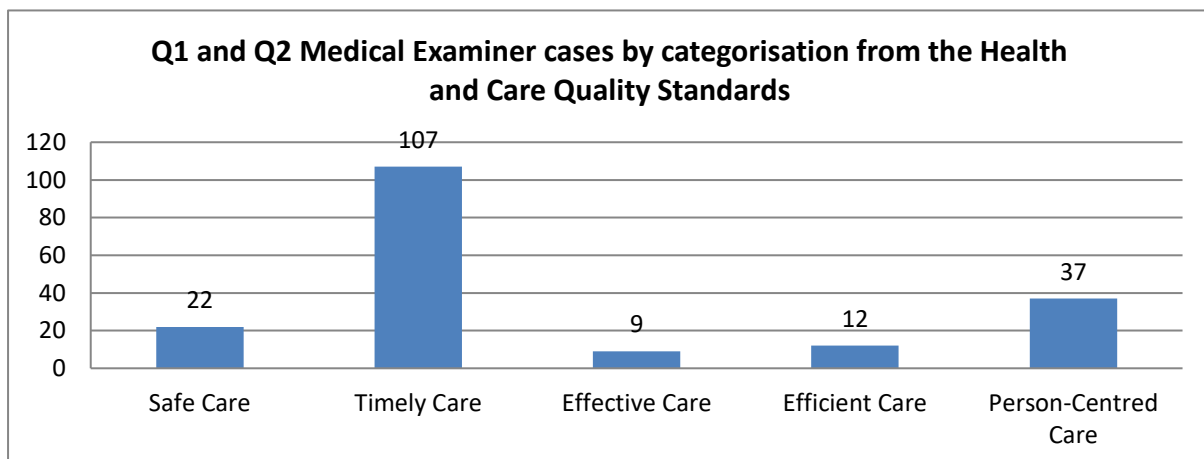
Graph 2



10. Graphs 3 and 4 provide information on the reasons for referral and Health and Care Quality Standards related to referrals. This enhanced thematic understanding is enabled by national development work on the Once for Wales Concerns Management System, in which the Trust actively participates. The work programme is now seeking to introduce additional granularity into the thematic coding structure to enable more detailed analysis.

11. It should be noted that Medical Examiner scrutiny is undertaken on a patient rather than organisational basis and it is not possible to distinguish the thematic allocations between the Trust and other organisations involved in the patients last episode of care. Caution is therefore advised when interpreting this data at an aggregated level.

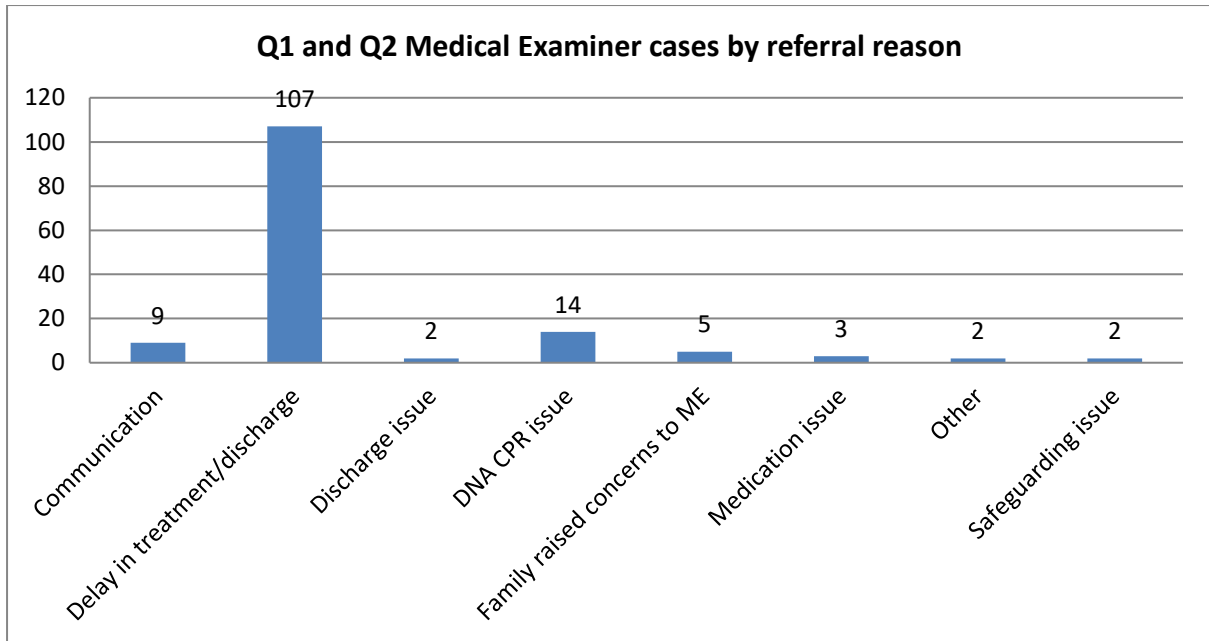
Graph 3





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12. Learning themes of Medical Examiner Referrals identified and discussed at ME Learning Panel include recurrent issues including:

- Deconditioning and long lies
- Possible opportunities for alternative Pathways and avoiding conveyance. There were cases where the escalation for emergency pre-hospital care was clearly inappropriate but being requested by other healthcare professionals, presumably as primary care options were limited or unsuitable.
- Absence of Advanced Care Planning and end of life care packages, education and preparation
- Number of patients opting to self-convey because of long Estimated Time of Arrivals (ETAs)
- Very poor patient and family experiences, predominately due to delays in responding in the community as a result of system pressures. Some cases demonstrate the intensely distressing nature of the situations families find themselves in as they are waiting.

Additional themes identified in Q1 and Q2 also include:

- Identification of atypical stroke presentations
- Caregivers/callers with Learning Disability who find themselves unsupported during long community waits
- Lack of planning, preparation and support for recognised terminal conditions such as Motor Neurone Disease where death was both anticipated and expected
- Consistent volume of concerns from bereaved relatives about CPR instructions being given to callers when a person already has a DNACPR



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## **Learning from mortality in Coronial work**

13. The Trust has received no Regulation 28 Reports since the last Learning from Death Report. This includes reports issued solely to WAST or jointly with other organisations.

## **Regional Integrated Intelligence Review**

14. The internal Regional Integrated Intelligence Review is progressing steadily. A broad range of data from across the organisation has been compiled and data analysis being undertaken by the Trust's Information and Digital Systems experts will facilitate an appropriate objective analysis of data provided from all Directorates. Multi-professional collaborative interpretation of the data analysis is planned, and alongside the qualitative information already provided by colleagues, will shape a holistic report on regional strengths and areas for improvement.

## **National Inquiries**

15. The Learning from Deaths Forum has previously acknowledged the Terms of Reference and the Modules being scrutinised by the Thirlwall Inquiry and the UK COVID-19 Inquiry.

16. An update in summer 2025 notes that the final report of the Thirlwall Inquiry is now expected to be completed by the end of November 2025, with publication in early 2026.

17. UK COVID-19 Inquiry: Most modules remain active, with any findings and recommendations yet to be published. Module 8, regarding the impact on Children and Young People is currently holding public hearings.

18. David Fuller Inquiry: This independent inquiry was established to investigate how David Fuller was able to carry out inappropriate and unlawful actions in the mortuaries at Maidstone and Tunbridge Wells NHS Trust and why they went apparently unnoticed. Phase 2 of the Inquiry looked at the broader national picture and considered if procedures and practices in other hospital and non-hospital settings, where deceased people are kept, safeguard the security and dignity of the deceased. NHS England Ambulance Services contributed directly to Phase 2. The Phase 2 report was published on 15 July 2025. The report makes a total of 75 recommendations, with five of these being focused on the ambulance sector.



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19. An assurance assessment against the five relevant recommendations will be undertaken and reported through the Trust's Clinical Governance structure. Clarification is also being sought from central NHS Wales leadership regarding the status of the report for NHS Wales.

### **RECOMMENDATION**

20. The recommendations are as set out in the front cover above.

### **NEXT STEPS**

21. Progress against the Trust PTR & Legal Services Performance Recovery Plan is being reported regularly into CQGG.



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Agenda Item No. 13

## REPORT TITLE

Patient Experience & Community Involvement Bi-Annual Report (April – Sep 2025)

## MEETING

Name of meeting	Quality, Patient Experience & Safety Committee
Date of meeting	04 November 2025
Public or Private	Public
If private - <a href="#">rationale</a>	Choose item from below

## REPORT SPONSOR

Executive sponsor	Liam Williams, Executive Director of Quality and Nursing
Author(s) of report	Leanne Hawker, Head of Patient Experience & Community Involvement

## PURPOSE OF REPORT

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

## REPORT SUMMARY:

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

1. This report presents the work of the Patient Experience and Community Involvement team (PECI) during April – September 2025. The work presented within this report is in line with 'The Peoples Experience Framework' (PEF) (WHC2024/015) and the Health and Social Care (Quality and Engagement) (Wales) Act 2020-21.



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2. For reference, NHS Wales define peoples experience as **‘the sum of all interactions, shaped by the culture of the organisation, staff and systems’**. This definition can also be applied to staff working within NHS organisations also. It incorporates every encounter and touchpoint, acknowledges how an organisation shapes an individual experience, how staff impacts on individual experience and how systems used also influence how and individual experiences the care and service provided.
3. The PECl Team are expecting an organisational change process (OCP) to realign certain functions with Trust key deliverables to be commenced in quarter three.

## RECOMMENDATION(S)

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

The QuEST committee is requested to:

1. Receive the report and accept the assurances that the Trust is meeting its statutory duties and responsibilities to capture, record, engage and act on peoples’ experiences.
2. Note the activities undertaken during this reporting period and acknowledge that PECl Reports will be shared publicly through the Trusts People & Community Network.
3. Note that the PECl team will be going through an OCP and therefore reports may look different with data being reported through more quality derived measures/impact as part of our core quality metrics for always on reporting where person centred care and people experience data are a core area.

## ADDITIONAL PAPER(S)

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

The QuEST Committee is requested to receive the following:

1. Patient Experience & Community Involvement (PECl) Bi-annual report for period April – September 2025.



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) [ <a href="#">link to objectives and what good looks like</a> ]	
<input checked="" type="checkbox"/> SO1: Providing the right care or advice, in the right place, every time	<input type="checkbox"/> SO2: Enabling our people to be the best they can be
<input type="checkbox"/> SO3: Being at the forefront of innovation and technology	<input checked="" type="checkbox"/> SO4: Developing services in collaboration
<input checked="" type="checkbox"/> SO5: Being quality driven and clinically led	<input type="checkbox"/> SO6: Delivering exceptional value

### RISK(S) THIS REPORT MITIGATES

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

### HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

Quality Domains (select all that apply) [ <a href="#">link to standards</a> ]		
<input type="checkbox"/> Safe	<input type="checkbox"/> Timely	<input type="checkbox"/> Effective
<input type="checkbox"/> Efficient	<input type="checkbox"/> Equitable	<input checked="" type="checkbox"/> Person Centred
Quality Enablers (select all that apply) [ <a href="#">link to standards</a> ]		
<input checked="" type="checkbox"/> Leadership	<input checked="" type="checkbox"/> Workforce	<input checked="" type="checkbox"/> Culture
<input type="checkbox"/> Information	<input 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) [ <a href="#">link to goals</a> ]		
<input type="checkbox"/> A socially responsible and inclusive employer	<input type="checkbox"/> An innovative and sustainable organisation	<input checked="" type="checkbox"/> A pro-active, accessible and equitable care provider
<input checked="" type="checkbox"/> n/a	<input checked="" type="checkbox"/> n/a	<input checked="" 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 checked="" type="checkbox"/> No <input type="checkbox"/> Yes
If yes, what impact assessment is attached	



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## APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee



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## SITUATION

1. Peoples' experience and its importance within the dimension of healthcare quality, alongside clinical excellence and patient safety, has been amplified over the last six months especially with a focus on understanding and improving the patient's journey and overall experience.
2. We've witnessed a move from centrally driven performance with focus on activity and meeting targets to a more sophisticated strategy that includes patient experience data. The Peoples' Experience Framework (PEF) has been incorporated within our approach to being quality led. The introduction of the National Peoples' Experience Survey (PES) and PREM changes, Welsh FFT, Civica and Datix compliment code changes has ensured that the Trust is positioned to capture and record against the required datasets within the PEF.
3. Experience data and themes have continued to be reported through Quality Management Group with agreed actions to take forward that demonstrates active learning and quality improvement through lived experiences.
4. Key themes from feedback have consistently related to long waits and timeliness in general, across all service areas. People continue to be anxious about our ability to meet their expectations of a timely response in an emergency or when they have a need of our services.
5. There has been continued positive feedback across all service areas, with people complementing our staff for being kind, caring and compassionate. We have continuously promoted and shared compliments received to staff.
6. As we evolve beyond reporting on traditional time-based metrics, we are aiming for a more balanced and nuanced approach that incorporates clinical outcomes, patient safety and experiential/relational measures in line with national policy and statutory requirements. However, we need to obtain sufficient volumes of feedback from service users primarily to the EMS/999 and 111 services, to make this experiential intelligence valuable. Success in developing measures of this type are currently reliant on satisfying the outcomes of the recommendations from ICO and our timely response.



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## BACKGROUND

7. We have a legal duty to capture and act on peoples' experiences and to engage with communities to listen and capture feedback so that their voices and lived experiences influence the ongoing design and delivery of our services as set out in:
  - The People's Experience Framework (WHC2004/015)
  - NHS Wales Performance Framework
  - Social Services and Well-being (Wales) Act 2014-18
  - Well-being of Future Generations (Wales) Act 2015-19
  - The National Principles for Public Engagement in Wales (2011)20
  - Health and Social Care (Quality and Engagement) (Wales) Act 2020-21
  - The Quality Standards - April 2023
  - A Healthier Wales 2022

## ASSESSMENT

8. The contribution and key deliverables of the PECI Team towards capturing, understanding, improving and measuring peoples' experiences, quality of services and enhancing the reputation of the Trust across communities is included within the Bi-Annual Report.

## RECOMMENDATION

9. The recommendation(s) are as set out in the front cover above.

## NEXT STEPS

10. As the team go through an OCP, experiential data will continue to be reviewed through QMG using a multidisciplinary teams approach to identify learning outcomes and improvements.

# Patient Experience & Community Involvement (PECI) Bi-Annual Report April – September 2025



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## Peoples Experience within the Welsh Ambulance Service

Information and data provided within this report has been captured using a variety of methods including service experience surveys, patient stories and the online 'Have your say' facility.

Peoples experience within the Welsh Ambulance Services University NHS Trust (WAST) is focused on ensuring people have as positive experience as possible. It is a fundamental component of person-centred care.

People's experience is influenced by our staff, people's expectations, their first and lasting impressions. It is defined by what it feels like to access and receive care based on their own perceptions of the care and treatment received.

Experience and feedback are essential components for monitoring and serving as quality indicators.

### 'The Experience Cycle'



"If quality is to be at the heart of everything we do, it must be understood from the perspective of patients." *Lord Darzi*

# **Section 1**

## **People's Experience - Insights**

## 999 Experience Survey

Our 999 patient experience survey is made available to members of the public through the WAST website and is frequently promoted across all available social media channels.

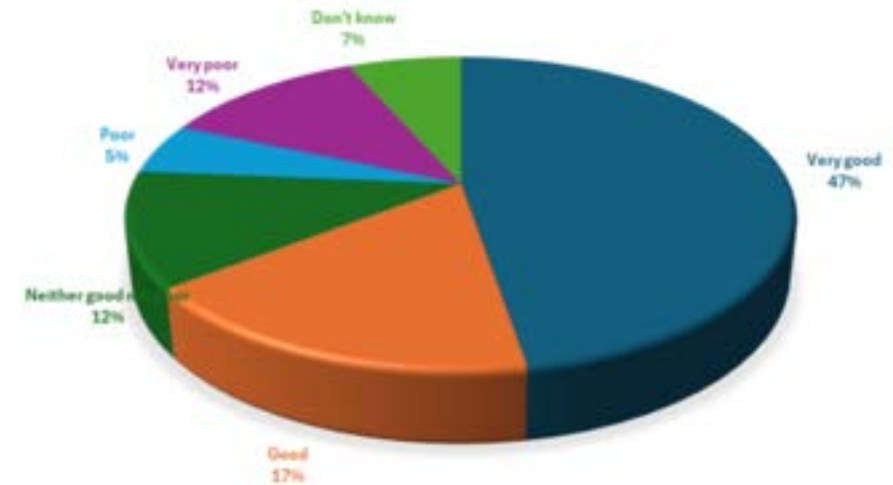
In this reporting period, we acknowledged that the low response rate to this survey does not paint a truly representative picture of what it feels like to be a 999 caller and every effort is being made to increase engagement with the survey.

We continue to progress work to retrospectively contact 999 callers by SMS Text to ask for their experience feedback. After consulting with the Information Commissioner, they have made 7 recommendations that we need to meet before we proceed to the next stage.

**In this reporting period 76 responses were received.**

A full breakdown can be found under ***Section 3 Reported Experience Measures (PREMs) Data.***

***Thinking of the last time you called 999. Overall, how would you rate your experience of the service we provided?***



Available Answers	Responses	Score (%)
Very good	36	47.00%
Good	13	17.00%
Neither good nor poor	9	12.00%
Poor	4	5.00%
Very poor	9	12.00%
Don't know	5	7.00%
<b>Total</b>	<b>76</b>	<b>100%</b>

# Peoples' Experience Framework – Ambulance Care (NEPTS)

## NEPTS Experience Survey

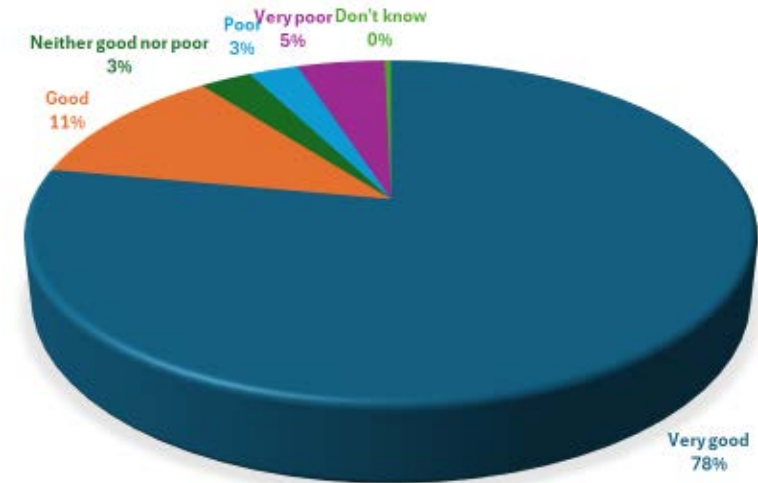
We continue to work closely with our Ambulance Care colleagues to capture the experiences of people who have received transport to planned hospital appointments.

Responses to this survey continue to provide high levels of assurance that NEPTS who receive transport are broadly satisfied with the service they receive. Survey results also highlight potential areas of quality improvement, with wait time for transport home following an appointment continuing to be the main area of concern.

We know these positive experiences contradict the high number of complaints received through Putting Things Right (PTR) and more work is being done to look specifically at the experiences of people who have transport cancelled as a result of Capacity Management Planning (CMP).

**In this reporting period 1,474 responses were received.** A full breakdown can be found under ***Section 3 Reported Experience Measures (PREMs) Data.***

*Thinking about the Non-Emergency Patient Transport Service, how was your overall experience of our service the last time you used it?*



Available Answers	Responses	Score (%)
Very good	1153	78.22%
Good	172	11.69%
Neither good nor poor	41	2.79%
Poor	39	2.66%
Very poor	69	4.65%
<b>Total</b>	<b>1,474</b>	<b>100%</b>

## NHS 111 Wales Experience Surveys

There are two surveys in place for NHS 111 Wales, separately collecting feedback about people's online experience and telephony experience.

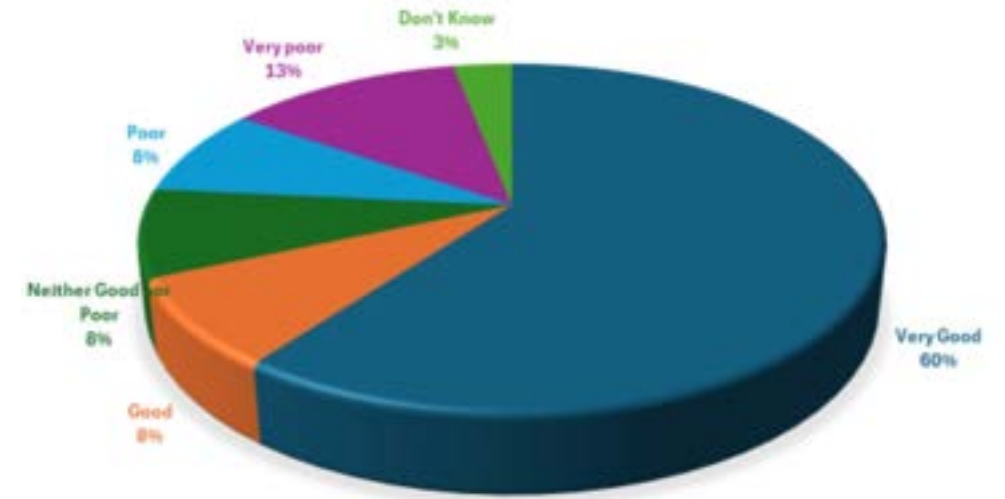
Both surveys are promoted online, through the NHS 111 Wales website and available social media platforms. Though we largely remain reliant on people using their initiative to seek out and access the 111 Wales experience surveys themselves.

Again, every effort is being made to increase engagement with these surveys to ensure we are capturing a broader range of views and can provide a service user experience data set that more accurately represents the experiences of NHS 111 Wales users.

**In this reporting period 98 responses to the telephony survey were received; and 189 to the Online survey.**

A full breakdown can be found under ***Section 3 Reported Experience Measures (PREMs) Data.***

*Thinking about the NHS 111 Wales service, how was your overall experience of our service today?*



Available Answers	Responses	Score (%)
Very Good	59	60.53%
Good	8	7.89%
Neither Good nor Poor	8	7.89%
Poor	8	7.89%
Very poor	12	13.16%
Don't Know	3	2.63%
<b>Total</b>	<b>98</b>	<b>100%</b>



ReciteMe is a cloud-based accessibility and language support tool designed to make websites more inclusive and user friendly.

From April to May, most users accessed the toolbar from mobile use (up to 79%). However, from June onwards there was a shift towards desktop use, with over 90% of sessions on desktop.

The consistent use of translation and visual customisation tools demonstrate that the NHS 111 Wales website continues to meet diverse accessibility needs.

The ReciteMe toolbar is providing measurable benefits for inclusivity across people's experience touchpoints.

Average pages viewed per session, were consistently above the industry average (2.8), between 3.65 and 5.05

**Total pages viewed**

**444**

## Translation

The translation tool was consistently the most used feature, making up 70-85% of interactions



## Screen Reader

English playback dominated (over 80% & in April and May)



## Styling

Styling tools e.g. screen mask, font colour/size were the second most popular. Supports visual accessibility



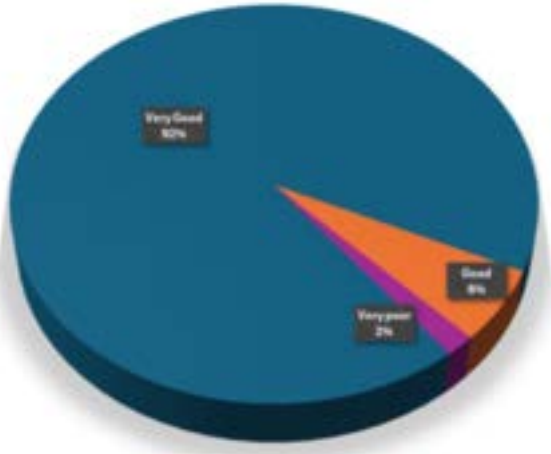
## Falls Assistant Experience Survey

We continue to support the WAST Falls Team with two Falls Experience surveys, a Level 1 Falls Assistant and Level 2 Falls Responder Survey.

Attending staff leave an invitation with the patient to complete a survey. The invitation contains a QR code to complete a survey online, as well as the phone number and email address for the PEGI Team.

**In this reporting period 119 Falls Assistant responses were received. 7 Falls Responder responses were received.**

*How was your overall experience with the Falls Assistant today?*



Available Answers	Responses	Score (%)
Very Good	110	92.54%
Good	7	5.97%
Neither Good nor Poor	0	0.00%
Poor	0	0.00%
Very poor	2	1.49%
Don't Know	0	0.00%
<b>Total</b>	<b>119</b>	<b>100%</b>

The PEGI Team is supporting colleagues across the Trust with several other bespoke experience surveys, including:

### Non-Conveyance Experience Survey

A QR code and alternative contact details on the new non-conveyance form will invite patients not transported to hospital to share their experience.

### The Grange Transfer & Discharge Service Experience Survey

A commissioning requirement of this service is to provide experience feedback. We are supporting colleagues to design and implement a survey.

### Ambulance Care Capacity Management Planning (CMP) Experience Survey

This will look at the impact of late cancellation of transport due to capacity management planning.

### Luscii Remote Monitoring Experience Survey

An experience survey will be added to the remote monitoring app.

# Compliments Received

April 2025	51	July 2025	45
May 2025	51	August 2025	57
June 2025	45	September 2025	57

Compliments are recorded and shared publicly to promote what we have done well and demonstrate how valued staff are by people, patients, their families and carers.

From the themes recorded from compliments, the engagement between our staff and their patients, callers and carers are enabling active participation and comfort whilst responding to their needs with kindness and professionalism. People have acknowledged how **'welcoming and helpful'** staff across all our Trust services have been, how people have felt **'safe and calm'** and that staff upheld such values as to be **kind, caring and compassionate**.

Compliments are shared with Trust staff via a dedicated page on internal communication channel Siren, station posters and directly with line managers.



Click the green 'Staff Compliments' button on the PECl page on Siren to discover what the public have been saying about our #TeamWAST colleagues!  
Please share your cards and emails with the PECl team so that they can be accurately recorded.

The People's Experience Framework (PEF) describes compliments as:

***'A positive or appreciative statement about any individual NHS Wales staff member, services, programme, or function, which includes the expression of praise, admiration, or congratulations which goes beyond common courtesy. This can be received through a variety of means including verbal and written'***

We acknowledge that we may be under-reporting compliment data. The online 'Have your say' facility on the Welsh Ambulance Service website allows people to log their compliments and feedback digitally, but compliments received via phone calls, thank you cards and letters sent directly to stations across the Trust are not always formally recorded.

We continue to promote and strengthen existing channels to ensure all compliments received are recorded and staff involved are acknowledged

The National Compliments Workstream, established to help bring together good practice across NHS Wales, now meets quarterly and WAST is represented by a member of the PEGI Team. An initial task carried out by the workstream has been reviewing current tags available within Datix Cymru that can be used to theme compliments received.

The workstream has agreed on a new national set of compliment themes that will be made available in Datix across Wales, allowing for consistency and greater ability to monitor and report on compliment themes and trends.

Reporting and promoting public compliments about our staff and services helps us to reinforce our cultural values and contributing to a more positive workplace.





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# Examples of Compliments Received

*I contacted NHS 111 Wales on 5th June 2025 for my grandmother, she is 74 years old, she has been in and out of hospital since Christmas 2024 with various infections and broken ribs. I requested a call back rather than waiting to be answered. I can't recall the name of the call taker but she was very attentive when I was answering her questions, she was very clear and caring. She passed my call to GP who called me back with a couple of questions and did a home visit very quickly after ending the phone call. He was brilliant and diagnosed a kidney infection and provided antibiotics from his mobile van, apologies again but I can't recall his name. The service we received was efficient and responsive, considering we were expecting my grandmother may have to be admitted to hospital (which she didn't want to do) we were all very relieved of the outcome. Thank you.*

*I just want to compliment the two kind ladies who took me to my hospital appointment in the Walton Centre, Liverpool. The whole journey was absolutely worry free and I just want to say what a wonderful service you run. A journey with no stress is wonderful, thank you so much.*

*This Monday morning, two of your voluntary ambulance crew, only 5 minutes after my 999 call, attended my severely distressed wife. Their performance was most praiseworthy, so much so that it surprised me they were working without financial reward. They not only helped calm my wife but put my own mind at rest with their professional attitude but perhaps more importantly, with their friendly, down to earth, openly approachable, and appropriately humorous manner. I will remember them for a long time to come.*

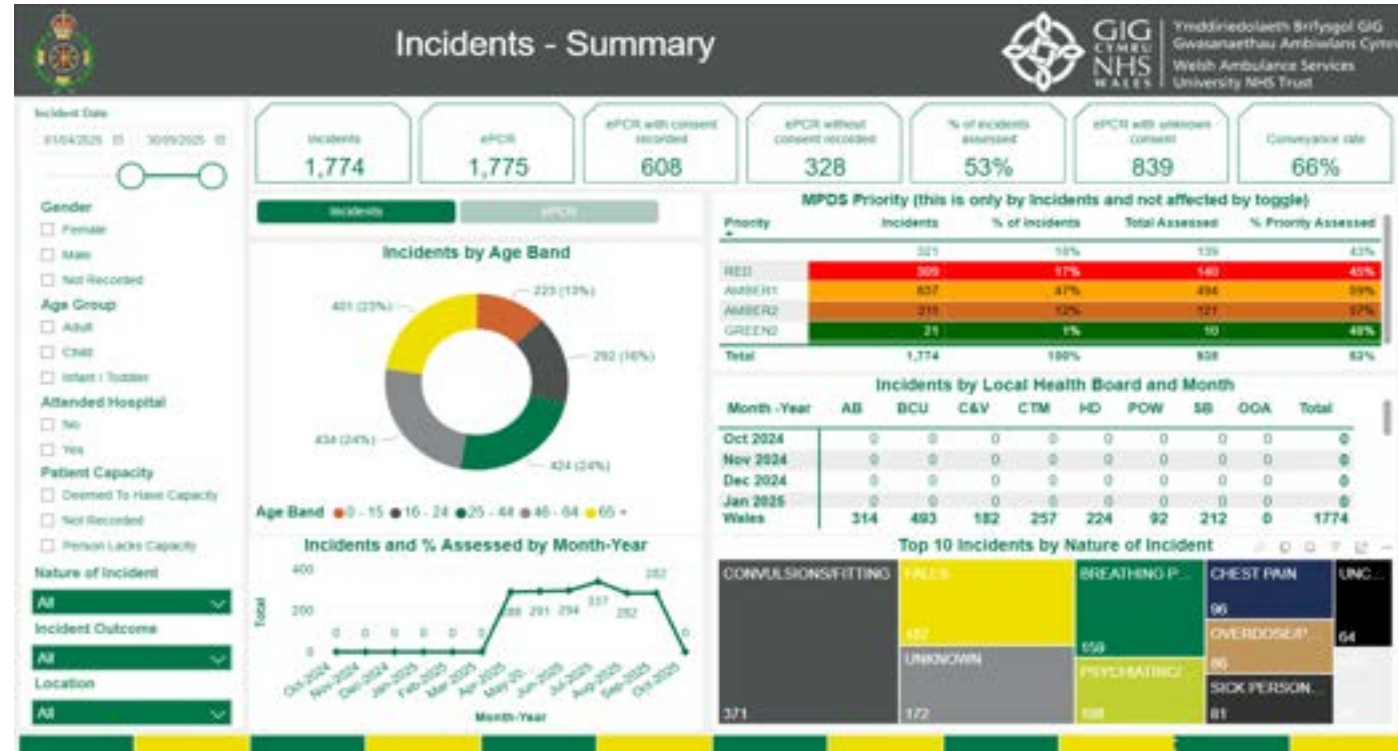
*I phoned 111 press 2 last night. I was put through to a call handler. When I phoned I was in crisis. I would just like to thank this service so much! The call taker helped to bring me back to reality and process my thoughts. I felt so helpless and needed that support, which he provided. I was heard and listened to! He provided so much care and compassion without judgment.*

## Learning disabilities dashboard

Between April and September 2025, there were 1,774 incidents recorded where the additional needs tab on the electronic Patient Clinical Record (ePCR) was used to record an additional need or learning disability. Convulsions/fitting, falls and breathing problems have been the top 3 known nature of incidents recorded. This data is valuable in helping us to understand a wider picture of health amongst the learning disability population, their potential demand on services and how we can better plan to support this vulnerable patient group in the community.

The Trust has now appointed a Learning Disability Clinical Specialist, who will sit within the Mental Health, Dementia and Learning Disability Team.

They will take up post in November 2025. The PECCI Team will work closely with them to Ensure that lived experience data, compliments, Complaints and clinical data collated through ePCR are triangulated and used together to support Ongoing improvements in care, patient experience and patient outcomes for people with a learning disability.



## Peoples' Stories

Stories are told by patients, relatives or carers about their first-hand experiences of using our services. They are co-produced with the storyteller so that they determine the key messages of and where the story will be shared.

Patient storytelling is a recognised practice for helping us understand what it feels like to be a user of our services, providing valuable insights into how we can enhance service delivery, and improve the experience for other patients.

We continue to explore new ways to present peoples lived experiences, including our online Virtual Videobooth, and the development of a platform for presenting stories in podcast form.

As well as presenting stories at Trust Board and QuEST Committee, we regularly contribute to the '**All Wales Digital Storytelling Network**' meetings. We are currently exploring options for participating in the '2026 Storytelling for Health and Wellbeing Conference', to be held in Cardiff.

## Six Goals for Urgent and Emergency Care National Programme

One of the Ministerial and Programme priorities for Urgent and Emergency Care (UEC) 2025/2026 was to implement an effective community-based falls response service (Six Goals Programme Framework) to enhance outcomes and experiences for those who fall by improving initial response times, reducing the risk of long lies and ensuring service users access community falls pathways when appropriate.

To highlight the importance of this work and the urgent need for improvement, we have shared a number of 'falls' related patient stories with the Falls Implementation Group for discussion.

Falls experience data is also captured through surveys see slide 9.

# **Section 2**

## **Citizen Voice &**

## **Community Involvement**

## 98 Network members

### Non-Conveyance Form Consultation

As the electronic ePCR used by the Welsh Ambulance Service is not yet able to send patients, relatives, and carers digital information directly from the ePCR, additional hard copy information still needs to be left for patients who are not being taken to the hospital. The Non-Conveyance Form helps patients, relatives, and carers understand the next steps in their care and the important things they should be aware of.

To ensure the information provided to people who are not taken to hospital is appropriate and useful, we asked Network members to review the proposed new form, asking them to provide feedback on language used in the form, layout and overall readability. Feedback received has been incorporated into the new form which will be used operationally by the end of the year.



**Non-conveyance Form**

In an emergency, or if any of the following symptoms are experienced, call 999  
Chest pain, difficulty breathing, suspected stroke (Face and/or arm weakness and/or slurred speech), severe blood loss, choking, fitting/convulsions, severe allergic reactions or any loss of consciousness noted by your relative / carer

Date: / / Time: : EPR / ePCR No: \_\_\_\_\_

Patient Name: \_\_\_\_\_

1. Following our assessment today **you will not be conveyed** to hospital by ambulance for the following reason(s):

Appropriate care has been provided at scene and you are safe to remain at home

Alternative care arrangements have been agreed

We have arranged alternative transport to take you to hospital

You have agreed to make your own way to hospital

You have refused to be conveyed to hospital against our advice

2. Reason for calling us today ( Please write clearly and avoid using technical terms and jargon)

You / your relative / carer contacted us today as you have experienced:

3. Benefits of non-conveyance and / or risks to be aware of :

Following assessment we have discussed and agreed on the following, which best suits your individual care needs:

### People & Community Voice Group

In recent months' the group undertook an annual effectiveness review to ensure a clear vision of reflection, learning and improvement to capture the Trust's aim of meaningful engagement as set out by the Trust's strategic goals.

#### Feedback from one of our Network members:

*"If the Service really wants volunteer 'advisers', it has to be a two-way relationship and not just a title."*

We have suspended holding further meetings of the group until further notice, as after an open discussion with the group, it became clear that more needs to be done for these meetings to provide the most value for Network members and the Trust.

## **WAST Quality Event**

At this year's WAST Quality Event, a panel of people living with Dementia or caring for someone with Dementia offered their personal insights into using our services and were available to answer questions from WAST staff in the audience. People attending the event told us how impactful it was to hear directly from people with lived experience, and a similar panel will now form part of all future Quality events.

## **Learning Disability Clinical Specialist Recruitment**

In support of the recruitment of a Learning Disability Clinical Specialist into WAST's Mental Health Team, a learning disability patient sat on the stakeholder panel, supported by PECL they actively participated in the selection process of the successful candidate.

Lived experience representation is crucial for WAST as a healthcare provider, it brings essential expertise from those who have navigated the system as patients, caregivers, or family members, which helps create more relevant, responsive, and equitable services.



## CEO Roadshows Spring 2025

The PECI Team attended all of the Spring 2025 CEO Roadshows across Wales, with an information table in the display area.

We used the events as an opportunity to talk to staff attending the roadshows about how we involve people and communities in the work that WAST does; and how we capture and use experience data to influence service delivery.



## Learning from experiences: the person-centred care symposium 2025

In May a member of the PECI Team attended the Person-Centred Care Symposium, hosted by the Point of Care Foundation and Picker Institute. The symposium aimed to help us understand, measure, and improve person-centred care by learning from both staff and patient experiences, and built on the Point of Care Foundation's other work, including the Experience Based Co-Design (EBCD) methodology.

The symposium concentrated on the relational aspects of care, using examples of both quantitative data and qualitative storytelling, with discussions covering why person-centred care is important, how to use patient experiences for quality improvement and building more compassionate systems.

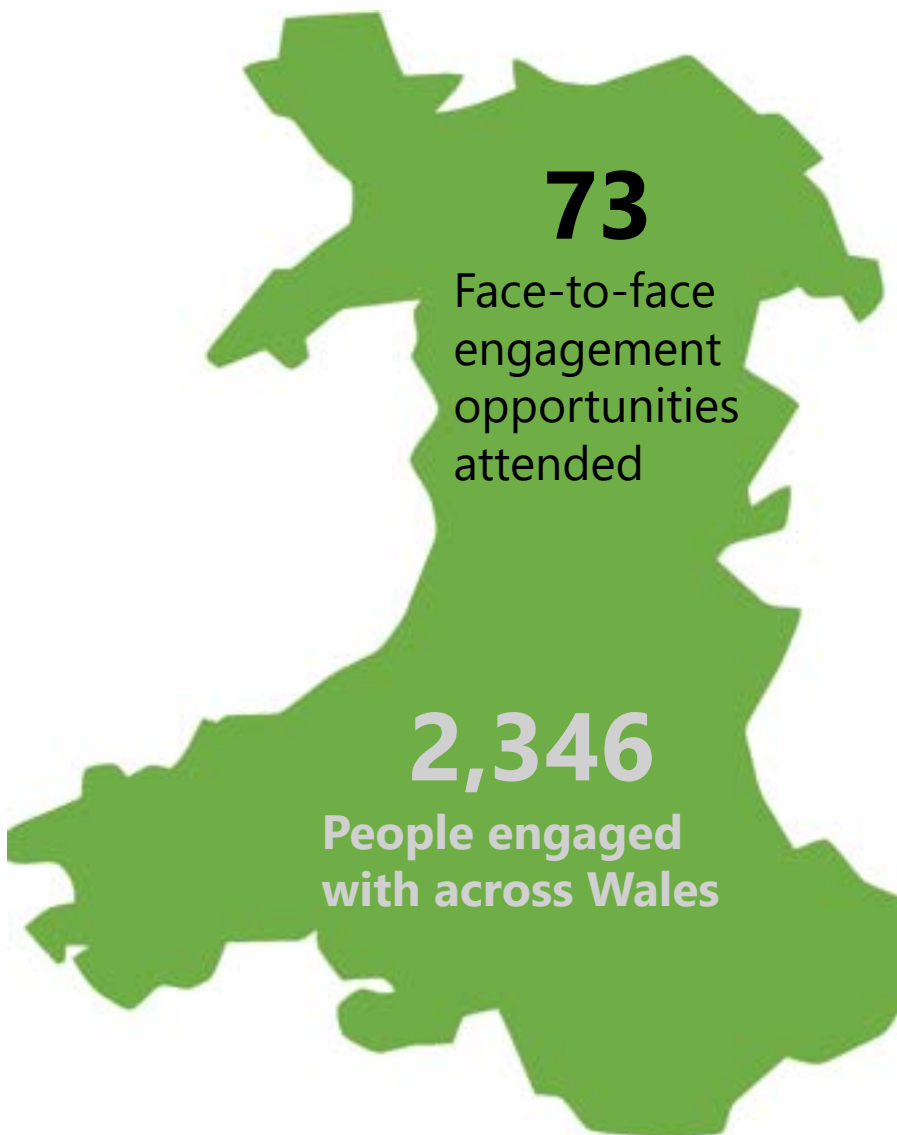




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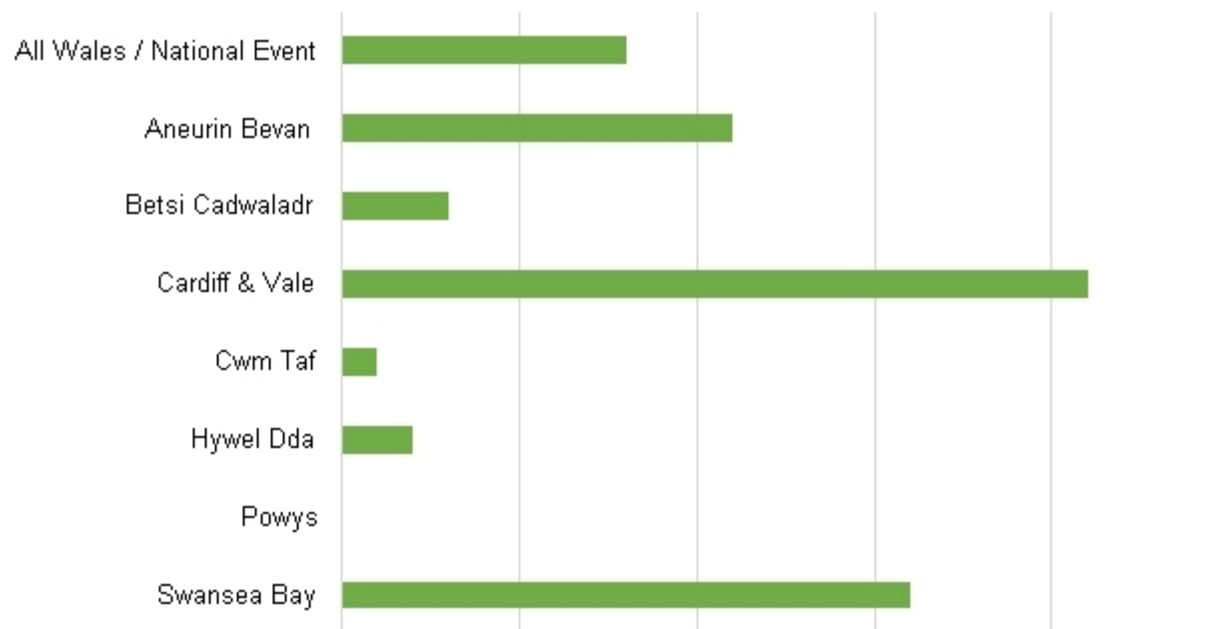
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# Community Involvement & Co-production

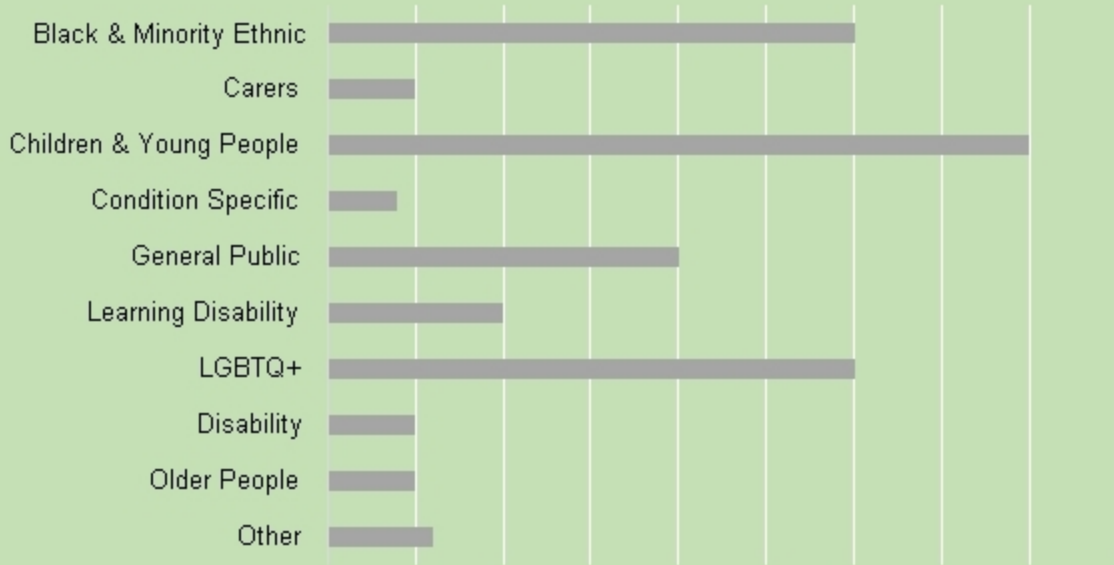


The Team attended a total of 73 face-to-face engagement opportunities across Wales, engaging with 2,346 people.

We listened to people's experiences of using Trust services, captured public sentiment and asked people to tell us what matters most to them if they should ever need to use our services in the future.

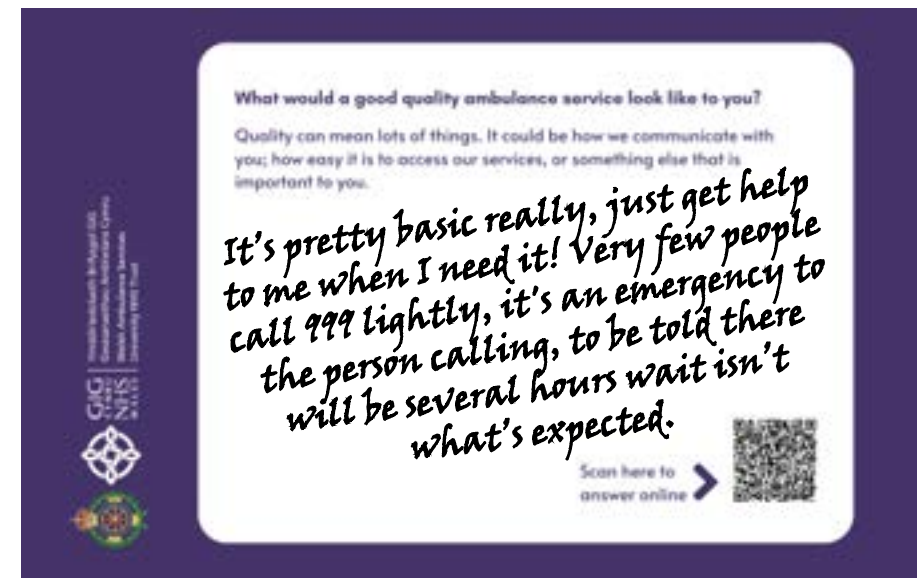


# Community Involvement & Co-production



Experiences and feedback, captured through our engagement with communities continued to cover a large cross section of the population.

Targeted engagement with groups known to experience health inequalities, barriers to accessing health care and those who have poorer health outcomes continued, ensuring the voices of the most vulnerable in society had an opportunity to share their views and experiences.



## LGBTQ+ Involvement

In June we supported the Trust to participate in Pride Cymru once again. This is Wales' largest event dedicated to celebrating diversity and inclusion and is an important date in the calendar for WAST and many others.

The event allowed us to engage with the LGBTQ+ community, talking to people about their experiences of using the services we deliver as well as offering information about careers, volunteering and demonstrating some essential life saving skills including CPR.

In July we also attended the LGBTQ+ Inclusion in Wales Conference 2025, hosted by Policy Insight Wales and chaired by Pride Cymru, the event brought together professionals from across sectors to discuss strengthening LGBTQ+ participation and inclusion in Wales and building on the aims of Welsh Government's [LGBTQ+ Action Plan for Wales 2023](#).





## Cardiff Mela

We attended Cardiff Mela again this year, an annual multicultural festival held in Cardiff Bay that celebrates Cardiff and Wales' diverse heritage.

Attending Cardiff Mela enables us to meet and engage with diverse local communities in an inclusive and accessible setting, connecting with communities that often face barriers to accessing healthcare, and to understand their specific needs and issues.

The updated [Anti-Racist Wales Action Plan 2024](#) tells us that experiences of racism when receiving health and social care continue to be reported within and outside of existing complaints systems.

Attending events such as Cardiff Mela provide a platform for us to continuously engage and build trust with marginalised communities, enabling us an opportunity to listen to the lived experiences of our service users.



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# Population Health and Peoples Experiences



## Interconnection between experience & population health

Taking a patient-centered approach that considers the needs and preferences of people, and health inequalities can lead to better health outcomes.

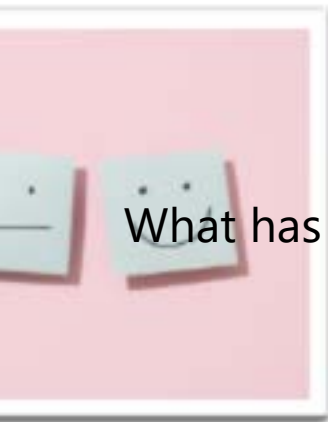
Our work has included:

- Focusing on peoples' experiences to identify and address disparities in care that contribute to health inequalities in the community.
  - Our work with learning disability groups has led to improvements in better pain management and pain scoring reducing anxiety and poorer experiences.
- We engaged communities to identify quality improvement initiatives that considers and addresses specific needs.
  - We identified safety concerns around seat belts for older and vulnerable patients using ambulance transport. They told us they didn't always feel safe when travelling. Work was undertaken to always remind/prompt people about wearing their seatbelts, this resulted in improved feedback scores.

# **Section 3**

## **Patient Reported Experience Measures (PREMs)**

## Aspects of a



What has been good

## Aspects of a quality experience based on peoples' feedback

A consistent theme from feedback received from patients, carers, communities and individuals over last six months have focused around waiting and timeliness in general across all service areas. Although the themes have been negative, there have been equally positive themes captured relating to staff working across all services.

What needs to improve



People have complimented the Trust on the professional and caring workforce.



The booking system introduced within Ambulance Care is appreciated by patients.



People have praised the good information provided by staff within the 111 service and its reassuring staff.



People are anxious on the length of time they are waiting in the community for a response and on the ETAs provided.



People are unhappy about the length of time it takes to return them home after their hospital appointments.



People are not happy with the length of time they wait for a call back from the 111 Wales service.

## **From April to September 2025 a total of 76 people used the 999 survey to provide feedback.**

Response rates to this survey remain disappointingly low and we acknowledge that such a low response rate cannot provide a truly representative picture of what it feels like to be an EMS service user across Wales.

We are committed to increasing engagement with this survey and are actively looking at ways in which we can achieve this. We still hope to gain permission to retrospectively to contact 999 callers by SMS Text Message to ask for their feedback. The Information Commissioner's Office (ICO) has responded to our submission and has suggested seven further actions that we should undertake before re-submitting our proposals to them.

Of responses received in this period, responses were received from all Health Board areas across Wales. Here's a brief overview of people's experiences:

- **61% of respondents said they felt confident in the ability of the person who answered their call to manage the call and provide appropriate advice.**
- **85% of respondents said they did not receive a call back from a clinical advisor.**
- **Of those who said an ambulance was sent, 63% said the wait time for an ambulance to arrive was acceptable.**
- **Of those who said an ambulance was sent, 88% said they felt safe whilst in the care of the ambulance crew.**
- **66% of people who completed the survey rated their overall experience as 'Good' or 'Very Good'.**





We have continued to work with colleagues in Ambulance Care to survey users of Non-Emergency Patient Transport (NEPTS), helping us to build a better understanding of their experiences and identifying areas of good practice and quality improvement opportunities.

**Between April and September 2025, a total of 1,474 NEPTS experience surveys were completed. Responses were received from all Health Board areas.**

We continue to take a multi-access approach, and the responses received come from people who were either sent a text message asking them to complete a survey, people who asked to receive a postal survey or users who visited the Trust's website to complete an online survey. Stickers asking patients to provide feedback are also displayed in a majority of NEPTS vehicles, the stickers show a QR code which people can use to access the survey online.

- **92% found the booking process easy.**
  - 28% of respondents said they used the new courtesy call back function and that it worked well.
  - A further 28% said they didn't know this option was available, suggesting messaging could be clearer.
- **94% said they were happy with the transport they received.**
- **A majority of people (90%) said their overall NEPTS experience was either Very Good or Good.**

The NEPTS patient experience survey results offers reasonable assurance that users are satisfied with the service received. However, we know that this positive feedback doesn't align with high numbers of complaints received through our Putting Things Right Team, many of which relate to late cancellation of transport. We are working with Ambulance Care colleagues to explore how we can gather feedback from users who have transport cancelled because of Capacity Management Planning (CMP), to better understand the impact of this.

# Peoples' Ambulance Care experience

The NEPTS Patient Experience survey also contains weighted questions, allowing us to produce Heat Map reports. These heat maps use a benchmark of 85 to indicate a positive response.

From the heat map below, we can see the benchmarks set were reached in all areas except one; with wait times for transport home being the only area where it is missed. Satisfaction with wait times for transport home following an appointment misses its benchmark for a fifth reporting period in a row.

	Booking			Transport & Journey								Overall Experience		
Responses	Did you find your booking experience easy?	Was our call handler polite and courteous during the call?	Do you feel you were given all of the information you required prior to your journey?	Were you happy with the transport you received?	Did you feel that the crew were polite and helpful towards you?	Were you given support to meet any additional needs you have? For example: communication; mobility;	If you asked for assistance, did you get it when you needed it?	How clean was the vehicle you travelled on?	During your journey, were you reminded/prompted about wearing your seatbelt?	Did you feel safe and secure during your journey?	How long did you wait for your transport to take you home after your appointment?	How would you rate your overall experience?	Were you able to communicate in your preferred language?	Overall
1474	92	98	95	94	97	96	98	97	97	97	84	89	90	96
Benchmarks	85	85	85	85	85	85	85	85	85	85	85	85	85	85

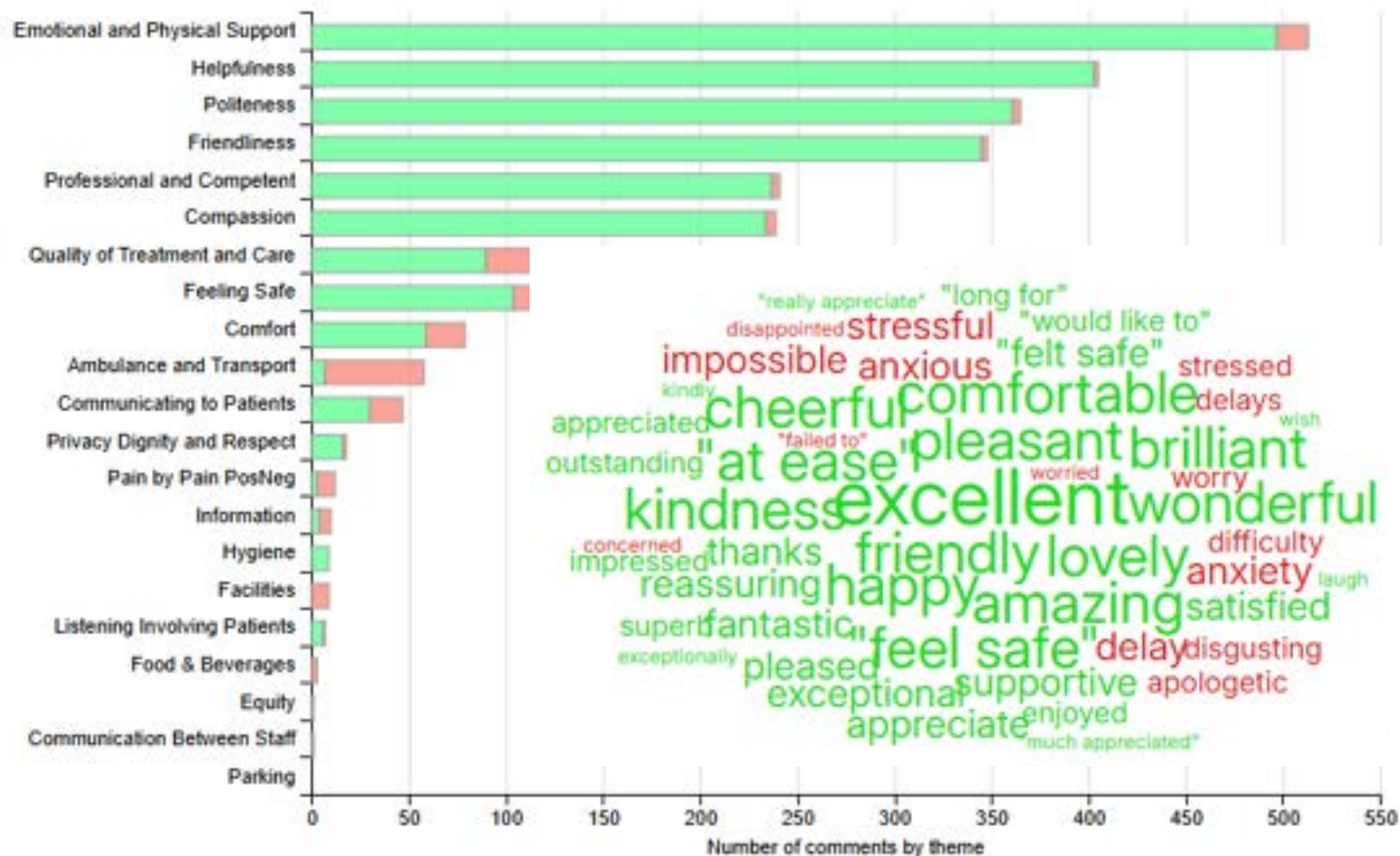
Patient concern about wait times for transport home continues to be regularly highlighted with Ambulance Care Managers via Quality Management Group (QMG), and we are assured it remains an area of focus for the Ambulance Care Team. Concerns remain focused around waits people feel are just overly long, uncomfortable waiting areas, no communication about length of wait and access to food or drinks during a long wait.

In April 2025, we added five core questions from the People Experience Framework (PEF) to the NEPTS experience survey. These included a new question about communicating in language of choice, rating overall experience from Very Good to Very Poor and providing free text feedback about particularly 'Good' or 'Bad' aspects of their experience.

# Peoples' Ambulance Care experience

Akumen pansesic text analysis of comments left shows us that people spoke about emotional & physical support, helpfulness, friendliness, politeness and compassion in positive tones. Overall transport and facilities were areas where people left comments which had a more negative sentiment behind them.

All Used Categories Pos/Neg Count



## What people said:

*"I'm not happy at all with the service, I have been cancelled for the second time in a row now and I'm finding it very stressful I'm not happy at all"*

*"Amazing service, it's made such a difference to my hospital visits having Help to use the service to take me and bring me back home safely by the very helpful, caring and kind professional people Thank you so much for letting me use this service"*

*"The booking was easy but cancelled again, wouldn't have minded if only an outpatient appointment but was for admission which upset me no end as I've been waiting for this op a long time"*

*"Sitting waiting in a wheelchair for transport home was very uncomfortable with the type of conditions that I have, I started getting numbing pains in my legs, it wasn't nice"*

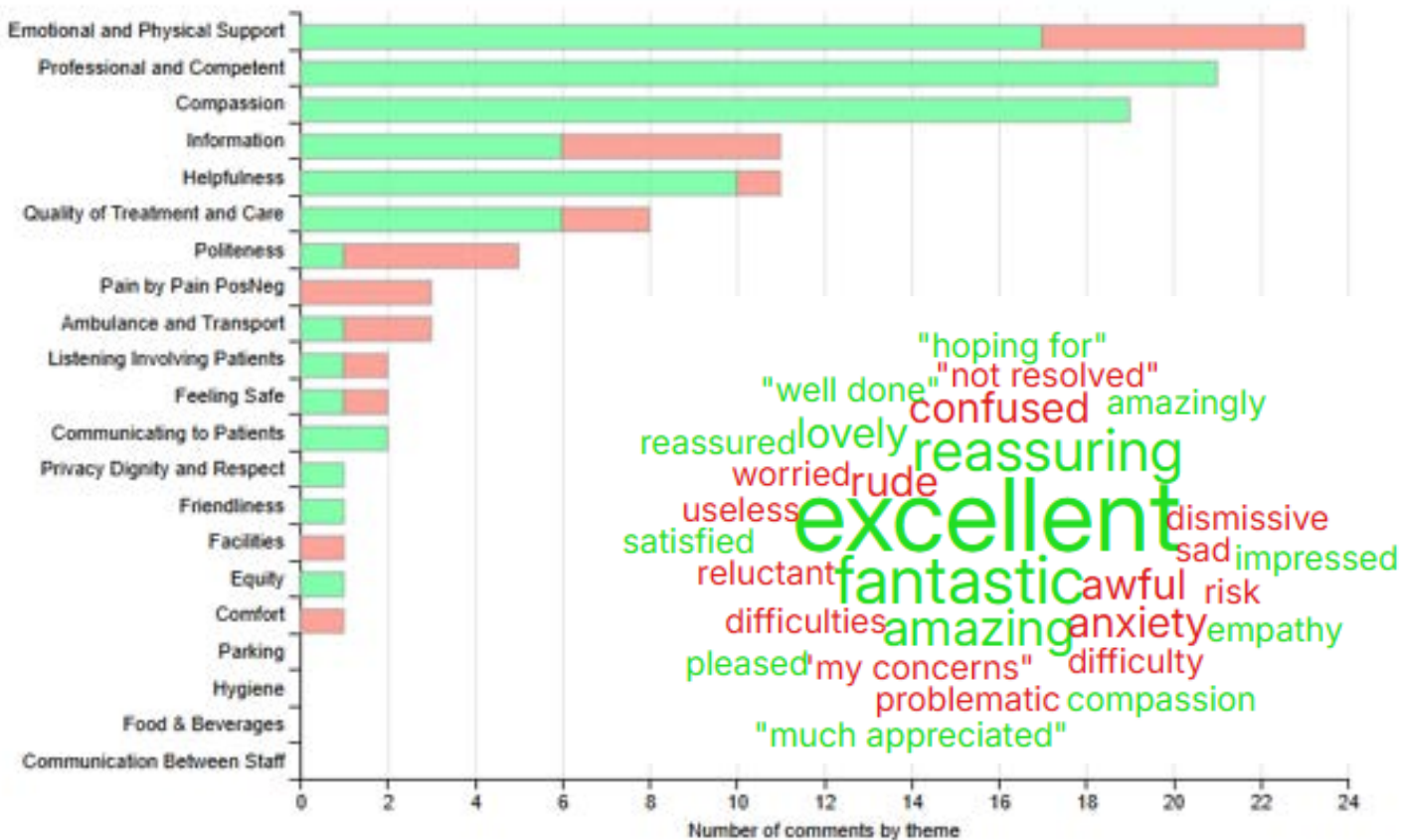
**Between April and September 2025, a total of 98 NHS 111 Wales patient experience surveys were completed.** Responses were received from all Health Board areas, though we acknowledge that this is a low response in comparison to overall call volumes and it is unlikely that responses received will provide a truly reflective picture of service user experience. Work continues with colleagues and the ICO to enable a greater reach of experience surveys.

- **56% of respondents told us that NHS 111 Wales had been their first port of call and that they had not been referred on from another service.**
- **71% of people told us they called 111 looking for health information or advice for themselves.**
- **66% of people told us they found their call to NHS 111 Wales ‘Extremely Helpful’ or ‘Helpful’.**
- **84% of people said they went on to follow the advice given to them by NHS 111 Wales.**

Responses	Access & Information Provided			Overall Experience			Overall
	How satisfied were you with how long it took for your call to NHS 111 Wales to be answered?	Do you feel that your call to NHS 111 Wales was helpful?	Did you follow the advice given to you by NHS 111 Wales?	Thinking about the NHS 111 Wales service, how was your overall experience of our service today?	Using a scale of 1 – 10 where 1 is very bad and 10 is very good, please rate your overall experience	Would you consider using the NHS 111 Wales service again?	
98	68	70	85	65	60	81	74
Benchmarks	85	85	85	85	85	85	

Arkun panesic text analysis of comments left shows us that people spoke about helpfulness and compassion in positive tones. Support, information and safety were areas which had a more negative sentiment behind them.

All Used Categories Pos/Neg Count



## What people said:

*"I'd had short shrift from the GP receptionist, I thought I'd best ring 111 instead. I am so glad that I did. I went through screening and then a clinical advisor called me back. They were very thorough and advised me to go to A&E which I wasn't expecting. They told me not to drive and what to wear and take. Turns out I needed emergency surgery to remove my appendix. I am so grateful for the advice this service gave me"*

*"The lady who dealt with me was very thorough and calm and I felt she treated me with care and consideration. She also arranged for an out of hours nurse to phone me to discuss it in more detail, which resulted in a prompt out of hours appointment. Really pleased with the care and service I received"*

*"Staff were all incredibly friendly and reassuring, whole process was very simple and all steps were well explained. The OOO GP was able to arrange for me to collect antibiotics from a nearby pharmacy and was very prompt in sending the prescription"*

# **Section 4**

## **Looking ahead**

## Organisational Change Process (OCP)

An impending OCP will significantly impact the future structure and purpose of the current PECl Team. The teams' functions will be realigned to best meet service changes.

This offers an opportunity to refocus and rebrand around peoples experience that will include:

- Changing the name of the team to 'Peoples Experience Team' (PET)
- Strengthening and embedding peoples experience within the QSPE Directorates quality structure
- Reframing and creating experience-based components of our work, threading them succinctly through the Duty of Quality.

## Measuring Quality of Experience

Measuring patient experience provides a benchmark for the overall quality of care, alongside clinical quality and safety measures, it is a key component in assessing the overall quality of Trust services.

We will be looking to introduce and strengthen our approach to:

- Experienced based co-design
- Emotional mapping - focusing on emotional and physical experiences of care
- Identifying and prioritising meaningful improvements across our services
- Managing 'expectations' by mitigating against negative feedback



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# Looking ahead

**We will work to achieve better health outcomes by using a person-centered approach across the following areas:**

**Value based Health Care approach:**

- PREMS
- Measuring what matters to 'patients'
- incorporating 'patients' perspectives to achieve better outcomes

**Population Health:**

- Interconnection between experience & population health – expand

**Integrate patient perspectives into service improvement and innovation processes**

- Utilise patient centered tools more effectively including experience-based co-design, emotional and journey mapping and co-design workshops.

**We will continue to engage with colleagues to improve experiential reporting across the Trust.**

To support the monitoring and evaluation of benefits and measures associated with the Trusts Clinical Model Transformation programme, there has been a review of the draft scorecards with a particular focus on integrating robust patient experience measures.

The challenge in obtaining sufficient volumes of feedback are well documented, we're confident that once the ICO is satisfied with our response to the seven recommendations then any experiential and relational metrics developed/used will, going forward, be dissected into demographic groups in line with the determinants of health. This will align with the Trusts future vision of creating a service better aligned with the principles of population health and prevention.



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Agenda Item No.

14

## REPORT TITLE

Clinical Audit Plan Q2 2025/6

## MEETING

Name of meeting	Quality, Patient Experience and Safety Committee
Date of meeting	4 November 2025
Public or Private	Public
If private - <a href="#">rationale</a>	Choose item from below

## REPORT SPONSOR

Executive sponsor	Andy Swinburn, Executive Director of Paramedicine
Author(s) of report	Vince Baglole, Head of Clinical Intelligence and Assurance Team

## PURPOSE OF REPORT

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

## REPORT SUMMARY:

1. This report provides an update to CIAG on the progress of the 2025/26 Clinical Audit Plan for Q2 (Jul – Sep).

- The following audits have been completed:



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25\_002 CI Care Bundle Compliance in IHT Patients

25\_004 Appropriate Use of Ketamine.

25\_005 St Johns Missing Records SBAR (preparatory work).

2. Revision to Clinical Audit Plan:

Non-medical prescribing is monitored through the Comparative Analysis System for Prescribing Audit (CASPA) by NHS Wales Shared Services Partnership (NWSSP). This negates the requirement to undertake a clinical audit and will be removed from the plan.

## RECOMMENDATION(S)

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

The group is requested to:

1. Approve the revision as detailed in the report, to the Clinical Audit Plan
2. Approve the Q2 Clinical Audit Plan
3. Note the additional intelligence work completed outside of the plan.

## ADDITIONAL PAPER(S)

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

The group is requested to receive the following:

1. Clinical Audit Plan Q2 2025
2. Clinical Audit Action Tracker September 2025

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

## STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

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



<input type="checkbox"/> SO3: Being at the forefront of innovation and technology	<input type="checkbox"/> SO4: Developing services in collaboration
<input checked="" type="checkbox"/> SO5: Being quality driven and clinically led	<input type="checkbox"/> SO6: Delivering exceptional value

### RISK(S) THIS REPORT MITIGATES

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

### HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

### WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [ <a href="#">link to goals</a> ]		
<input type="checkbox"/> A socially responsible and inclusive employer	<input 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 checked="" type="checkbox"/> No <input type="checkbox"/> Yes
If yes, what impact assessment is attached	

### APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
14 October 2025	Clinical Intelligence and Assurance Group
4 November 2025	Quality Patient Experience and Safety Committee



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## SITUATION

1. The Clinical Audit Plan is presented to the Clinical Intelligence and Assurance Group (CIAG) on quarterly basis to seek approval for wider sharing.

## BACKGROUND

2. The Trust's annual Clinical Audit Plan allows the planning and prioritisation of clinical audits across the financial year. It is a dynamic document, updated quarterly to reflect those audits that are either planned, currently underway, have been completed. Various groups and committees receive quarterly updates, and it is made available on the Trust's intranet

## ASSESSMENT

3. The following audits from the Clinical Audit Plan have been completed:
  - 25\_002 CI Care Bundle Compliance in IHT Patients
  - 25\_004 Appropriate Use of Ketamine
  - 25\_005 St Johns Missing Records SBAR (preparatory work).
- The following audits were commenced:
  - 25\_003 Appropriate Use of Antimicrobials (see below)
  - 25\_006 Clinical Frailty Scale Follow Up audit
- Revision to Clinical Audit Plan:
  - Non-medical prescribing is monitored through the Comparative Analysis System for Prescribing Audit (CASPA) by NHS Wales Shared Services Partnership (NWSSP). This negates the requirement to undertake a clinical audit and will be removed from the plan.
- During the planned clinical audits outlined above, the following additional intelligence work has been undertaken:
  - 15 clinical intelligence requests have been completed. 8 of these were requested under Freedom of Information Act. This figure does not include the rolling data requests that are being provided.
  - Technical specifications have been completed for the following EMERG category calls; Generic Pain Management, Generic ePCR Diagnostic Codes,



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Breathing Spo2 Change and Generic NEWS Score Change. Anaphylaxis is in progress and inclusion criteria for convulsions CI have been agreed.

- CIAT is conducting a focused analysis in partnership with C&V HB and BCUHB to understand whether patients who had a confirmed stroke and self-presented to A&E had any prior contact with the Welsh Ambulance Service (WAST).

## RECOMMENDATION

4. The recommendations are as set out in the front cover above.

## NEXT STEPS:

The Clinical and Intelligence Assurance Team continue to work through the approved audit plan, reporting monthly updates through CIAG and a Q3 update in due course.

The Non-medical prescribing audit is removed and assurance against this component is reported through the Medicines Management Assurance Report utilising data through the CASPA system alongside information drawn from individual prescribing reviews.



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# Clinical Audit Plan



2025/2026

Quarter 2

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Final V1

Last Updated 01 Oct 2025

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# Introduction

Clinical audit is one of a range of quality improvement methodologies that can deliver improved processes and outcomes. It measures against a standard, and can improve quality and unwarranted variations in practice, and support continuous and sustainable improvement. Clinical audit is a key enabler in evidencing the Health & Care Quality Standards 2023, providing assurance and compliance with the duty of quality.

The development of this annual plan takes into consideration a number of aspects including the resources available both in terms of funding and skills. As is often the case in healthcare there are substantially more requests for clinical audits than there are resources available to manage them. For this reason, it has been necessary to prioritise and tailor the plan so that it is realistic, achievable and that expectations are not overreached.

The plan is developed in consultation with the Clinical Intelligence & Assurance Team (CIAT), and senior clinical, and non-clinical managers within the Trust. It is expected that managers will ensure there is an opportunity for staff at all levels to contribute to the development of the plan and undertake clinical audits.

Following requests to undertake clinical audits, a proposal form will be provided by the CIAT allowing the aims, objectives, author, and a sponsor to be identified, along with identifying the necessary data and level of support required from the CIAT. A [How to Undertake a Clinical Audit](#) document is available on the Trust's intranet to guide and support staff.

The decision for clinical audit topics chosen for inclusion will be influenced by:

- ❖ Local and Trust priorities (e.g. Integrated Medium-Term Plan (IMTP) and Local Delivery Plans (LDPs))
- ❖ Clinical risk (e.g., linked to clinical risk registers or identified potential risks)
- ❖ Opportunities to improve clinical effectiveness and evidence-based practice (e.g., efficacy of treatment, new initiatives, pilot projects)
- ❖ Opportunities to quality assure clinical data (e.g., Clinical Indicator reports from electronic Patient Clinical Record (ePCR) data)
- ❖ National inquiries/patient safety incidents/Regulation 28 reports

- ❖ Guidance documents (e.g., National Institute for Health and Care Excellence (NICE), Association of Ambulance Chief Executives (AACE), and the Joint Royal Colleges Ambulance Liaison Committee (JRCALC)
- ❖ National Ambulance Service Clinical Quality Group
- ❖ Policy documents relating to health and healthcare
- ❖ Other benchmarking activities as appropriate

A number of new service delivery models are often required for a modern ambulance service. The robust evaluation of service development topics is essential and needs to be planned from their inception.

It is not always possible to predict at the start of a financial year all the topics that will require evaluation and therefore flexibility in setting a Clinical Audit Plan is required, resulting in the annual plan being a dynamic document, updated quarterly.

As part of the development and updating of this plan, the CIAT have streamlined and improved the process, forms and templates used. This approach has been further supported following an internal audit. When the CIAT receive topics for suggested audits, they are added to a spreadsheet and a prioritisation tool is used to assist in identifying the order for inclusion on the plan.

The aim of this plan is to detail the clinical audits that are either planned, currently underway or have been completed during the financial year **(Table 1 & Table 2)**

It is expected that all the topics identified in the plan will be initiated during the course of a financial year. Those initiated during Q3 or Q4 may not be fully completed and will need to be considered in the subsequent year's plan.

The completed clinical audit reports are available on the Clinical Audit page of the Trust's Intranet website. (<https://nhs.wales365.sharepoint.com/sites/AMB-Intranet-Medical/SitePages/Clinical-Audit-Programme.aspx>)

## Head of Clinical Intelligence & Assurance

Clinical Audit Plan 2025 / 26	Approved by:	Date Approved:
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**Table 1 – Summary** (Full information in Table 2)

*	N/A = Not due to start	Not started/not progressing	Not started, decision made	**Progressing as planned	Completed
** A clinical audit is deemed as started once a clinical audit proposal and criterion table have been approved by the CIAT and the ePCRs and/or data supplied					
Clinical Audit Classification		Tier 1 = UK Ambulance Services or Trust wide		Tier 2 = Health Board/Locality/Team	

This section contains confirmed clinical audits (This is a dynamic document, and topics will be added during the reporting year as required)										
Ref	Tier	Clinical Audit Title	Clinical Audit Author	Clinical Audit Sponsor	Audit Start Date	Current Status (RAG)*				
						Q4 2024/2025	Q1	Q2	Q3	Q4
23_009	1	ePCR Clinical Data Assurance - STEMI Clinical Indicator follow up audit	Clinical Intelligence & Assurance Team	Head of Clinical Intelligence & Assurance	Indicative Q4 24/25					
TBC	1	ePCR Clinical Data Assurance - Return of Spontaneous Circulation (ROSC) at Hospital Clinical Indicator Re-audit	Clinical Intelligence & Assurance Team	Head of Clinical Intelligence & Assurance	To commence after ePCR changes implemented	N/A	N/A	N/A		
24_005	1	Drug administration documentation	Clinical Intelligence & Assurance Team	Head of Clinical Intelligence & Assurance	December 2024					
TBC	1	Failed Pathways Recording on ePCR Audit	TBC	Assistant Director of Clinical Development	TBC	N/A	N/A	N/A	N/A	N/A
25_001	1	ROLE Form Images in ePCR follow up audit	Clinical Intelligence & Assurance Team	Head of Clinical Intelligence & Assurance	Q4					
CIAT_006	1	Clinical Frailty Scale (CFS) – follow-up audit (action from CIAT23_003)	Clinical Intelligence & Assurance Team	Head of Clinical Intelligence & Assurance	September 2025	N/A	N/A			

<b>TBC</b>	1	Use of Magnesium Sulfate	Clinical Intelligence & Assurance Team	Head of Medicines Management	Indicative Q3 2025/26	N/A	N/A	N/A		
<b>25_002</b>	1	CI Care bundle compliance in Interhospital (IHT) patients	Clinical Intelligence & Assurance Team	Head of Clinical Intelligence & Assurance	Indicative Q1 2025/26	N/A				
<b>TBC</b>	1	Non-medical prescribing	Clinical Intelligence & Assurance Team	Head of Medicines Management	Indicative Q2 2025/26	N/A				
<b>TBC</b>	1	Trauma in older people Tool	Clinical Intelligence & Assurance Team	TBC	Indicative Q4 2025/26	N/A	N/A	N/A		
<b>25_003</b>	1	Appropriate use of antimicrobials	Clinical Intelligence & Assurance Team	Head of Medicines Management	Commenced Q1 2025/26	N/A				
<b>25_004</b>	1	Appropriate use of Ketamine	Clinical Intelligence & Assurance Team	Regional Clinical Lead – Consultant Paramedic	Commenced Q1 2025/26	N/A				
<b>25_005</b>	1	St John’s data breach – missing records. Preparatory work for missing records.	Clinical Intelligence & Assurance Team	Head of Clinical Intelligence & Assurance	Indicative Q1 2025/26	N/A				

**Table 2 – Full Information**

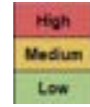
Ref	Clinical Audit Title	Rationale/Drivers	Clinical Audit Author	Clinical Audit Contact/Support	Audit Start Date	Comments
23_009	ePCR Clinical Data Assurance - STEMI Clinical Indicator follow up audit	To ascertain if improvements have resulted following completion of actions from the previous audit.	Clinical Intelligence & Assurance Team	Head of Clinical Intelligence & Assurance	Indicative Q4 24/25	Update further delayed, and problems with consistent roll out @19/12, and whether all changes have been implemented. UI changes investigated, and SBAR presented to ePCR-CRG (28/3) to confirm outstanding issues. Following Autumn 24 UI release – the CI technical specification was updated and deployed by IDS. Start date of audit anticipated January 25.  Audit completed presented to CIAG 08.05 2025
TBC	ePCR Clinical Data Assurance - Return of Spontaneous Circulation (ROSC) at Hospital Clinical Indicator Re-audit	To ascertain if improvements have resulted following completion of actions from the previous audit.	Clinical Intelligence & Assurance Team	Head of Clinical Intelligence & Assurance	Indicative Q3 25/26	Funding required for these specific changes. Autumn 2024 deployment.  The 'Point of closure nudge tool' has been activated to improve outcome compliance.  Technical spec updated and being reviewed by IDS.

Ref	Clinical Audit Title	Rationale/Drivers	Clinical Audit Author	Clinical Audit Contact/Support	Audit Start Date	Comments
						<p>Agreed in CIAG on 12 July to defer to Q3 at earliest.</p> <p>Clarification of resuscitation definition and case selection required 07.06.25 by subject matter experts. Proposal to CQGG to also report on a "JRCALC subset".</p> <p>Further decisions made to align reporting with Warwick, Welsh Registry and Joint Commissioning Committee (JCC).</p> <p>In the interest of efficiency CIAG to determine if this should be undertaken together with JRCALC and CFR subset QA work.</p>
24_005	Drug administration documentation	To ensure that drugs administered to the patient are documented within the ePCR drugs section in line with the relevant parts of section 10.0 of the Medicines Management Policy 4.0	Clinical Intelligence & Assurance Team	Clinical Intelligence & Assurance Team	Q3 24/25	<p>SQL developed.</p> <p>SBAR completed in preparedness for December 2024 CIAG. However, due to REAP4 paper shared for information via email. No comments received as of 02.01.25 suggesting changes required to criterion table. Approved.</p> <p>Audit completed, presented to CIAG 20 03 25</p>

Ref	Clinical Audit Title	Rationale/Drivers	Clinical Audit Author	Clinical Audit Contact/Support	Audit Start Date	Comments
TBC	Failed Pathways Recording on ePCR Audit	Following an update to the ePCR User Interface to record the inability to refer patients onto pathways, an audit would assist in identifying areas for improvement for patient care and avoid unnecessary admission to Emergency Departments.	TBC	Clinical Intelligence & Assurance Team	TBC	Required UI changes presented to ePCR CRG 29.05.24 CR0048, likely release Oct/Nov 2024 Revised date for UI changes Spring 2025 Sponsor has requested a clinical intelligence report be generated to inform the need for the audit. On hold as likely implementation is Dec 2025 with wider roll-out Jan 2026.
25_001	ROLE Form Images in ePCR re-audit	To ascertain if improvements have resulted following completion of actions from the previous audit.	Clinical Intelligence & Assurance Team	Clinical Intelligence & Assurance Data Specialist	Q4 24/25	SQL developed and data obtained. Audit undertaken. Completed audit presented to CIAG in April 2025.
25_006	Clinical Frailty Scale (CFS) – follow-up audit (action from CIAT23_003)	This is an action from an audit undertaken in 2023	Clinical Intelligence & Assurance Co-ordinator	Clinical Intelligence & Assurance Co-ordinator	Q2 25/26	Commenced latter part of Sept 2025 Proposal presented to CIAT team meeting 26 09 25 SQL developed, Data cleanse underway.
TBC	Use of Magnesium Sulfate	PGD being developed in 2025, potential need for audit when embedded into practice.	Clinical Intelligence & Assurance	Clinical Intelligence & Assurance Team	Indicative Q3 2025/26	Indications for use, severe asthma in adults and children Pre-eclampsia, Eclampsia, Torsade de Pointes.

Ref	Clinical Audit Title	Rationale/Drivers	Clinical Audit Author	Clinical Audit Contact/Support	Audit Start Date	Comments
			Co-ordinator			CIAT will be notified when online training of Magnesium sulfate has reached 50% In the interim CIAT will supply monthly data on its use to Regional HBCL
25_002	CI Care bundle compliance in Interhospital Transfer (IHT) patients.	<p>CIAG approved change to global IHT metric encompassing many more cases which would have previously been included in a Clinical Indicator.</p> <p>CIAG requested an audit to provide assurance going forwards relating to the care bundle in CI patients transported by WAST from smaller NHS premises to definitive care.</p>	Clinical Intelligence & Assurance Co-ordinator	Clinical Intelligence & Assurance Team	Indicative Q1 2025/26	Audit commenced in Q1 as planned. Completed and findings presented in CIAG 12 09 25
TBC	Non-medical prescribing	Policy 9.3: - Regular programmes of audit of compliance with information governance, records management standards and prescribing practice will be established. The Head of Medicines Management must include non-medical prescribing audits as part of the Trust's annual clinical audit plan, reporting these results through the Advanced Clinical Practice Delivery Group and Optimising Care Group and available for assurance.	Clinical Intelligence & Assurance Co-ordinator	Clinical Intelligence & Assurance Team	Indicative Q2 25/26	Preparatory work being undertaken. Meetings scheduled 29 05 25, 24 06 25 20 08 25 VB met with JL 26/9 Decision made to amend the current version of the policy. This will go to APSG and Policy Group for approval.
TBC	Trauma in older people Tool	Trauma in Older People Tool is a rebranding and is due for re-launch	Clinical Intelligence & Assurance	Clinical Intelligence & Assurance Team	TBC	

Ref	Clinical Audit Title	Rationale/Drivers	Clinical Audit Author	Clinical Audit Contact/Support	Audit Start Date	Comments
		Potential need for audit once embedded into practice.	Co-ordinator			
25_003	Appropriate use of antimicrobials.	Supporting antimicrobial stewardship. Medicine Management Policy 2024 V4.0 (16.5).	Clinical Intelligence & Assurance Co-ordinator	Head of Medicine Management.	Commenced Q1 2025/26	Preparatory work being undertaken. Meeting scheduled 29 05 25
25_004	Appropriate use of Ketamine	Action from CHARU working Group to ensure compliance to the Advanced Clinical Interventions SOP: Advanced Analgaesia with Ketamine and PGD guidance.	Clinical Intelligence & Assurance Lead Administrator / Co-ordinator	Regional Clinical Lead-Consultant Paramedic	Commenced Q1 2025/26	SQL developed Spreadsheet developed Audit commenced Present to CIAG Oct 2025
25_005	St John's data breach – missing records - Preparatory work for missing records.	The audit will support a risk assessment undertaken (DATIX 20266) following the data breach and the results provided to Information Governance Steering Group (IGSG) by providing details of information the Trust holds in relation to incidents where there is a missing Patient Clinical Record completed by St Johns Falls Response.	Clinical Intelligence & Assurance Team	Clinical Intelligence & Assurance Team	Q1 2025/26	Chairs action request SBAR sent 21.05.25 This work will determine if there is a requirement to proceed to a full audit. Response received from KH (IG) on 10/09, in summary, group supported taking audit to CQGG for clinical sign off. Agreed that no further risk would be uncovered by reviewing all incidents.



**Progress and delivery to actions key:**

- Red - Off track and not likely to deliver
- Amber - Off track and recovery action taken
- Green - On track for delivery as planned
- Blue - Action complete

ID	Date Approved	Reference	Title	Action No.	Action Priority	Action	Accountable Manager	Date Due	Comments ↑	Progress to Actions RAG-B
A	12/07/2024	CIAT24_001	Older Adult Fallers Discharged at Scene Clinical Indicator - ePCR Clinical Data Assurance	1	High	The results of this clinical audit to be shared with all staff via the WAST intranet.	Kevin Webb	31/07/2024	18/07/2024 - Clinical audit posted on the intranet	Complete
				2	Medium	Task and finish group to be established to develop and launch the Older Fallers – Discharged at Scene CI and agree ePCR UI changes required.	Kath Charters	30/09/2024	26/09/2024 - inaugural meeting took place. Next meeting scheduled 4/11/24 27/08/2024 - RS emailed RCLs to request representation from operational staff 23/08/2024 - T&F group inaugural meeting scheduled for 26/9/24 08/08/2024 - KC/RS/RT to meet in August to agree T&F group membership and scope	Complete
				3	Medium	Older Fallers – Discharged at Scene CI criterion table to be updated for approval at CIAG.	Ruth Saele	31/10/2024	31/12/2024 - SBAR including updated criterion table to be submitted to CIAG 9/1/25 for approval 04/12/2024 - SBAR including updated criterion table to be submitted to CIAG 13/12/24 for approval (meeting cancelled due to REAP 4) 07/11/2024 - next group 25/11/24 to focus on falls referrals. 30/10/2024 - to be further discussed at T&F group on 4/11/24 To be agreed at T&F group prior to submission to CIAG	Complete
				4	Medium	ePCR UI change request to be submitted to the Clinical Reference Group.	Kath Charters	31/01/2025	04/12/2024 - no further UI changes are to be made until Spring 2025, these will be progressed by CRG and this action can be closed. To be agreed at T&F group prior to submission to CRG	Complete
				5	Medium	Write CI Technical Specification.	Kath Charters	31/03/2025	19/05/2025 - Completed technical specification sent to I&DS 19/05/25 29/04/2025 - Anticipated completion of technical specification to I&DS w/e 02/05/25. 01/04/2025 - KC in progress, anticipated completion 4/4/25 13/02/2025 - CI Technical Specification is not dependent on any new ePCR UI changes. To follow CIAG approval of CI criterion table and the implementation of all pending and any additional UI changes affecting the CI data collection.	Complete
				6	Medium	Develop, quality assure, and implement the CI.	Kath Charters	31/12/2025	07/08/25 - Update from SG: script has been completed and is being reviewed. To follow all previous actions. Implementation to include education and awareness.	On Track
B	09/01/2025	CIAT24_002	Tranexamic Acid Administration 2023/24	1	High	The results of this clinical audit to be shared with all staff via the WAST intranet.	Kevin Webb	31/01/2025	13/1/25 - clinical audit report published to intranet 10/1/25 - NP at add QR code in infographic and post report on intranet w/c 13/1	Complete
				2	High	Provide feedback to staff where TXA was indicated but not administered.	Carl Powell	28/02/2025	25/04/25 CP confirmed that feedback has been forwarded to crews 14/04/25 RS email to CP for update 31/3/25 - RT requested CP for update 3/3/25 - CP advised this is in progress 28/2/25 - RT email to CP to request update 13/2/25 - CP has confirmed he will arrange feedback to staff, and collate any responses 10/1/25 - RT to contact CP regarding feedback process	Complete
				3	Medium	Issue a Clinical Notice with infographic to highlight key findings, recommendations, areas of good practice and areas for improvement.	Kevin Webb	28/02/2025	03/09/25 - Clinical Notice 29/2025 published 06/08/25 - Draft Clinical Notice sent to GL/CP/TA for comments 03/07/25 - Clinical notice commenced and in working draft 03/06/25 - RT to draft clinical notice 29/04/25 - GL confirmed communication of audit findings by clinical notice 13/02/25 - Draft clinical notice dependent on clarification of flush guidance from HJ & SF, and any insights gained from staff feedback e.g. on gender disparity. 10/01/25 - RT to draft clinical notice for CP/TA comments and GL approval	Complete
				4	Medium	Health Board Clinical Leads to share the Clinical Notice and infographic at their respective Operational Meetings.	Regional Clinical Leads (BT, MJ, SM)	31/03/2025	04/09/25 RT email to RCLs (BT, MJ, SM) with request to cascade via HBCLs. Clinical audit findings will also be shared via the next CIAT Newsletter. 14/04/25 RS Mode of communication to advise of findings will follow once action no 2 completed. Awaiting update To follow publication of Clinical Notice	Complete
				4a	Medium	RS: updated 08 08 25. Additional action arising from CIAT24_002 TXA initially scheduled for CIAG 13 12 24, which was cancelled and presented on 09 01 25 Exploration required around the gender disparity in TXA administration	Vince Baglole	13/06/2025	04/09/25 KC sent update request to KD regarding suggested tool tip in ePCR Major Trauma section including a statement on gender disparity 13/06/25 TXA gender disparity SBAR presented to CIAG 04/06/25 KC advised CCIO via email of work undertaken by CIAT to explore use of TXA nudge facility within ePCR. However this is not feasible and a tool tip has been suggested (as per email) with suggested wording	At Risk
C	20/03/2025	CIAT24_005	Drug administration documentation in ePCR	1	High	The results of this clinical audit to be shared with all colleagues via the WAST intranet.	Vince Baglole	30/04/2025	04/04/25 Report published to intranet following amendment of recommendations and infographic in line with discussion at CIAG 20/3/25	Complete
				2	Medium	Clinical audit infographic to be distributed to clinicians via local communications channels such as noticeboards, station briefings etc	Regional Clinical Leads (BT, MJ, SM)	31/05/2025	04/06/25 Copy of final report including infographic emailed to BT & SM for sharing via HBCLs. 03/06/25 Confirmation received from MJ. Clinical Audit Newsletter published on WAST intranet, including link to the report and infographic. 14/04/25 RS emailed Regional Clinical Leads reminding of action and request for confirmation as complete.	Complete
				3	Medium	This clinical audit to be included on the agenda of the Medicines Management Group (when convened) to discuss findings and implications for the Medicines Management Policy e.g. information recording requirements for medical gases and flushes.	Vince Baglole	TBC	03/09/25 - Update from HJ: date of next meeting TBC 31/07/25 - Inaugural meeting of MMG covered purpose of the group 25/06/25 - Head of Medicines Management advised no update yet 04/06/25 Head of Medicines Management advised inaugural meeting dependent all required members being confirmed. 02/04/25 Head of Medicines Management advised inaugural meeting in process of being arranged.	On Track
	12/09/2025	CIAT25_002	Inter-Hospital Transfer Patients - Clinical Indicator Bundle Compliance	1	High	CIAG to note this audit found no evidence of the additional IHT patients excluded since January 2025 receiving suboptimal care by WAST, and to accept this as assurance	Vince Baglole	12/09/2025	12/09/25 Clinical audit report approved at CIAG and assurance accepted to confirm the decision to widen the definition of IHTs from January 2025.	Complete





**GIG**  
CYMRU  
**NHS**  
WALES

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

Agenda Item No. 15

## REPORT TITLE

Risk Management and Board Assurance Framework Report

## MEETING

Name of meeting	Quality, Patient Experience & Safety Committee
Date of meeting	04 November 2025
Public or Private	Public
If private - <a href="#">rationale</a>	n/a

## REPORT SPONSOR

Executive sponsor	Trish Mills, Director of Corporate Governance / Board Secretary
Author(s) of report	Julie Boalch, Assistant Director of Corporate Governance & Risk

## PURPOSE OF REPORT

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

## REPORT SUMMARY:

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

1. The purpose of the report is to provide assurance in respect of the management of the Trust's principal risks, specifically the two risks that are relevant to Committee's remit.
2. A summary of these risks is set out in Annex 1 with a detailed description contained within the Board Assurance Framework (BAF). All updates are highlighted in blue and show changes to the narrative, mitigating actions, controls, and assurances.

3. The more detailed description contained within the BAF (Annex 4) provides the Committee with an opportunity to review the controls in place against each principal risk and the assurance provided against those controls where applicable. This will assist Members in evaluating current risk ratings supported by the scoring matrix (Annex 2).
4. Members can take assurance that each of the principal risks have been reviewed during this reporting period in line with the agreed schedule detailed at Annex 3 with continual and dynamic focus on the highest rated risks scoring 15-25. Attention has been given to the risk ratings of each risk and the mitigating actions identified and taken to ensure that risks achieve their target score. This is in addition to the standard and regular review of all controls, assurances, and any gaps.
5. The Executive Leadership Team (ELT) will consider the principal risk activity on 29 October 2025 and the review of each risk undertaken throughout the reporting period 2025 by Risk Owners. There have been no material changes to the principal risks during this period.
6. The Trust's two highest scoring **Risks 223** (*the Trust's inability to reach patients in the community causing patient harm and death*) and **Risk 224** (*Significant handover 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*) remain static at the highest score of 25.
7. While the Trust continues to demonstrate high levels of internal assurance, recent national focus on care standards and system performance provides a welcome opportunity to strengthen consistency and improve the effectiveness of wider system responses. Historic variation in adherence to national handover standards and the delivery of improvement plans has limited the extent to which the Trust can mitigate this risk through internal controls alone. However, increasing national scrutiny, greater transparency, and a shift toward more integrated, system-based accountability present a clear opportunity to improve consistency and collective impact across organisational boundaries.
8. The introduction of W45 from 1 October 2025 and the efforts made by the majority of Health Boards in the preceding months, is a welcome step toward reducing avoidable patient harm by supporting more timely transfers of care and improving the overall experience for patients awaiting treatment. A clinically led Handover-45 taskforce has been formed and workshops hosted by the NHS Wales Performance and Improvement are ongoing to support local improvement plans.
9. The Audit Wales report, published in June 2025, regarding the effectiveness of unscheduled care arrangements across NHS Wales provides a critical external perspective on whole-system performance and identifies further levers to drive national consistency and accountability. Achieving the target risk score will ultimately rely on sustained partnership

working, improved operational alignment across organisations, and the embedding of nationally agreed standards into routine delivery at every level of the system.

10. Phase one of the Trust's Clinical Transformation Model - specifically the introduction of Code Changes for response was successfully implemented on 1 July 2025, representing a key milestone in the delivery of an enhanced clinical model aligned to patient acuity, workforce capability, and risk reduction. Work towards the go live of Phase two is underway.
11. Strategic mitigation remains focused on both internal transformation and system-wide influence. The Trust continues to engage proactively with national and regional programmes - including the Six Goals for Urgent and Emergency Care - to support shared learning, alignment of expectations, and strengthened collective ownership of outcomes.
12. The risk data is being presented in themes and categories and supports the identification of any gaps and escalations required. A more detailed action plan that supports these risks will be held at an operational level.
13. The risks continue to be reported to the Trust Board, with a focus on the actions to mitigate these two risks that are within its control, and these are highlighted in the avoidable harm dashboard that is presented at each Board meeting. Further mitigations and transformative actions are described in the Integrated Medium Term Plan (IMTP) and are presented to committees and Trust Board in a variety of reports e.g. IMTP Assurance Report and described in the Monthly Integrated Quality & Performance Report to address these risks.
14. Most of the Trust's actions in the avoidable harm dashboard have been completed and a several efficiencies and improvements implemented that have stabilised performance; however, the Trust is unable to completely mitigate the scale of handover lost hours due to the environment which it is operating in.
15. Whilst there have been no further material changes made during this period, the BAF includes a commentary for each risk for the Risk Owner to describe the rationale for each of the risk ratings which is particularly important where ratings have remained static.

## RECOMMENDATION(S)

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

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

1. Consider contents of the report including:
  - a. The controls in place against the risks.
  - b. The actions described to further mitigate the risks.

## ADDITIONAL PAPER(S)

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

The Finance & Performance Committee is requested to receive the following:

1. Annex 1 - Summary table
2. Annex 2 – Scoring Matrix
3. Annex 3 – Frequency of Risk review
4. Annex 4 - Board Assurance Framework

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) [\[link to objectives and what good looks like\]](#)

<input checked="" type="checkbox"/> SO1: Providing the right care or advice, in the right place, every time	<input checked="" type="checkbox"/> SO2: Enabling our people to be the best they can be
<input checked="" type="checkbox"/> SO3: Being at the forefront of innovation and technology	<input checked="" type="checkbox"/> SO4: Developing services in collaboration
<input checked="" type="checkbox"/> SO5: Being quality driven and clinically led	<input checked="" type="checkbox"/> SO6: Delivering exceptional value

## RISK(S) THIS REPORT MITIGATES

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

## HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

<input checked="" type="checkbox"/> Safe	<input checked="" type="checkbox"/> Timely	<input checked="" type="checkbox"/> 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 checked="" 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 checked="" type="checkbox"/> No <input type="checkbox"/> Yes
If yes, what impact assessment is attached	

## APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
29 August 2025	Executive Leadership Team

**Annex 1 – Corporate Risk Register Summary**

**CORPORATE RISK REGISTER**

<b>RISK ID</b>	<b>NEW RISK TITLE</b>	<b>NEW SUMMARY DESCRIPTION</b>	<b>EXECUTIVE OWNER</b>	<b>RISK SCORE</b>
223 QuEST	The Trust's inability to reach patients in the community causing patient harm and death	<p><b>IF</b> significant internal and external system pressures continue</p> <p><b>THEN</b> there is a risk of an inability and/or a delay in ambulances reaching patients in the community</p> <p><b>RESULTING IN</b> patient harm and death</p>	Director of Operations	<p><b>25</b> <b>(5x5)</b></p> 
224 QuEST	Significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service	<p><b>IF</b> patients are significantly delayed in ambulances outside A&amp;E departments</p> <p><b>THEN</b> there is a risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised</p> <p><b>RESULTING IN</b> patients potentially coming to harm and a poor patient experience</p>	Director of Quality & Nursing	<p><b>25</b> <b>(5x5)</b></p> 

## Annex 2 - Risk Scoring Matrix

Consequence:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
<b>Safety &amp; Well-being - Patients/ Staff/Public</b>	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 stay 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 a large number of patients.
<b>Quality/ Complaints/ Assurance/ Patient Outcomes</b>	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.
<b>Workforce/ Organisational Development/ Staffing/ Competence</b>	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.
<b>Statutory Duty, Regulation, Mandatory Requirements</b>	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.
<b>Adverse Publicity or Reputation</b>	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.
<b>Business Objectives or Projects</b>	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.
<b>Financial Stability &amp; Impact of Litigation</b>	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.
<b>Service/ Business Interruption</b>	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours. Some disruption manageable by altered operational routine.	Loss/interruption of >1 day. Disruption to a number of 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.
<b>Environment/Estate/ Infrastructure</b>	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.
<b>Health Inequalities/ Equity</b>	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.

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
5 Almost Certain: Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

### Annex 3 - Frequency of Risk Review

Risk Score	Review Frequency	Risk Rating
15 – 25 Red	Review monthly	High
8 – 12 Amber	Review quarterly	Medium
1 – 6 Green	Review every 6 months	Low

<b>Risk ID</b> 223	<b>The Trust’s inability to reach patients in the community causing patient harm and death</b>	<b>Date of Review:</b>	01/10/2025	<b>TREND</b>	<b>OVERALL</b> 25 (5x5)			
		<b>Date of Next Review:</b>	01/11/2025	➡				
<b>IF</b> significant internal and external system pressures continue	<b>THEN</b> there is a risk of an inability and/or a delay in ambulances reaching patients in the community	<b>RESULTING IN</b> patient harm and death	<b>External (LxC)</b>			<b>Internal (LxC)</b>		
			<b>Inherent</b>					
			<b>Current</b>					
			<b>Target</b>					

**Strategic objective 1: Providing the right care or advice, in the right place, every time**

Work has continued to contribute to the design and development of a different approach to the Trust’s highest scoring risks in a way that describes the internal and external controls, assurances and gaps which have been separated into those that the Trust manages and those that it monitors.

The next steps will include testing separate risk scores for internal and external mitigations, to support the demonstration of the impact of actions taken. This will not affect the overall score of 25 (5x5) which reflects the severity of patient harm and death.

Each of the assurances against the controls have been described over three lines of assurance. A future piece of work will be undertaken to score the effectiveness of these controls and assurances.

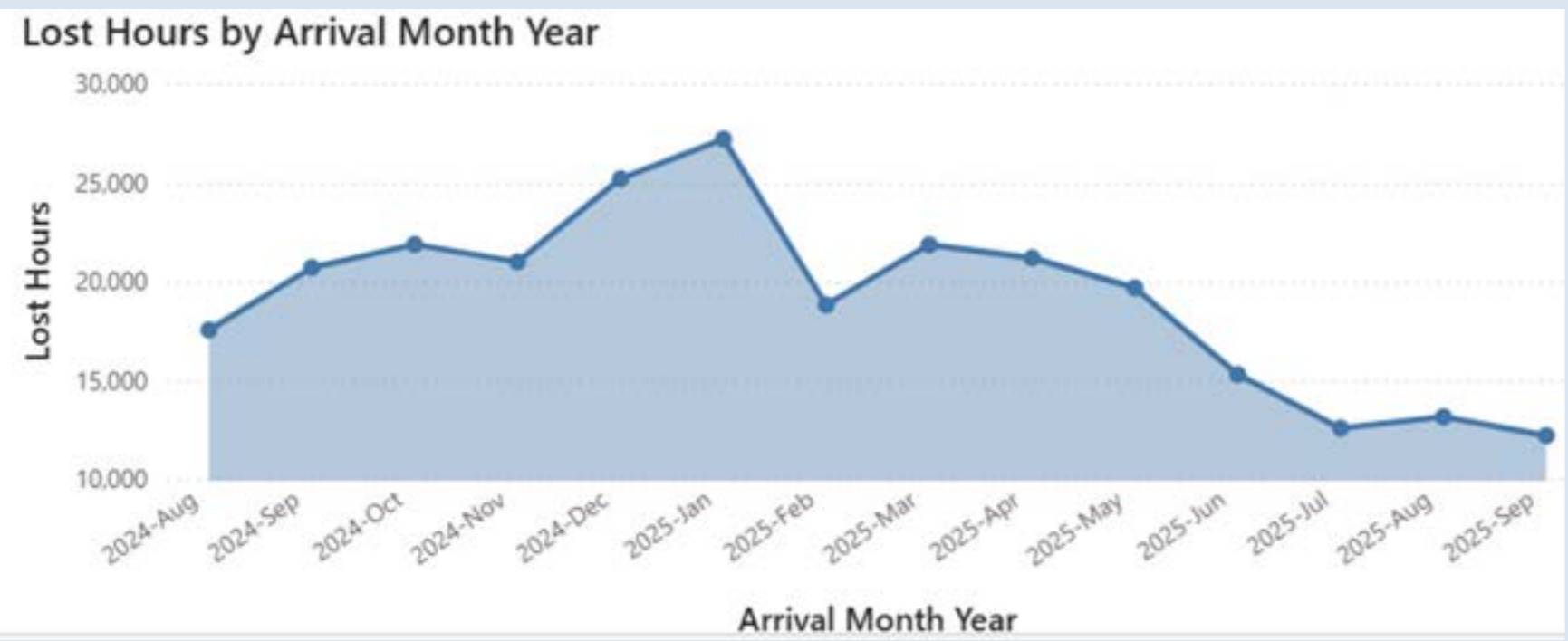
The way the data is being presented in themes and categories supports the identification of any gaps and escalations required. A more detailed action plan that supports these risks will be held at an operational level. This working draft is for discussion purposes and to highlight the direction of travel. There is still work to be done on this document.

**DRAFT Risk Appetite Level – Open**

We are open to taking risks regarding changes to processes impacting the right care or advice. We understand that innovation and improvement may involve some risk, and we are prepared to embrace these opportunities to enhance our service delivery.

<b>EXECUTIVE OWNER</b>	Executive Director of Operations	<b>ASSURANCE COMMITTEE</b>	Quality, Safety and Patient Experience Committee
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**Risk Commentary**



This risk remains at the highest possible level, reflecting the enduring impact of significant ambulance handover delays at Emergency Departments and timely access to definitive care. The strategic implications for the Trust are considerable, with patient harm, deterioration, and poor experience continuing to generate regulatory scrutiny, including through Prevention of Future Deaths reports.

The Trust has implemented a mature and embedded internal control environment, underpinned by real-time clinical and operational oversight through the Operational Delivery Unit (ODU), the Clinical Safety Plan (CSP), and system-level escalation mechanisms such as REAP and national risk huddles. These controls are further supported by structured assurance mechanisms including internal and external incident reporting, compliance monitoring, and governance review processes.

<b>Risk ID</b> 223	<b>The Trust's inability to reach patients in the community causing patient harm and death</b>	<b>Date of Review:</b>	01/10/2025	<b>TREND</b>	<b>OVERALL</b> 25 (5x5)
		<b>Date of Next Review:</b>	01/11/2025	➔	

Phase one of the Trust's Clinical Transformation Model - specifically the new performance framework - has now gone live, representing a key milestone in the delivery of an enhanced clinical model aligned to patient acuity, workforce capability, and risk reduction. In parallel, early adoption of the *Wait 45* handover standard by some Health Boards represents a positive step toward reducing avoidable patient harm by supporting more timely transfers of care and improving the overall experience for patients awaiting treatment.

While the Trust continues to demonstrate high levels of internal assurance, recent national focus on care standards and system performance provides a welcome opportunity to strengthen consistency and improve the effectiveness of wider system responses. Historic variation in adherence to national handover standards and the delivery of improvement plans has limited the extent to which the Trust can mitigate this risk through internal controls alone. However, increasing national scrutiny, greater transparency, and a shift toward more integrated, system-based accountability present a clear opportunity to improve consistency and collective impact across organisational boundaries.

Strategic mitigation therefore remains focused on both internal transformation and system-wide influence. The Trust continues to engage proactively with national and regional programmes - including the Six Goals for Urgent and Emergency Care - to support shared learning, alignment of expectations, and strengthened collective ownership of outcomes.

The received Audit Wales report into the effectiveness of unscheduled care arrangements across NHS Wales provides a critical external perspective on whole-system performance and identifies further levers to drive national consistency and accountability. Achieving the target risk score will ultimately rely on sustained partnership working, improved operational alignment across organisations, and the embedding of nationally agreed standards into routine delivery at every level of the system.

**The introduction of W45 from 1 October and the efforts made by the majority of Health Board in the preceding months is a welcome step. Several sites, including BCU however continue to be problematic with W45 improvements not yet realised.**

<b>CONTROLS</b>		<b>ASSURANCES</b>		
MONITOR - External		External <b>Monitor outcomes and provide regular reports to stakeholders. This ensures while external factors may impact the risk it is monitored and managed effectively.</b>		
1. External Handover Improvement Group (NHS Exec)	1. Established handover improvement group led by the Director of Operations, NHS Exec to address persistent delays in ambulance handovers at Emergency Departments. The groups' purpose is to coordinate improvement plans across Health Boards, monitor compliance with national guidance and facilitate audits and performance tracking through NHS Exec oversight. <b>The introduction of W45 from 1 October and the efforts made by the majority of Health Boards in the preceding months, is a welcome step. A clinically led Handover-45 taskforce has been formed and workshops hosted by the NHS Wales Performance and Improvement are ongoing to support local improvement plans.</b>			
2. Welsh Health Circular	2. Setting national standards for 15-minute patient handover timeframe, clinical practice, quality governance and operational safety mandating actions like early warning score implementation and infection control whilst also embedding legal compliance through frameworks e.g Duty of Quality. Outcomes are primarily overseen by the Welsh Government through a combination of national audit programmes and governance frameworks. The External Handover Improvement Group has been established consider the elements of the Welsh Health Circular.			
3. Mitigating Avoidable Harm Actions	5. Actions were developed in direct response to persisting and escalating system pressures. The avoidable harm paper outlines a strategic framework to reduce patient risk with key measures including the clinical safety plan, Immediate release protocol and governance via the Serious Clinical Incident Forum (SCIF). Outcomes are monitored through risk scores, DATIX reporting, clinical audits and patient harm indicators. Actions were developed in direct response to persisting and escalating system pressures.			
MITIGATE - Internal <b>How do we know the controls are effective. How will these impact the target risk score?</b>		Internal <b>over the three lines of assurance. How do we know the assurances are effective</b> <b>Provide assurance on managing controls to ensure the Trust is doing everything in its capacity to reduce the impact of the risk</b>		
<b>Control 1 – Policies/SOPs</b> Regional Escalation Protocol, Immediate Release Protocol v.1.3 (Released August 2024), Resource Escalation Action Plan (REAP – v5.1 released January 2025), Clinical Safety Plan (CSP – released December 2024).	<b>First Line of Assurance</b> Daily conference calls (National Huddle) to agree RE levels in conjunction with health boards, weekly Performance, Demand and Capacity meetings to review REAP levels.	<b>Second Line of Assurance</b> ODU dashboards, Performance Demand and Capacity performance metrics data and DATIX and compliance reporting to the COO's.	<b>Third Line of Assurance</b> Ministerial Advisory Group and Audit Wales investigation of Urgent and Emergency Care System Audit received June 25, actions being worked through.	

<b>Risk ID</b> 223	<b>The Trust's inability to reach patients in the community causing patient harm and death</b>	<b>Date of Review:</b>	01/10/2025	<b>TREND</b>	<b>OVERALL</b> 25 (5x5)
		<b>Date of Next Review:</b>	01/11/2025	➔	

<b>Control 2 – Performance/Tactics</b> ETA Scripting, CCC Emergency Rule, Red call performance, Transfer of Care, ARA (Swansea and YGC), EMS Demand and Capacity Review.	<b>First Line of Assurance</b> Daily conference calls (National Huddle) to agree RE levels in conjunction with health boards, weekly Performance, Demand and Capacity meetings to review REAP levels. Local Business Meetings performance discussions.	<b>Second Line of Assurance</b> ETA dashboard, UHP reporting in local and business meetings. ODU dashboards, Performance Demand and Capacity performance metrics data, MIQPR (Monthly Integrated Quality and Performance Report). Patient Harm Mitigations Report (Bi-Monthly).	<b>Third Line of Assurance</b> Ministerial Advisory Group, Audit Wales investigation of Urgent and Emergency Care System Audit received June 25, actions being worked through.
<b>Control 3 – Operational Activities</b> National Risk Huddles, Performance, Demand and Capacity meetings, WAST Serious Clinical Incident Forum (SCIF), Operational Handover Group	<b>First Line of Assurance</b> Daily Risk Huddles, Weekly Performance Demand and Capacity Meetings, Local business meetings.	<b>Second Line of Assurance</b> Patient safety highlight reports. ODU Dashboards, Performance, Demand and Capacity performance metrics, MIQPR (Monthly Integrated Quality and Performance Report). Patient Harm Mitigations Report (Bi-Monthly).	<b>Third Line of Assurance</b> Ministerial Advisory Group, NHS Exec Handover Group, Audit Wales investigation of Urgent and Emergency Care System. Audit received June 25, actions being worked through.
<b>Control 4 – Resources</b> 24/7 Operational Delivery Unit, Strategic, Tactical and Operational 24/7 system to manage escalation plans, APP (Advanced Paramedic Practitioner) deployment model, APP Navigation, CFR recruitment and deployment and CHARU implementation.	<b>First Line of Assurance</b> CSP review and escalation, On Call team start and end of shift, Performance, Demand and Capacity Meetings, Senior Leadership Team meetings.	<b>Second Line of Assurance</b> Shift reports, CSP review, On Call rota review, APP Dashboard, Volunteer performance highlight reporting.	<b>Third Line of Assurance</b> Ministerial Advisory Group, Audit Wales investigation of Urgent and Emergency Care System. Audit received June 25, actions being worked through.
<b>Control 5 – Clinical Model Transformation (CMT)</b> Consult and Close (including Mental Health Practitioners), Clinical review of code sets, Remote Clinical Support, Rapid Clinical Screening, expansion of See and Treat resources.	<b>First Line of Assurance</b> CPAS, DCR and CQGG Meetings, Clinical Model Transformation Project Board. Senior Leadership Team Meetings. Performance, Demand and Capacity Meetings.	<b>Second Line of Assurance</b> Performance, Demand and Capacity metric reporting, CPAS/DCR reporting, Volunteer highlight reporting, clinical model transformation highlight report.	<b>Third Line of Assurance</b> Audit Wales investigation of Urgent and Emergency Care System. Audit received June 25, actions being worked through.

<b>GAPS IN CONTROLS</b>	<b>GAPS IN ASSURANCE</b>
External	External
1. Inconsistent compliance with 15-minute handover standard by Health Boards which is inconsistent with the National standard set out by the Welsh Health Circular. Although national guidance exists, adherence is variable across sites and Health Boards, limiting WAST's ability to fully mitigate risk independently. These gaps are aligned and consistent with the gaps in Risk 224 of the Board Assurance Framework.	1. While Health Boards have developed handover improvement plans, there is currently no routine, structured mechanism for independent review or validation of their implementation, progress, or effectiveness. External Scrutiny is primarily limited to periodic updates through forums such as IQPD or JCC which may not provide consistent assurance of impact. These gaps are aligned and consistent with the gaps in Risk 224 of the Board Assurance Framework. <b>The W45 initiative, once embedded across all Health Boards, will help support to address this gap.</b>
2. Operational pressures within Emergency Departments and inpatient areas continue to affect the ability of Health Boards to consistently adhere to the 15-minute handover expectation, despite the presence of national guidance. These gaps are aligned and consistent with the gaps in Risk 224 of the Board Assurance Framework.	2. There is limited independent scrutiny or assurance regarding how capacity pressures within Emergency Departments and inpatient settings are being addressed by Health Boards. These constraints directly affect handover performance but fall outside of WASTs operational control or influence. Limiting the Trust's ability to mitigate the risk independently. These gaps are aligned and consistent with the gaps in Risk 224 of the Board Assurance Framework.
3. Local Delivery Units limited to 2 Health Board Areas (Hywel Dda and BCU)	3. Inconsistency with the Local Delivery Units being implemented in only two Health Boards however recognising that the LDUs within Hywel Dda and BCU are in their infancy with potential rollout Pan Wales dependant on the success of the measurable outcomes.
5. Inconsistent pathways across Health Boards	5.
4. Local Delivery Units – Hywell Dda and BCU	6. A model to replicate oversight and scrutiny across Health Boards, like the Trust's Operational Delivery Unit (ODU). Activity will be based on the System Escalation Framework actions complemented by Local Action Plans – Date of implementation of LDUs to be confirmed. Moved from Control to Gap in control - SLT will be content to move to control upon completion of implementation of LDUs.

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	01/10/2025	TREND	OVERALL 25 (5x5)
		Date of Next Review:	01/11/2025	➔	
5. Ministerial Advisory Group (MAG)		7. Providing independent oversight of NHS Wales performance and recommending standardise clinical pathways to reduce delays and improve outcomes. MAG promotes better use of data to monitor patient safety, while its recommendations are embedded into national risk frameworks and Board Assurance processes to ensure system-wide impact. Moved to Gap currently - only 1 meeting has taken place so far. SLT content to move to control once meetings are fully established			
Internal		Internal			
1. Clinical Model Transformation (CMT) not fully implemented		1. Due to the implementation not being fully established there may be gaps in assurance meaning limited evidence currently or certainty that the controls are working as intended, however, as the model progresses the measurable outcomes will be reviewed and any concerns/issues addressed and monitored through actions. Current methods of monitoring the CMT includes CMT Project Board and an approved governance, reporting structure through T&F Groups.			
Actions to reduce risk score or address gaps in controls and assurances	Action Owner (Internal only)	Completion / Milestone date	Progress Update		
1. 6 weeks test of change Morriston	Sonia Thompson, Assistant Director of Operations		<p><b>OCT25 – Test of change now moved to BAU, discussions will be started within Swansea Bay to explore W45 options similar to Cardiff and Vale.</b></p> <p>July25 - Majority of test of change has remained, still seeing improvements in handover. Work ongoing with the Health Board looking at increase in front door attendance.</p> <p>Jun 25 – Currently in week 6 with average handovers remaining under 50 minutes. WAST qualitative and quantitative data has been shared with Health Boards to continue the trial.</p>		
2. Royal Glamorgan working to 45 minute handover	Sonia Thompson, Assistant Director of Operations		<p><b>OCT25 – No progressional update however the 2 CTM sites are still performing well in relation to Notification to Handover Performance.</b></p> <p>July25 - Ongoing progressing well, monitored locally, new measures put in place are being effective. Taking more of a risk at the front door and implemented a helicopter nurse</p> <p>Jun 25 – Handovers with average of 30 mins. Current ongoing discussion to rollout trial in other areas.</p>		
3. Clinical Model transformation (CMT) - 12 month pilot programme conducted to understand the full implications of the changes, identify issues and provide valuable insights into the effectiveness of the Clinical service model.	Pete Brown, Assistant Director of Operations, Integrated Care		<p><b>OCT25 - The Clinical Model Transformation (CMT) Programme is advancing care delivery with new 999 call categories launching in December to prioritise responses based on clinical needs, supported by new screening codes. The NHS111.Wales Virtual Assistant, Albot, has answered over 7,000 queries, with planned enhancements like multilingual capabilities. Community care is being strengthened through initiatives like a dedicated Falls Desk, Advanced Paramedic Practitioner scheduling, and an extended Mental Health Response Vehicle pilot. Digital health services are improving accessibility, and tools like the CMT Manager's Information Pack and Patient Personas are being developed to enhance understanding and keep patient experience central.</b></p> <p>July 25 - The Clinical Model Transformation Programme has made strong progress, including the launch of the Access to Transport for Planned Care initiative, improved emergency call handling with new categories and CAD updates, and the soft launch of the 111.Wales Virtual Assistant. Video consultations are now available for Integrated Care clinicians, and urgent care delivery is being enhanced through new scheduling models, improved Falls Services, and the evaluation of the Mental Health Response Vehicle trial—all contributing to a more responsive, patient-centred system.</p>		
4. Cross reference the IMTP 2025-27 plan/deliverables with Corporate Risk 223	Judith Bryce, Assistant Director of Operations, National Ops and Support	COMPLETE	<p><b>July25</b> – Cross checking complete, CMT holds more focussed approach to mitigating handover</p> <p>Jun 25 – this is planned for the IMTP assurance meeting on 14<sup>th</sup> July.</p>		
5. Audit Wales investigation of Urgent and Emergency Care System: Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time?	Chief Executive Officer	COMPLETE	<p><b>July25</b> – Audit received and actions being worked through. Audit Wales are supportive of the actions taken by WAST and there is positivity received on what WAST are doing.</p> <p>Jun 25 – Awaiting report from Audit Wales</p> <p>May 25 – Awaiting report from Audit Wales which will come through Audit Committee.</p>		

<b>Risk ID</b> 224	<b>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 &amp; Effective Service for Patients</b>	<b>Date of Review:</b>	03/10/2025	<b>TREND</b>	<b>OVERALL</b> 25 (5x5)			
		<b>Date of Next Review:</b>	03/10/2025	➔				
<b>IF</b> patients continue to be significantly delayed in ambulances outside Accident and Emergency Departments	<b>THEN</b> there is a continued risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised	<b>RESULTING IN</b> patients coming to significant harm and a poor patient experience	<b>External (LxC)</b>		<b>Internal (LxC)</b>			
			<b>Inherent</b>					
			<b>Current</b>					
			<b>Target</b>					

**Strategic objective 1: Providing the right care or advice, in the right place, every time**

Work has continued to contribute to the design and development of a different approach to the Trust's highest scoring risks in a way that describes the internal and external controls, assurances and gaps which have been separated into those that the Trust manages and those that it monitors.

The next steps will include testing separate risk scores for internal and external mitigations, to support the demonstration of the impact of actions taken. This will not affect the overall score of 25 (5x5) which reflects the severity of patient harm and death.

Each of the assurances against the controls have been described over three lines of assurance. A future piece of work will be undertaken to score the effectiveness of these controls and assurances.

The way the data is being presented in themes and categories supports the identification of any gaps and escalations required. A more detailed action plan that supports these risks will be held at an operational level. This working draft is for discussion purposes and to highlight the direction of travel. There is still work to be done on this document.

**DRAFT Risk Appetite Level – Open**

We are open to taking risks regarding changes to processes impacting the right care or advice. We understand that innovation and improvement may involve some risk, and we are prepared to embrace these opportunities to enhance our service delivery.

<b>EXECUTIVE OWNER</b>	Executive Director of Quality and Nursing	<b>ASSURANCE COMMITTEE</b>	Quality, Patient Experience and Safety Committee
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This risk remains at the highest possible level, reflecting the enduring impact of significant ambulance handover delays at Emergency Departments on timely access to definitive care. The strategic implications for the Trust are considerable, with patient harm, deterioration, and poor experience continuing to generate regulatory scrutiny, including through Prevention of Future Deaths reports.

The Trust has implemented a mature and embedded internal control environment, underpinned by real-time clinical and operational oversight through the Operational Delivery Unit (ODU), the Clinical Safety Plan (CSP), and system-level escalation mechanisms such as REAP and national risk huddles. These controls are further supported by structured assurance mechanisms including internal and external incident reporting, compliance monitoring, and governance review processes.

Phase one of the Trust's Clinical Transformation Model - specifically the introduction of Code Changes for response - has now gone live, representing a key milestone in the delivery of an enhanced clinical model aligned to patient acuity, workforce capability, and risk reduction. In parallel, early adoption of the *Wait 45* handover standard by some Health Boards represents a positive step toward reducing avoidable patient harm by supporting more timely transfers of care and improving the overall experience for patients awaiting treatment.

While the Trust continues to demonstrate high levels of internal assurance, recent national focus on care standards and system performance provides a welcome opportunity to strengthen consistency and improve the effectiveness of wider system responses. Historic variation in adherence to national handover standards and the delivery of improvement plans has limited the extent to which the Trust can mitigate this risk through internal controls alone. However, increasing national scrutiny, greater transparency, and a shift toward more integrated, system-based accountability present a clear opportunity to improve consistency and collective impact across organisational boundaries.

Strategic mitigation therefore remains focused on both internal transformation and system-wide influence. The Trust continues to engage proactively with national and regional programmes - including the Six Goals for Urgent and Emergency Care - to support shared learning, alignment of expectations, and strengthened collective ownership of outcomes.

The Audit Wales report into the effectiveness of unscheduled care arrangements across NHS Wales will provide a critical external perspective on whole-system performance and may identify further levers to drive national consistency and accountability. Achieving the target risk score will ultimately rely on sustained partnership working, improved operational alignment across organisations, and the embedding of nationally

<b>Risk ID</b> 224	<b>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 &amp; Effective Service for Patients</b>	<b>Date of Review:</b>	03/10/2025	<b>TREND</b>	<b>OVERALL</b> 25 (5x5)
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agreed standards into routine delivery at every level of the system. The persistence of long handover delays also has a secondary impact on staff wellbeing, contributing to moral injury, stress and frustration at being unable to provide timely care. This interlinks with Risk 558 (staff wellbeing), underlining the wider organisational and cultural impact of this risk.

<b>CONTROLS</b>		<b>ASSURANCES</b>		
MONITOR - External		External <b>Monitor outcomes and provide regular reports to stakeholders. This ensures while external factors may impact the risk it is monitored and managed effectively.</b>		
1. <b>Welsh Health Circular WHC/2024/041: NHS Wales Hospital Handover Guidance (15-minute standard)</b> National directive setting out compliance expectations for handover of care within 15 minutes. WAST operates in alignment with this standard, however the operational responsibility for implementation and compliance lies primarily with Health Boards. As such, this constitutes an external control which influences WAST risk exposure but sits outside the Trust's direct control.		1. Real-time ODU oversight and Clinical Safety Plan escalation where patients are delayed beyond 15 minutes, with clinical risk managed via NEWS triggers and local management actions. Handover performance reported via IQPR and discussed through SLT and Quality Governance forums. Trends, outliers, and sustained delays are highlighted and tracked over time.  Oversight by Welsh Government through the Six Goals Programme and Joint Commissioning Committee. Handover compliance is also subject to scrutiny through national audit programmes (e.g. Audit Wales), and regulatory inspections (e.g. HIW).		
2. <b>Six Goals for Urgent and Emergency Care Programme</b> Goal 4 <i>Rapid response in physical or mental health crisis</i> . The quality statement for this goal includes: Those arriving by ambulance at a hospital facility should be transferred safely from ambulance clinicians to the care of hospital clinicians in order of clinical priority and always in a timely manner (an hour at most).		2. Organisational performance is monitored externally through Six Goals Programme Board, Quality and Delivery Board, Integrated Quality, Planning & Delivery (IQPD) meetings, Joint Executive Team (JET) meetings, NHS Performance Board and managed within the NHS Wales Oversight and Escalation Framework.		
3. <b>NHS Wales Performance Framework 2024-25</b> Measures 52 and 53 provide the expected performance targets in respect of ambulance handover timescales: 52. Number of ambulance patient handovers over one hour 53. Percentage of ambulance patient handovers within 15 minutes		3. Organisational performance is monitored externally through Quality and Delivery Board, Integrated Quality, Planning & Delivery (IQPD) meetings, Joint Executive Team (JET) meetings, NHS Performance Board and managed within the NHS Wales Oversight and Escalation Framework.		
4. <b>NHS Wales Quality and Safety Framework and Duties of Quality and Candour</b> The National Quality Management System (NQMS) brings together data from a number of sources, including patient safety incidents, for triangulation and to inform a range of activities in relation to learning and quality and governance assurance. The duty of quality in the Health and Social Care (Quality and Engagement) (Wales) Act 2020 ("the 2020 Act") has two aims - to improve the quality of services, and to improve outcomes for people in Wales. Together, the domains of quality and quality enablers create the health and care quality standards 2023.		4. Organisations provide statutory reporting against the Duties of Quality and Candour. National ED survey on Civica People Experience platform, results are monitored on a national Quality and Safety dashboard (Beacon)		
5. <b>Nationally led operational escalation responses</b> Risk Huddles, hospital escalation levels and daily national operational call				
<b>MITIGATE - Internal</b> <i>How do we know the controls are effective. How will these impact the target risk score?</i>		<b>Internal</b> <i>over the three lines of defence. How do we know the assurances are effective</i> <b>Provide assurance on managing controls to ensure the Trust is doing everything in its capacity to reduce the impact of the risk</b>		
<b>Control 1: Policies/SOPs/Resources</b> Regional Escalation Protocol, Immediate Release Protocol v.1.3 (Released August 2024), Resource Escalation Action Plan (REAP – v5.1 released January 2025), Clinical Safety Plan (CSP – released December 2024).		<b>First Line of Assurance (Operational)</b> ODU shift reports, CSP real-time updates, REAP actions logged and enacted in real time; daily huddle	<b>Second Line of Assurance (Internal Monitoring)</b> Senior Leadership Team (SLT) weekly review of Resource Escalation Action Plan (REAP),	<b>Third Line of Assurance</b> JCC and IQPD reporting.

Risk ID 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	Date of Review:	03/10/2025	TREND	OVERALL 25 (5x5)
		Date of Next Review:	03/10/2025		
<p>The CSP provides a structured, tiered framework for managing operational and clinical safety risks, including delayed handovers. It is supported by the 24/7 ODU, which ensures real-time oversight, escalation, and action planning. Together, they act as core controls to dynamically mitigate risk, coordinate escalation across the system, and support staff in delivering safe care under pressure. These are real-time, operational risk management controls that actively shape outcomes, especially in the face of delayed care environments.</p> <p>REAP outlines predefined escalation actions aligned to risk levels and is reviewed weekly by the SLT. National and local risk huddles enable shared situational awareness, trigger cross-system escalation, and ensure timely mitigation actions are documented and followed up.</p>	<p>notes and agreed actions monitored by Operational Delivery Unit</p>	<p>Integrated Quality and Performance Report (IQPR)</p>	<p>Ministerial Advisory Group and Audit Wales investigation of Urgent and Emergency Care System (report from Audit Wales received and actions being worked through)</p>		
<p><b>Control 2: Clinical Guidance for staff</b></p> <p>A Clinical Guidance document for WAST clinicians delayed outside the Emergency Department provides direction to WAST clinicians when asked to support care of a patient awaiting their care to be handed over to the hospital. The guidance ensures safe and appropriate clinical management within appropriate scopes of clinical practice.</p> <p>The Clinical Notice 07/2021 <i>Escalating a clinical concern with a deteriorating patient outside the Emergency Department</i> instructs staff to raise concerns with the Nurse in Charge of the Emergency Department and provides information on the internal escalation process through the DOM via EMSC, and then for senior clinical support via the on-call system. Clinical risk-triggered escalation using NEWS <math>\geq 5</math> for patients is reinforced via national clinical notices.</p>	<p><b>First Line of Assurance (Operational)</b></p> <p>Datix incident reporting of any cases where clinical concerns are escalated. Incident management processes are followed in accordance with the Trust's Adverse Incident Policy.</p> <p>Compliance with mandatory training and competency standards</p>	<p><b>Second Line of Assurance (Internal Monitoring)</b></p> <p>Oversight of incident management and learning through Ambulance Practice Steering Group (APSG), Clinical Quality Governance Group and QuEST.</p>	<p><b>Third Line of Assurance</b></p> <p>National reporting of high severity incidents.</p> <p>Ministerial Advisory Group and Audit Wales investigation of Urgent and Emergency Care System (report from Audit Wales received and actions being worked through)</p>		
<p><b>Control 3: Clinical Governance mechanisms</b></p> <p>Prompt and responsive learning from concerns (complaints and incidents) or from mortality reviews related to patient harm during delayed handover of their care should inform continuous system improvements.</p> <p>Incidents, complaints or medical examiner scrutiny referrals resulting in serious harm to a patient are reviewed at the Trust's Serious Case Incident Forum. Where harm may be attributed to delays in being able to handover their care at the Emergency department, cases are shared with the respective Health Board of patient residence to review the measures undertaken at the time of the delay to minimise risk and to identify opportunities to reduce harm in future. This is in line with <i>Section 4 Joint investigation process of the National Policy on Patient Safety Incident Reporting (May 2023)</i>.</p> <p>Learning from these incidents should be shared with the Trust once the Health Board has completed their investigation.</p>	<p><b>First Line of Assurance (Operational)</b></p> <p>Incident reports (Datix); regular meetings to capture learning medical examiner referrals; SCIF meeting records; immediate actions taken and documented in safety briefings.</p> <p>The Clinical Advisory Group (CAG) reviews complex or high-risk cases related to delayed handovers, provides peer clinical scrutiny, triangulates themes from Datix, SCIF, complaints and medical examiner referrals, and advises on pathway changes. It also acts as the key clinical forum to escalate patient safety concerns, ensuring that frontline clinical voice is embedded into decision-making and that assurance is provided to CQGG on learning effectiveness</p>	<p><b>Second Line of Assurance (Internal Monitoring)</b></p> <p>Reporting to Clinical Quality Governance Group (CQGG); assurance papers to QuEST and other Board Committees</p> <p><b>Reporting to Clinical Quality Governance Group (CQGG), with CAG acting as a feeder forum to provide clinical triangulation and assurance.</b></p> <p><b>Assurance papers to QuEST and other Board Committees.</b></p>	<p><b>Third Line of Assurance</b></p> <p>NHS Wales Internal Audit, external reporting of severe harm incidents (Nationally Reportable Incidents).</p> <p>Ministerial Advisory Group and Audit Wales investigation of Urgent and Emergency Care System (report from Audit Wales received and actions being worked through)</p>		

<b>Risk ID</b> 224	<b>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 &amp; Effective Service for Patients</b>	<b>Date of Review:</b>	03/10/2025	<b>TREND</b>	<b>OVERALL</b> 25 (5x5)
		<b>Date of Next Review:</b>	03/10/2025		

**Frequent responsive learning from concerns (complaints and incidents), mortality reviews, and medical examiner scrutiny is essential to driving continuous system improvements in relation to patient harm during delayed handovers of care. The Clinical Advisory Group (CAG) provides a critical forum for clinicians to review a selection of these cases, test learning against national clinical standards, and ensure professional oversight of system risks and mitigations before they are escalated to governance committees.**

<p><b>Control 4: Implementation of Duty of Quality, Candour &amp; Quality Standards</b> Internal governance structures, led by the Clinical Quality Governance Group and operationalised through the Quality Management Group (QMG), provide a structured approach to embedding statutory duties. These frameworks act as corporate controls to ensure care quality, transparency, and continuous improvement, particularly during periods of operational pressure such as delayed handovers.</p> <p>Where patient harm is identified during delayed handovers, Duty of Candour requirements are triggered. These are reported both internally via CQGG and externally through statutory annual reporting to Welsh Government. This ensures that harm events linked to delayed handovers are subject to openness, patient/family communication, and system-wide accountability.</p> <p>The Patient Harm Mitigation Report (bi-monthly) provides a standing review of handover-related harm cases, trends in medical examiner referrals, and the outcomes of SCIF reviews. This forms part of the evidence base considered by CQGG and QuEST in providing internal assurance.</p>	<p><b>First Line of Assurance (Operational)</b> Compliance with statutory reporting duties – training and awareness uptake</p>	<p><b>Second Line of Assurance (Internal Monitoring)</b> Monthly updates through Quality Management Group (QMG)? Monitoring via CQGG Quality dashboard under development</p>	<p><b>Third Line of Assurance</b> Welsh Government assurance through Duty of Candour/Duty of Quality annual reporting.  Ministerial Advisory Group and Audit Wales investigation of Urgent and Emergency Care System (report from Audit Wales received and actions being worked through)</p>
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<p><b>Control 5: Clinical Model Transformation (CMT)</b> Consult and Close (including Mental Health Practitioners), Clinical review of code sets, Remote Clinical Support, Rapid Clinical Screening, expansion of See and Treat resources.</p>	<p><b>First Line of Assurance (Operational)</b> CPAS, DCR and CQGG Meetings, Clinical Model Transformation Project Board. Senior Leadership Team Meetings. Performance, Demand and Capacity Meetings.</p>	<p><b>Second Line of Assurance (Internal Monitoring)</b> Performance, Demand and Capacity metric reporting, CPAS/DCR reporting, Volunteer highlight reporting, clinical model transformation highlight report.</p>	<p><b>Third Line of Assurance</b> Ministerial Advisory Group and Audit Wales investigation of Urgent and Emergency Care System (report from Audit Wales received and actions being worked through)</p>
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<b>GAPS IN CONTROLS</b>	<b>GAPS IN ASSURANCE</b>
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External	External
<p>1. Inconsistent compliance with 15-minute handover standard by Health Boards Although national guidance exists, adherence is variable across sites and Health Boards, limiting WAST's ability to fully mitigate risk independently.</p> <p>2. Operational pressures within Emergency Departments and inpatient areas continue to affect the ability of Health Boards to consistently adhere to the 15-minute handover expectation, despite the presence of national guidance.</p>	<p>1. While <b>Health Boards have developed handover improvement plans, there is currently no routine, structured mechanism for independent review</b> or validation of their implementation, progress, or effectiveness. External scrutiny is primarily limited to periodic updates through forums such as IQPD or JCC, which may not provide consistent assurance of impact.</p> <p>2. There is limited independent scrutiny or assurance regarding how capacity pressures within Emergency Departments and inpatient settings are being addressed by Health Boards. These constraints directly affect handover performance but fall outside of WAST's operational control or influence, limiting the Trust's ability to mitigate the risk independently.</p>

<b>Risk ID</b> <b>224</b>	<b>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 &amp; Effective Service for Patients</b>	<b>Date of Review:</b>	<b>03/10/2025</b>	<b>TREND</b>	<b>OVERALL</b> <b>25 (5x5)</b>
		<b>Date of Next Review:</b>	<b>03/10/2025</b>		

Internal	Internal
1. There is no structured or independent mechanism to validate the effectiveness of Health Board actions in response to delayed handover harm cases shared by WAST. Assurance remains dependent on Health Board feedback and periodic forums (e.g., IQPD/JCC), which do not consistently evidence impact	1. Routine audit of patient deterioration and management during delayed handovers is not yet embedded across all sites, limiting the ability to quantify the full scale of harm and test the effectiveness of mitigation
2.	2. Improved reporting on outcomes of joint investigations - there is no structured or independent mechanism to validate the effectiveness of Health Board actions in response to delayed handover harm cases shared by WAST. Assurance remains dependent on Health Board feedback and periodic forums (e.g., IQPD/JCC), which do not consistently evidence impact. This is an assurance gap that Audit Wales and Ministerial Advisory Group may help close

<b>Actions to reduce risk score or address gaps in controls and assurances</b>	<b>Action Owner (Internal only)</b>	<b>Completion / Milestone date</b>	<b>Progress Update</b>
1. Contribution to the development of a national joint investigation learning repository	Assistant Director of PTR	Q1 2026	Pilot of the new module being undertaken with WAST and Cardiff and Vale UHB <b>14.8.25: Pilot completed with Cardiff and Vale. Evaluation Meeting to take place in September 2025</b>
2. Clinical Model transformation (CMT) - 12-month pilot programme conducted to understand the full implications of the changes, identify issues and provide valuable insights into the effectiveness of the Clinical service model.	Assistant Director of Operations, Integrated Care	Q2 2026	01.07.2025 - Go Live implementation commenced 1 <sup>st</sup> July - phase one, code changes <b>July 25 Update: Strong progress continues across the Clinical Model Transformation Programme, with key milestones including improved 999 call categorisation, launch of the 111 Virtual Assistant, video consultations in Integrated Care, and enhanced urgent care through new scheduling, Falls Services, and the Mental Health Response Vehicle trial</b>
3. Cross reference the IMTP 2025-27 plan/deliverables with Corporate Risk 224	Deputy Director of Nursing, QSPE	COMPLETE	14.8.25: Cross reference action complete
4. Audit Wales investigation of Urgent and Emergency Care System: Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time?	Chief Executive Officer		May 25 – Awaiting report from Audit Wales which will come through Audit Committee. <b>14.8.25: Report received and identified recommendations to be completed</b>



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Agenda Item No.

16

## REPORT TITLE

2025/26 Quality Governance Reviews

## MEETING

Name of meeting	QUEST
Date of meeting	4 November 2025
Public or Private	Public
If private - <a href="#">rationale</a>	n/a

## REPORT SPONSOR

Executive sponsor	Trish Mills, Director of Corporate Governance/Board Secretary
Author(s) of report	Trish Mills, Director of Corporate Governance/Board Secretary

## PURPOSE OF REPORT

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

## REPORT SUMMARY:

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

1. The approach to the 2025 quality and governance reviews, previously referred to as effectiveness reviews, has been revised. The Audit, Risk and Assurance Committee (ARAC) has initiated a programme of work to explore opportunities for further efficiencies within the Board's governance framework. To support this, a sub-group of ARAC has been established to



oversee the review. The focus of the review is on reassessing the distribution of delegated responsibilities across the Board's committees, with the aim of improving efficiency and effectiveness. This work responds directly to findings from the 2024/25 reviews, particularly those relating to Non-Executive Director (NED) availability, quorum challenges, the volume of meetings, and the transitional status of the Academic Partnerships Committee (APC).

2. The review is driven by key project objectives:

- Aligning committee remits more closely to the six strategic objectives
- Improving efficiency and effectiveness in governance
- Reducing meeting frequency and alleviating quorum/NED availability pressures
- Ensuring strong scrutiny, challenge, and support through increased NED attendance on key committees
- Balancing workloads and minimising disruption during a period of executive transition

3. A number of options were considered, with the preferred option to be further considered by the full ARAC at their meeting on 2 December. This option reduces the number of committees from seven to six, with each committee having four NEDs and a quorum of three. It recommends that the Academic Partnership Committee (APC) is disbanded, redistributing its functions (research, innovation, partnerships) to the Finance and Performance Committee (FPC) and the People and Culture Committee (PCC). Remit adjustments will be made to ARAC (resilience, cyber, information governance). This option meets the project's objectives, including improved NED attendance, reduced meeting frequency, and better alignment to strategic objectives.

4. However, it is proposed that full implementation of Option 1 – particularly the major changes affecting FPC and ARAC – is deferred. The Board will be starting a development and effectiveness programme with an external provider in Q4, running into Q1 2026/27 and part of their scope will be a review of committee responsibilities and structures, therefore making major changes before that work is completed would be premature.

5. Notwithstanding the broader work on committee structures, this committee is required to undertake a review of its effectiveness annually. Members will recall that the 2024/25 review was extensive therefore this year ARAC has agreed a light-touch review consisting of a qualitative survey seeking views on the terms of reference, membership and any changes to operating arrangements.

6. The survey results are included in this report, and draft changes have been made to the terms of reference in line with these results and the broader work undertaken by the ARAC sub-group. There was broad agreement that the committee's membership is appropriate and diverse, but concerns exist about the number of attendees, with some questioning the value added by non-contributing participants. The committee is seen as effective, with high engagement, robust agendas, and strong scrutiny. However, there is a desire for more focus on the effectiveness of



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the Quality Management System (QMS) as a whole, including quality planning, control, and improvement, not just assurance. The terms of reference are generally viewed as suitable, though some respondents suggest opportunities to further strengthen references to the QMS, to introduce value based healthcare, and ensure ongoing alignment with committee priorities.

## RECOMMENDATION(S)

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

The Committee is requested to:

- (a) Note the wider board committee framework changes proposed and provide feedback on the recommendations.
- (b) Note the responses to the survey and proposed actions, inviting members who did not have an opportunity to complete the survey to provide further feedback.
- (c) Approve changes to the terms of reference.

## ADDITIONAL PAPER(S)

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

Annex 1 – Marked up changes to the committee’s terms of reference

Annex 2 – Progress on changes agreed to operating arrangements following the 2024/25 reviews

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

As noted in the SBARN



## HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

## WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [ <a href="#">link to goals</a> ]		
<input type="checkbox"/> A socially responsible and inclusive employer	<input checked="" type="checkbox"/> An innovative and sustainable organisation	<input 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 checked="" type="checkbox"/> No <input type="checkbox"/> Yes
If yes, what impact assessment is attached	

## APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
16 July and 24 September	ELT discussions on 2025-26 reviews
25 July and 30 September	ARAC Sub-Group discussions on 2025-26 reviews
2 September 2025	ARAC update on quality and governance review
7 October 2025	APC meeting re quality and governance review
30 October 2025	NED discussion on quality and governance review
4 November 2025	Approve changes to the terms of reference



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## SITUATION

2. This paper seeks the committee's endorsement for changes to its terms of reference for 2026/27, effective from 1 April 2026 as part of the annual round of quality and governance reviews (formerly known as effectiveness reviews). It also brings members up to date with wider changes proposed for the board's committee framework.

## BACKGROUND

3. Following the 2024/25 committee quality and governance reviews, the Audit, Risk and Assurance Committee (ARAC) identified opportunities to further streamline the Trust's governance structure. A project plan was initiated with the aim of ascertaining if the endorsed spread of board responsibilities could be redistributed in a way that is more efficient and effective. A sub-group of ARAC was formed to support this work.
4. The project takes account of the key concerns raised during the 2024/25 reviews which included Non-Executive Director (NED) availability and consequent quorum pressures, the transitional status of the Academic Partnerships Committee (APC) post-university Trust status, and the high volume of meetings (52 ordinary meetings a year).
5. The review aimed to align committees wherever possible to our six strategic objectives, so they are best placed to drive progress, monitor outcomes and performance, and to respond to emerging priorities.
6. ARAC will formally consider the outputs of the sub-group at its meeting on 2 December and the effect on the board's committee structure, along with the views of this committee on the proposed changes. They will also be asked to endorse the changes to this committee's terms of reference at that meeting. The board will then be asked to endorse the recommendations of ARAC and approve the terms of reference at their January 2026 meeting.

## ASSESSMENT

### The Board's Committee Framework

7. From July to September the Executive Leadership Team (ELT) and the ARAC sub-group considered a number of issues and options, some of which fully met the objectives of the project and others that only partially met the scope. Those included:



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- Option 1 reduces the number of committees from seven to six. Each committee would have four NEDs and a quorum of three. The Academic Partnership Committee (APC) would be disbanded. Its functions relating to research, innovation, and commercial partnerships would move to the Finance and Performance Committee (FPC), while its responsibilities for education partnerships and collaboration would move to the People and Culture Committee (PCC). To balance the extra responsibilities transferred to FPC, the areas of resilience, cyber security, and information governance (mainly internal controls) would transfer from FPC to ARAC.
  - Options 2-4 included variations on committee frequency, further remit reallocation, and consideration of a new research/innovation committee. Each has specific advantages or drawbacks, with some not fully aligning with all project objectives or raising particular concerns.
8. Option 1 was favoured by the ELT and the ARAC sub-group as it meets the project's objectives, including increased NED attendance, reduced meeting frequency, and better alignment to strategic objectives.
  9. However, it is proposed that full implementation of Option 1 – particularly the major changes affecting FPC and ARAC – is deferred. The Board will be starting a development and effectiveness programme with an external provider in Q4, running into Q1 2026/27. The programme will review whether the current number and scope of committees are right for an organisation of WAST's size and complexity. It will also look at whether the Board's focus, timing, and balance between strategy, performance, risk management, and culture are appropriate. The findings from this review (expected in Q1) are likely to influence both the remit and meeting frequency of some committees, especially FPC, where there is currently significant overlap with work going to the Board. This may lead to further changes to terms of reference mid-year.
  10. In light of this, it will be recommended to ARAC that the following changes to the Board's committee framework take effect from 1 April 2026, with any material changes deferred until the external provider has reported back to the Board on committee structures:
    - APC will continue to meet twice annually in 2026/27, with a focus on the research and development portfolio. This was agreed at the APC meeting on 7 October.



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- APC delegated responsibilities relating to education partnerships and collaboration will transfer to PCC and those related to commercialisation will transfer to FPC.
- Four NEDs will be asked to attend each of the following committees: FPC, QUEST, PCC and ARAC. This will ensure a quorum of three per meeting. The board skills mix has been updated, and the Trust Chair and NEDs will hold discussions in October on their committee commitments.
- Minor changes are proposed for the Quality, Patient Safety and Experience Committee (QUEST) with the transfer of value based healthcare from FPC.
- No changes are proposed for the Charity or Remuneration Committees.

11. Any changes to terms of reference proposed by this committee from today's meeting will also be reflected in updated terms of reference.

12. Committee members are invited to provide any feedback on the above which will be communicated to ARAC.

### **The QUEST Committee**

13. In parallel with the work on the wider committee structures, each committee is required to complete an annual effectiveness review. Members will recall that the 2024/25 quality and governance reviews for this committee were comprehensive, involving a detailed examination of the terms of reference and the assurance reporting arrangements for each delegated responsibility. These reviews led to several changes to the terms of reference.

14. A number of improvements were agreed as a result of the 2024/25 reviews, and they are being monitored by ARAC. The most recent monitoring report on these is at Annex 2.

15. Given the extensive review undertaken in 2024/25, ARAC agreed that this year's approach would be qualitative. A survey of members was carried out to gather feedback on the proposed changes to the terms of reference (including membership) and to identify what is working well and where improvements could be made. Six responses were received as set out below together with replies in red where appropriate:



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Survey Topic	Responses
<p><b>Are there any changes you wish to see to the terms of reference</b></p>	<ul style="list-style-type: none"> <li>At 3.6, there is a reference to the Quality Management System, I wonder if there is opportunity to strengthen this perhaps, as I don't recall seeing much focus on the effectiveness of the totality of the QMS arrangement in WAST. <b>Executive Director of Quality and Nursing may wish to provide more details on the QMS in upcoming meetings.</b></li> <li>No - I feel that the Terms of Reference are appropriate and meet the needs and priorities of the Committee, after their previous review.</li> <li>The transfer over to QUEST of value based healthcare from the Finance and Performance Committee, aligning to the effective H&amp;CQ Standard. <b>Value based healthcare has been included in the draft amendments.</b></li> </ul>
<p><b>Are there any changes you would like to see to the committee's membership</b></p>	<ul style="list-style-type: none"> <li>The membership appears fine however, there often a lot of people in attendance which can be very useful for people to hear and contribute to the discussion and certainly helps with being more transparent, I am interested to also understand if there are any unintended consequences around this, for example on constructive challenge.</li> <li>Too many attendees at this meeting - there are colleagues who attend who do not, or are not required to, contribute. This raises questions about the value of attendance.</li> </ul> <p><b>QUEST meetings are held in public and are therefore open to members of staff and the public to join. Links to join are therefore not vetted or restricted. It is helpful for the Chair to know who will be in the physical or virtual room and all attempts are made to ensure that occurs to enable effective management of the meeting.</b></p> <ul style="list-style-type: none"> <li>I believe that the membership is appropriate - a good mix of relevant skills and background of NEDs, alongside key Officers, who are prescribed attendees.</li> </ul>
<p><b>What works well in this committee</b></p>	<ul style="list-style-type: none"> <li>Level of scrutiny, opportunity to showcase items, good discussions and ability to update attendees on the issues</li> <li>Participants appear to contribute well and present there topics confidently. The Chair is supportive and encouraging to all participants.</li> <li>Confident that the Committee serves its purpose</li> <li>Robust Agendas that focus on relevant priorities.</li> <li>Good quality of Reports - well written and clear.</li> <li>Presentation of agenda items have generally improved over recent months, with presenters confident in the fact that Members have read the papers in advance of the meeting.</li> </ul>



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Survey Topic	Responses
	<ul style="list-style-type: none"> <li>• Good discussion at each meeting - high level of engagement, strong balance between scrutiny and support.</li> <li>• The 'atmosphere' in meetings is positive - high levels of engagement. upbeat, proactive and responsive.</li> <li>• High level of engagement and attendance - with Members having prepared well in advance of the meeting. Strong feedback/assurance to Trust Board.</li> <li>• I believe that this Committee is effective and delivers on its remit.</li> <li>• Chairing, transparency and integrity, patient / lived experience.</li> <li>• The committee is well chaired and well attended. Subject matter experts are given the opportunity to present on their areas of expertise.</li> </ul>
<p><b>What improvements would you recommend</b></p>	<ul style="list-style-type: none"> <li>• Very little. I think Bethan does a great job in keeping us moving whilst allowing for discussions and questioning.</li> <li>• I think it would be good to be able to test and take assurance on the QMS system effectiveness as a whole. I.e. We have a lot on Quality assurance, but less on quality planning arrangements, quality control effectiveness and quality improvement capacity and capability. <b>The Executive Director of Quality and Nursing to take account of comments for future reports.</b></li> <li>• Agenda can sometimes be incredibly heavy loaded. <b>All attempts are made to streamline agendas by adherence to the cycle of business and focused agenda setting meetings with the Chair and relevant Executive Sponsors. Recognising that this is a quarterly meeting we continue to strive for reporting that is succinct, dashboard based where possible, and for presentations to be proportionate.</b></li> <li>• Where plans are signed off by the Committee, it would be good to see some focus on outcomes and achievement of deliverables. <b>Noted and for all committee members to bear in mind in the preparation of plans and oversight and monitoring responsibilities, particularly where reporting may not be providing this level of assurance and triangulation.</b></li> <li>• If presentations are kept to a minimum i.e. a third of the time allocated to the item at most, this will allow time for questions and clarification, support and challenge. Often presentations of papers that will have been read by members takes a long time meaning items run over and agenda items at the end of the meeting feel the need to truncate their presentation or the questioning of their papers. <b>The recent writing and presentation guidance includes the need to do this, and it is reiterated to presenters ahead of meetings.</b></li> </ul>



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Survey Topic	Responses
	<ul style="list-style-type: none"> <li>Some presenters could benefit from only drawing attention to key points within Reports, or setting context - this will then allow more time for constructive dialogue. <b>As above.</b></li> <li>The Committee will benefit from ongoing monitoring and consideration of progress of delivery of the Clinical Transformation Model. <b>The overall CMT programme is monitored via the IMTP by the Finance and Performance Committee, however this committee receives the Quality Impact Assessments and monitors outcomes following implementation via their KPIs and clinical indicators.</b></li> <li>Ensure 3 NEDs for every meeting. <b>Noted – ARAC recommends four NEDs on the committee and three for quorum.</b></li> </ul>

16. Based on the recommendations from the ARAC sub-group, responses to the qualitative survey, and discussions between NEDs and the Trust Chair on membership, a marked up version of the proposed changes to the terms of reference is at Annex 1 for endorsement by the committee.

### RECOMMENDATION

17. The recommendation is as set out in the front cover above.

### NEXT STEPS

18. Submission to ARAC and for onward approval of the board of:

- (a) The preferred option and implementation plan for the broader committee structures along with the views of this committee.
- (b) Changes to terms of reference of this committee including membership changes if any.

19. At the next meeting of this committee the cycle of business will be updated for approval.

20. The annual report of this committee will be presented for endorsement in Q1 of 2026/27 before being presented to ARAC and the board.



## QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE

### TERMS OF REFERENCE AND OPERATING ARRANGEMENTS

**2025/262026-27**

#### 1. INTRODUCTION

- 1.1. The Trust's Standing Orders provide that *"The Board may and, where directed by the Welsh Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees"*.
- 1.2. In line with Standing Orders, the Board shall nominate annually a Committee to be known as the Quality, Patient Experience and Safety Committee. This Committee has a key assurance role on behalf of the Board in relation to the Trust compliance with the Commissioning Core Quality Requirements, the NHS Wales Health & Care Quality Standards 2023 and the Health and Social Care (Quality and Engagement) (Wales) Act 2020. The detailed terms of reference and operating arrangements set by the Board in respect of this Committee are set out below.
- 1.3. The Committee plays an important role in supporting the Board in fulfilling its responsibilities by:
  - providing advice on strategic development and performance within the terms of reference;
  - undertaking scrutiny and gaining assurance on key aspects of organisational performance, and supporting achievement of the Trust's strategic goals;
  - carrying out specific responsibilities on the Board's behalf; and
  - providing a forum where ideas can be explored in greater detail than Board meetings are able to allow, providing time and space to consider issues in greater depth.



Regular and timely reporting and escalations to the Board on the issues within the Committee's remit allow for more focused discussions.

## 2. PURPOSE

- 2.1. The Committee is responsible for scrutinising improvements in outcomes in quality, patient experience, effectiveness, and safety to reduce incidences of avoidable harm.
- 2.2. The Committee will provide oversight of, and seek assurance on, statutory and regulatory compliance on areas within its remit.
- 2.3. The Committee shall, in carrying out its functions and responsibilities, consider how their decisions secure an improvement in the quality of health services (the duty of quality) as outlined in The Health and Social Care (Quality and Engagement) (Wales) Act 2020. This includes but is not limited to ensuring the provision of high-quality, safe, and effective healthcare services that meet the needs of patients, service users, and their families.
- 2.4. The Committee shall demonstrate the duty of quality through its own operating arrangements, ensuring that its processes, procedures, and decision-making mechanisms uphold the highest standards of transparency, accountability, and governance. It shall regularly review and refine its operating procedures to align with best practices and legal requirements, fostering an environment of continuous improvement. Furthermore, the Committee shall monitor, assess, and report on the implementation of Health and Care Quality Standards, outcomes, and performance indicators where relevant within their remit.
- 2.5. In alignment with the Wellbeing of Future Generations (Wales) Act 2015, this Committee will adopt a long-term perspective in its deliberations and decisions. The Committee will consider the broader implications of its actions, particularly in relation to the three wellbeing objectives established by the trust in order to contribute positively to the wellbeing of future generations. These objectives are: 1) being a socially responsible and inclusive employer, 2) fostering an innovative and sustainable organization, and 3) ensuring we are a proactive, accessible, and equitable care provider.



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### 3. DELEGATED RESPONSIBILITY

The Committee will:

#### **Strategic Development and Delivery**

- 3.1. Oversee and contribute to the development of the Trust's strategies and plans for the delivery of high quality and safe services, consistent with the Board's overall strategic direction and any requirements and standards set for NHS bodies in Wales.
- 3.2. Consider the implications for quality, safety and equitable care in strategies and aligned plans.
- 3.3. Receive assurance on the implementation of strategies and plans within the remit of the Committee, with a particular focus on the impact of desired outcomes in those strategies and plans.

#### **Safe Care, Equitable Care**

- 3.4. Receive assurance on compliance with the Duty of Quality and the Duty of Candour as set out in the Health and Social Care (Quality and Engagement) (Wales) Act 2020 to improve the quality of healthcare provided by the Trust and to support the delivery of an open and honest reporting and continuous learning culture.
- 3.5. Receive assurance that the Health and Care Quality Standards 2023 are embedded Trust wide with actions taken in relation to any identified non-compliance.
- 3.6. Receive assurance that there is a quality management system in place that ensures compliance with relevant standards and regulations, facilitates continuous improvements and processes, and enhances patient safety and patient experience.
- 3.7. Receive assurance that there is a process in place for quality impact assessments. Consider the implications for quality and safety and equitable care arising from the development of the Trust's corporate strategies and plans, or those of its stakeholders and partners, including those arising from any Committees of the Board.

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Model Standing Orders – Schedule 3.6: Quality, Patient Experience and Safety Committee TORs

Approved by Trust Board ~~[29 May 2025]~~ TBC



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- 3.8. Receive reports on significant concerns or adverse findings highlighted by external bodies in relation to clinical quality safety, effectiveness and patient experience and seek assurance of the actions being taken by management to address these.
- 3.9. Receive assurance that the Trust is compliant with the Dementia Standards, Mental Health Act 1983, Code of Practice, and the Mental Capacity Act 2005.
- 3.10. Review the annual infection prevention and control plan and receive assurance on its implementation and the systems in place to ensure compliance with statutory and regulatory requirements for infection prevention and control.
- 3.11. Receive assurance that the Trust is meeting its obligations with respect to safeguarding of children and vulnerable adults.
- 3.12. Review the impact of professional standards and staffing issues on patient care, noting the People and Culture Committee has oversight of the selection, training, registration, and revalidation for staff.
- 3.13. Ensure that robust arrangements are in place for the review of patient safety incidents (to include near misses) to identify similarities or trends and areas for focused or organisation-wide learning.
- 3.14. Review and recommend to the Board the Trust's annual Duty of Candor and Quality Report(s) and quality improvement priorities for the coming year, monitoring progress against these priorities and their impact on patient safety.
- 3.15. Review policies in its remit and endorse policies for Board approval that relate to complaints and incidents in line with Putting Things Right.

### **Effective, Timely**

- 3.16. Receive assurance that the care planned and provided across the breadth of the organisation's functions is evidence-based, clinically effective and quality driven and where this falls beneath expected standards, the impact is reviewed to support continuous improvement.
- 3.17. Approve the Trust's clinical audit plan that meets the standards set for the NHS in Wales; review the outcomes of clinical audits in line with the clinical audit plan and provide assurance to the Audit, Risk and Assurance Committee in this respect.



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- 3.18. Advise the Board on a set of key indicators for quality, patient experience and clinical safety, and monitor performance against those indicators.
- 3.19. Receive assurance that there is an ethos of continual quality improvement and regular methods of updating the workforce in the skills needed to demonstrate quality improvement throughout the organisation.
- 3.19.3.20. Receive assurance on delivery of core aims in relation to delivering value and development of value based healthcare in an out of hospital setting.

### **Patient Centred**

- 3.20.3.21. Oversight of patient experience feedback, including themes, trends and learning, and approve the Patient Experience Plan on behalf of the Board.
- 3.21.3.22. Receive assurance that the organisation has a patient centred approach, putting patients, patient safety, quality of care and safeguarding above all other considerations.
- 3.22.3.23. Receive assurance that the Patient Experience & Community Involvement (PECI) continuous engagement model is taken into account in the design and delivery of services, ensuring the full implementation of lessons learnt.
- 3.23.3.24. Receive assurance that lessons are learned from patient experience information and patient safety and workforce related incidents, complaints, and claims, and that learning from reports and incidents is embedded in the Trust's practices, policies and procedures.
- 3.24.3.25. Receive assurance that there is good collaborative team and partnership working to provide the best possible outcomes for its citizens.
- 3.25.3.26. Ensure any matters raised by the Executive Director of Quality & Nursing (including in their role as Caldicott Guardian), Executive Director of Paramedicine, or other Directors in relation to patient safety and clinical risk are considered and addressed promptly and fully.

### **Risk and Audit**

- 3.26.3.27. Oversee the effective management of strategic and principal risks, as set out within the Board Assurance Framework (BAF), as appropriate to the purpose of the Committee.



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3.27:3.28. Seek assurance that governance arrangements are appropriately designed and operating effectively to ensure the provision of high quality, safe healthcare and services across the whole of the Trust's activities, and that these are compliant with relevant legislation.

3.28:3.29. Receive and gain assurance from internal and external audits in their remit. The Committee will receive assurance that management actions to address recommendations are in place via the audit tracker and receive appropriate reporting as agreed by the Audit, Risk and Assurance Committee. This Committee will, where appropriate, scrutinise the impact of actions in response to audit recommendations.

## 4. AUTHORITY

- 4.1. The Committee is authorised by the Trust Board to investigate, or have investigated, any activity within its terms of reference. In doing so, it will have the right to seek any information it requires from any employee or inspect any books, records, or documents relevant to its remit, ensuring patient/client and staff confidentiality as appropriate. All employees are directed to cooperate with any reasonable request made by the Committee.
- 4.2. The Committee is authorised by the Board to obtain outside legal advice or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Trust's procurement, budgetary and other requirements.
- 4.3. The Committee is authorised to approve Trust wide policies other than those policies reserved to the Board ~~in accordance with the policy for the Review, Development and Approval of Policies.~~
- 4.4. The Committee is authorised to approve the annual clinical audit plan.

### Chair's Action

- 4.5. There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Committee. This is most likely, but not exclusively, to arise with respect to approval of policies



particularly given the current backlog.

- 4.6. In these circumstances, the Chair and the Lead Executive, supported by the Director of Corporate Governance/Board Secretary as appropriate, may deal with the matter on behalf of the Committee after first consulting with at least two other Members (Non-Executive Directors).
- 4.7. The Director of Corporate Governance/Board Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

### **Sub-Committees**

- 4.8. The Committee may establish sub-Committees or task and finish groups to carry out on its behalf specific aspects of Committee business. Formal sub-Committees may only be established with the agreement of the Board.

## **5. MEMBERSHIP AND QUORUM**

- 5.1. The Trust's Standing Orders at 3.3.5 and 3.3.6 provide the rules around Committee membership. That includes that the designation of Chair, definition of member roles and powers, and terms and conditions of appointment are determined by the Board, based on the recommendation of the Trust Chair. Executive Directors and other Trust officers cannot be appointed as Committee Chairs, nor should they be appointed to serve as 'members' on any Committee set up to review the exercise of functions delegated to them. They may however be 'in attendance' as appropriate.
- 5.2. The application of these provisions means that the designation of 'members' in NHS Wales Committees is applied to Non-Executive Directors. This ensures there is independent scrutiny, support and challenge, and is a relevant for quorum (see below) and – where it is required – for voting
- 5.3. Notwithstanding the above, the 'members' and 'prescribed attendees' listed below are often referred to collectively as members or membership.

### **Committee Membership**

- 5.4. The Committee will comprise ~~three~~four Non-Executive Directors, one of



whom will be designated as Chair, and the following prescribed attendees:

- Executive Director of Quality and Nursing (Committee Lead)
- Executive Director of Paramedicine
- Executive Director of Operations
- Executive Director of Strategy, Planning and Performance
- Director of Digital Services
- Trade Union Partners (x 3)
- Chairs of Sub-Committees (where established)
- Director of Corporate Governance/Board Secretary

- 5.5. In the absence of the Committee Chair, one of those in attendance must be designated as Chair of the meeting.
- 5.6. Members may send deputies in their absence who will act with their full authority. To instigate a substitution arrangement, the member of the Committee must notify the Director of Corporate Governance/Board Secretary before the day of the meeting that he/she is unable to attend and the name of the member who will attend as the substitute.
- 5.7. The Chair of the Trust Board and the Chief Executive have a standing invitation to attend meetings. In addition, the Committee Chair may invite others (either Trust staff or persons outside the Trust) to attend all or part of the meeting to assist with its discussions on any particular matter. The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge, and expertise

### Quorum

- 5.8. The quorum for meetings of the Committee shall be ~~two~~three Non-Executive Directors.
- 5.9. ~~While only two Non-Executive Directors are required for quorum, it is strongly recommended that all three Non-Executive Director members be present at each meeting to ensure robust discussion and effective oversight. The presence of all Non-Executive Directors is crucial for fostering diverse perspectives and maintaining rigorous challenge and scrutiny. Therefore,~~ Other Non-Executive Directors of the Board may be co-opted to meetings where it is not possible ~~for all to reach a quorum~~three Non-Executive Directors to attend.



## Member Appointments

- 5.10. The membership of the Committee shall be determined by the Board, based on the recommendation of the Trust Chair, taking account of the balance of skills and expertise necessary to deliver the Committee's remit, and, subject to any specific requirements or directions made by the Welsh Government.
- 5.11. Non-Executive Directors shall be appointed to hold office for a period of one year at a time, (membership being reviewed by the Chairman of the Board on an annual basis) up to a maximum of their term of office. During this time a member may resign or be removed by the Board.
- 5.12. Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the Trust Chair and, where appropriate, on the basis of advice from the Trust's Remuneration Committee.

## 6. COMMITTEE MEETINGS

### Secretariat and Support to Committee Members

- 6.1. The Director of Corporate Governance/Board Secretary, on behalf of the Committee Chair, shall:
  - (a) arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and
  - (b) ensure the provision of a programme of organisational development for Committee members, as part of the Trust's overall Board development programme.

### Frequency of Meetings

- 6.2. Meetings shall be held no less than quarterly or otherwise as the Chair of the Committee deems necessary, consistent with the Trust's annual plan of Board business. Meeting agendas, papers and minutes shall be circulated no less seven days prior to each meeting.



### **Withdrawal of individuals in attendance**

- 6.3. The Committee may ask any member or individual who is normally in attendance but who is not a member to withdraw to facilitate open and frank discussion of any particular matter.

## **7. RELATIONSHIPS AND ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS**

- 7.1. The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.
- 7.2. The Committee, through its Chair and members, shall work closely with the Board's other Committees and groups to provide advice and assurance to the Board through the:
- (a) joint planning and co-ordination of Board and Committee business; and
  - (b) sharing of appropriate information;
- in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall assurance framework.
- 7.3. The Committee will consider the assurance provided through the work of the Board's other Committees and sub-groups to meet its responsibilities for advising the Board on the adequacy of the Trust's overall framework of assurance.
- 7.4. The Committee shall embed the Trust's corporate standards, priorities and requirements, e.g. equality and human rights through the conduct of its business.

## **8. REPORTING AND ASSURANCE ARRANGEMENTS**

- 8.1. The Committee Chair shall:



- (a) report formally, regularly and on a timely basis to the Board and the Chief Executive (Accountable Officer) on the Committee's activities. This includes a written highlight report, the submission of Committee minutes and written reports where appropriate throughout the year;
- (b) bring to the Board and the Chief Executive (Accountable Officer's) specific attention any significant matter under consideration by the Committee; and
- (c) ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant Committees of any urgent/critical matters that may affect the operation and/or reputation of the Trust.

8.2. The Director of Corporate Governance/Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any sub Committees established.

## 9. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

9.1. The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum (as set out in section 6)

## 10. REVIEW

10.1. These terms of reference and operating arrangements shall be reviewed at least annually but more frequently if required.

## Item 10.2 Annex 1

Group	Changes to operating arrangements	Progress Update	Intended Completion Date	Completion Status
<b>Section 1: Board and all committees</b>	1.1 Further consideration to holding board meetings at venues other than Cardiff in 2025/26.	Work has begun on this consideration, and it is intended that it will be brought to the ARAC in December 2025.	01 January 2026	
	1.2 Introduce progress reports on 'what good looks like' for the strategic objective within committee remits will support the call for more of a strategic focus.	This is an action that sits outside of CorGov and is being advanced by the Strategy, Planning and Performance Directorate.	30 October 2025 – <i>check in date</i>	
	1.3 Revised approach to minutes for the Trust Board and its committees.	Draft developed and being consulted on. Q2 deliverable	30 September 2025	
	1.4 Updated board skills matrix for board members, which is aligned to the board committees.	The updated skills mix questionnaire will be shared with the board by the end of August 2025.	30 September 2025	
	1.5 Where possible in 2025/26 the introduction of more hybrid meetings.	This is happening for all committees where it is considered appropriate / welcomed by the respective Chair.	n/a	

**Item 10.2 Annex 1**

Group	Changes to operating arrangements	Progress Update	Intended Completion Date	Completion Status
	1.6 A reduction in the reporting against the audit tracker will be considered by ARAC in an attempt to reduce volume for committees and increase assurance.	This is a Q4 deliverable on our CorGov Directorate Plan and is in progress.	Q4 2025/26	
	1.7 New report front covers and SBAR templates. This includes a short form report which includes a requirement to set out purpose of report and alignment to strategic objectives, wellbeing objectives and health and care quality standards. This will support the desire to use more presentations over SBAR where appropriate.	The <a href="#">new templates</a> and report writing guidance was published w/c 12 August 2025	n/a	
	1.8 Writing guidance will set out the purpose of the executive summaries in an attempt to ensure they are reflective of the comments received by members of the board and the committees of the board.	The <a href="#">new templates</a> and report writing guidance was published w/c 12 August 2025	n/a	

**Item 10.2 Annex 1**

Group	Changes to operating arrangements	Progress Update	Intended Completion Date	Completion Status
	1.9 Presentation guidance and support will be provided to colleagues in the Trust.	The <a href="#">new templates</a> and report writing guidance was published w/c 12 August 2025	n/a	
	1.10 Feedback following meetings on reports – both positive and where there are areas of improvement – are encouraged from committee members. This will ensure that we are working towards a continuous improvement in paper length and assurance.	No formal action required. Feedback is being given in meetings regarding report quality and the assurances that this affords.	n/a	
	1.11 A 'reading room' will be established in iBabs for documents that members may wish to review for further information, but which are not vital for scrutiny and oversight.	Completed; in use for all board committees and the board via iBabs.	n/a	
	1.12 Members encouraged to pose questions to report writers before meetings and allowing more time for questioning during sessions were suggested to enhance engagement.	No formal action required.	n/a	

**Item 10.2 Annex 1**

<b>Group</b>	<b>Changes to operating arrangements</b>	<b>Progress Update</b>	<b>Intended Completion Date</b>	<b>Completion Status</b>
	<p>1.13 Continue with agenda setting meetings and encourage themes for meetings to aid in the flow and triangulation. Members are encouraged to review the agenda both when it is commissioned and closer to the meeting and alert the secretariat if insufficient time has been allocated. Likewise, presenters should ensure they are cognisant of the time allocated which includes time to present and for discussion.</p>	<p>No formal action required as the agenda setting meetings are continuing throughout 2025/26.</p>	<p>n/a</p>	
<p><b>Section 2: Academic Partnership Committee</b></p>	<p>2.1 Consideration for greater use of presentations within meetings to reduce the number of papers received. This was specifically in reference to Academic Partnership Committee but will be considered for all committees.</p>	<p>No formal action required. Noted that where presentations are in use, cover papers are requested to make it clear to the audience what it has been received for, to aid discussion.</p>	<p>n/a</p>	
<p><b>Section 3: Audit, Risk and Assurance Committee</b></p>	<p>3.1 The Corporate Governance Team will ensure that ARAC is aware of the discussion on internal audit reports from</p>	<p>This is business as usual.</p>	<p>n/a</p>	

**Item 10.2 Annex 1**

Group	Changes to operating arrangements	Progress Update	Intended Completion Date	Completion Status
	committees if they review them ahead of ARAC, and vice versa when they come to ARAC first.			
	3.2 Trending on risk scores will be added to the risk management report.	This is business as usual from Q2 2025/26.	n/a	
	3.3 A paper setting out a more focused understanding of where the three lines of defence sit within the organisation and their importance will be cycled into the work programme.	This will be brought to ARAC in quarter three in December 2025 with the Governance and Accountability handbook. The outline of the handbook is before ARAC at this meeting.	30 October 2025	
	3.4 The committee induction programme for ARAC and other committees will be rolled out as new members join.	The committee induction for each committee is being delivered as required / when new members join respective committees.	n/a	
<b>Section 4: Charity Committee</b>	4.1 A further development session to be considered for the Corporate Trustee in 2025/26 on trustee responsibilities.	This has been programmed for the board development day in February 2026.	28 February 2026	

**Item 10.2 Annex 1**

Group	Changes to operating arrangements	Progress Update	Intended Completion Date	Completion Status
	4.2 Lived experience to demonstrate on new proforma the charitable impacts beyond staff benefits.	This is business as usual.	n/a	
	4.3 Committee to maintain a strong focus on equality, diversity and inclusion in its strategic direction.	No formal action required. Equality, diversity and inclusion matters considered within the charity's operations as business as usual.	n/a	
<b>Section 5: Finance and Performance Committee</b>	5.1 A board development session on the use of the MIQPR will be held on 24 April 2025, and the annual review of all MIQPR metrics will come through committees in May.	Complete	Complete	
	5.2 A new finance dashboard is in development and will be considered by the committee in 2025/26.	WAST (and other NHS Wales orgs) are dependent on a national dashboard being developed as part of the NHS Wales finance system refresh (Oracle Financials). If no national solution is produced by end of Dec 25, then WAST will tailor an internal bespoke solution commencing in	March 2026 – <i>Check in for December 2025</i>	

**Item 10.2 Annex 1**

Group	Changes to operating arrangements	Progress Update	Intended Completion Date	Completion Status
		Quarter 4 of the 2025/26 Financial year in readiness for rollout from Quarter 1 of the 2026/27 financial year.		
<b>Section 6: WASPT</b>	6.1 Continue with agenda setting meetings with the co-chairs and encourage themes for meetings to aid in the flow and triangulation as well as timing of individual items. Members are encouraged to review the agenda both when it is commissioned and closer to the meeting and alert the secretariat if insufficient time has been allocated. This will ensure there is sufficient time for solution focused discussions and airing of issues.	No formal action required. This is business as usual.	n/a	
	6.2 The terms of reference provide that papers are available seven days before the meeting, however this does not always align with the Trade Union	This is business as usual, and the Corporate Governance Team work closely with Trade Union Partners (TUPs) to align publication of papers with TUP	n/a	

**Item 10.2 Annex 1**

Group	Changes to operating arrangements	Progress Update	Intended Completion Date	Completion Status
	Partners pre-meeting timetable. Best endeavours are made to ensure papers are available for that pre-meet and likewise Trade Union Partners will endeavour to timetable that meeting within the seven days to allow for a full pack to be available.	pre-meets to allow TUP time to review the papers and raise any issues ahead of the meeting.		
	6.3 Partnership working will continue in 2025/26 to ensure that there is continuous effort to maintain trust and openness, the details of which will be discussed in the group.	No formal action required.	n/a	
	6.4 The sessions on how to run effective meetings and on financial reporting will be carried over into 2025/26.	<i>Financial reporting:</i> Finance colleagues will deliver this session, and it is intended for Q3 2025/26. Arrangements will be progressed from September.	20 December 2025	

**Item 10.2 Annex 1**

Group	Changes to operating arrangements	Progress Update	Intended Completion Date	Completion Status
	6.5 The sessions on how to run effective meetings and on financial reporting will be carried over into 2025/26.	<i>Effective meetings:</i> The delivery of this action is aligned to the meeting practice and participation guidance coming out in Q2 2025/26.	30 September 2025	
	6.6 There are opportunities to learn more about legislative changes, as well as policy issues through workshops post WASPT meetings, as well as taking advantage of employment-related sessions with the People Services Team which will be explored in 2025.	No formal action required.	n/a	

**Item 10.2 Annex 1**

<b>Colour</b>	<b>Meaning</b>	<b>Typical Action</b>
<b>Blue</b>	Completed	No further action needed
<b>Green</b>	On track	Continue as planned
<b>Amber</b>	Minor issues	Monitor closely, possibly mitigate
<b>Red</b>	Major issues	Escalate and intervene urgently



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Agenda Item No.

17

## REPORT TITLE

Audit Tracker 25-26 Q2 Reporting (July-September 2025)

## MEETING

Name of meeting	Quality, Patient Experience and Safety Committee
Date of meeting	04 November 2025
Public or Private	Public
If private - <a href="#">rationale</a>	n/a

## REPORT SPONSOR

Executive sponsor	Trish Mills, Director of Corporate Governance/Board Secretary
Author(s) of report	Lisa Trounce, Head of Compliance and Assurance

## PURPOSE OF REPORT

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

## EXECUTIVE SUMMARY:

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

1. This paper provides the Committee with the 2025/26 Q2 position with respect to management actions for audits within the purview of this committee.
2. The Audit Handbook notes that it is the responsibility of this committee to:
  - Receive audits in their remit;
  - Monitor management actions to address recommendations; and
  - Scrutinise impact of actions in response to audit recommendations in terms of, for example, quality improvement, the provision of more efficient and effective patient care, improved governance, better use of resources etc.



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3. The Audit Tracker has been updated in Quarter 2 of 202/26. In an attempt to manage volume of papers, the tracker has been added to the Ibabs reading room filtered to the actions assigned to this committee for oversight. This digital reading room hosts documents for additional information, not essential for scrutiny or decision-making. Access to the reading room is through the documents/shared folder in Ibabs' main menu. Documents in the reading room will not be posted on the Trust's website with committee papers; however, copies can be provided to those without access to Ibabs upon request.

### Internal Audit

4. During 2025/26 Quarter 2, there were a total of 21 open internal audit recommendations relevant to the Committee. Of these 21 open audit recommendations, ten were due for closure in quarter, nine were not due, and dates were to be advised for the remaining two.
5. By the end of the quarter, five (50%) of the audit actions due for closure in quarter were confirmed as completed: Four (40%) of these met their original deadlines, and one (10%) was completed after two deadline revisions.
6. New revised deadlines have been proposed for two recommendations: one from 2023/24 (on third revision), and one from 2024/25 (on its second revisions), with first revised dates to be advised for two further actions.
7. As shown in the table below, these new revised deadlines relate to the 2023/24 Electronic Patient Clinical Records (ePCR) internal audit, and 2024/25 Patient Experience and Community Involvement internal audit:

Trust Audit Ref. No.	Internal Audit	Directorate	Original Date	1 <sup>st</sup> Revised Date	2 <sup>nd</sup> Revised Date	3 <sup>rd</sup> Revised Date
23/24-686	e-PCR	Digital	Sep24 (with Clinical Directorate)	Mar25 (transferred to Digital)	Sep25	<b>Apr26</b>
24/25-044	PECI	QSPE	Apr25	<b>TBA</b>		
24/25-045	PECI	QSPE	Aug25	<b>TBA</b>		
24/25-048	PECI	QSPE	Mar25	Jul25	<b>Mar26</b>	

8. The open ePCR audit recommendations, transferred from the Clinical Directorate to the Digital Directorate in March 2025, were discussed previously at committee following agreement with Internal Audit colleagues that the completion dates should be extended to April 2026. At that time it the 2<sup>nd</sup> revised date for Action Ref: 686 was considered to be achievable and was not amended. However, as this has not been realised therefore, as an exception, a 3<sup>rd</sup> revised date of Apr26 has been applied to align this action to the other three open e-PCR audit actions that are ongoing (681, 683 and 684).



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9. Particular attention is drawn to the three open 2024/25 recommendations relating to the Patient Experience and Community Involvement (PECI) internal audit, and the statement below kindly supplied by the Executive Director of Quality and Nursing:

*"The Committee is advised that an outline plan for changes to the PECI team proposed by the executive, has been formally shared with the relevant Directors for consideration. On receipt of agreement to proceed, the associated mitigations against the audit recommendations will be updated, and any new actions will be formally captured within the assurance audit tracker.*

*While the tracker currently shows no updates, this reflects an interim position only and work continues to ensure that the team are making a full contribution to the organisations ongoing service development. Assurance is given that once Directorate confirmation is secured, the tracker will be amended to demonstrate both the mitigations already in train and any additional actions required to address the audit findings."*

10. At the end of quarter there were a total of 16 open audit recommendations remaining relevant to this committee. Of these, eight (50%) are due to be completed during Q3 (between October – December 2025), and another six are due for completion during Q4 (between January - March 2026), with dates for two 2024/25 actions to be advised.

### **External Audit**

11. During 2025/26 Quarter 2, there were 38 open external audit recommendations relevant to the Committee: 8 relating to the 2023/24 Quality Governance Follow Up Review, and 30 remaining actions resulting from the Welsh Risk Pool (WRP) Concerns Assessment undertaken in 2024.
12. Of the 38 open external audit recommendations, 13 were due for closure in quarter, and 25 not yet due.
13. By the end of the quarter, four (31%) of the 13 audit recommendations due for closure were confirmed as completed, plus a further two other actions which were not due for completion until December 2025, making a total of six.
14. New revised deadlines have been proposed for ten (26%) open audit recommendations: two relate to the 2024 Quality Governance Follow Up Review (both on 1<sup>st</sup> revised dates, originally due in September and December 2025); and eight relate to the WRP Concerns Assessment 2024 (seven on 1<sup>st</sup> revised dates, and one on 2<sup>nd</sup> revised date).
15. Attention is drawn to the four open recommendations related to the 2024 WRP Concerns Assessment for which agreed deadlines have not been recorded – these are yet to be confirmed as they are dependent on automated extraction work.



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## RECOMMENDATION(S)

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

The Committee is requested to:

- (a) Receive assurance on the monitoring of management actions to address recommendations in the Tracker, noting any revised dates for actions.
- (b) Receive assurance regarding the open audit recommendations relating to the Patient Experience and Community Involvement.

## ADDITIONAL PAPER(S)

Annex 1: Audit Tracker 2.0 – 2526 Q2 Updates - Internal Audit up to 2324 (QuEST)

Annex 2: Audit Tracker 2.0 – 2526 Q2 Updates – Internal Audit 2425 (QuEST)

Annex 3: Audit Tracker 2.0 – 2526 Q2 Updates – External Audit up to 2324 (QuEST)

Annex 4: Audit Tracker 2.0 – 2526 Q2 Updates – External Audit 2425 (QuEST)



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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) [ <a href="#">link to objectives and what good looks like</a> ]	
<input type="checkbox"/> SO1: Providing the right care or advice, in the right place, every time	<input type="checkbox"/> SO2: Enabling our people to be the best they can be
<input type="checkbox"/> SO3: Being at the forefront of innovation and technology	<input type="checkbox"/> SO4: Developing services in collaboration
<input checked="" type="checkbox"/> SO5: Being quality driven and clinically led	<input checked="" type="checkbox"/> SO6: Delivering exceptional value

### HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

### WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [ <a href="#">link to goals</a> ]		
<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 checked="" type="checkbox"/> No <input type="checkbox"/> Yes
If yes, what impact assessment	N/A [DPIA Checklist > DPIA not indicated]

### APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
21 October 2025	Director of Corporate Governance/Board Secretary
04 November 2025	Quality, Patient Experience and Safety Committee

## POLICIES RECOMMENDED FOR COMMITTEE APPROVAL AND ADOPTION

<b>Committee</b>	Quality, Patient Experience and Safety Committee (QuEST)	<b>Date of Meeting</b>	04.11.2025
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<b>Presenting Officer</b>	Trish Mills, Director of Corporate Governance / Board Secretary
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Policy Name	Directorate	EQA Completed	Date of Policy Group	Date of ADLT	Points of Note
[New] Prevent Policy	Quality and Nursing	Yes – No Issues Identified	22.09.2025	13.10.2025	FOR COMMITTEE APPROVAL



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# Prevent Policy

<b>Policy Number:</b>	117	<b>Version No:</b>	V0.7 Draft	<b>Supersedes:</b>	New Policy
<b>Date of Approval:</b>	TBC	<b>Review Date:</b>	3 years from approval date	<b>Impact Assessments Completed:</b>	Yes
<b>Classification of Document:</b>	Safeguarding	<b>Type of Document:</b>	Policy	<b>Approved by:</b>	Quality, Patient Experience and Safety Committee
<b>Brief Summary of Document:</b>	The Welsh Ambulance Services University NHS Trust (WAST/'The Trust') recognises that all service users have the right to expect health care that is safe and to be protected from harm. This Policy outlines how the Trust will raise concerns about an individual who may be at risk of being drawn into terrorism or committing terrorist acts.				
<b>Scope:</b>	To outline the collective and individual requirements of all WAST staff to follow Prevent legislation. Included within 'WAST staff' are employees, bank workers, volunteers, non-executive director board members appointed by Welsh Government, students, apprentices and any individual representing WAST.				
<b>To be read in conjunction with:</b>	<p>The following WAST documents:</p> <ul style="list-style-type: none"> <li><a href="#">WAST Safeguarding Children and Adults at Risk Policy 2024</a></li> <li><a href="#">WAST Violence Against Women, Domestic Abuse and Sexual Violence VAWDASV - 2024</a></li> <li><a href="#">WAST Information Governance Policy (2018)</a></li> <li><a href="#">WAST Recruitment and Selection Policy, Process and Guidance (2016) [2024 under consultation currently]</a></li> <li><a href="#">WAST Putting Things Right Policy (2023)</a></li> <li><a href="#">WAST Adverse Incident Reporting Policy and Procedure (2023)</a></li> <li><a href="#">WAST Consent to Examination &amp; Treatment Policy (2024)</a></li> <li><a href="#">WAST Data Protection Policy (2024)</a></li> <li><a href="#">WAST Management of Allegations Policy (2018) [2025 currently under review]</a></li> <li><a href="#">WAST Employee Wellbeing Policy and Guidelines 2013</a></li> </ul> <p>The following Legislation and National Guidance:</p> <ul style="list-style-type: none"> <li><a href="https://www.legislation.gov.uk/ukpga/2000/11/contents">https://www.legislation.gov.uk/ukpga/2000/11/contents</a>;</li> <li><a href="#">Prevent duty guidance: England and Wales (2023) - GOV.UK</a></li> <li><a href="#">CONTEST STRATEGY: The United Kingdom's Strategy for Countering Terrorism 2023 – July 2023 (publishing.service.gov.uk)</a></li> </ul>				



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<b>Owning Committee</b>	Quality, Safety & Patient Experience Committee		
<b>Policy Lead:</b>	Vicky Maxwell	<b>Job Title:</b>	Assistant Director of Safeguarding
<b>Trade Union Lead:</b>	Christian Fox		Trade Union Partner
<b>Executive Director:</b>	Liam Williams	<b>Job Title:</b>	Executive Director of Quality & Nursing

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## Version Control Sheet

Version	Date	Author	Summary of Changes
V0.1	01/07/2025	Vicky Maxwell	New Policy [Initial Draft]
V0.2	18/07/2025	Lisa Trounce	Quality check / edit of Draft Policy prior to submission to Policy Group: <ul style="list-style-type: none"> <li>• Version number amended</li> <li>• Gaps on Front cover populated</li> <li>• Version control sheet updated</li> <li>• Approval Route and dates supplied</li> <li>• Minor formatting throughout</li> <li>• Information added to footer</li> <li>• Impact Assessment information moved from section 5 to summary page 4</li> <li>• Comments added to be resolved</li> <li>• Contents Page updated</li> </ul>
V0.3	18/07/2025	Vicky Maxwell / Lisa Trounce	Comments resolved. Draft policy finalised in readiness for presentation to Policy Group on 28/07/2025.
V0.4	08/09/2025	Vicky Maxwell	Post consultation changes: <ul style="list-style-type: none"> <li>• 2.0 Scope – Updated to provide further clarification and advise it is under pinned by SOPs</li> <li>• 3.3 Concerns Regarding a WAST Colleague – 2<sup>nd</sup> paragraph added re: referral to Occupational Health</li> <li>• 5.2 Welsh Language Impact Assessment – first sentence added re: no negative impacts identified.</li> <li>• Appendix 1 – Definition of 'extremism' amended</li> </ul>
V0.5	18/09/2025	Lisa Trounce	Review and editing of policy following post consultation changes prior to consideration by Policy Group on 22/09/2025.



Version	Date	Author	Summary of Changes
V0.06	22/09/2025	Lisa Trounce	Policy prepared for presentation to ADLT in October 2025 for endorsement: Version number updated, comments removed, and approval route updated.
V0.07	22/10/2025	Lisa Trounce	Policy prepared for presentation to QuEST Committee meeting in November 2025 for approval: Version number and approval route updated.

<b>Keywords</b>	Prevent, Safeguarding, Adult at Risk, Child at Risk, Radicalisation.
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### Impact Assessment Reviews

Area	Date of Review	Name of Reviewer
Data Protection	01/04/2025	Sarah Botterill
EqlA / Welsh Language	10/06/2025 03/06/2025	Kathryn Cobley Melfyn Hughes
Environment	10/06/2025	Chris Davies
Quality	25/06/2025	Kate Blackmore

### Policy Approval Route

Meeting Title	Meeting Date	Purpose/Outcome
Policy Group	28/07/2025	To Approve for Trust-wide Consultation
Trust-wide Consultation	07/08/2025 – 04/09/2025	Staff Engagement
Policy Group	22/09/2025	Recommend for Approval
Assistant Directors Leadership Team (ADLT)	13/10/2025	Endorsement / Recommend for Approval
Quality, Patient Experience and Safety Committee (QuEST)	04/11/2025	Approval and Adoption



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**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 [Amb\\_policies@wales.nhs.uk](mailto:Amb_policies@wales.nhs.uk)

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## 1. INTRODUCTION AND AIM

The aim of ['Prevent'](#) is to stop people from becoming terrorists or supporting terrorism. Prevent also extends to supporting the rehabilitation and disengagement of those already involved in terrorism.

In the UK, terrorism is legally defined in the [Terrorism Act 2000](#). The act defines terrorism as the use or threat of action that endangers life, causes serious violence or damage to property, or seriously interferes with or disrupts an electronic system.

The Welsh Ambulance Services University NHS Trust (WAST) recognises its responsibility to take all reasonable steps to prevent people from being drawn into terrorism.

This policy sets out the aims, objectives and scope for the provision and development of measures to safeguard vulnerable patients/service users or WAST colleagues.

The HM Government's [CONTEST STRATEGY: The United Kingdom's Strategy for Countering Terrorism 2023 \(publishing.service.gov.uk\)](#) was updated in July 2023 to reflect the findings from a review of all aspects of counter-terrorism and to future-proof the strategy in its response to heightened threats.

The strategy outlines four 'P' work strands:

- Prevent: to stop people becoming terrorists or supporting terrorism.
- Pursue: to stop terrorist attacks.
- Protect: to strengthen our protection against a terrorist attack.
- Prepare: to mitigate the impact of a terrorist attack.

The aim is that by working collaboratively with multi-agency partners, the Trust will meet its legislative obligations in relation to Prevent.

The objectives of the policy are to provide clear guidance on reporting any prevent safeguarding concerns or allegations of abuse or exploitation, and to set out the levels of responsibility to ensure that:

- Staff members are aware of the policy.
- Vulnerable children and adults at risk of harm are safeguarded against the influence of any form of radicalisation whilst under the care of the Welsh Ambulance Service.
- Staff members consider the potential risk of radicalisation and feel confident identifying suspected signs of radicalisation.
- Staff members receive the appropriate levels of Prevent training.

- Any concerns regarding radicalisation are reported and thoroughly investigated.
- Appropriate action is taken to safeguard the vulnerable patient, service user or staff member or volunteer.
- The Trust complies with relevant legislation and partnership policies.

In the UK, radicalisation, within the context of terrorism, is defined as the process by which an individual comes to support or become involved with extremist ideologies and potentially engage in terrorist activity.

## 2. SCOPE

To outline the collective and individual requirements of all WAST staff to follow Prevent legislation. Included within 'WAST staff' are employees, bank workers, volunteers, non-executive director board members appointed by Welsh Government, students, apprentices and any individual representing WAST.

Preventing someone from becoming a terrorist or supporting terrorism is no different from safeguarding vulnerable individuals from other forms of exploitation. Therefore, this Policy sits alongside the WAST Safeguarding Adult and Children at Risk Policy.

This Policy is an overarching policy and should be read in conjunction with the listed policies and relevant standard operating procedures (SOPs). The SOP's will provide operational guidance for staff to manage the Prevent concerns.

## 3. PREVENT POLICY

### 3.1 Notice / Check / Share

**NOTICE** – Are you worried about a patient/staff member, someone acting or saying things which concerns you? Use your professional judgement, if something doesn't feel right, it may not be!

**CHECK** – Speak with your manager, or WAST Safeguarding Team. Check your concern with them- does your concern also worry them?

**SHARE** – Make a Prevent report following the WAST reporting process via Doc-works.

### 3.2 Raising Concerns

**If you believe there is an immediate terrorist threat: an immediate risk to persons or property or, a crime has been committed, then the police should be contacted on 999 without delay. Consent of the individual does not need to be obtained.**

Police should also be informed promptly if you have information which, might be of material assistance in preventing an act of terrorism, or securing the arrest, prosecution or conviction of someone involved in the commission, preparation or instigation of an act of terrorism" versus when we should make a Prevent referral. (See the notes for Terrorism Act 2000 and DPA 2018 below).

If you are suspicious of something that could identify a terrorism threat anywhere in the UK, you can call the confidential Anti-Terrorist Hotline on 0800 789 321. **This does not replace the need to complete a Safeguarding Report or to inform the WAST Safeguarding Team.**

Prevent is based on the active engagement of the vulnerable individual and is at a pre-criminal stage before any crime has been committed, therefore appropriate consent should be obtained from the individual involved in most cases (or their parents or guardian if aged under 18 years) prior to a referral to Prevent.

You should try to get consent, but do not do this if it would place the vulnerable person or others at risk of serious harm, document your justification for disclosing without consent.

Consider wider safeguarding and mental health concerns and whether adult or child's safeguarding or mental health referrals are needed alongside or instead of a prevent referral. [WAST Safeguarding SOPs & Guidance Documents](#)

Advice can also be obtained from the safeguarding team on 01792 315884/  
[amb\\_wastsafeguarding@wales.nhs.uk](mailto:amb_wastsafeguarding@wales.nhs.uk)

If it is deemed that a Prevent safeguarding report needs to be made, this must be completed promptly.

**WAST utilise the digital reporting system Doc-works Scribe and you should refer to your relevant SOPs for further guidance. [PREVENT](#)**

Prevent reports should contain concerns based on a person's vulnerability to radicalisation and should not solely be because of the person's faith, race or ethnic origin.

If the adult or child are identified to be persons at risk, then also complete a safeguarding referral via the Doc-works Scribe system.

The incident should also be escalated to the DOM/Locality Manager and the WAST Prevent Lead via the Safeguarding Team should be informed of the Prevent referral by emailing [amb\\_wastsafeguarding@wales.nhs.uk](mailto:amb_wastsafeguarding@wales.nhs.uk)

A Datix should be completed outlining details of the incident and actions taken.

All Prevent concerns and actions must be clearly documented in the patient record. This should include the rationale for completing or not completing a Prevent safeguarding report.

All documentation should be clear, concise, complete, factual and limited to what is necessary. Further guidance about record keeping can be obtained from the [WAST Records Management Policy](#).

### 3.3 Concerns regarding a WAST Colleague

Where there is a concern about a WAST colleague, this should be raised with the with a senior in the WAST Safeguarding Team and People Services Department in the first instance. The colleagues line manager or appropriate senior should be included in the conversation. If deemed necessary, the reporter will be supported to complete a Prevent safeguarding report.

In some cases, the line manager or the individual affected may feel it is appropriate to make a referral to [Occupational Health & Wellbeing Occupation](#) to provide support for the member of staff; this must be done with the staff members consent. This referral is in addition to and not instead of the processes set out in this policy.

Staff should be familiar with the NOTICE-CHECK-SHARE procedure for evaluating and sharing concerns. The package shares best practice on how to articulate concerns about an individual and ensure that they are robust and considered.

## 4. TRAINING AND IMPLEMENTATION

- 4.1 WAST is committed to providing high quality evidence-based education to an engaged and skilled workforce operating within an organisational culture and framework that enables colleagues to work to the top of their skill set to deliver high quality care and services with competence and confidence.
- 4.2 The Safeguarding Team will undertake and review a training needs analysis annually to inform the organisational safeguarding training requirements commensurate to all roles.
- 4.3 WAST safeguarding training will consider [Prevent duty training - GOV.UK](#) standards and the relevant intercollegiate documents.
- 4.4 Staff are encouraged to discuss any concerns or queries regarding education and training with a member of the Trust's Workforce Education and Development Team, by telephoning 0300 123 2319 or emailing [amb\\_EandDHub@wales.nhs.uk](mailto:amb_EandDHub@wales.nhs.uk)

## 5. IMPACT ASSESSMENTS

### 5.1 Equality Impact Assessment

In accordance with the Equality Act 2010, all policies will be subject to an Equality Impact Assessment (EqIA). This enables resources to be targeted effectively and can help to reduce inequalities. The EqIA is process to find out whether a policy will affect people differently on the basis of their 'protected characteristics': age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion, sex or sexual orientation and if it will affect their human rights.

An equality impact assessment, inclusive of Welsh Language Impact Assessment has been undertaken prior to this policy's approval to help promote fair and equal treatment in the delivery of services. It is the responsibility of the Policy Lead to ensure that impact assessments are undertaken during development or review of a policy. No potential negative impacts were identified during the equality impact assessment.

### 5.2 Welsh Language Impact Assessment

The policy has been reviewed in an EqIA and no negative impacts on Welsh language were identified. The final policy will be available in Welsh.

Under the The Welsh Language (Wales) Measure 2011 the Trust's Welsh Language Scheme has been replaced by Welsh Language Standards. This means that the Trust, when formulating new policies or reviewing or revising existing policies, is required to assess what effect a policy decision would have on opportunities for persons to use the Welsh language and on treating the Welsh language no less favourably than the English language. Further guidance can be obtained from the Welsh Language Officer. A Welsh language impact assessment was undertaken as part of the equality impact assessment.

### 5.3 Environmental Standards and Impact Assessment

This policy will put the relevant requirements in place (such as waste management plan, reduction of CO<sub>2</sub> emissions & reduction of carbon footprint) in order to ensure that the Welsh Ambulance Services NHS Trust ongoing commitment to reduce its impact on the environment is maintained and to become a more sustainable organisation in line with Trust policy and Environmental Governance System.

The digitalisation of the safeguarding reporting process has reduced the requirement for high numbers of paper safeguarding reports. Paper safeguarding reports are required at a much lower number as they are only required for the contingency process. However, the Policy Group or Employment Policy Sub Group will ensure that the Estates Team have had an opportunity to consider all policies within the process in order to establish whether an impact assessment, waste management plan, or CO<sub>2</sub> Reduction Plan is required.

### 5.4 Counter Fraud

#### **Anti-Fraud and Corruption Concerns**

The Welsh Ambulance Services NHS Trust is committed to taking all necessary steps to counter fraud, bribery and corruption within the Trust. Staff should report suspected incidents of fraud and corruption to the Trust Local Counter Fraud Specialist, who will be happy to discuss any issues or concerns. Alternatively staff may contact the confidential NHS Counter Fraud Authority, Fraud and Corruption Reporting line on 0800 028 40 60; or the on-line reporting facility Service <https://cfa.nhs.uk/report-fraud> Fraud investigations may lead to disciplinary action and / or prosecution and civil recovery procedures.

### 5.5 Records Management

The Welsh Ambulance NHS Services Trust (WAST) recognises the importance of sound records management arrangements for both clinical and corporate records. The Trusts'

records are its corporate memory, providing evidence of actions and decisions and representing a vital asset to support daily functions and operations. Records support policy formation and managerial decision-making, protect the interests of the Trust and the rights of patients, staff and members of the public. Further information is contained within the [WAST Records Management Policy](#).

## 5.6 Information Governance

Information Governance (IG) is an overarching term used to describe all aspects of information management. The Trust and its staff shall ensure that they provide satisfactory assurance to stakeholders as to how the organisation fulfils its statutory and organisational responsibilities in relation to the management of information. It will enable management and staff to make correct decisions, work effectively and comply with relevant legislation and the organisations aims and objectives.

The IG framework ensures that it sets out the high level principles for confidentiality, integrity and availability of information to promote and build a level of consistency across the Trust.

It is important that all service users remain confident that their personal information is kept secure and safe.

Timely and effective information sharing is a key factor in safeguarding. WAST colleagues should share information in line with the [WAST Information Governance Policy \(2018\)](#), the [WAST Data Protection Policy \(2024\)](#) and [Confidentiality Code of Conduct \(2021\)](#).

WAST colleagues should ensure they are familiar with the [Data Protection Act \(2018\)](#), [UK General Data protection Regulation \(2021\)](#) and their responsibilities through statutory and mandatory information governance training.

Safeguarding concerns should be shared in accordance with the [Prevent and the Channel process in the NHS: information sharing and governance - GOV.UK](#)

Any information shared with external agencies must be documented in WAST records.

Disclosures can be permitted if it is required by law or is permitted by a statutory process that sets aside the duty of confidentiality with consent, or where there is substantial public interest e.g. to prevent serious harm.

If WAST colleagues are not sure about information sharing or consent issues in relation to safeguarding concerns, they should seek advice from the [Safeguarding Team](#), [Caldicott Guardian](#) ([The Caldicott Principles, 2020](#)) or [Information Governance Team](#).

## **6. ROLES AND RESPONSIBILITIES**

### **6.1 Chief Executive**

The Chief Executive, as Accountable Officer, has overall responsibility for ensuring the Trust has appropriate policies in place to ensure the organisation works to best practice and complies with all relevant legislation.

The Chief Executive is the executive member of the Trust Board with overall accountability in relation to safeguarding, ensuring that the Trust has policies and procedures in place and complies with its legal statutory obligations.

### **6.2 Executive Director of Quality and Nursing**

The Executive Director of Quality and Nursing provides assurance to the Trust board, commissioners, partner agencies and the public that the Trust are completing its corporate safeguarding functions which, includes Prevent. The Executive Director of Quality and Nursing chairs the Safeguarding Strategic Group.

### **6.3 Assistant Director of Safeguarding**

The Assistant Director of Safeguarding (previously known as the Head of Safeguarding) is the Prevent lead who ensures the strategic management of all safeguarding matters, including Prevent providing leadership, expert and specialist guidance on safeguarding matters.

The Assistant Director of Safeguarding has strategic responsibility for the development and implementation of systems and processes for safeguarding, working with partner agencies in line with local and national standards and legislation.

This includes overall responsibility for policy development, safeguarding operational oversight and safeguarding supervision. The Assistant Director of Safeguarding will advise Education and Development regarding changes and updates, and agreeing the content of learning materials co-produced with the Education & Development team.

The Assistant Director of Safeguarding oversees the Safeguarding Team.

## 6.4 Safeguarding Team

To fulfil the role, the Assistant Director of Safeguarding is supported by the Safeguarding Team, who ensure that the Trust and its colleagues comply with relevant legislation, regulation and guidance.

The Safeguarding Team are responsible for the safeguarding corporate function and provide specialist support, peer review, supervision, and ensuring compliance with training. The Safeguarding Team provide expert opinion for safeguarding adults, children and young people.

Advise Education and Development regarding changes and updates, and agreeing the content of learning materials co-produced with the Education & Development team.

## 6.6 Directors

The Directors are responsible for the effective management of and compliance with this policy. They are responsible for ensuring that all policies within their remit are maintained and updated by liaising with the appropriate policy leads. They are responsible for ensuring that the appropriate advice and assistance is provided to authors and that consideration is given to any training and resources implications that are defined. Each Director will appoint a Policy Lead for their Directorate.

## 6.7 Head of Compliance and Assurance

The Head Compliance and Assurance will act as the Trust's 'Policy Process Manager' and operational gatekeeper with the responsibility for providing guidance, advice and support for the process on behalf of the Trust.

In addition, be responsible for:

- Managing the maintenance of the Trust's central Policy Tracker and Policy Database (including ensuring a record of completed equality impact assessments submitted with policies is maintained).
- Facilitation of the Trust's internal Policy Group.
- Management of the Trust wide consultation process for all policies.
- Issuing reminder notices to ensure the timely review of policies.
- Ensuring up-to-date guidance and documentation regarding the policy process is accessible.

- Publishing policies onto the Trust's internet/intranet sites and working with the Communications Team to ensure comprehensive notification that new policies is maintained across the Trust.
- Maintain an archive of previous versions of any revised or reviewed policies.

## 6.8 Service Managers / Clinical Leads / Locality Managers

Are responsible for:

- Ensuring that new members of staff that join the Trust are made aware of the policy control system at local induction, and how to access Trust wide and local policy documents specific to their area.
- Understanding the policy process and their role in supporting best practice.
- Working with staff without access to the intranet to ensure they have access to relevant documentation.
- Ensuring that local arrangements are established to monitor the receipt and understanding of all relevant Trust documents; thus reducing the risk of misuse of misinterpretation.

## 6.9 Line Managers

Are responsible for:

- Ensuring that the staff for whom they are responsible are aware of and adhere to this document. This includes ensuring that:
  - Copies of the Trust policies are readily available and accessible to all staff.
  - Information is disseminated on a regular basis, to ensure staff have read and understood the relevant documents and are aware of any new guidance or revisions.
  - The identification of specific staff training needs on the implementation of new or updated documents.
  - Systems exist to enable the review, audit and compliance testing of all relevant departmental policies as required.

## 6.10 All Staff

Are responsible for ensuring that:

- They comply with the provisions of this Policy and, where requested, to demonstrate such compliance. Failure to comply will be dealt with in accordance with the appropriate Trust policies.
- Information regarding failure to comply with the policy, for example, lack of training, inadequate equipment, is reported to their line manager and that the incident reporting system is used where appropriate.
- Their practice is in line with policies in use across the Trust and specific to their area of work.
- Information regarding any changes in practice, organisational structure or legislation that would require an urgent review of documents is immediately reported to their line manager.

## 7. AUDIT AND MONITORING

- 7.1 The Safeguarding Team has a responsibility to undertake regular audit to monitor compliance and effectiveness of this policy.
- 7.2 All Prevent referrals are routinely monitored and quality assured by the Safeguarding Team.
- 7.3 The Safeguarding Strategic Group (SSG) has been established to support the Trust Executive Lead for Safeguarding in the provision of assurance to the Board on all matters relating to safeguarding children and adults at risk.
- 7.4 Reporting and monitoring of safeguarding standards is completed via internal reporting mechanisms. SSG reports quarterly and escalates matters to Clinical Quality Governance Group (CQGG), which in turn reports and escalates matters to ELT.
- 7.5 Themes, trends or lessons learned will be communicated to WAST colleagues through a variety of means including bulletins and operational updates, communicated through training and notices.
- 7.6 The Trust's Safeguarding Team review, monitor and record feedback from Local Authorities in relation to WAST Safeguarding Reports and act as necessary.



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## 8. REFERENCES

[A 10 step guide to sharing information to safeguard children | ICO](#)

[CONTEST STRATEGY: The United Kingdom's Strategy for Countering Terrorism 2023 – July 2023 \(publishing.service.gov.uk\)](#)

[Counter-terrorism and confidentiality - The MDU](#)

[Data Protection Act \(2018\),](#)

[Prevent duty guidance: England and Wales \(2023\) - GOV.UK](#)

[PREVENT](#) WAST Siren page

## 9. APPENDICES

Appendix 1	Definitions of Terms
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## Appendix 1: Definition of Terms

<b>Terrorism</b>	Actions of individuals or groups who seek to bring about social or political change through actions intended to cause serious harm, loss of life or raise attention through fear and/or damage to property to cause loss of life, disruption or raise attention by fear and/or damage to property.
<b>Radicalisation</b>	The process of grooming an individual to support, encourage or condone violence to advance terrorist ideology.
<b>Extremism</b>	<p>Extremism is the promotion or advancement of an ideology based on violence, hatred or intolerance, that aims to:</p> <ol style="list-style-type: none"> <li>1. negate or destroy the fundamental rights and freedoms of others; or</li> <li>2. undermine, overturn or replace the UK's system of liberal parliamentary democracy and democratic rights; or</li> <li>3. intentionally create a permissive environment for others to achieve the results in (1) or (2).</li> </ol> <p>The definition used is from the <a href="#">UK Government (2024)</a></p> <p>The types of behaviour below are indicative of the kind of promotion or advancement which may be relevant to the definition and are an important guide to its application. Further context is defined by the <a href="#">UK Government (2024)</a> and should be considered as an essential part of the definition.</p>
<b>CONTEST 3.0 Strategy</b>	Sits under the Home Office and is a national strategy or long-term plan of action designed to reduce the risk of terrorism, by stopping people becoming terrorists, preventing terrorist attacks, strengthening the UK's resilience to terrorism and facilitating emergency preparedness procedures in the event of attack.
<b>Prevent Strategy</b>	Safeguarding and support those at most risk of radicalisation through early intervention, identifying them and offering support.



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	<p>Enabling those who have already engaged in terrorism to disengage and rehabilitate.</p> <p>Tackling the causes of radicalisation and respond to the ideological challenge of terrorism.</p>
<b>Vulnerability</b>	<p>In the context of <i>Prevent</i> is a person who is susceptible to extremists' messages and is at risk of being drawn into terrorism or supporting terrorism at a point in time.</p>
<b>Channel</b>  <b>Channel (cont'd)</b>	<p>Multi-agency approach to protect people at risk from radicalisation. It is entirely voluntary and requires the consent of the individual and or their parent or guardian (if aged under 18 years) to participate.</p> <p>Channel uses existing collaboration between local authorities, statutory partners (such as education and health sectors, social services, children's and youth services and offender management services, the police and the local community) to:</p> <ul style="list-style-type: none"><li>• identify individuals at risk of being drawn into terrorism.</li><li>• assess the nature and extent of that risk; and</li><li>• develop the most appropriate support plan for the individual concerned.</li></ul> <p>Channel is about safeguarding children and adults at risk from being drawn into committing terrorist-related activity. It is about early intervention to protect and divert away from the risk they face before illegality occurs.</p>



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Agenda Item No.

19

## REPORT TITLE

Committee Priorities and Cycle of Business Monitoring Report 2025/26

## MEETING

Name of meeting	Quality Patient Experience and Safety Committee
Date of meeting	04 November 2025
Public or Private	Public
If private - <a href="#">rationale</a>	n/a

## REPORT SPONSOR

Executive sponsor	Julie Boalch Assistant Director of Corporate Governance and Risk
Author(s) of report	Sarah Harland, Corporate Governance Officer

## PURPOSE OF REPORT

- |  |                                      |
|--|--------------------------------------|
| <input type="checkbox"/> Approval                            | <input 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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## REPORT SUMMARY:

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

### Cycle of Business Monitoring

1. This report updates the Committee on progress against the priorities it set for 2025/26 and progress against the agreed its cycle of business (CoB). The Committee's CoB was approved by the Committee in May 2025. Each meeting agenda is set by referencing the cycle, together with the forward planner, action log and highest rated principal risks.
2. Members are asked to note that the receipt of the *Spotlight on Clinical Indicators Report* has been deferred from the quarter two and three meetings as agreed, with the Committee Chair. This is due to the regular receipt of the clinical indicators by the Committee over the last two financial years, and the desire to avoid duplication of business.
3. Members are also asked to note the deferral of the *Annual Infection, Prevention and Control (IPC) Report* from the November 2025 meeting. This Report was due for receipt in August 2025 and deferred to November 2025. The Executive Director of Quality and Nursing has requested that the receipt of the report be deferred to February 2026.
4. The rationale for the deferral is that changes within the Directorate have delayed the finalisation of the report. Also, it is preferable to include - with the IPC Annual Report - the baseline IPC assessment which is being drafted by the Trust. For future reporting the intention is to consolidate the annual IPC reporting within the Trust's Annual Duty of Quality Report, to avoid duplication and present a more complete picture.

### 2025/26 Committee Priorities

5. During the effectiveness reviews, it was agreed that it is good practice for Committees to set priorities for the forthcoming year. The priorities, which are set out below, were agreed by the Trust Board in May 2025 and will be tracked quarterly in the monitoring report.
6. The monitoring report is at Annex 1. The 'pre-agenda setting' key indicates that items in green show where these are cycled for a particular meeting. Items in beige indicate that these are a prompt at agenda setting and may be ad hoc items such as business cases or external reports.
7. The 'post-agenda setting' key indicates that items in blue were either on the agenda as scheduled or was an *ad hoc* item which was discussed in agenda setting and scheduled. The orange indicates where an item was programmed for receipt but has been deferred to a future meeting. The Committee's priorities and progress against them is as follows:



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Priority	Progress
<ul style="list-style-type: none"> <li>Continued monitoring and reporting on performance against the Duty of Quality and Duty of Candour</li> </ul>	<ul style="list-style-type: none"> <li>Future updates on the implementation of the Duty of Candour and Duty of Quality will be programmed as required, informed by the prompts on the Cyle of Business.</li> <li>The Duty of Quality Annual Report 2024/25 was received by the Committee at its meeting on 13 June 2025 and was approved by the Trust Board on 26 June 2025 for publication.</li> </ul> <p><u>2024/25 Progress</u> <i>(included as this priority was carried over into 2025/26)</i></p> <ul style="list-style-type: none"> <li>An update on the Duty of Quality Implementation Plan was received in February 2025. Included within the report, an update was provided on the progress on developing self-assessments against the Health and Care Quality Standards.</li> </ul>
<ul style="list-style-type: none"> <li>Prioritising the implementation of the new Strategic Quality Plan to ensure tangible outcomes</li> </ul>	<ul style="list-style-type: none"> <li>The Committee will receive a progress update against the delivery of the Strategic Quality Plan 2025/28 at the November 2025 meeting.</li> <li>This follows the receipt of the Strategic Quality Plan 2025-2028 by the Committee at its meeting on 09 May 2025, which was approved by the Trust Board approved the plan on 29 May 2025.</li> </ul>
<ul style="list-style-type: none"> <li>Focus on the Clinical Model Transformation, ensuring robust quality assurance and patient experience improvements</li> </ul>	<ul style="list-style-type: none"> <li>The Committee continues to monitor progress through regular updates and highlight reports; scrutiny of evaluation findings and interim reports; and assurance that the transformation aligns with statutory duties and strategic goals.</li> <li>Verbal updates on the Ministerial Advisory Group Wait-45 Taskforce and Revised Performance Framework were provided at the August 2025 meeting. A further update on the position with Wait-45 will be provided at the November 2025 meeting. This activity is not a part of the Clinical Model Transformation; however, it is often discussed in relation to this organisational change.</li> </ul>



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## RECOMMENDATION(S)

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

The Committee is requested to take ASSURANCE from the update.

## ADDITIONAL PAPER(S)

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

1. The Committee is requested to receive the:  
Quality, Patient Experience and Safety Committee Cycle of Business Monitoring Report - November 2025

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

N/A

## 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



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## 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 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 checked="" type="checkbox"/> No <input type="checkbox"/> Yes
If yes, what impact assessment is attached	





## APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
04 November 2025	Quality, Patient Experience and Safety Committee

PAPER	PRE C'EE FORUM	FREQUENCY	Q1	Q2	Q3	Q4	LEAD	PURPOSE	COMMENT/COMPLIANCE
<b>QUEST COMMITTEE - CYCLE OF BUSINESS 2025/26</b>									
<b>TERMS OF REFERENCE NOTED IN RED TEXT</b>									
Quality Plan aligned to Delivering Excellence 2030	CQGG/TB	Initial and cyclical review					EDQN	Approval	Plan for approval in 2025/26 (including QIA and EqIA) Q3 Included in Quality Plan Progress Update. The population/public health detail will be incorporated into the update report in Q3 regarding the Quality Plan deliverables.
Clinical Plan aligned to Delivering Excellence 2030	CQGG/TB	Initial and cyclical review					EDP	Approval	Plan for approval in 2025/26 (including QIA and EqIA) Q2 Included in Clinical Plan Progress Update
Quality Impact Assessments	CQGG	Ad Hoc					EDQN/DP	Assurance	See Notes
TBC assurance reporting on 'what good looks like' for QUEST remit	STB	TBC					EDQN/DP	Assurance	Reporting developing in 2025/26
Duty of Quality Report (to include Duty of Candour)	CQGG/TB	Annually	→				EDQN	Endorsement	Q1: this was taken to the Extraordinary meeting on 13 June 2025.
Meds management report	CQGG	Annually					EDP	Assurance	Standalone report in Q1 on meds management (& medical devices by exception) & exception report - see Note 10
External reports	CQGG	Ad Hoc					EDQN/DP	Assurance	
Dementia Standards Report	CQGG	Annually					EDQN	Assurance	See Notes. Mental health encompasses a broad range of specialisms, including <b>dementia</b> , learning disabilities, substance misuse, neurodiversity, child and adolescent mental health (CAMHS), older people's mental health, post-natal mental health, and adult mental health. Mental health as an umbrella term for all of these.
Annual Mental Health Report	CQGG	Annually					EDQN	Assurance	See Notes re legislative compliance reporting requirement. Regular KPIs being developed 2025/26
Annual IPC report	CQGG	Annually		→	→		EDQN	Assurance	Metrics also included in MIQPR. Q2 report deferred to Q3. Q3 receipt deferred to Q4. Will be brought back in Q4 with the IPC Standards Self-Assessment.
Annual safeguarding reports	CQGG/TB	Annually					EDQN	Assurance	Annual safeguarding report (All Wales and WAST). Quarterly metric in MIQPR on risk report data and referrals
MIQPR report	ELT	Quarterly					EDSPP	Assurance	Includes balanced scorecard of all Board level metrics
Putting Things Right Report	CQGG	Quarterly					EDQN/DP	Assurance	See Notes
Policies for review and approval	Policy Group	Ad Hoc					BS	Approval	Board to approve PTR policy (SoRD). Note AW recommendations on PTR and Adverse Incident Policies in the 2024 quality governance review follow up. Q3 Prevent Policy for Committee approval.
Clinical audit plan	CQGG/AC	Annually					EDP	Approval	QUEST report to Audit Committee that plan endorsed. See Note 9
Monitoring report on clinical audit	CQGG	Quarterly					EDP	Assurance	
Spotlight On' clinical indicators	CQGG	Quarterly		→	→		EDP	Assurance	To provide more focus on clinical care (started in Q2 23/24)
MIQPR annual review of QUEST metrics	ELT	Annually					EDSPP	Approval	To review and agree Board level metrics for coming year
PTR report annual review of metrics	CQGG	Annually					EDQN	Approval	To review and agree the Committee level metrics for the coming year (over and above MIQPR metrics - if any) currently contained in PTR report
Near Miss and Low Harm Intelligence Report	TBC	Annually					EDQN	Assurance	Onward assurance is provided to the ARAC regarding these arrangements (added in 08072025); for Q2 this was included in the PTR Report. Report issued to ARAC on 020925.
Mortality Report	CQGG	Bi-annually					EDQN	Assurance	See Note 12
PECI report	TBC	Bi-annually					EDQN	Assurance	See note 11
Patient story	N/A	Quarterly					EDQN	Assurance	
Patient story updates	N/A	Quarterly					EDQN	Assurance	
Audit recommendation tracker	ELT	Quarterly					BS	Assurance	
Audits within purview of Committee	Audit	Ad Hoc					Relevant Director	Assurance	
Board Assurance Framework	ELT	Quarterly					BS	Assurance	
Corporate Risk Register	ELT	Quarterly					BS	Assurance	
<b>SUB-GROUPS</b>									
Where applicable	N/A	Ad Hoc					N/A	N/A	No sub-committees - however may set up task and finish groups from time to time
<b>GOVERNANCE</b>									
Committee effectiveness review annual report	Audit/Board	Annually					BS	Approval	
Review of Terms of Reference	Audit/Board	Annually					BS	Approval	
Committee Cycle of Business annual refresh	N/A	Annually					BS	Approval	Q1: Dealt with via chair's action in April.
Committee Cycle of Business monthly review	N/A	Quarterly					BS	Review	Review against cycle progress at each meeting
Committee Review of Annual Priorities	N/A	Quarterly					BS	Review	
<b>PROMPTS</b>									
Operations Report	SLT	QUarterly					EDO	Information	

EDQN = Executive Director of Quality and Nursing  
EDO = Executive Director of Operations  
EDP = Executive Director of Paramedicine  
EDSPP = Executive Director Strategy, Planning and Performance  
BS = Board Secretary

**Key: Pre-agenda setting**  
 Cycled for each meeting  
 Ad hoc item - prompt for agenda setting  
 Reporting developing

**Key: Post-agenda setting**  
 Presented as cycled  
 Ad hoc / item considered - not programmed  
 Item deferred  
 Reporting developing

1	<b>Putting Things Right Report</b>	<p>Note in February 2024 Quest PTR report that future reports will move to aggregated thematic reviews to determine patterns and trends corporately and at Health Board levels.</p> <p>Audit Wales Quality Governance Review 2022 made recommendations related to quality information. The 2024 Quality Governance Follow Up Review (October 2024) re-opened previously closed recommendations as follows:</p> <ul style="list-style-type: none"> <li>- R1 Develop a system to triangulate learning themes across its quality assurance reports. This should ensure clarity about what improvement actions have been taken as a result and how learning has been disseminated across the organisation. This has been re-opened</li> <li>- R2 Enhance Covid-19 reporting in the integrated quality and performance report by including information about the harm caused to patients by ongoing service pressures caused by the virus. This can remain closed and is superseded given the risk posed by C19 now.</li> <li>- R3 Work with health bodies so that there are systems to determine the outcomes for patients who have received emergency ambulance services. This should particularly seek to understand the consequence and harm resulting from service failures such as long ambulance waits. This has been re-opened</li> <li>- R4 Develop patient outcome measures to support its existing quality measures. This has been re-opened.</li> </ul> <p>Report says: We found the Trust continues to face challenges in reporting patient outcomes due to differing patient systems in place across organisations. However, there is more the Trust can and should do to triangulate and identify themes and learning.</p> <p>The Putting Things Right report summarises some of the key themes from joint investigations and incidents, but not others such as concerns or mortality reviews. However, neither report (PTR and MIQPR) provides triangulation with other information to identify broader key themes and there is limited information on what is being done to address challenges and identify and implement learning.</p> <p>05 November 2024 meeting: Discussion re reporting of low and no harm events (in relation to the near-miss report). Need to consider how best to receive / frequency.</p>
2	<b>Duty of Quality and Duty of Care</b>	<p>The 2024 Quality Governance Follow Up Review recommendations as follow:</p> <p>R4 - The Trust should take steps to increase compliance rates for duty of quality and duty of candour training to ensure staff have a good understanding of their responsibilities under the requirements</p>
3	<b>Annual Quality Report</b>	<p>H&amp;C (Q&amp;E) Act will have a requirement to publish an annual report setting out the steps taken to secure improvements in the quality of health services. WG is also required to publish an annual report on the steps they have taken to comply with the duty of quality also. Introduced for end of 23/24</p> <p>The 2024 Quality Governance Follow Up Review recommendations as follow:</p> <p>R4 - The Trust should take steps to increase compliance rates for duty of quality and duty of candour training to ensure staff have a good understanding of their responsibilities under the requirements</p>
4	<b>Annual Duty of Candour Report</b>	<p>H&amp;C(Q&amp;E) Act s.7: publish report after the end of the reporting year (s.8(1)). Duty of Candour Regulations will be developed 23/24.</p> <p>Introduced for end of 23/24. The DoC Annual report will not be a standalone annual report. Details will be presented in the Annual PTR report to prevent duplication.</p> <p>The 2024 Quality Governance Follow Up Review recommendations as follow:</p> <p>R4 - The Trust should take steps to increase compliance rates for duty of quality and duty of candour training to ensure staff have a good understanding of their responsibilities under the requirements</p>
5	<b>Dementia Standards</b>	<p>Funding requests made annually to WG for dementia programme. The All Wales Dementia Care Pathway of Standards published in 2021. WG national steering group with WAST representation.</p> <p>Reporting on compliance against the 20 dementia care pathway standards being developed in 23/24 (see Nov 22 QUEST paper for link to standards).</p>
6	<b>QIA</b>	<p>The QIA process was endorsed by QUEST. Thereafter CQGG reviews all QIAs and the Chairs of CQGG will escalate those in their professional judgment should be reviewed by QUEST.</p> <p>QUEST paper 110523 - <u>CQGG will:</u></p> <ul style="list-style-type: none"> <li>(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;</li> <li>(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</li> <li>(c) Have oversight of the framework and central repository for all QIAs; initial screening and full QIA.</li> <li>(d) have oversight of onward report to the Executive Management Team; Quality, Patient Experience and Safety (QuEST) Committee and; Trust Board, as appropriate.</li> </ul> <p>Reports to QuEST will identify QIAs completed and explicitly identify those that have required EMT review and authorisation.</p>
7	<b>Clinical Audit</b>	<p>Clinical audit is an important way of providing assurance about the quality and safety of services. The Trust's Clinical Audit Team provides training and support to clinical team leaders such as senior paramedics. The type of support provided by the team includes developing audit proposals, preparing and collating data (for example patient clinical records) and writing audit reports. The Trust does not have a clinical audit policy but follows an internal audit recommendation has developed a clinical audit guide and audit proposal template to support staff.</p> <p>QUEST to assure Audit Committee that clinical audit plan in place via AAA from Chair of QUEST.</p> <p>Clinical Audit Internal Audit done in 2023/24 - see recommendations</p> <p>Audit Wales Quality Governance Review Update 2024 made recommendations related to clinical audit:</p> <p>R3 - There are opportunities to further enhance reports on the Trust's Clinical Audit function, by:</p> <ul style="list-style-type: none"> <li>B3.1 More clearly highlighting any changes made to the approved Clinical Audit Plan; and</li> <li>B3.2 Capturing key findings, outcomes and learning from completed audits</li> </ul> <p>Report notes that whilst more recent clinical audit progress reports have provided a better summary of progress, there remains scope for reports on clinical audit to provide stronger assurance to the QuEST on its activity. The accompanying clinical audit tracker provides members with an update on recommendations arising from clinical audits, however, our review found it can be difficult to understand the key issues raised from looking only at the recommendations and progress reports do not currently highlight any findings from clinical audits. The Internal Audit review found that actions to address recommendations are monitored via relevant internal groups However, it remains difficult for QuEST members to be assured about the outcomes of clinical audit activity, and whether learning from clinical audits is becoming embedded to improve the Trust's performance without the inclusion of further narrative within progress reports</p>
8	<b>Meds Management and Medical Devices</b>	<p>Meds management sits in the Ambulance Practice Steering Group that feeds into CQGG. It reviews compliance with controlled drugs; patient group directives (directives for registrants for prescription only drugs e.g. flu vaccine etc) which are regularly reviewed; JRCALC guidelines; meds management and controlled drugs policy; audit of controlled drugs. Standalone report will be presented to QUEST in Q4 setting this out and proposing assurance reporting.</p> <p>Any exception reporting on meds management or medical devices to Quest by exception.</p> <p>MM audit compliance in Q1</p> <p>New Meds Management Policy August 23 says at 16.6 To support the principles of antimicrobial stewardship, an annual audit of antimicrobial use by APs will be conducted and the findings reported to the Trust Ambulance Practice Steering Group, appropriate Trust Committees and where appropriate, National Antimicrobial Stewardship Forum</p>
9	<b>Mortality reviews</b>	<p>In August 2021 the Delivery Unit issued the All Wales Learning from Mortality Review Framework. The Framework is a significant shift from the Trust's previous method of undertaking Mortality Reviews. The Framework document sets out that NHS organisations in Wales should undertake Mortality Reviews in relation to requests for information from the newly formed Medical Examiners Service (MES) in Wales.</p> <p>Mortality review meetings provide a systematic approach for the peer review of patient deaths to reflect, learn and improve patient care. Mortality reviews are conducted when a patient dies whilst in the Trust's care, including whilst waiting for an ambulance to arrive. To aid learning the Trust also reviews cardiac arrests where patients have survived. A Serious Case Incident Forum scrutinises issues identified through mortality reviews. Identification of cases is via several sources including ME referral, incident reporting (internal and from system partners), HM Coroner, internal clinical reviews, clinical audit processes and horizon scanning. See Mortality Reviews Framework (QUEST 110523) with reporting to Quest at 7.1 and proposed to come via the Patient Safety Report with numbers of reviews, learning and actions. Oversight of the mortality review process is by CQGG at least six monthly.</p> <p>Audit Wales Quality Governance Review 2022 made recommendations related to mortality reviews. The 2024 Quality Governance Follow Up Review (October 2024) re-opened previously closed recommendations as follows:</p> <p>R3 The QuEST Committee does not receive adequate assurances on mortality reviews. The Trust should ensure the QuEST Committee receives quarterly update reports to include:</p> <ul style="list-style-type: none"> <li>B3.1 The number of reviews undertaken, and the numbers of reviews required but not yet complete. <b>This has been re-opened.</b></li> <li>B3.2 Any significant concerns, lessons learned and what changes have been made as a result. <b>This has been re-opened.</b></li> <li>B3.3 Updates on actions to address the mortality review backlog. <b>This has been re-opened.</b></li> <li>B3.4 Updates on progress implementing the all-Wales Learning from Mortality Reviews Framework. <b>This can remain closed.</b></li> </ul> <p>R4 The Trust has a significant backlog of mortality reviews. The Trust should develop an action plan to reduce the backlog, reporting progress at each QuEST meeting. <b>This has been re-opened.</b></p> <p>Report writers should refer to the 2024 follow up report which noted that whilst the Trust has implemented the new framework for mortality reviews, there is fluctuating performance relating to delivering timely mortality reviews and there is scope for more consistent reporting of mortality review activity, outcomes and learning.</p> <p>See Learning From Deaths report to QUEST 13 August 2024 for background detail.</p>
10	<b>Mental Health</b>	<p>Reporting to include compliance Mental Health Act 1983, Code of Practice, and the Mental Capacity Act 2005, DoLS etc. See consent to examination and treatment policy endorsed at ELT 130224 with monitoring through clinical audit plan and responsibilities listed.</p> <p>Mental health KPIs to be developed in 2025/26</p>

11	<b>Quality Plan</b>	<p>Audit Wales Quality Governance Review Follow Up 2024 recommendations:</p> <p>Quality Strategy</p> <p>R1 - As the Trust develops a new Quality Plan in 2024, it should ensure that delivery is achievable within the resources available. The plan should clearly detail the funding required, the risks of under-delivery (due to capacity and resource constraints) and be underpinned with an implementation plan.</p> <p>Quality Strategy monitoring</p> <p>R2 - There is scope to strengthen quality strategy implementation plan delivery reporting. To enhance clarity, the Trust should, in its progress reports:</p> <p>Q2.1 Provide timescales for the expected delivery of each action;</p> <p>Q2.2 Differentiate between the progress of individual actions and strategic outputs; and</p> <p>Q2.3 Ensure that progress reports are reported regularly and are included in the QuEST cycle of business [note the report indicates quarterly from August 2024]</p>
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