Bundle Quality, Patient Experience and Safety Committee 5 August 2025

Agenda attachments

Item 00 Quest Agenda 5 August 2025 - Open

OPENING ITEMS

1 09:30 - Chair's Welcome, Apologies and Quorum

2 Declarations of Interest

Item 02 Board Member Register of Interests - Updated 21 July 2025

3.1 Minutes of the Open Meeting 9 May 2025

Item 03.1 2025-05-09 Draft QUEST Open Minutes

3.2 Committee Highlight Report 9 May 2025

Item 03.2 Quest Committee Highlight Report 9 May 2025

3.3 Minutes of the Extraordinary Meeting 13 June 2025

Item 03.3 2025-06-13 Draft QUEST Open Minutes

3.4 Committee Highlight Report Extraordinary Meeting 13 June 2025

Item 03.4 Quest Committee Highlight Report 13 June 2025 - Extraordinary

4 Action Log & Matters Arising

Item 4 Action Log

4.1 FOR APPROVAL, ASSURANCE AND DISCUSSION

5 09:40 - Operations Directorate Quarterly Report Q1 2025/26

Item 05 Operations Quarterly Report for Committees 25-26 Q1 Final

6 10:10 - Patient Story - Sophie's Story

Sophie lives with a learning disability and some mental health conditions. 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 experiences but finds the frequent long waits for a return call frustrating at times.

When she's been referred to hospital by 111, 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 is often complex and full of jargon – not learning disability friendly. Sophie describes a positive experience of using 111 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.

6.1 Patient Story Updates

Item 6.1 Update Tracker Dylan Cope

7 10:40 - Monthly Integrated Quality Performance Report

Item 07 MIQPR SBAR QUEST June 2025

Item 07 Appendix 1 MIQPR Top Indicator Dashboard QUEST June 2025

7.1 11:00 - COMFORT BREAK

8 11:15 - Revised Performance Framework

Item 08 Executive Summary Performance measures

Item 08 Letter to Jeremy Griffiths from JK 30 May 2025

Item 08 Appendix 1 Purple Arrest Data Definition

Item 08 Appendix 2 Out of Hospital Cardiac Arrest Report

Item 08 Appendix 3 RCSO Data Definition Document

9 11:30 - Ministerial Advisory Group Wait 45 Taskforce

This is a verbal item, therefore there is no paper.

10.1 11:45 - Putting Things Right Report - Q1 2025/26 (to include the near miss/harm intelligence data)

Item 10.1 Putting Things Right Report Q1 2025-26

Item 10.1 Annex 2 Putting Things Right Report Q1 2025-26

10.2 Putting Things Right & Legal Services Performance Organisational Recovery Plan

Item 10.2 Executive Summary - PTR & Legal Services Performance Improvement Plan

Item 10.2 Annex 2 PTR Legal Services Performance - Organisational recovery Plan v0.4

11 12:15 - Annual Safeguarding Report 2024/25

Item 11 SBAR Safeguarding Annual Report

Item 11 Annex 1 Annual Report 2024-2025 - Draft 6 24-07-2025

12 Annual Infection and Prevention Control Report 2024/25 [DEFERRED]

12.1 12:30 - LUNCH

13 13:10 - Clinical Audit Plan and Action Tracker Q1 (Update) 2025/26
- Item 13 QuEST Clinical Audit Plan & Action Tracker Q1 2025-26 update
- Item 13 Appendix 1 Clinical Audit Plan 2025 - 26 July
- Item 13 Appendix 2 Clinical Audit action Tracker July

14 13:20 - Clinical Plan Progress Update
- Item 14 Executive Summary Clinical Plan 2025 2030
- Item 14 Clinical Plan Presentation QuEST July 2025

15 13:35 - Risk Management and Board Assurance Framework
- Item 15 Executive Summary Risk Management Report QuEST 050825

16 13:45 - Audit Tracker

Please note that the following are available in the Reading Room:
Annex 1 - Audit Tracker 2.0 - 25-26 Q1 Internal Audit Actions (Up to 2023/24)
Annex 2 - Audit Tracker 2.0 - 25-26 Q1 Internal Audit Actions (2024/25)
Annex 3 - Audit Tracker 2.0 - 25-26 Q1 External Audit Actions (2023/24)
Annex 4 - Audit Tracker 2.0 - 25-26 Q1 External Audit Actions (2024/25)

- Item 16 SBAR Audit Tracker to Committees - 25-26 Q1 Reporting (Apr-Jun25) - QuEST 050825

16.1 Internal Audit Start of Shift Procedure
- Item 16.1 Internal Audit Report comments from ARAC - Start of Shift Procedure
- Item 16.1 Appendix 1 WAS-2425-11 Start of Shift Procedure_Final Internal Audit Report

16.2 Internal Audit Emergency Communication Nurse System Implementation
- Item 16.2 Internal Audit Report comments from ARAC & FPC - ECNS
- Item 16.2 Appendix 1 WAS-2425-12 ECNS Final Internal Audit Report_for Trust issue

16.3 CONSENT ITEMS

17 Audit Wales: Urgent and Emergency Care Report Arrangements for Managing Demand - WAST
- Item 17 UEC Arrangements for Managing Demand - WAST

18 Committee Cycle of Business Monitoring Report and 2025/26 Priorities
- Item 18 QuEST Committee Cycle of Business Monitoring Report and Committee Priorities Q1
- Item 18 Annex 1 Quest Committee Cycle of Business Monitoring Report
- Item 18 Annex 2 Quest Committee Cycle of Business Notes

18.1 CLOSING ITEMS

19 13:55 - Key Messages for the Board

20 Reflections and Summary of Decisions/Actions

21 Any Other Business

22 Date & Time of the Next Meeting: 4 November 2025

Agenda Status:	[OPEN] QUEST COMMITTEE - 5 AUGUST 2025					Deadline for Papers: 25 July 2025			Last good practice Exec Review: 30 July 2025	
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**
	OPENING ITEMS									
1	Chair's Welcome, Apologies and Quorum	Verbal	Information	Standing	n/a	Chair				
2	Declarations of Interest	Verbal	To State Conflicts	Standing	n/a	Chair				
3	3.1 Minutes of the Open Meeting: 9 May 2025 3.2 Committee Highlight Report 9 May 2025 3.3 Minutes of the Extraordinary Meeting 13 June 2025 3.4 Committee Highlight Report Extraordinary Meeting 13 June 2025	Paper	Approval	Standing	n/a	Chair				
4	Action Log & Matters Arising	Paper	Discussion	Standing	n/a	Chair				
	FOR APPROVAL, ASSURANCE AND DISCUSSION									
5	Operations Directorate Quarterly Report Q1 2025/2026	Paper	Assurance	CoB	Operations	Lee Brooks	Judith Bryce Toni-Marie Norman			
6	Patient Story - Sophie's Story - NHS 111 Wales and 111 press#2	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			
7	Monthly Integrated Quality Performance Report	Paper	Assurance	CoB	SPP	Hugh Bennett	Hugh Bennett Mark Thomas Mel O'Connor			
	COMFORT BREAK									
8	Revised Performance Framework	Verbal	Assurance	Ad hoc	Quality	Andy Swinburn (Jonathan Chippendale)	n/a			
9	Ministerial Advisory Group Wait 45 Taskforce	Verbal	Assurance	Ad hoc	Quality	Liam Williams	n/a			
10	10.1 Putting Things Right Report - Q1 2025/26 (to include the near miss/low harm intelligence data) 10.2 Putting Things Right & Legal Services Performance Organisational Recovery Plan	Paper	Assurance	CoB	Quality	Liam Williams	Wendy Herbert Alison Kelly Claire Appleton			
11	Annual Safeguarding Report 2024/2025	Paper	Approval	CoB	Quality	Liam Williams	Vicky Maxwell Wendy Herbert			
12	Annual Infection and Prevention Control Report 2024/2025 **[Item Deferred]**	Paper	Approval	CoB	Quality	Liam Williams	Penny Durrant			
	LUNCH									
13	Clinical Audit Plan and Action Tracker Q1 (Update) 2025/26	Paper	Assurance	CoB	Clinical	Andy Swinburn (Jonathan Chippendale)	Jonathan Chippendale			
14	Clinical Plan Progress Update	Paper	Assurance	CoB	Clinical	Andy Swinburn (Jonathan Chippendale)	Jen Lloyd			
15	Risk Management and Board Assurance Framework [To include update on 'manage and monitor' regarding risks 223 and 224]	Paper	Assurance	CoB	Gov	Julie Boalch	n/a			
16	Audit Tracker and any Internal Audits reports: 16.1 Start of Shift Procedure 16.2 Emergency Communication Nurse System Implementation	Paper	Assurance	CoB	Gov	Trish Mils	Lisa Trounce,Skye Banks			
	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.									
17	Audit Wales: Urgent and Emergency Care Report Arrangment for Managing Demand - WAST	Paper	Assurance	Ad hoc	Gov	Lee Brooks	n/a			
18	Committee Cycle of Business Monitoring Report and 2025/26 Priorities	Paper	Approval	CoB	Gov	Trish Mills	Alex Payne			
	CLOSING ITEMS									
19	Key Messages for the Board	Verbal	Discussion	Standing	n/a	Chair	n/a			
20	Reflections and Summary of Decisions/Actions	Verbal	Discussion	Standing	n/a	Chair	n/a			
21	Any Other Business	Verbal	Discussion	Standing	n/a	Chair	n/a			
22	Date & Time of the Next Meeting: 4 November 2025	Verbal	Information	Standing	n/a	Chair	n/a			
	CLOSE									

Position
Assistant Director, Commissioning & Performance
Assistant Director of Corporate Governance and Risk
Executive Director of Operations
Consultant Paramedic - Urgent Care
Chair and Non-Executive Director
Executive Director of Strategy, Planning and Performance
Director of Corporate Governance/Board Secretary
Executive Director of Quality and Nursing

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Left Trust
BEAUMONT-WOOD, Rhiannon	**Non-Executive Director** * Member of the Remuneration Committee * Member of the the Audit, Risk and Assurance Committee * Member of the Quality, Patient Experience and Safety Committee	Dorset Integrated Care Board (NHS Dorset), Non-Executive Director	Financial Interest	May 2023		
		Nursing and Midwifery Council (NMC), Designated Council Member for Wales	Financial Interest	June 2024		
		RBW Executive and Professional Coaching Ltd, Company Director (Company No 14938585) and Shareholder	Financial Interest	June 2023		
		Currently on coaching framework with Health Education and Improvement Wales	Financial Interest	June 2024		
		Registered Nurse (NMC)	Non-Financial Professional	January 1985		
		Registered Specialist Community Public Health Nurse	Non-Financial Professional	September 1996		
		Member of the Royal College of Nursing	Non-Financial Professional	2007		
BEESLEE, Jayne	**Non-Executive Director** * Chair of the Finance and Performance Committee * Member of the Remuneration Committee * Member of the Academic Partnership Committee	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		
		Fellow Chartered Institute of Personnel & Development	Non-Financial Personal	01 April 2006		
BROOKS, Lee	**Executive Director of Operations**	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	**Non-Executive Director** * Chair of the Audit, Risk and Assurance Committee * Chair of the Charity Committee * Member of the Finance and Performance Committee * Member of the Remuneration Committee	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		
		Interim Finance Director for Torfaen Leisure Trust	Directorships	01 September 2023	29 February 2024	
		Member of Governing Body / Independent Member – Kaplan International Colleges UK Ltd [05268303	Directorships	01 March 2024		
		Independent Member - Kaplan Open Learning (inc member of the Audit & Risk Committee)	Directorships	21 March 2024		
DENNIS, Colin	**Chair of Trust Board and Non-Executive Director** * Chair of Remuneration Committee	Chair - Citizen Housing [Charity] (previously WM Housing Group)	Position in Charity or Voluntary Organisation	01 January 2015	January 2025	
		Company Director - Citizen Treasury PLC (previously WM Housing Treasury Ltd)	Directorships	29 August 2017		
		Company Director - Citizen Treasury Vehicle Ltd	Directorships	04 September 2017		
		Chair - North Devon Homes	Position in Charity or Voluntary Organisation	01 October 2021	January 2025	
		Company Director - North Devon Homes	Directorships	01 April 2022		
		Chair - Green Square Accord (Housing Association)	Position in Charity or Voluntary Organisation	26 March 2024		
		Company Director - LowCarbonLiving Homes Ltd [04207671]	Directorships	26 March 2024		
		Company Director - Green Square Estates Ltd [8719365]	Directorships	26 March 2024		
EVANS, Bethan	**Non-Executive Director** * Chair of Quality, Patient Experience & Safety Committee * Member of Finance & Performance Committee * Member of People & Culture Committee * Member of Remuneration Committee	Chief Executive Officer (Employed) at My Choice Healthcare Limited.	Any Other Interest	01 June 2019		
		Non-Executive Board Member at Beacon Housing (Social Housing Organisation - Community Benefit Society)	Position in Charity or Voluntary Organisation	01 November 2019		
		Company Director - My Choice Healthcare South Wales Limited	Directorships	11 March 2020		
		Company Director - Moorlands Rehabilitation (Staffordshire) Limited.	Directorships	20 December 2019		
		Company Director - Moorlands Property Ltd	Directorships	16 August 2022		
		Company Director - Springfield (Bargoed) Limited.	Directorships	12 March 2020		
		Company Director - Springfield Property Lettings Ltd	Directorships	16 August 2022		
		Company Director - Homes of Excellence Limited	Directorships	19 March 2021		
		Company Director - Victoria House Care Property Limited	Directorships	05 March 2020		
		Company Director - My Choice Healthcare (Four) Limited	Directorships	27 April 2022		
		Company Director - Luk Ros Property Limited	Directorships	12 March 2020		
		[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
EVANS, Bethan [continued]	**Non-Executive Director** * Chair of Quality, Patient Experience & Safety Committee * Member of Finance & Performance Committee * Member of People & Culture Committee * Member of Remuneration Committee	Company Director - Hawthorn Court Property Limited	Directorships	27 April 2022		
		[Previously called My Choice Healthcare (Three) Limited, Company name changed 12.08.2022 - #13371375]	*Directorships*	*27 April 2022*		
		Company Director - Ocean Living Property Limited	Directorships	22 July 2022		
		Company Director - Hawthorn Court Care Limited	Directorships	22 July 2022		
		Company Director - Glyncornel 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		
HUTCHINGS, Hayley	**Non-Executive Director** * Member of the Remuneration Committee * Member of the Academic Partnership Committee * Member of the People and Culture Committee		Employed at Swansea University, Professor of Health Services Research	Financial Interest	17 June 1995	31 May 2025
HITCHON, Estelle	**Director of Partnerships and Engagement**	Member of Academi Wales Expert Panel	Position in Charity or Voluntary Organisation	15 July 2024		
		Independent Governor (Non-Executive Director), Coleg Sir Gar/Coleg Ceredigion	Non-Financial Personal	01 January 2025		
JACKSON, Ceri	**Non-Executive Director & Vice Chair of the Trust Board** * Chair of the People and Culture Committee * Member of the Charity Committee * Member of Audit Committee * Member of Quality, Patient Experience & Safety Committee * Member of Remuneration Committee	Management Consultant primarily working in third sector	Interest in Companies and Securities	01 May 2019		
		Associate Director of SamKat Consulting Ltd in my capacity as self-employed management consultant	Directorships	01 June 2021		
		Charity Trustee - Stroke Association Trustee, Chair Wales Advisory Group.	Position in Charity or Voluntary Organisation	08 October 2020		
		Charitable Company - Stroke Association - Company Director	Directorships	08 October 2020		
KILLENS, Jason	**Chief Executive**	Honorary Professor - Swansea University	Personal or Departmental Sponsorship	2019	31 May 2025	
		Emeritus Professor - Swansea University	Non-Financial Professional	31 May 2025		
		Chairperson – Association of Ambulance Chief Executives (AACE)	Non-Financial Professional	September 2024		
		Company Director of the Association of Ambulance Chief Executives (AACE), Co No. (07761209)	Directorships	September 2024		
		Officer of the Order of St John	Any Other Interest	January 2024		
		Member of the Order of St John	Any Other Interest	2009	2024	
KNEESHAW, Carl	**Director of People**	Chartered Fellow of Chartered Institute of Personnel and Development	Personal or Departmental Sponsorship	April 2020		
		Fellow of Institute of Leadership	Personal or Departmental Sponsorship	October 2020		
		Safeguarding Lead for local outreach charity, Brunstad Christian Church – Huntworth, Bridgwater, Somerset	Position in Charity or Voluntary Organisation	September 2018		
LEWIS, Angela	**Director of Culture Change**	Nil Declaration				
MARSH, Rachel	**Executive Director of Strategy, Planning and Performance**	Nil Declaration				
MILLS, Patricia (Trish)	**Director of Corporate Governance/ Board Secretary**	Nil Declaration				
PARRY, Hugh	**Trade Union Partner**	Nil Declaration				
ROWAN, Hannah	**Non-Executive Director** * Chair of Academic Partnership Committee * Member of Charity Committee * Member of People & Culture Committee * Member of Remuneration Committee	Director, St Martin's Associates (Business consulting and coaching)	Directorships	04 April 2022		
		Non -Executive Director Qualifications Wales (regulator for all non degree qualifications in Wales)	Any Other Interest	01 April 2021		
		Trustee MAE Cymru (Christian charity which champions gender equality in church of Wales)	Position in Charity or Voluntary Organisation	13 November 2021	November 2023	
		Elected member, The governing body of the church in Wales (Parliament of church in Wales - voting member)	Any Other Interest	01 April 2021		
		Relative (Parent) is a Non-Executive Director for Social Care Wales	Any Other Interest	01 April 2017		
SAMMUT, Jonathan (Jonny)	**Director of Digital Services [appointed 26.09.2023]**	Fellow of the British Computer Society – FBCS	Any Other Interest	04 March 2024		
		Panel Member of the UK CIO Advisory Panel – Digital Health	Any Other Interest	05 July 2023	2 June 2025	
		Federation of Informatics Professionals - Leading Practitioner	Any Other Interest	25 April 2024		
		Chair of BCS Hub Wales	Any Other Interest	20 June 2025		
SWINBURN, Andrew (Andy)	**Executive Director of Paramedicine**	Strategic Advisor to College of Paramedics	Any Other Interest	01 January 2020		
TURLEY, Christopher	**Executive Director of Finance and Corporate Resources**	Treasurer of Royal Gwent Hospital League of Friends.	Position in Charity or Voluntary Organisation	01 February 2022	05 November 2024	
TURNER, Damon	**Trade Union Partner**	Nil Declaration				

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Left Trust
WILLIAMS, Liam	**Executive Director of Quality and Nursing [from 01 August 2022]**	Chair/Director - Thornbury Carnival Community Interest Company Voluntary	Position in Charity or Voluntary Organisation	01 August 2019		
		Member Royal College Nursing	Any Other Interest	01 August 2022		
		Committee member - Royal College Nursing, Nurses in Management and Leadership Forum Steering Committee	Position in Charity or Voluntary Organisation	01 August 2022		
		Vice Chair - Royal College of Nursing, Nurses in Management and Leadership Forum Steering Committee	Position in Charity or Voluntary Organisation	03 February 2025		

WELSH AMBULANCE SERVICES NHS TRUST

MINUTES OF THE OPEN SESSION OF THE MEETING OF THE QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE HELD ON 9 MAY 2025 VIA TEAMS

Meeting started at 09:30

PRESENT:

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

IN ATTENDANCE:

Claire Appleton	Assistant Director of Putting Things Right
Jayne Beeslee	Non-Executive Director
Kate Blackmore	Assistant Director of Quality Governance
Julie Boalch	Assistant Director of Corporate Governance and Risk
Peter Brown	Assistant Director of Operations
Jonathan Chippendale	Consultant Paramedic
Louise Colson	Head of Infection, Prevention and Control
Dr. Penelope Cresswell-Jones	Specialty Registrar in Public Health (Item 15 only)
Penny Durrant	Deputy Director of Nursing, Quality and Governance
Leanne Hawker	Head of Patient Experience & Community Involvement
Wendy Herbert	Deputy Director of Quality and Nursing
Fflur Jones	Performance Auditor, Audit Wales (Left during item 34/25)
Mark Marsden	Trade Union Partner
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Trish Mills	Director of Corporate Governance/ Board Secretary
Steve Owen	Corporate Governance Officer
Hugh Parry	Trade Union Partner
Alex Payne	Corporate Governance Manager
Felicity Quance	Deputy Head of Internal Audit
Andy Swinburn	Executive Director of Paramedicine
Liam Williams	Executive Director of Quality and Nursing
Keith Williams	(Left during item 26/25 and returned during 28/25)

OBSERVERS:

Skye Banks	Compliance Administrator
Sian Lane	Joint Commissioning Committee
Angela Mutlow	Llais
Claire Muxworthy	Clinical Intelligence and Assurance Co-ordinator

APOLOGIES:

Lee Brooks	Executive Director of Operations
Alison Kelly	Business and Quality Manager
Osian Lloyd	Head of Internal Audit
Henry Garrard	Director of Digital Services
Jonny Sammut	Trade Union Partner

22/25 PROCEDURAL MATTERS

The Chair extended a warm welcome to everyone advising that the meeting was being recorded. Apologies were noted from Lee Brooks, Alison Kelly, Osian Lloyd, Henry Garrard and Jonny Sammut.

Declarations of Interest
There were no further declarations of interest to those already listed in the Register.

Minutes
The Minutes of the meeting held on 4 February 2025 were received and confirmed as a correct record.

Committee Highlight Report – 4 February 2025
The committee highlight report dated 4 February 2025 was received. The attendance box at the end of the report was to be amended to include Rhiannon Beaumont-Wood as having attended the meeting.

Chair's Action
The ratification of the Chair's action to approve the Committee Annual Report, Terms of Reference and Cycle of Business was noted.

Action Log
The action log was considered:

Action Number 03/25: Committee Effectiveness review. *As a committee it was agreed that Comments on the Draft Annual Report should be forwarded via email for consideration. For the Priorities for 2025/26: It was requested that any ideas around priorities should be sent through by e mail. Terms of Reference: The Committee noted any amendments will be made before finalising and issued via Chair's Action to the committee for endorsement*. This work was now complete, and it was agreed to close the action.

Action Number 04/25 – Patient Story - *It was agreed that Jonny Sammut would look at what the Trust had in place from a digital perspective, website etc. in terms of accessibility and how to develop this further and improve accessibility for patients who faced barriers in accessing the service*. Jonny Sammut has considered this and the Trust does not currently have approved software in place - we have engaged with our partners at Microsoft and Apple to start conversations on what technologies may be available and these will be explored (with relevant business cases presented). It was agreed to close the action.

Action Number 04/25a: patient Story - *The Chair asked that the People and Culture Committee (PCC) monitor the progress of the wider accessibility initiative, focusing on supporting deaf individuals and others facing barriers to accessing services and engaging with the Trust.* It was agreed that as Chair of the PCC, Ceri Jackson, would take this action forward which has now been transferred to the PCC. It was agreed to close the action.

Action Number – 06/25: *The Duty of Quality Implementation Plan - Closure Report. It was agreed that the Duty of Quality Implementation Plan closure report be added as a Consent Item section at the next meeting*. Added to the Consent Item section for 9 May 2025 meeting. It was agreed to close the action.

Action Number 08/25- *Datix Recovery and Implementation Plan, It was agreed that Jonny Sammut would update Jayne Beeslee, the Non-Executive Director (NED), who is the NED Trust Board Digital Champion), with regards to her involvement in the All Wales Digital Network and the issues which are being address through this Improvement Plan*. A meeting with the Chair of FPC and the Director of Digital has been arranged in May to discuss this. It was agreed to close the action.

Action Number 13/25 - *Cancelled Calls Potential Impact Analysis. The information contained in the presentation was comprehensive and detailed, Jonathan Chippendale explained that approximately 50% of these cancelled calls likely resulted in patients who then self-presented at the Emergency Department. It was suggested by Liam Williams it would be beneficial for a more comprehensive evaluation and benefits realisation report be presented to the Committee. It was therefore agreed that Liam Williams would liaise with Rachel Marsh and Andy Swinburn to undertake this task*. Liam Williams advised that legally privileged advice had been sought and gained to confirm the opportunity for data linkage. The current advice prohibited the Trust from explicitly linking data in the national data repository for this purpose. A submission to Commissioners and Policy advisors to request Cabinet Secretary authority to work consistently with PHW and Digital Health and Care Wales has been made. It was agreed to close the action.

Committee AAA report dated

The Chair drew the Committee's attention to the contents of the AAA report for their information; this highlighted the key points from the meeting on 4 February 2025.

RESOLVED: That

(1) Apologies were recorded for Lee Brooks, Alison Kelly, Osian Lloyd, Henry Garrard and Jonny Sammut

(2) The Minutes of the Open meeting held on 4 February 2025 were confirmed as a correct record.

(3) The Committee ratified the decision made by Chair's Action to approve the Committee Annual Report, Terms of Reference and Cycle of Business.

(4) Consideration was given to the Action Log and the AAA report as described above.

23/25 OPERATIONS DIRECTORATE QUARTERLY REPORT – 2024/25 Q4

Peter Brown presented the Operations Report for quarter four, highlighting key issues such as the scrutiny on the Manchester Arena inquiry submission, the LIFE X and control room outage, the Clinical Model Transformation, the end of shift pod implementation at Glangwilli, ambulance care cancellations, integrated care updates and the Emergency Communication Nurse System (ECNS) audit. Further detailed information was contained in the update report.

Following a query on the increased volume of incidents requiring audit and investigation within integrated care, Peter Brown commented that there had been a significant increase compared to previous levels, which has posed some challenges in the short term with respect to auditing processes. He highlighted that the focus has shifted from routine and random audits to more targeted audits of specific cases. However, due to the increased audit activity during this period, some audits have not been completed as promptly as would be ideal, which was reflected in the challenges mentioned in the Putting Things Right (PTR) paper.

Liam Williams noted that while this impact was expected, it has still increased pressure on the response times to complaints and investigations, particularly affecting the 30-day target for complaints and the backlog of overdue investigations.

The Chair acknowledged that the Trust was taking all possible measures. Nevertheless, the situation remained extremely challenging. It was crucial to discuss this matter openly, as there were associated risk factors.

Ceri Jackson asked about the level of optimism in terms of reducing the handover delays and the impact these have on patients. Peter Brown referred to the Ministerial Advisory Group which announced a goal to reduce handover delays to 45 minutes, which was welcomed. However, the standard was 15 minutes, so this target should be seen as an improvement, not the final goal. To deliver the expected care for patients and improve staff work experience, the Trust needs to reduce handover delays to 15 minutes.

Ceri Jackon asked about the risk regarding the volume of concerns investigations and audits outstanding. Liam Williams commented that the Trust was developing a risk which would formally enter the Trust's governance processes in due course.

Rhiannon Beaumont-Wood sought confirmation that the audits were adapting promptly to various pathways to provide timely learning and improvement. Liam Williams gave assurance this was being managed through two main routes at an organisational level: the Technical Advisory Group and the Clinical Advisory Group, established in Q3 last year.

Following a request from Rhiannon Beaumont-Wood regarding the move to Ty Elwy. Peter Brown advised the committee that the team has successfully transitioned to Ty Elwy from 8 May 2025 The transition has been operationally smooth and effective in terms of service delivery.

RESOLVED: The Operations Report was received and noted.

24/25 PATIENT STORY

Lucie Jones presented the distressing experience narrated by Dylan's parents, Mr and Mrs Cope. Dylan was a nine-year-old boy who tragically died in December 2022 from sepsis. An investigation led by Aneurin Bevan University Health Board examined Dylan's care leading up to his death, involving NHS 111Wales. In December 2022, Mr Cope contacted 111Wales when call volumes were at their highest recorded level. Dylan had experienced severe abdominal pain, initially suspected to be appendicitis, but later diagnosed as having flu, following a hospital assessment. Dylan was subsequently discharged from hospital and when his condition worsened, his parents contacted NHS 111Wales for advice. While waiting for a call back from a clinician, Dylan's condition rapidly deteriorated. Dylan became critically unwell and following emergency surgery at the University Hospital of Wales in Cardiff, Dylan very sadly died several days later from a ruptured appendix and sepsis.

There were multiple failings and missed opportunities that may have prevented Dylan's death, and members were moved both by the circumstances that led to his death, and the drive that Mr and Mrs Cope have to ensure that his legacy is meaningful change at all levels. This includes to the delivery of services in 111Wales, and in the aftermath of tragedy, in details such as delivery of communication and the need for humanity and compassion to be at the forefront.

Lucie has been the family liaison since January 2023, meeting with Mr and Mrs Cope along with a colleague from the Sepsis Trust.

Liam Williams noted that the new Call Prioritisation Streaming Service (CPSS) used in NHs 111Wales and the Emergency Communication Nurse System used in Remote Integrated Care Service (RICS) were both implemented with Dylan in mind. Specifically, assurance was given that CPSS contained multiple red flags for sepsis symptoms which were not present in the previous system. Additionally, as part of the increased specialist knowledge and leadership being developed for RICS, an advanced clinical practitioner has been employed to improve paediatric care and support audits and learning opportunities. It was also noted that improvements in the approach to correspondence have been made by the Trust, with further adjustments sought through recent consultations on changes to the Welsh Government Putting Things Right regulations and guidance.

The committee acknowledged the ongoing efforts to ensure Dylan's legacy leads to meaningful change, and thanked Mr and Mrs Cope for their candour and their courage in sharing Dylan's story.

Peter Brown advised the committee he has had numerous interactions with Mr and Mrs Cope and acknowledged the incredible bravery of the family. Dylan's legacy continues to be a focal point of discussions and underscores the importance of quick response times, high-quality assessments, continuous education, and practice enhancement within the Trust.

Wendy Herbert, advised committee that Mrs Cope's goal and passion was to create a legacy for her son Dylan, ensuring he did not die in vain by raising awareness about sepsis. One of the Trust's aims was to educate both the public and clinicians on identifying sepsis

symptoms, which vary among individuals. The Putting Things Right (PTR) team has worked diligently under regulatory frameworks, making subtle but impactful changes to communication that could help other grieving parents.

Rhiannon Beaumont-Wood was reassured to hear that the new system addressed and responded to some of the issues raised and was pleased to hear of the early involvement of the third sector in the process. Their expertise was invaluable, and utilising their knowledge appropriately was beneficial. She queried about the support provided to staff who have been involved in supporting Mr and Mrs Cope.

Peter Brown commented that many colleagues were affected by this incident, notably PTR colleagues. The call handler involved decided not to return to work after the experience, despite being offered full support. The clinician received significant well-being support and has continued in their role. Those involved in investigations also sought and received well-being support.

Rachel Marsh discussed the 111Wales service as a gateway for individuals with urgent care needs. As an organisation, there was a need to focus on various performance and quality aspects of the service, such as response time and follow-up call speed. These elements were becoming increasingly important for the healthcare service provided to patients, similarly to those who call 999.

Members felt strongly that the board should also hear Dylan's story, and the video will be shared at the 29 May 2025 meeting.

The Chair expressed confidence in the actions that have already been taken and that the Trust remains committed to doing its utmost to continuously learn from these experiences which was part of Dylan's legacy. She extended her gratitude to Lucie, Leanne, and others involved, not only for sharing the story with committee today but also for the work they have done supporting Dylan's parents. Additionally, the Chair extended an appreciation to the wider team for thoroughly analysing what went wrong and identifying areas for improvement.

RESOLVED: The Committee received the Patient Story via a video.

25/25 STRATEGIC QUALITY PLAN 2025-28 [TO INCLUDE EQUALITY IMPACT ASSESSMENT]

Kate Blackmore presented the report acknowledging that the plan recognised the financial challenge faced by the Trust and across the NHS in Wales and subsequently had adopted a pragmatic approach. While the aim of the plan was to be more ambitious and extend efforts further, it was essential to be realistic about the capacity and resources, especially considering significant transformation programmes already underway within the Trust.

Kate Blackmore further stated that the plan aimed to be delivered using a co-production approach, seeking input from service users, staff, and the broader organisation to understand what quality meant to them. The team preparing the plan responded to committee feedback by including a draft Equality Impact assessment (EqIA). Contributions

were also received from the Welsh language lead and Trade Union partners. Kate added that further amendments may follow based on ongoing consultations with executive leads and, she was working on final formatting tweaks, before publication and onward transmission to Trust Board for approval.

Ceri Jackson welcomed the level of ambition in the plan. However, she raised concerns about resourcing and capacity to drive this work, given the level of change in the Trust and asked for reassurance on this point.

Liam Williams confirmed that the Trust was focusing on maturity, dedicated resources, and prioritising efforts. At the executive level, the Trust was balancing these priorities, aiming to embed strategic levers into the clinical model for improvement.

Rhiannon Beaumont-Wood welcomed the plan, appreciating the ambition shown in addressing inequalities and aiming to have a significant impact on population health. She was curious about the strong emphasis on the Corporate Parenting role. While it was important to address the needs of children in care, there should also be a broader focus on children and young people, particularly if the Trust aimed for substantial gains in population health through initiatives for unborn and young individuals.

Kate Blackmore responded in relation to Corporate Parenting in that the Trust focused on this area specifically because it represented a new commitment for the organisation. The objective through the strategic quality plan was to position the Trust for readiness as it developed its next long-term strategy.

The Chair sought clarity on the alignment with the clinical plan and whether any substantive changes were anticipated once full alignment was achieved. Kate Blackmore anticipated no major changes once the plan was finalised.

The Chair, on behalf of the committee thanked Kate Blackmore for her work on the plan.

The committee endorsed **the Strategic Quality Plan 2025-27** for approval by the Board.

At this stage of the meeting the Duty of Quality Implementation Plan Closure Report (brought forward from consent items) was presented to the committee and approved.

RESOLVED: That

1. **The committee endorsed the Strategic Quality Plan 2025-27for Board approval.**
2. **Approved the Duty of Quality Implementation Plan Closure Report.**

26/25 QUALITY IMPACT ASSESSMENT - URGENT CARE RESPONSE SERVICE

The Quality Impact Assessment (QIA) for the Urgent Community Response under the Clinical Model Transformation (CMT)programme was received for assurance.

Ceri Jackson referred to the definition of urgent and emergency care and questioned whether this definition remained static from a policy perspective. She added that the

discussion among Vice Chairs of other Trusts suggested that a review was important for the Trust. Rachel Marsh commented that the definition being developed may differ slightly from the current understanding and could also vary from definitions used in other parts of the UK. It was anticipated that within the next few months, Welsh Government will issue a policy statement that clarifies how urgent care will be defined in Wales.
Members noted that the QIA was a key component of the programme, and was crucial for improving outcomes, preventing unnecessary hospital admissions, and aligning to the strategic priorities within NHS Wales. The QIA was comprehensive, and members took assurance on the approach and outcomes.

RESOLVED: The Quality Impact Assessment (QIA): Clinical Model Transformation: Urgent Community Response was received for assurance.

27/25 PUTTING THINGS RIGHT REPORT - Q4 2024/25

Claire Appleton presented the report and drew attention to the following areas:

The impact of high demand across Trust Emergency and Non-Emergency Services has resulted in several significant issues:

- Harm due to extensive response times in the community for emergency care
- Distress caused by cancellations of pre-booked transport
- Large volume of high harm cases shared with Health Boards for joint investigation.
- Increase in Nationally Reportable Incident (NRI) reporting and Duty of Candour cases

There have been challenges in providing timely complaint responses; (reducing percentage of complaints responded to in 30 working days and high number of open, overdue responses.

There were two Public Interest Reports published by the Public Service Ombudsman for Wales and the findings of the Annual Welsh Risk Pool Concerns Assessment were included.

Liam Williams added that the report highlighted a high volume of activity across the Trust. Notably, this winter the Trust restricted its use of the no-send policy, which in previous years resulted in patients with lower acuity needs seeking care by alternative means, often through self-presentation at Emergency Departments. This change has allowed the Trust to support more patients with urgent care needs, although it has increased risk exposure and incident reporting. The Trust was still assessing the impact of this policy shift on system risk and patient outcomes.

Rhiannon Baumont-Wood, commented regarding the Welsh Risk pool report, and noted the overall rating of substantial despite having three substantive and four limited recommendations. The report mentioned differing opinions on the importance of coding, which seemed more applicable for the Trust and sought clarity on whether these differences have been resolved or if there were opportunities to influence this aspect more effectively.

Claire Appleton explained that the assessment covered records from January to March last year, focusing on case management and data input into the Datix system. While the processes were found to be robust, some quick fixes in data input could improve accuracy.

The overall assurance was strong, but the data did not fully reflect this, which impacted the rating. The Datix system setup, influenced by Health Boards, led to some user engagement issues. A recovery and improvement plan has been implemented to address these challenges.

Ceri Jackson expressed her concerns with some of the indicators in the report regarding resources, winter pressures, handover delays, and the lack of assurance these factors brought. Furthermore, the Ombudsman reports highlighted delayed responses, deficiencies in the complaints investigation process, and concerns about the robustness of Trust investigations. She questioned, considering the upcoming challenges in the next few months, whether the Trust was at risk of completing the quantity of Ombudsman investigations.

Liam Williams advised that the primary measure of assurance was ensuring thorough incident reporting and review processes to facilitate learning and improvement. He added there was a recognised need for enhanced scrutiny on audit processes linked to the PTR recovery plan. He added that the demand during the winter season was consistent with high levels from previous years, compounded by multiple viral infections impacting the NHS significantly. This demand influenced the quality and operations reports, highlighting the pressures faced. There were two Public Service Ombudsman reports which have been closely managed in collaboration with the Ombudsman's office. Gaps have been identified in systems and processes, which have since been addressed to ensure more effective operation.

The Committee asked for an update on the progress with the PTR recovery plan which Wendy Herbert agreed to provide at the next meeting.

RESOLVED: The Quality, Patient Experience & Safety Committee received the report for discussion and identifies any additional assurance requirements.

28/25 MONTHLY INTEGRATED QUALITY PERFORMANCE REPORT

Prior to the update, Rachel Marsh updated members regarding MIQPR metrics for the committee, advising that at a recent board development discussion, it was agreed not to change the board level metrics, though new metrics from the new performance framework starting 01 July 2025 will be included, along with adjustments from ongoing work on Amber and Green metrics.

Rachel Marsh presented the report, with members noting that the board will receive and discuss the MIQPR at its meeting in May 2025. The report highlighted high levels of call abandonment in the 111 service and the need for improved call answering performance.

Clinical response times for P2 and P3 categories were discussed, noting that many calls were not being returned within the expected two and four hour windows. The impact of handover delays was emphasised, with significant lost hours and long waits for red and amber calls.

Rhianon Beaumont-Wood raised a point about the inequalities data, concern over sickness levels, and queried how the Trust could improve the flow of patients into Same Day Emergency Care (SDEC).

Rachel Marsh advised there was a metric for staff inequalities in the data. However, they will not be changed this year, but they remained a focus for the long term. Members recognised that SDEC has been a challenging issue. It was frequently addressed in meetings with the Welsh Government and Joint Commissioning Committee (JCC).

In terms of sickness rates, Peter Brown advised that levels have decreased in the last two months and were now just below 7% for call handlers. While this level was not optimal within the organisation, it compared positively to other 111 contact centre environments.

Ceri Jackson raised the point that at Emergency Departments there was a noticeable impact on older people.

Liam Williams mentioned that the Welsh Government was working on frailty and deconditioning, with policy leads reporting to the Cabinet Secretary. This work was driving the workflow within the Six Goals Programme focused on building neighbourhood capacity and capability. There was significant pressure on improving care transfers, building community capacity to prevent hospital admissions, with the focus primarily to addresses older people, frailty, and avoiding deconditioning.

It was agreed that Rachel Marsh would conduct a deep dive analysis on the disproportionate impact of handover delays on older people and provide that information at the next meeting in November 2025.

An error was pointed out in paragraph 19 of the report regarding response abstractions. It stated that EMS abstraction levels decreased to 33.86% on March 25, below the 30% benchmark figure. This should read as above the 30% benchmark.

RESOLVED: The Committee: considered the Monthly Integrated Quality & Performance Report and actions being taken and acknowledged that it provided sufficient assurance.

29/25 MEDICINES MANAGEMENT ASSURANCE REPORT (INCLUDING AUDIT COMPLIANCE REPORT)

Jonathan Chippendale presented the Medicines Management Assurance Report. The technical details outlined in the report highlighted the efforts to improve compliance, accuracy and monitoring within the Medicines Management system. The areas covered in the report included:

1. Vehicle medicines Audit
2. Omnicell Monthly Cycle Count
3. Unresolved Controlled Drug Discrepancies on the Omnicell System
4. Patient Group Directions (PGD) – Evidence of Signed Authorisations
5. Expired PGDs
6. Abloy System

7. Notification Alerts
8. Controlled Drug Quarterly Occurrence Reports
9. Medication Errors
10. Penthrox (Ref audit report)
11. Antimicrobial report

Jonathan Chippendale added that the Advance Paramedic Practitioners were providing leadership and expertise, particularly in the use of antimicrobials, which was crucial for maintaining high standards of care. Furthermore, the transition to electronic systems had improved accuracy and monitoring.

Andy Swinburn discussed how the Trust's electronic systems offered superior insight into medicine use compared to other ambulance services. The implementation of more prescribers for antimicrobials enhanced decision-making on appropriate use.

The committee recognised the plans in place to improve overall compliance levels in medicines management.

RESOLVED: The Committee noted the contents of the report.

30/25 INTERNAL AUDIT REPORT: ROLL OUT OF PENTHROX

Jonathan Chippendale advised the committee that the audit assessed the impact of the rollout of Penthrox on patients and staff and highlighted the need for updated training modules for Community First Responders (CFR), improved access to Omnicell cabinets and safes, better protocol compliance, and reporting on the benefits of Penthrox.

Members noted that four medium-rated recommendations were made and accepted by management, and the actions will be monitored by this committee.

The Internal Audit report was erroneously omitted from the papers and the committee noted it would be uploaded following the meeting.

RESOLVED: The Committee noted the discussion at the meeting of the ARAC on the 06 March 2025, and the assurance that was received following receipt of the audit report and agreed management actions.

31/25 LEARNING FROM DEATHS (MORTALITY REVIEWS) REPORT - QUARTERS 3 AND 4 OCTOBER 2024 - MARCH 2025

The report detailed the operationalisation of the National Mortality Review Framework, including case volumes, triage, and learning elements. The disproportionate impact on older people was highlighted, with concerns about the provision in the system of equitable services to all communities. The thematic learning from Medical Examiner referrals indicated areas for improvement in end-of-life care and advanced care planning. There were continued efforts to improve collaboration with primary care and community services to enhance advanced care planning and end-of-life care.

Ceri Jackson raised concerns about whether the NHS was genuinely providing equitable services to communities.

Following a query, Wendy Herbert stated that as an organisation, the Trust does exceptionally well in end-of-life care. However, there was a lack of key partners for advanced care planning within the community, which was typically managed by primary or secondary care.

Rhiannon Beaumont -Wood sought to understand more around the cohort of patients that were self-conveying asking if it was possible to extrapolate any direct learning from any system. Furthermore, she asked if there was anything the Trust could do about the limitations of the Medical Priority Dispatch System (MPDS) categorisation.

Andy Swinburn explained that regarding the tracking of individual patients and their subsequent appearances elsewhere in the system, this data was not currently captured.

Andy Swinburn stated that the Trust will soon be the only UK ambulance service using MPDS as England was switching to NHS pathways. Although MPDS has strong evidence for identifying sick patients, it lacked specificity and often grouped many people together. While MPDS was effective in finding and categorising sick people, it also included many others who may not need urgent care.

Peter Brown noted that emerging evidence indicated that a significant number of patients were cancelling appointments following a remote clinical assessment. The ongoing work aims to understand the reasons behind these cancellations.

RESOLVED: The Committee received the report for discussion and identified any additional assurance requirements.

32/25 PATIENT EXPERIENCE AND COMMUNITY INVOLVEMENT BIANNUAL REPORT (OCTOBER 2024 - MARCH 2025)

The Patient Experience and Community Involvement (PECI) biannual report (October 2024 to March 2025) was received. The report emphasised the importance of the patient experience as a critical dimension of quality within the Trust. It highlighted efforts to increase real-time feedback from service users and the focus on patient-reported outcome measures, versus experience measures.

Leanne Hawker, following a question regarding the determination of priorities, explained that they were based on what was being emphasised at a national level in NHS Wales. There was a significant focus on national experiences, such as the maternity initiative and the upcoming survey for children and young people later this summer. Many of these priorities were being guided by national directives in Wales. There was also a substantial effort to increase survey returns and improve learning outcomes, supported by the Data Protection Impact Assessment (DPIA) currently with the Information Commissioner's Office for approval.

RESOLVED: The Committee noted the contents of the report.

33/25 UPDATE ON HEALTH INEQUALITIES MATURITY MATRIX AND POPULATION HEALTH PLAN

Liam Williams introduced the work undertaken by Dr Penelope Creswell-Jones, a specialist registrar from Public Health Wales during their six-month rotation with the Trust.

Dr. Penelope Creswell-Jones provided a presentation on the health inequalities maturity matrix and population health plan which described the progress made, its ambition and recognised the benefits of multidisciplinary collaboration to reduce and address health inequalities. The plan supported delivery of the Trust's strategic objectives and compliance with the health and care quality standards, including equitable, timely and effective services. Members were advised of the numerous opportunities related to data and intelligence, both at the level of individual patient care and improving quality through various risk assessments and tools. She added that investment in time and resources was necessary to achieve these goals, along with the Trust's commitment and accountability related to population health. Furthermore, future registrar placements may also contribute to this progress.

Ceri Jackson suggested exploring funding opportunities through the Charity for potential trust and foundations to support innovation and pilot projects in the public health space. This approach could help seize opportunities and drive forward initiatives related to population health and tackling inequalities.

RESOLVED: The Committee noted the report and received the presentation.

34/25 FOCUS ON CLINICAL INDICATOR - RETURN OF SPONTANEOUS CIRCULATION

The committee received a presentation on the clinical indicator related to Return of Spontaneous Circulation (ROSC) which emphasised the continuous improvement in ROSC rates.

Members held a discussion which highlighted the importance of evolving metrics to better reflect patient outcomes and the need for system-wide measures to improve care pathways and patient experiences.

Andy Swinburn offered to consider pausing clinical indicator presentations to committee, suggesting that it might be more beneficial to wait until new clinical indicators were developed as part of the clinical model change. This approach would avoid repeating information and provide updated and relevant insights once the new indicators are established. It was agreed this proposal would be further discussed outside of the meeting.

Jonathan Chippendale mentioned, following a question by the Chair, that other ambulance services such as East Midlands has a ROSC performance of around 23%, while London, considered an outlier, has a higher performance of approximately 29-30%.

RESOLVED: The Committee received the presentation on the clinical indicator related to the Return of Spontaneous Circulation (ROSC)

35/25 CLINICAL AUDIT PLAN AND ACTION TRACKER Q4 (UPDATE) 2024/25

The Clinical Audit Plan and Action Tracker update for Q4 2024/25 was received with no escalations.

Rhiannon Beaumont–Wood asked for an update on the safeguarding referrals audit. Jonathan Chippendale commented that he would collaborate with safeguarding colleagues to clarify the requirements of the audit. Furthermore, flexibility will be maintained to incorporate additional assurance needs as they arise, whether from patterns of events or specific requests.

RESOLVED: The committee noted the Q4 2024-25 Clinical Audit Plan and Action Tracker update.

36/25 AUDIT TRACKER Q4 2024/25

Trish Mills provided an update on the audit tracker, noting a correction in the report that six out of fourteen audit recommendations due for closure in the quarter were closed, which was a 40% closure rate, doubling the previous quarter's performance. There were no other escalations mentioned.

RESOLVED: The Committee

(1) Received assurance on the monitoring of management actions to address recommendations in the Tracker, noting any revised dates for actions.
(2) Supported the proposed approach to review the outstanding Electronic Patient Clinical Records (ePCR) audit recommendations.

37/25 FEEDBACK FROM EFFECTIVENESS REVIEW, COMMITTEE CYCLE OF BUSINESS MONITORING REPORT AND 2025/26 PRIORITIES

Trish Mills discussed feedback related to the effectiveness review, committee cycle of business, and monitoring report. The Chair's action for the approval of the Annual Report and Terms of Reference was ratified. Additionally, she proposed focusing on no more than three priorities for the year, emphasising that these should align with existing work rather than adding new tasks.

The three priorities discussed were:

1. Focus on the Clinical Model Transformation (CMT), ensuring robust quality assurance and patient experience improvements.
2. Continued monitoring and reporting on performance against the duty of quality and duty of candour.
3. Prioritising the implementation of the new strategic quality plan to ensure tangible outcomes.

Ceri Jackson advocated the importance of focusing on the CMT. She also suggested continuing the focus on the Duty of Candour and considering the progress around the implementation plan of the strategic quality plan.

Rhiannon Beaumont-Wood supported the idea of focusing on the CMT as a priority. She also suggested conducting deep dives on specific areas such as the 111 service to better understand quality assessment and the experiences of Community First Responders.

Andy Swinburn emphasised the importance of considering the absence of baselines for many of the elements being reviewed in the CMT. He cautioned that while reviewing these elements, it might illustrate harm or deterioration in patients' conditions, which previously might not have been quantified.

Bethan Evans highlighted three key areas of focus: the continuous measurement of performance against the Duty of Quality and Candour; the CMT, and the implementation of the quality strategy.

Bethan Evans suggested considering an email poll to gather feedback from members on the frequency and duration of meetings aimed to address the recurring theme in feedback about the length of agendas and meetings, and whether more frequent, shorter meetings might be more effective than less frequent, longer ones.

Trish Mills mentioned that the Audit, Risk and Assurance Committee (ARAC) was considering the frequency and structure of meetings, including the Academic Partnership Committee (APC), within Q1 and Q2. This review will consider quorum requirements, frequency, and the natural crossroads of the APC.

Bethan Evans suggested that committee members be mindful of the ongoing work to address the feedback received about meeting frequency and duration.

RESOLVED: The Committee

(1) Ratified the decisions made by Chair's Action effective the 24 April 2025 in relation to the outputs of the annual committee effectiveness review.
(2) Noted the output of the Mentimeter survey held on the 04 February.
(3) Noted note the proposed changes to operating arrangements for 2024/25 and the outcome of the meeting of the ARAC on the 01 May 2025.
(4) Discussed and agree its priorities for the 2025/26.
(5) Noted the cycle of business monitoring report for quarter one of 2025/26.

38/25 RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK

Julie Boalch presented the report advising that this was the same data that was presented to Trust Board in March 2025 acknowledging that the risks have all been updated in readiness for the next round of governance.

Liam Williams highlighted that the focus of the committee agenda remains on the system pressures and the impact this has on people which is discussed and highlighted

throughout the meeting. The discussions are directly related to managing and assuring members against the risks identified, particularly those associated with the clinical model transformation and patient care.

A risk relating to concerns in relation to the overdue investigations and audit processes and the need to put more scrutiny on the Putting Things Right recovery plan and the wider organisational impacts is in development.

RESOLVED: The Committee considered the contents of the report.

39/25 CONSENT ITEMS

The following two reports were received for information:

Health Inspectorate Wales Report

Llais Report - Getting Urgent and Emergency Healthcare in Welsh Hospital

RESOLVED: The Health Inspectorate Wales Report and Llais Report - Getting Urgent and Emergency Healthcare in Welsh Hospital were received.

40/25 KEY MESSAGES FOR THE BOARD

These would be articulated on the Committee's Highlight report.

RESOLVED: The Committee noted that the key messages for the Board would be articulated through the Committee highlight report

41/25 REFLECTIONS AND SUMMARY OF DECISIONS/ACTIONS

Members' reflections on the meeting included:

1. The deeply moving story of Dylan and the need to keep the patient at the heart of what we do.
2. Robust discussions and good updates provided throughout the agenda.
3. Concerns regarding capacity challenges within the Trust, particularly regarding concerns and investigations progress.
4. The need for balance throughout the agenda regarding presentations and discussion was acknowledged, given the extensive business for the committee and the length of the meetings.
5. The committee welcomed Jayne Beeslee, Non-Executive Director, who observed as part of her ongoing induction. Additionally, Sian Lane, a colleague from the Joint Commissioning Committee, observed the meeting.

Date of Next meeting: 13 June 2025

Meeting concluded at 15:20

QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE
HIGHLIGHT REPORT TO BOARD

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

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

Trust Board Meeting Date	29 May 2025
Committee Meeting Date	9 May 2025
Chair	Bethan Evans

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. **Handover delays continue to present patient safety risks and extended waits in the community** with red performance being outside of what is acceptable to deliver a safe emergency service. The Trust's focus is to implement a change in how it responds to patient demand through the Clinical Transformation Programme (CMT). The committee also received an update on the Ministerial Advisory Group regarding handover delays, which aims to move to a 45 minute position. There was optimism about the firm positioning of this initiative and a commitment to work with the system to achieve it, noting that the standard is 15 minutes.

2. The Trust has navigated a particularly challenging winter, with demand levels comparable to the exceptional pressures of 2022/23, including the impact of multiple community viral infections. In contrast to previous years, the 'no send' policy from the Clinical Safety Plan was not routinely applied, enabling the Trust to provide care to more patients with urgent needs. While this decision supported patients, it also meant that the Trust held more risk directly - risk that would ordinarily sit across the wider system - which contributed to an increase in incidents and complaints.

3. Although this impact was anticipated, it has nonetheless placed additional and increased pressure on our response times to complaints and investigations, particularly affecting the **30-day target for complaints, and the backlog of overdue investigations**. Against this backdrop - and in the context of the two recent Public Interest Reports from the Public Services Ombudsman for Wales and the annual Welsh Risk Pool Concerns Assessment - committee members sought assurance on progress toward recovery and on timely learning. They noted the following positive developments and mitigating actions:

   - The PTR and Datix recovery plans previously reviewed by the committee;

- Investment in the PTR team in 2024/25 to help manage the backlog of investigations, and now additional investment in audit capacity within operational and clinical teams, with recruitment underway and impact expected in Q2;
- Continued confidence in incident reporting systems, including enhancements to support earlier learning from complaints and incidents;
- A proactive approach to learning from the point of care, including through patient complaints and Medical Examiner processes;
- Organisational risks 223 and 224 continuing to inform our assurance arrangements and current response structures;
- A new, specific risk relating to audit processes and overdue investigations in development;
- Operational and QIA reporting refined to better capture demand pressures and the changes implemented in response.

There was a recognition that the key driver to making this required change is the ability of the system to reduce the significant impact experienced by people as a result of the breadth and depth of handover delays.

4. The committee will review progress against the recovery plans in August 2025 to gain further assurance.

ADVISE

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

5. Members expressed thanks to **Mr and Mrs Cope, parents of Dylan Cope.** Dylan's story, shared by his parents Corinne and Lawrence, detailed the tragic death of their nine-year-old son, Dylan from sepsis in December 2022. Dylan experienced severe abdominal pain, initially suspected to be appendicitis, but later diagnosed as having flu, following a hospital assessment. Dylan was subsequently discharged from hospital but when his condition worsened, they contacted NHS 111 Wales (111) for advice. Whilst waiting for a call back from a clinician Dylan's condition rapidly deteriorated. Dylan became critically unwell and following emergency surgery at the University Hospital of Wales in Cardiff Dylan tragically died several days later from a ruptured appendix and sepsis.

   Members felt strongly that the board should also hear Dylan's story, and the video will be shared at the May board meeting. There were multiple failings and missed opportunities which may have prevented Dylan's death, and members were moved both by the circumstances that led to his death, and the drive that Mr and Mrs Cope have to ensure that his legacy is meaningful change at all levels. This includes to the delivery of services in 111, but also in the aftermath of tragedy, in details such as delivery of communication and the need for humanity and compassion to be at the forefront.

   Members were told that changes to the Remote Clinical Service were implemented with Dylan in mind, including multiple safety nets for red flag sepsis symptoms. Additionally, an advanced clinical practitioner has been employed to improve paediatric care and support audits and learning opportunities. Improvements in the approach to correspondence have been made, with further adjustments sought through relevant Welsh Government regulations.

The committee acknowledged the ongoing efforts to ensure Dylan's legacy leads to meaningful change, and thanked Mr and Mrs Cope for their candour and their courage in sharing Dylan's story, and likewise for the WAST staff who have been supporting Mr and Mrs Cope.

6. The Committee received **an update following the patient story from Gemma, which was received by the committee in February.** Gemma shared her experience as a profoundly deaf British Sign Language user in accessing healthcare.

7. **The Strategic Quality Plan 2025-27** was received and endorsed for approval by the board. The plan is attached at Annex A. Members acknowledged the need to prioritise the implementation of the plan, balancing its ambition with capacity and resource availability. Members were assured that quality is embedded into the CMT programme and noted the importance of educating and training staff to integrate the strategic levers into their roles.

8. The Committee received the **Operational Update for Q4 2024/25,** and of note highlighted scrutiny on the Manchester Arena inquiry, business continuity challenges, the CMT programme, end-of-shift pod implementation, ambulance care cancellations, integrated care planning, and ECNS audit. Discussions on the overdue investigations and bottlenecks from an audit perspective are noted in the alert section above.

9. The **Health Inspectorate Wales** report on the Emergency Department at the Grange University Hospital, and the **Llais** report entitled Getting Urgent and Emergency Healthcare in Welsh Hospitals were received.

10. Members' **reflections** on the meeting included:

    - The deeply moving story of Dylan and the need to keep the patient at the heart of what we do.
    - Robust discussions and good updates provided throughout the agenda.
    - Concerns regarding capacity challenges within the Trust, particularly regarding concerns and investigations progress.
    - The need for balance throughout the agenda regarding presentations and discussion was acknowledged, given the extensive business for the committee and the length of the meetings.
    - The committee welcomed Jayne Beeslee, Non-Executive Director, who observed as part of her ongoing induction. Additionally, Sian Lane, a colleague from the Joint Commissioning Committee, observed the meeting.

11. The committee **met briefly in private** to approve the minutes of the February private session.

ASSURE

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

12. The **Monthly Integrated Performance Report (MIQPR)** was received, with members noting that the board will receive and discuss the MIQPR at its meeting in May. The report highlighted high levels of call abandonment in the 111 service and the need for improved call answering performance. Clinical

response times for P2 and P3 categories were discussed, noting that many calls are not being returned within the expected two and four-hour windows. This was the subject of discussion in Dylan's story also. The impact of handover delays was emphasised, with significant lost hours and long waits for red and amber calls. The importance of focusing on inequalities data and metrics, including geographic and protected characteristics, to better understand and address disparities in service delivery was raised, as were challenges in improving flow into SDEC pathways and the need for better collaboration with Health Boards to operationalise direct referrals.

13. The **Putting Things Right (PTR) Report** for Q4 2024-25 was received. The board will note the alert above regarding response times to complaints, but also of note was good work around compliance with the five working day target for issuing Duty of Candour initial letters.

14. The Public Service Ombudsman of Wales (PSOW) has published two **Section 23 Public Interest Reports** involving the Trust during March 2025 (one issued jointly to WAST and Swansea Bay University Health Board). The joint report detailed a missed opportunity for clinical review from CSD and a poor standard of complaint investigation. The second report identifies issues with clinical record-keeping and aspects of the complaints handling process; delays in information sharing and a lack of completeness within the investigation. The recommendations have largely already been undertaken, with evidence of completion being provided to the PSOW.

15. The **Annual Welsh Risk Pool (WRP) Concerns Assessment** has received an overall substantial rating, notwithstanding four areas of limited assurance regarding management of concerns, organisational learning and WRP reimbursement process. The Report highlights that processes for legal case management are considered to be an exemplar arrangement. Actions to address the issues will be monitored via the audit tracker

16. **The Learning from Deaths (mortality reviews) report Q3 and Q4** detailed the operationalisation of the National Mortality Review Framework, including case volumes, triage, and learning elements. The disproportionate impact on older people was highlighted, with concerns about the provision in the system of equitable services to all communities. The thematic learning from medical examiner referrals indicated areas for improvement in end-of-life care and advanced care planning. There are continued efforts to improve collaboration with primary care and community services to enhance advanced care planning and end-of-life care.

17. The **Quality Impact Assessment (QIA) for the Urgent Community Response** under the CMT programme was received. Members noted that this as a key component of the programme, and is crucial for improving outcomes, preventing unnecessary hospital admissions, and aligning to the strategic priorities within NHS Wales. The QIA was comprehensive, and members took assurance on the approach and outcomes.

18. The **Medicines Management Assurance Report** was received. The technical and detailed discussion highlighted the efforts to improve compliance, accuracy and monitoring within the Medicines Management system. The Advance Paramedic Practitioners are providing leadership and expertise, particularly in the use of antimicrobials, which is crucial for maintaining high standards of care. The transition to electronic systems improves accuracy and monitoring. Members were assured on the ongoing improvements despite the recognised challenges.

19. **Internal audit on Roll-out of Penthrox** was presented. The audit assessed the impact of the rollout of Penthrox on patients and staff and highlighted the need for updated training modules for Community First Responders, improved access to Omnicell cabinets and safes, better protocol compliance, and reporting on the benefits of Penthrox. Four medium-rated recommendations were made and accepted by management, and the actions will be monitored by this committee.

20. Committee received a presentation on the **clinical indicator related to Return of Spontaneous Circulation (ROSC)** which emphasised the continuous improvement in ROSC rates despite extended response times and the importance of measuring patient outcomes that matter most to them, such as survival to discharge without neurological deficits. The discussion highlighted the importance of evolving metrics to better reflect patient outcomes and the need for system-wide measures to improve care pathways and patient experiences.

21. The **Clinical Audit Plan and Action Tracker update for Q4 2024/25** was received with no escalations.

22. The **Patient Experience and Community Involvement (PECI) biannual report (October 2024 to March 2025)** was received. The report emphasised the importance of the patient experience as a critical dimension of quality within WAST. The report highlighted efforts to increase real-time feedback from service users and the focus on patient-reported outcome measures, versus experience measures. The significant work undertaken by the PECI team was noted, which included attendance at 96 events and engaging with over 5000 people.

23. Members received a presentation on the **health inequalities maturity matrix and population health plan** which described the progress made, its ambition and recognised the benefits of multidisciplinary collaboration to reduce and address health inequalities. The board's endorsement of the population health principles, commitments, aims, and vision will continue to strengthen the approach and keep momentum. The plan supports delivery of the Trust's strategic objectives and compliance with the health and care quality standards, including equitable, timely and effective services.

24. An update was received on the **Audit tracker** with 40% (18% 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.

25. The outputs of the Committee's **annual effectiveness review** were discussed and the terms of reference and annual report that were approved by Chair's Action were ratified. The committee set its priorities for 2025/26 as:

    - Focus on the clinical model transformation, ensuring robust quality assurance and patient experience improvements.
    - Continued monitoring and reporting on performance against the duty of quality and duty of candour.
    - Prioritising the implementation of the new strategic quality plan to ensure tangible outcomes.

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.

It's important to note that the focus of the committee agenda remains on the system pressures and the impact this has on people which is discussed and highlighted throughout the meeting. The discussions are directly related to managing and assuring members against the risks identified, particularly those associated with the clinical model transformation and patient care.

It was noted that patient safety risks and learning opportunities may not be identified in a timely way if the number of open, uninvestigated incidents is not addressed.

New Risks Identified:

A risk relating to concerns in relation to the overdue investigations and audit processes and the need to put more scrutiny on the Putting Things Right recovery plan and the wider organisational impacts is in development.

COMMITTEE AGENDA FOR MEETING		
Operations Directorate Quarterly Report for Q4 2024/25	Patient story	Quality Plan 2025-27 and EqIA
Quality Impact Assessment (Urgent Care Response Service)	Putting Things Right Report with Annual WRP concerns assessment and section 23 Public Service Ombudsman for Wales reports	Monthly Integrated Quality and Performance Report and annual review of metrics
Medicines management assurance report	Internal audit – roll out of Penthrox	Learning from deaths (mortality reviews) report Q3 and Q4
PECI Biannual report	AACE benchmarking tool public health update	Focus on clinical indicator – ROSC
Clinical audit tracker	Audit tracker	Feedback from effectiveness review and setting of priorities
Risk management and BAF	Duty of quality implementation closure report (consent item)	HIW report (consent item)
Llais report – getting urgent and emergency healthcare in Welsh hospitals (consent item)		

COMMITTEE ATTENDANCE					
NAME	**9 MAY 2025**	**13 JUN 2025**	**5 AUG 2025**	**4 NOV 2025**	**3 FEB 2026**
Bethan Evans (Chair)					
Ceri Jackson					
Rhiannon Beaumont-Woods					
Liam Williams					
Andy Swinburn					

Lee Brooks	Peter Brown				
Rachel Marsh					
Jonny Sammut	Keith Williams				
Trish Mills					
Mark Marsden					
Hugh Parry					
Henry Garrard					

	Attended
	Deputy attended
	Apologies received
	No longer member

WELSH AMBULANCE SERVICES NHS TRUST

MINUTES OF THE OPEN SESSION OF THE EXTRAORDINARY MEETING OF THE QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE HELD ON 13 JUNE 2025 VIA TEAMS

Meeting started at 09:30

PRESENT:

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

IN ATTENDANCE:

Claire Appleton	Assistant Director of Putting Things Right
Kate Blackmore	Assistant Director of Quality Governance
Julie Boalch	Assistant Director of Corporate Governance and Risk
Jonathan Chippendale	Consultant Paramedic
Penny Durrant	Deputy Director of Nursing, Quality and Governance
Leanne Hawker	Head of Patient Experience & Community Involvement
Sarah Harland	Corporate Governance Officer
Jason Killens	Chief Executive Officer
Mark Marsden	Trade Union Partner
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Steve Owen	Corporate Governance Officer
Hugh Parry	Trade Union Partner
Alex Payne	Corporate Governance Manager
Felicity Quance	Internal Audit
Andy Swinburn	Executive Director of Paramedicine
Liam Williams	Executive Director of Quality and Nursing

APOLOGIES:

Lee Brooks	Executive Director of Operations
Wendy Herbert	Deputy Director of Quality and Nursing
Trish Mills	Director of Corporate Governance/ Board Secretary
Jonny Sammut	Director of Digital Services

42/25 PROCEDURAL MATTERS

Declarations of Interest

There were no other declarations of interest to those already in the register of interests.

Apologies

Apologies were recorded from Lee Brooks, Wendy Herbert, Trish Mills and Jonny Sammut.

The Committee RESOLVED To:

(1) Note there were no other declarations of interest other than those already on the register.
(2) Note the apologies recorded for Lee Brooks, Wendy Herbert, Trish Mills and Jonny Sammut

43/25 DUTY OF QUALITY ANNUAL REPORT 2024/25

Liam Williams advised the committee that Kate Blackmore has led colleagues from across the Trust to create the report. The report has been reviewed by Executives individually and by the Executive Leadership Team and agreed upon at the Clinical Quality Governance Group. It was now presented for endorsement prior to submission for approval to the Trust Board for publication.

Kate Blackmore commented that following the publication of last year's first Duty of Quality Annual Report, feedback was sought from the NHS Executive Quality team and the Chair of the National Reference Group for the Duty of Quality. Both provided highly positive feedback on the initial report. The reference group reconvened to review all Duty of Quality annual reports across NHS Wales prior to generating this year's report. The team adhered to a similar format and incorporated guidance from the Communications Team regarding the accessibility of the report on the website. It was recommended that the Sway platform be used instead of publishing a PDF to better support accessibility tools. Consequently, the 2024/25report appears slightly different from the 2032/24 report.

Kate added that the team used the Health and Care Quality Standard self-assessment to generate content against the twelve Health and Care Quality Standards for this year's report. Additionally, content from the Integrated Medium Term Plan (IMTP) was used to outline the Trust's intentions with a quality perspective for the next twelve months, providing a comprehensive report that included reflection, assessment, and forward-looking goals.

The Committee noted that whilst the Duty of Candour reporting will be incorporated into the Annual Putting Things Right Report for 2024/25, which will be published in October, the Duty of Quality report content was aligned with this activity as it helps the Trust hear the citizen's voice and produces opportunities to learn and drive improvement. The annual report has been produced using Sway to ensure the Trust meets its accessibility requirements when published on the website.

Ceri Jackson noted the challenges of making the report accessible to the public while meeting requirements. Feedback indicated reports were too long, often exceeding 50 pages. Kate Blackmore noted that initial drafts were shorter, but converting to Sway made them longer. She will continue efforts to keep reports as concise as possible while covering the full scope of quality duties.

Ceri Jackson added that the Trust's focus on digital and prioritisation, were fundamental to the Trust's work and priorities, particularly in collaboration with partners. As priorities were considered for the upcoming year, she asked how the Trust could ensure it was making informed and effective decisions concerning these areas. Liam Wiliams commented that the IMTP has a level of investment that has been made available for this financial year to strengthen the approach to data and digital.

Ceri Jackson raised another query regarding Equality, Diversity and Inclusion (EDI) which she considered to be an overarching theme but would appreciate any additional insights on this subject. Kate Blackmore added that the team had collaborated closely with the EDI team to identify key elements that would align with the Equitable standard. Over the next 12 months, the aim was to enhance accessibility by promoting resources more effectively, beyond just publishing them in committee papers.

Rhiannon Beaumont-Wood remarked on the importance of leveraging this report to foster a sense of pride among staff and enhance their contributions. This included discussions on data, clinical care bundles, and reporting. Additionally, she emphasised the need to collaborate with partners to improve accessibility.

Kate Blackmore explained that the Trust was preparing to launch the quality hub and introduce the Life QI tool, along with new software tools designed to enhance efficiency. From clinical compliance to bundle work, steps have been taken to reframe the electronic Patient Care Record (ePCR) for improved usability. The Duty of Quality page will feature a promotional piece to motivate staff to take assurance and pride in this significant journey.

Liam Williams added that the work completed to build the Clinical Model Transformation Programme has been carried out ensuring close cooperation with NHS partners across Wales. This work led to the cabinet secretary's agreement on the change to the Red Code set, involving collaboration across health boards, policy groups, and NHS service leadership areas.

Bethan Evans stated that she would send an email after the meeting with specific examples of how the Trust could frame things differently to be more accessible to the public. She suggested emphasising the importance of collaboration and co-production in the strategy, noting that this was fundamental to future success. Strengthening this section might better engage partners and clarify the significance of these efforts.

In addition, at the conclusion of the report addressed to the public and the patient reference group, a succinct summary might provide a more refined closing. This summary could emphasise the Trust's accomplishments over the past year while recognising the tasks that lie ahead, reaffirming dedication to patient safety and our aspiration to develop a high-quality, responsive emergency service.

In conclusion, Bethan Evans added that effective report writing required the clear communication of objectives and achievements. Including a final summary could help provide a more consistent ending.

Kate Blackmore stated that the Sway document in today's pack was updated, but the narrative Word document annex was not as the papers were already submitted.

The committee reviewed, commented in detail, endorsed and supported the onward transmission to the Board following a final review.

Jason Killens commented it was an excellent piece of work that showcased the wide range of the Trust's achievements. The journey undertaken and the exceptional efforts of everyone involved was clear.

Bethan Evans expressed her gratitude for the leadership provided by Jason Killens, noting that this would be his final attendance at the Quest meeting.

Jason Killens expressed his gratitude to Bethan and all members of the committee for their exceptional contributions to the Trust. This committee faced considerable challenges, managing extensive content and activities with remarkable dedication.

The Committee RESOLVED To review, comment on and endorse the Duty of Quality Annual Report 2024/25, subject to a final check, for onward approval at Trust Board.

Date of Next meeting: 5 August 2025

Meeting concluded at 10:15

QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE
HIGHLIGHT REPORT TO BOARD

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

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

Trust Board Meeting Date	26 June 2025
Committee Meeting Date	13 June 2025 – Extraordinary Meeting
Chair	Bethan Evans

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. Nil

ADVISE

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

2. The committee held an extraordinary meeting to receive the **2024/25 Duty of Quality Annual Report** for endorsement ahead of approval at Trust Board on 26 June 2025.

3. The report ensures the requirements of the Duty of Quality statutory guidance 2023 are met and describes the Trust's compliance against the duty itself and its ambition for the years ahead. The annual report summarises the Trust's quality improvement progress across the 12 Health and Care Quality Domains during 2024/25; noting progress to improve the quality of our services and population outcomes and sets out the Trust's intentions for 2025/26.

4. The critical role of digital data was emphasised with the focus on building strong foundations for digital and data capabilities which are essential for supporting clinical practice and transformation. There is a plan to promote and make Equality, Diversity and Inclusion related intelligence more accessible through the duty of quality web page.

5. The launch of the Quality Hub and new tools like Simply Do and Life Qi will support improvement journeys, planning, and reporting and highlights that these initiatives are part of the effort to build QI capacity across the Trust. A key focus for the next year is on local and national partnership, collaboration and co-production.

6. The Committee noted that whilst the Duty of Candour reporting will be incorporated into the Annual Putting Things Right Report for 2024/25, which will be published in October, the Duty of Quality report content is aligned with this activity as it helps the Trust hear the citizen's voice and produces opportunities to learn and drive improvement. The annual report has been produced using Sway to ensure the Trust meets its accessibility requirements when published on the website.

7. Four annexes to the report provide additional context and documentation related to the Duty of Quality Annual Report and statutory guidance.

ASSURE

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

8. Nil.

RISKS

9. Nil.

COMMITTEE AGENDA FOR MEETING		
Duty of Quality Annual Report 2024/25		

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					
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Lee Brooks	Peter Brown				
Rachel Marsh					
Jonny Sammut	Keith Williams				
Trish Mills		Juile 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
27/25	9 May 2025	Putting Things Right Report	An update was requested on the progress of the Putting Things Right Recovery plan, it was agreed this would be provided at the next meeting.	Wendy Herbert	5 August 2025	Update 28 July 2025 The Putting Things Right Recovery Plan was presented at the meeting of the Executive Leadership Team on 30 July 2025 for further consideration and next steps ahead of the meeting of the QuEST committee on 5 August 2025, Liam Williams will give a verbal update to this effect. If the committee is satisified with this update, this item can be proposed for closure	Complete
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	04-Nov-25	Open
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	05/08/2025 A meeting has been arranged on 4 September 2025 with Liam Williams, Ceri Jackson and David Hopkins to explore funding opportunities through the charity.	Complete

OPERATIONS DIRECTORATE
QUARTERLY REPORT FOR COMMITTEES
2025-26 Q1 (April – June 2025)

National Operations & Support

IMTP

Launch of Assemble

The Volunteer Service has launched a brand-new Volunteer Management System which improves our access to volunteer demography, volunteer availability and acts as a single source of communication to volunteer groups across the Trust. Training was developed and delivered by a Volunteer Support Officer. Feedback from volunteers was excellent including comments such as "This is probably the biggest advance since Penthrox" and "You truly deserve credit for this piece of work."

Volunteer Steering Group Refresh

The Volunteer Steering Group membership has been refreshed with a newly elected Chair taking position in April 25. A volunteer representative is also now included in the attendance of the WAST Charity Committee.

Volunteer Structure

The Volunteer Steering Group has now commenced a review of the Volunteer Structure which will address gaps in capacity within the volunteer service by upskilling volunteers and implementing a consistent structure across volunteer teams, localities and territories which will improve volunteer experience.

Volunteer Responder Pathway

Applications opened for CWR to CFR transition courses which relates to our new volunteer pathway. 30 applications have been received with 28 CWRs progressing onto CFR transition courses from July.

General Update

Business Continuity (BC) Software

Implementation of BC software continues with data being provided to the supplier to pressure test the system. Additional information is being sought from various departments and support is required to get this information in a timely manner. Support via the Operations Senior Operations Team (SOT) is being sourced to facilitate this. Rollout to wider departments and directorates is scheduled for August with full implementation to complete Sept-Oct 25.

Resourcing, EMS Coordination and Quality

General Update

Estates

The refurbishment of Llangunnor estates has been completed. After consultation with colleagues working from the site, Ty Tywi was selected as the name for the newly renovated site.

Operational teams relocated from Bryn Tirion to Ty Elwy, finishing with EMSC on 8 May 2025. WAST became the first Trust to implement the life X control room solution in new facilities. The Ty Elwy Coordination and Communications Centre was officially opened by High Sheriff Julie Gillbanks on 12 June 2025, with Lee Brooks and Andy Swinburn attending.

MAIT

Multi Agency Incident Transfer (MAIT) allows incidents to be electronically shared between WAST, police, and fire services, negating the need for telephone contact. It went live on Monday, 16 June 2025 with Gwent Police and South Wales Police. Other emergency services will join in phases.

Training

CMT (Clinical Model Transformation) training was undertaken and successfully rolled out prior to the July 1st launch of the new Ambulance Performance Framework. Relevant SOPs have been updated, and training feedback will help shape the CMT FAQs.

Yorkshire Ambulance Services

We continue to support Yorkshire Ambulance Service (YAS) by answering a proportion of their 999 call activity whilst they complete their training on their replacement triage software (NHS pathways replacing MPDS). This support is likely to continue until early October 2025. There are discussions ongoing to establish whether the level of support can be reduced slightly during the busier summer months when annual leave uptake will be higher. WAST has agreed income because of this support and regularly monitors for any significant performance consequences.

Kings Ambulance Service Medal (KAM)

Laura Charles, Operations Manager at Vantage Point House, has been awarded the 2025 King's Ambulance Medal for her dedication and commitment to the Ambulance Service.

Operations Quality

The Operations Quality OCP planning is ongoing, with the intention to move broader call audit functions (CPSS and ECNS), and complaints/coroners' investigations across from Integrated Care into Operations Quality. The first phase of this is the recruitment of 10 CPSS Quality Auditors, which has been approved, and the recruitment process is well underway and are now live on TRAC.

Challenges

EMSC Sickness

We will continue efforts to address sickness and support staff. There has been a slight improvement in our current position since the last quarter's update, following workshops conducted by the EMSC leadership team, trade union partners, and people services.

Operations Quality

Operations Quality continues to experience challenges in completing and returning investigations for concerns and coroners. There are now 117 outstanding concerns investigations of which 94 have breached the Welsh Govt. Tier 1 target. However, there are now 27 outstanding coroner's statements down from 55 at the end of Q4.

Challenges persist in obtaining key information for investigations involving clinician input (Clinical Support Desk). Teams are collaborating to expedite requests and prioritise coroner's statements as needed by Legal Services, having returned three Schedule 5 statements to HMC by the requested date.

IMTP

EMSC Reconfiguration and Restructure

We held an EMSC restructure review with Trade Union partners and colleagues, and feedback will be incorporated into ongoing operations. The evaluation included the single allocator model, and teams will pursue identified quick wins. Largely positive feedback, recognising the development opportunities and career progression now available within EMSC. Some themes identified within the feedback highlighted was that roles were now clearly defined, issues were heard and actioned, good collaboration with Trade Union Partners and felt that the consultation process was robust and transparent. One of the main concerns from the feedback was the changes to the zones/border realignment which will be further reviewed.

Resourcing

Move from Geographical to Functional Model:

This process aims to standardise operations, with a dedicated resourcing team assigned to each of the four main business areas. As part of the phased rollout, Ambulance Care Coordination and Central and West resourcing for Ambulance Care Assistants have joined the North Resourcing team. Ongoing improvements and feedback will inform future planning. We are on track to implement the full model by the end of Quarter 3.

111 to GRS:

Currently, the 111 teams use ShiftTrack as a rostering system but plan to transition to GRS. To minimise staff disruption, a project team has set up a test environment and will collaborate further with Total Mobile for testing. Two groups are being established: one to complete pre-production rostering in GRS and self-roster, and another to review post-production processes like meal break management and intraday activity.

eTimesheet & GRS to Cloud:

The project board and working groups are established, with good progress on eTimesheets and GRS cloud migration. July's partnership meetings will discuss some matters relating to terms and conditions and reaching agreement on those for the electronic timesheet.

Emergency Medical Service

Challenges

Continued System Pressures

Delayed handover of care at Emergency Departments across Wales remains a significant challenge in being able to provide a safe level of emergency service. . 21,181 hours were lost in April, 19,670 in May and 15,276 in June. The impacts of these pressures are regularly discussed at Committee and Trust Board.

Community Wait Times

While handover delays have seen a degree of improvement compared to January 2025 at 27,212 hours and June 15,276, this has not fully translated into improved Red performance. However, while it is recognised that there have been some improvements in Red response, from January 2025 48.3% to 50.7% end of June, overall, the Red performance fell short of 65%. We have however experienced an improving trend in our Amber median and Amber 95th percentile wait times (Amber median reporting 149 minutes in January 2025, and 93 minutes in June 2025 – according to EMS Operations Power BI report).

IMTP

APP Roster Review

Work is now progressing with the full roster review of all APP rotas. The roster review will take account of all aspects of APP work including all rotational and commissioned workstreams as well as the APP operational contribution. The rotational models currently undertaken by WAST APPs include Primary Care (including GPOOH) and APP Navigator models.

Team Based Working

An initial workshop has been arranged to discuss the approach to pilot Team Based Working into EMS. Initially this will be undertaken as a pilot process likely in an urban and rural setting to fully understand the implications and change adaptions required to accommodate. Timelines and locations will be discussed and agreed at the workshop, planned in for 28th July 2025 in Cardiff.

General Update

EV Solo Response Vehicle (SRV) Introduction

EMS will soon see the role out of the 24/25 SRV, which includes the Ford Transit Hybrid (PHEV) along with the Maxus (BEV). The Maxus battery powered electric vehicle will be the first vehicle commissioned by Welsh Government that will be fully electric.

To support the role out and subsequent evaluation of these vehicles, supportive infrastructure has been put in place; this includes a number of 50kw chargers at locations across Wales.

A training package is also in development to support staff in the use of the EV, alongside an accompanying SOP to support the 4-month evaluation determining the future use of electric vehicles across Emergency Operations.

End of Shift Overruns

Trade Union Partners (TUP) and leadership teams have worked to understand the current issues through three overrun workshops focusing on the following:

- Workshop 1: Analysis of the current position, blue sky thinking, welcoming all ideas
- Workshop 2: Exploring feasible solutions and realistic options
- Workshop 3: Developing an agreed plan for implementation

Next step is to complete a paper mapping out future options with recommendations to support meaningful change to improve end of shift overruns and support staff welfare. Dialogue with trade unions is ongoing.

Finance - Overtime

Following the reasonable assurance outcome from our internal audit, the following measures have been applied:

To ensure maximum uptake whilst maintaining equity of services we have proposed the following:

- Overtime hours to be allocated in the same manner as previous years once budget has been set. Therefore, each health board area will have an allocation dependant on vacancies at the beginning of FY.
- During the monthly review, any underspends in the previous month will be offered to those areas with a strong likelihood of uptake to maximise potential

for expenditure. These additional hours will be subject to the same criteria/UHP levels.

- At the end of every quarter, a review of all overtime activity to be undertaken to assess utilisation. Any areas consistently under-utilising their allocation will have a review and potential change to hours available. Surplus hours will then be re-allocated to other areas to ensure maximum uptake.

Hospital Trials

Royal Glamorgan Hospital (RGH)

A suite of tactics have been employed across the Emergency Department to focus on reduced notification to handover (N2H). Continuous dialogue between WAST and RGH is ongoing with regular evaluation of performance. N2H for the 3 weeks preceding this report averages between 23-40mins which demonstrates a significant reduction already seen from previous averages of 90 minutes.

Morriston Hospital

Conducting a 6-week PDSA across the whole system to support reduction in handover times. Average handover since inception (2nd June) is 61 mins which also demonstrates a significant reduction from previous average of 160 minutes.

EAP Training

EAP training continues to progress well. The following table provides an overview of the 'live' position of staff who have completed their training:

Total number of EMT 2 staff who have applied for the EAP course	494	
Total EMT2 staff trained to date		
Matrix	48	
Pentwyn	46	
Ty Elwy	46	
Total	140	28%
Total number of EMT3 staff trained to EAP	37	

In addition, there are a total of 40 staff currently on courses, and a further 174 staff due to complete the course prior to the end of the year. This means that 354 or 72% of EMT2 staff will have become EAPs by the end of the year. Whilst we are supporting the release of staff to attend the EAP training programmes, unfortunately there is an impact on UHP during these times. Attempts to mitigate this are to spread out the release of staff across service

areas to reduce the effect of UHP, when staff must be released in areas that are already low in UHP due to other abstractions, the release for EAP training does compound the position. The forthcoming winter UHP position is a slight concern, and we will continue to mitigate the effect of reduced UHP by ensuring staff are released in targeted areas rather than overburdening any individual area. The ongoing work with the Financial Savings Plans and overtime allocation will also look to mitigate the effects of release of staff for EAP training.

Ambulance Care

Challenges

Call Taking

Call taking continues to be a challenge with a continual turnover of staff. Work is ongoing through a digital perspective to consider alternative ways of reducing activity, such as voice recognition and improved texting services and digital access.

Courtersy call back is now live and patients no longer have to wait actively on the phone line but instead can choose to have WAST re-call them when their place in the queue presents itself.

IMTP

Digital Innovation

Quarter 1 saw a major upgrade to the Cleric CAD system, which allows the service to build on the work completed to date to further develop patient commuinication options.

In July, patients will begin to receive texts when our crew is on route to pick them up, which will allow them to get ready in advance, reducing wait times as well as providing another opportunity for the patient to tell us that they no longer need the transport and minimise unnecessary journeys. Further text engagement will also follow through quarter 2, including additional texts when journeys are cancelled and through the booking process.

Roster Review

The NEPTS roster review saw a significant amount of feedback received regarding the review process and particularly the impact that the proposed outcomes would have on the staff across the service. This feedback was shared via the working party meetings either direct from colleagues or through Trade Union Partners.

Following the completion of the 2nd working party, a commitment was made by the service management team to review the feedback and consider the most appropriate way forward.

Upon completion of this exercise, it was agreed that rather than continue with the existing plan and timelines, a request would be made to the data modelling partners to consider alternative proposals that provide different options such as longer shift lengths and a reduced amount of Saturday working which was identified as some of the pressures. Until this work is completed no additional working parties are held, and we will continue to work in partnership as we progress this workstream.

General Update

Purple Review and UCS allocation

On the1st July 2025, WAST went live with its new approach to high-priority incident responses. The current red category was replaced by three new classifications: Purple Arrest, Red Emergency, and RCS0.

As part of this transition, Urgent Care Service (UCS) began responding to Purple calls. They will act as first and co-response resource, like Community First Responders, to deliver Basic Life Support. Emergency Medical Services (EMS) will continue to be dispatched. We have established a notification protocol so that UCS management are alert to UCS attending a Purple Arrest incident so staff support can be provided.

Integrated Care

Challenges

Call Handling Performance

Call taking performance has improved month on month. In March, 11.18% of calls were abandoned in 60 seconds, performance was 10.15% in June 2025 (down from 10.51% in May25). The team have a performance recovery plan, to achieve below 10% abandonment, which has proved challenging. This is in part due to absence, increased demand on weekends, and some periods of increased abstractions (training etc). The team have considered and implemented numerous operational tactics, which has continued to maintain improvement. The team are awaiting the rostering practice review including capacity modelling to test if we have sufficient resource to meet performance.

General Update

Launch of New Emergency Ambulance Performance Framework

The team have been actively working with colleagues from across the Trust to "go live" and implement organisational changes on the 01st of July 2025. The team have reviewed over 50 Standard Operating Procedures (SOP'S) and made changes to around 15, in preparedness for "go live". This has required considerable efforts in ensuring appropriate governance to support the changes. New processes have been developed, to ensure patients have access to a Rapid Assessment Queue, and briefings have been provided to all teams within Integrated Care.

Care Planning Workshop

The Integrated Care Team held a Care Planning Workshop in Cwmbran in May 25. This workshop discussed feedback from frontline clinicians and focused on developing a set of priorities for care planning as part of the RICS programme of work. An SBAR is currently being developed and will be shared through the RICS Project Board, to consider the next steps for care planning.

Simply Do Ideas Platform

The Quality Improvement Team have worked with the Integrated Care Team, to become the first users to use their new improvement idea engagement platform. This platform will eventually replace the WIIN platform, which has been in operation for some years. The platform has been operational for a few weeks and is focused on generating ideas for improving call taking performance. All Call Handler Coordinators have been invited to use the platform, with over 16 ideas being submitted to date.

Process Group RICS

A new group (subgroup of the RICS Project Borad) has been formed to lead the process elements of the RICS Clinical Model for Transformation. Chaired by the Head of Service for Integrated Care the group will focus on; Care Planning; Integration of SOPs, remote scheduling, Implementation of new call flow and categorisation model.

Consult and Close

Consult and Close activity has remained high within Integrated Care (20.15% in March and May 2025). This equated to 6,766 incidents in March, to 6829 in May 2025.

Pan Operations

Staff Survey – Quality and Support Day

Following the findings from the NHS Wales Staff Survey 2024, the Operations Directorate agreed, through discussions in EMG (EMS Management Group) and SOT (Senior Operations Team) meetings, that a forthcoming Quality and Support Day will concentrate on the Staff Survey. All service areas agreed a collaborative approach to the Q&S Day with the following focus:

- To comprehend the experiences of staff who took part in the survey and to pinpoint the obstacles encountered by those who did not complete it.

- To collect feedback on the 2024 staff survey results and to ascertain what actions and next steps staff feel would be most beneficial.

Data is currently being collected and discussed within the service areas, with a view to develop action plans for improvements.

PATIENT STORY TRACKER
DYLAN COPE

Dylan's GP referred him to A&E Grange Hospital, 6 Dec 2022, with suspected appendicitis. He was discharged, appendicitis ruled out, but symptoms worsened by 10th Father rang NHS 111 Wales, recorded message advised of a possible 45-min wait before call answered. It would be 2 hours before call answered. 111-call handler failed to record red-flag symptoms, giving the family false reassurance they could wait for a clinician to call back. His symptoms worsened and he was taken back to A&E, from where he was transferred by ambulance to UHW with sepsis. He died on 14th Dec. The family believe Dylan's chances of survival would've been greater had 111 service not made errors. Letters from WAST/111 were felt to be impersonal, lacking humanity and failed to acknowledge catastrophic nature of what had happened to Dylan because of the errors and omissions.

THEMES IDENTIFIED

1. **Amendments to PTR response, letter templates to ensure processes are not put before humanity and compassion and that wording is appropriately sensitive particularly regarding preventable death of a young child.**
2. **Improvement to triage of children presenting with symptoms (rapid temperature drop/sign of circulatory failure) and the need for call back times from a clinician from NHS 111.**
3. **Sepsis awareness improvements for NHS 111/999 staff.**

GOAL

- Implement the learning from the lessons identified through PTR process and coroners.
- Provide transparency and assurance on learning and actions being taken/ implemented.
- Increase staff awareness and understanding of sepsis in the 'unwell child'.
- Deliver a human compassionate experience to bereaved parents/families.

PRIMARY DRIVERS

Address the needs within NHS 111 Wales service including:

- Improvement to call taking;
- Functionality of the triage system
- call back times from a clinician.
- Address online symptom checkers for children (sepsis)
- Improve education on sepsis

And;

- Provide public with sepsis information as part of remote integrated care and remote triage.

SECONDARY DRIVERS

Better integration with other services incl. GP Out of Hours.

Improve information and support via the NHS 111 Website.

Enhance service user experience

Deliver compassionate communication

From discussion with Corrine Cope

- Improve documentation and improve letters
- Provide 2 letters – 1 human/personalised and a second which includes jargon/regulation narrative.
- Support/prepare families for coroners.
- Improve statement handling
- As soon as solicitor involved you lose an advocate, Solicitors are not advocates.
- Action to HOPE network on the above (Lucie)
- Improve staff understanding of sepsis.
- Support for families going to coroner's court

ACTIONS

Redesign process of an unwell child questions;

Clinical Review/assessment of online symptom checkers.

Review education and training of Sepsis within the Trust.

Review PTR letter template and response (especially where child has died).

Record further digital story focusing solely on sepsis awareness for staff

From discussion with Corrine Cope

- Improve governance process regarding release of call/s
- Introduce appropriate grief phrases in letters where child has died.
- Deliver training/refresher session on sepsis /think sepsis'/develop public resources/leaflet
- Create Podcast of Dylan's story.

RESPONSIBILITY FOR ACTIONS

- Assistant Clinical Director for Remote Clinical Care
- Assistant Director of Operations, Operations Transformation
- Head of Patient Safety Concerns and Learning
- Head of Patient Experience & Community Involvement

PROGRESS

- Meetings held with family to progress learning and improvements ensuring close working and clear communication with them throughout every step.
- Demonstration of the new NHS 111 system, to Dylan's family.
- New website will support multiple languages, provide tailored triage results, and offer links to the Directory of Services based on the symptom checker disposition. Changes aim to ensure symptom checkers are fit-for-purpose, compliant with regulations, and provide an improved experience
- Changes to PTR letters but remaining balanced with regulations.

OUTCOME

Assurance and evidence of changes made including:

- how Red Flag signs of Sepsis are identified at multiple points.
- CAS changes made to questioning and escalation for sepsis, meaning it is highly unlikely a case like this could occur again.
- Changed wording within PTR responses letters.
- Improved staff understanding of grief/bereaved families
- Ongoing improvements following conversations with Corrine Cope and Sepsis Trust.
- Learning from Dylans story presented at WAST Quality Event

Story action timeline

Date of incident	Start of PTR process	Investigation outcome letter sent	PTR Family meeting	Patient story Video recorded	Catch-up Meeting with Family	Story played at QUEST Committee	Story played at Trust Board	Story played at Digital Story-telling Network
December 2022	December 2022	January /February 2024	September 2024	January 2025	March 2025	May 2025	May 2025	May 2025

29 July 2025
v3

AGENDA ITEM No	**7**
OPEN OR CLOSED	**Open**
No of ANNEXES ATTACHED	**1**

MONTHLY INTEGRATED QUALITY & PERFORMANCE DASHBOARD – June 2025

MEETING	QUEST
DATE	5th August 2025
EXECUTIVE	Estelle Hitchon – Interim Director of Strategy, Planning & Performance/Director of Partnerships and Engagement
AUTHOR	Mark Thomas – Commissioning & Performance Manager Hugh Bennett - Assistant Director, Commissioning & Performance
CONTACT	Mark.Thomas12@wales.nhs.uk Hugh.Bennett2@wales.nhs.uk

EXECUTIVE SUMMARY

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 **June 2025.**

2. The report aims to provide an integrated view of quality & 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. Data quality issues have been identified and are being addressed within 111 and APPs with the result that there are a number of Board approved metrics which are not available at this time.

4. The response times for red 8-minute performance was 50.7% in June 2025, with performance marginally decreasing compared to May 2025. The Amber 1 median was 1 hour 29 minutes, which was also a slight improvement on the 1 hour 51 minute 12-month average. The Trust knows these extended times (the ideal is 18 minutes) lead to avoidable patient harm. The Trust continues to work on tactical actions within its control to mitigate this risk including maintaining levels of EA production (91% in June, slightly below the benchmark) and fully rolling out the CHARU service (85% in June); whilst also undertaking more transformative actions through the Clinical Model Transformation (CMT) Programme.

5. The Trust lost 15,278 hours to handover in June 2025 (30-days), one of the lowest levels for four years. However, this level of lost capacity is still difficult to compensate for, despite all of the actions being taken by the Trust.

6. The 2024/25 budget included further investment in activities designed to shift demand left and mitigate the impact of handover lost hours investing in clinical screening and APPs (both delivered), which form part of the CMT Programme.

7. 111 call handling performance has stabilised post-delivery of the new 111 CAS, but the service did not achieve the 5% abandonment rate in June 2025, with performance improving slightly to 10% from 10.5% in May 2025. There is currently a review of 111 rostering practice – initial report expected in late July.

8. Ambulance Care, in particular, Non-Emergency Patient Transport Service's (NEPTS) performance is stable, with both oncology and renal journeys remaining above target in June 2025. The NEPTS transport roster review has now started, which is a key efficiency.

9. 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 & Culture Plan. Sickness absence was 7.50% in June 2025. The IMTP ambition is to reach 6%. The Trust will continue its focus on sickness absence. EMS abstractions remain above the 30% benchmark figure in June 2025 at 32.63%.

10. The Trust is continuing to deliver its Clinical Model transformation (CMT) programme at pace. Key parts went live in December, in particular, remote clinical screening (RCS), which was a cultural shift in how the Trust manages 999-demand. There are early indications in the data in this report that the clinical model transformation changes implemented over the winter are having an effect. The new Purple Arrest and Red Emergency categories were announced on 11 March 2025 and went live, as planned, on 01 July 2025.

RECOMMENDATION

QUEST is asked to: -

i. **Consider** the June 2025 Integrated Quality & Performance Report and actions being taken and determine whether:

a) The report provides sufficient assurance.

b) Whether further information, scrutiny or assurance is required, or

c) Further remedial actions are to be undertaken through Executives.

REPORT APPROVAL ROUTE
23.07.2025 Assistant Director Commissioning & Performance 30.07.2025 Executive Leadership Team (ELT)

REPORT APPENDICES
Appendix 1 – Top Indicator Dashboard

REPORT CHECKLIST			
Confirm that the issues below have been considered and addressed		**Confirm that the issues below have been considered and addressed**	
EQIA (Inc. Welsh language)	x	Financial Implications	x
Environmental/Sustainability	x	Legal Implications	x
Estate	x	Patient Safety/Safeguarding	x
Ethical Matters	x	Risks (Inc. Reputational)	x
Health Improvement	x	Socio Economic Duty	x
Health and Safety	x	TU Partner Consultation	x

SITUATION

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 **June 2025.**

2. The report aims to provide an integrated view of quality & 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:-

Slide Title	Slide No.
Red Performance Indicators	6
Amber Performance Indicators	7
Clinical Indicators	9
Clinical Indicators	10
Patient National Reportable Incidents & Patient Concerns	11
Patient & People Safety Indicators	12
Coroners, Mortality and Ombudsmen Indicators	13
Potential Patient Harm Indicators	16

BACKGROUND

3. This Integrated Quality & Performance Report contains information on key indicators at a highly summarised level which aims 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/Board 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 in 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 likes' 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. Appendix 2 to this report sets out the key areas of discussion.

ASSESSMENT

Our Patients – Quality, Safety and Patient Experience

5. **Call answering** (safety): the speed at which the Trust is able to answer a 999 or 111 call is a key patient safety measure.

6. **999** call answering times worsened in June 2025 with the 95th percentile increasing to 26 seconds, compared to 22 seconds in May 2025. The 65th percentile and median performance remain consistently good; and data quality checks have been undertaken. Work is currently being undertaken on demand and capacity analysis of 999 call demand.

7. **111 call answering performance has minimally improved over recent weeks,** with the call abandonment performance for June 2025 being 10%, not achieving the 5% target. Recruitment has been undertaken to ensure that staff in post reflect the establishment position, and this has seen performance improve, but high abstraction levels are having an effect. It should be noted that there is also a reduction in the commissioned level of call handler FTEs in 2025/65 compared to 2023/24 (-4%).

8. 111 demand in June 2025 was 9.39% lower than during June 2024. The Trust procured a third party in January 2025 to undertake a collaborative (with commissioners) and independent review of the Trust's 111 call handler rostering practices, including a review of demand levels and required staffing capacity.

9. **111 Clinical response:** clinical ring back times for patients with the highest priority remained above target at 96.4%. Response times for lower priority calls declined, recording 87.5% and 52% for P2CT and P3CT respectively. This is consistent with previous years but needs to be monitored closely over the coming months.

10. **Ambulance Response** (safety / patient experience): the red 8-minute response performance for June 2025 was 50.74%, remaining below the 65% target, and increasing slightly compared to May 2025. The Trust is reaching more red patients in 8-minutes, but the denominator (demand) has also grown. The Amber 1 median in June was 1 hour and 29 minutes and the Amber 1 95th percentile was 5 hours 18 minutes. The Clinical Safety Plan and CHARUs will protect red demand, but Amber is where the impact of handover lost hours is felt i.e. there is a strong correlation. These long response times have a known impact on

avoidable patient harm. The red and amber categories are currently undergoing a major transformation as announced by the Cabinet Secretary. Red was replaced by Arrest and Emergency on the 01 July 2025 and Amber will be replaced by Orange and Yellow in quarter 3 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, but the lost capacity through handover at hospital remains extremely challenging and largely out of the Trust's control to address. The Trust's main focus is to implement a material change in how it responds to patient demand by evolving its clinical model through the Clinical Model Transformation (CMT) programme, elements of which have been implemented. 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 extreme level of lost hours to **handover outside Emergency Departments** remains the critical component of long waiting times and patient safety incidents. 15,278 hours were lost during June 2025. Cardiff & Vale's handover lost hours continues to remain comparably much lower, due to an organisational focus within the health board. There was also a dramatic improvement with both Swansea Bay and Cwm Taf Morgannwg in June 2025. While some small improvements have been seen in other health boards, Betsi Cadwaladr health board remains significantly high but just below its two-year average figure, with 6,064 hours being lost within the health board during June 2025. WG has re-iterated to health boards the critical importance of improvements in this area and the reduction of all over 45-minute waits was a recommendation from the recent Ministerial Advisory Group on Performance and Productivity. The WG pan-Wales target of no handovers of more than one hour, equates to 7,500 lost hours.

13. **Ambulance Care (Patient Experience)**: Oncology performance in June 2025 was 76.3%, achieving the 70% target. Renal performance remained above target, achieving 72.57%; however, advanced discharge & transfer journey performance increased marginally to 80% (95% target). Same day discharge & transfer journey performance was just 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 (now started) 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 eight NRI's to the NHS Executive in June 2025, more than May 2025 (3) and 18 serious patient safety incidents were referred to health boards under the Joint Investigation Framework. In June 2025 complaint response times improved to 88%, compared to the 72% recorded in May 2025, exceeding the 75% target for the first time over the past 12 months, however cases remaining complex.

15. **Clinical outcomes**: The percentage of suspected stroke patients who are documented as receiving an appropriate stroke care bundle was 89.8% in June 2025, minimally decreasing and remaining below the 95% performance target. Work is ongoing to improve reporting and compliance through the ePCR system, and this improvement is being seen clearly in most of the clinical indicators. The return to spontaneous circulation (ROSC) compliance rate also decreased to 19.3% in June 2025 compared to 22.6% in May 2025.

16. The Trust can report on call to door times for Stroke and STEMI patients. For June 2025, these highlight call to hospital door times of two hours and 24 minutes for stroke patients and two hours and twenty-six minutes for STEMI. Clearly these times are too long and are representative of the longer response times for all calls, because of the pressures and issues outlined in this report.

17. In June 2025, 5,953 patients **cancelled** their ambulance (this figure excludes patients who refused treatment). This is a significant reduction on previous levels. This reduction is likely to be the impact of switching on RCS through the winter. The Trust believes that 50% (of the pre-RCS switch on figure) of this combined number is unmet demand and is likely to be presenting elsewhere in the system. Anecdotal evidence from health boards suggests that as the Trust has switched on RCS and as the level of patient cancellations has dropped, so has the demand presenting elsewhere in the system. Caution is required at this stage though 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 115,205 Ambulance Response unit hours during June 2025 and delivered an emergency ambulance unit hours production (UHP) of 91%, remaining below the 95% target.

19. **Response Abstractions:** EMS abstraction levels increased minimally to 32.63% in June 2025, remaining minimally above the 30% benchmark figure. Response sickness abstractions stood at 6.48% (benchmark 5.99%).

20. **Trust sickness absence:** the Trust's overall sickness percentage was 7.50% in June 2025, up on the 6.83% recorded in May 2025. 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 June 2025 but increased slightly to 81.81%. Compliance for Statutory and Mandatory training also increased slightly to 88.05% continuing 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 is likely to undertake a round of a pan-Wales of CEO Roadshows in mid-October 2025.

Finance & Value

23. **Financial Balance**: the reported outturn performance at Month 3 is a deficit of £0.197m with a forecast to the year-end of breakeven. The Trust is forecasting achievement of both its External Financing Limit and its Capital Expenditure Limit.

Partnerships & System Contribution

24. The consult & close rate was 19.1% in June 2025, a slight decrease from the previous month continuing to achieve the IMTP ambition (and Welsh Government target) of 17%.

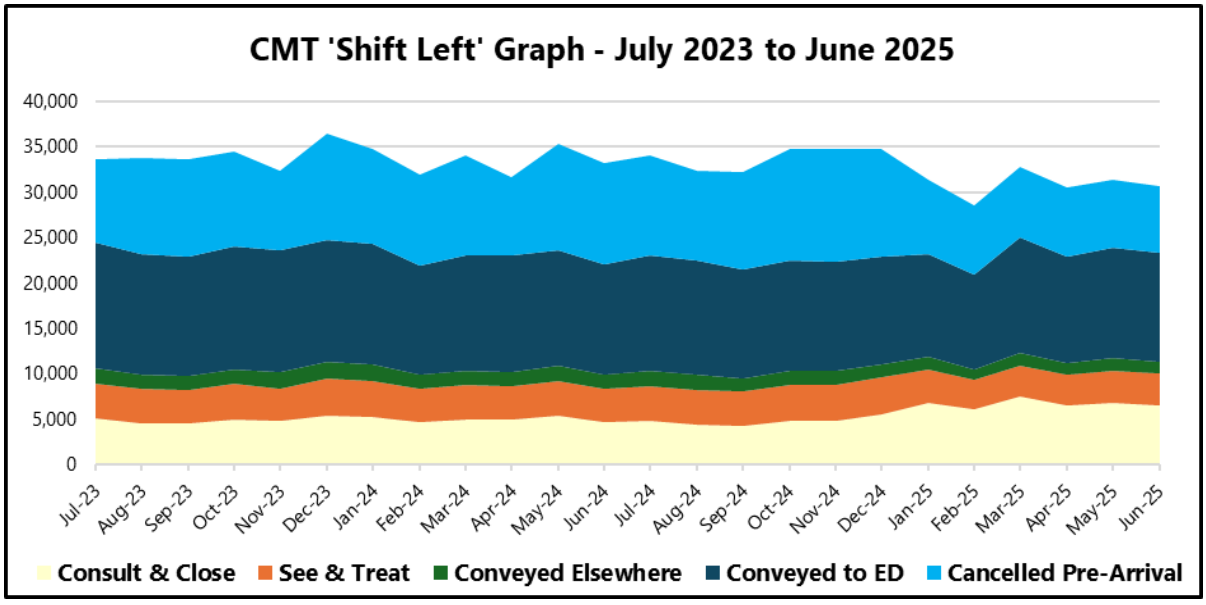
25. Same Day Emergency Care (SDEC) centres continue only to see a low level of ambulance activity and handover levels remain extreme, which makes further work on the clinical model, before next winter, a tactical imperative.

Summary

26. The indicators used at this high-level highlight that 111 has been resilient during the winter months, more so than in in previous years. However, performance variation during 2025 and the level of performance for 111 remains a hot topic with the JCC and WG.

    For the 999-emergency pathway, the Trust produced good metrics on what it can control e.g. production, abstractions etc. and managed to turn on new elements of its clinical model transformation programme, which appears to be having a positive effect. Hospital handover lost hours have also declined to the lowest levels seen since September 2021. These improving levels give further strategic imperative to continuing with the clinical model transformation and work by WG on focusing health boards on further reducing handover lost hours.
    NEPTS performance was stable, with the NEPTS transport re-roster started, but which is proving complex.

27. The graph below has been included to show in broad terms what the outcomes (dispositions) are for 999 callers and to track changes. It shows that since December 2024 there has been a decrease in the number of resources that were cancelled pre-arrival. It also highlights that there has been an increase in the Consult and Close rate over the same period.



RECOMMENDATIONS

QUEST is asked to: -

i. **Consider** the June 2025 Integrated Quality & Performance Report and actions being taken and determine whether:

a) The report provides sufficient assurance.
b) Whether further information, scrutiny or assurance is required, or
c) Further remedial actions are to be undertaken through Executives.

Welsh Ambulance Services University NHS Trust

Monthly Integrated Quality & Performance Report

June 2025

Annex 1 – Top Indicator Dashboard

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

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

by Commissioning & Performance Team

Section 1: Monthly Indicators / Top Indicator Dashboard

Top Monthly Indicators	Target 2025/26	May-25	Jun-25	2 Year Average	RAG
Our Patients					
Timeliness Indicators					
NHS111 Call Handling Abandonment Rates	< 5%	10.5%	10.0%	8.9%	R
111 Clinical Triage Call Back Time (P1)	90%	97.4%	96.4%	97.6%	G
999 Call Answer Times 95th Percentile	00:06	00:22	00:26	00:23	R
999 Red Response within 8 minutes	65%	50.0%	50.7%	49.2%	R
999 Amber 1 Median	00:18	01:29	01:29	01:35	R
Oncology Journeys arriving within 45 mins and up to 15 minutes after appointment time	70%	74.7%	76.3%	73.5%	G
Advanced Discharge & Transfer journeys collected less than 60 minutes after booked time (NEPTS)	90%	76.1%	80.0%	79.7%	R
Clinical Outcomes / Quality Indicators					
Return of Spontaneous Circulation (ROSC)	Increasing Trend	22.6%	19.3%	19.9%	A
Stroke Patients with Appropriate Care	95%	89.9%	89.8%	83.7%	A
Stroke Call to Hospital Door Times	Reduction Trend	02:23	02:24	02:25	R
ST-Elevation Myocardial Infarction (STEMI) with Appropriate Care	95%	69.1%	69.1%	56.5%	R
National Reportable Incidents reports (NRI)		3	8	4	
Can't Send & Cancelled by Patient Volumes	Reduction Trend	6,015	5,953	8,601	G
Concerns Response within 30 Days	75%	72%	88%	57%	G
Enactment of the Duty of Candour Total		10	10	5	
Our People					
Capacity					
Hours Produced for Emergency Ambulances	95-100%	93%	91%	89%	A

Top Monthly Indicators	Target 2025/26	May-25	Jun-25	2 Year Average	RAG
Health & Well-being					
Sickness Absence *(all staff)*	6.0%	6.83%	7.50%	7.76%	R
Mental Health Absence Rates	Reduction Trend	2.34%	N/A	2.33%	R
Staff Turnover Rate	Reduction Trend	8.18%	8.44%	8.30%	G
Statutory & Mandatory Training	>85%	87.56%	88.05%	79.16%	G
PADR/Medical Appraisal	>85%	81.35%	81.81%	74.05%	A
Number of Shift Overruns	Reduction Trend	3,745	3,441	3,723	G
Inclusion & Engagement / Culture					
NEPTS % of Total Calls Answered in Welsh	Increasing Trend	2.82%	2.53%	1.9%	G
Value					
Financial balance - annual expenditure YTD as % of budget expenditure YTD	100%	100%	100%	100%	G
EMS Utilisation Metric (CHARU)	Increasing Trend	28.1%	26.6%	28%	G
Average Jobs per Shift (All Vehicles)	Increasing Trend	2.64	2.33	2.35	R
NEPTS on the Day Cancellations	Reduction Trend	13.4%	14.7%	13%	R
Partnerships / System Contribution					
Inverting the Triangle					
Successful Consult & Close Outcome	17.0%	20.2%	19.1%	15.3%	G
% Of Total Conveyances taken to a Service Other Than a Type One Emergency Department	Increasing Trend	10.10%	10.09%	11.2%	R
Number of Handover Lost Hours	7,500	19,670	15,278	21,619	R
NHS111					
NHS111 Dental Calls	Increasing Trend	8,827	8,749	7,894	G
Consult & Close Volumes by NHS111	Increasing Trend	2,372	2,238	1,310	G

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)

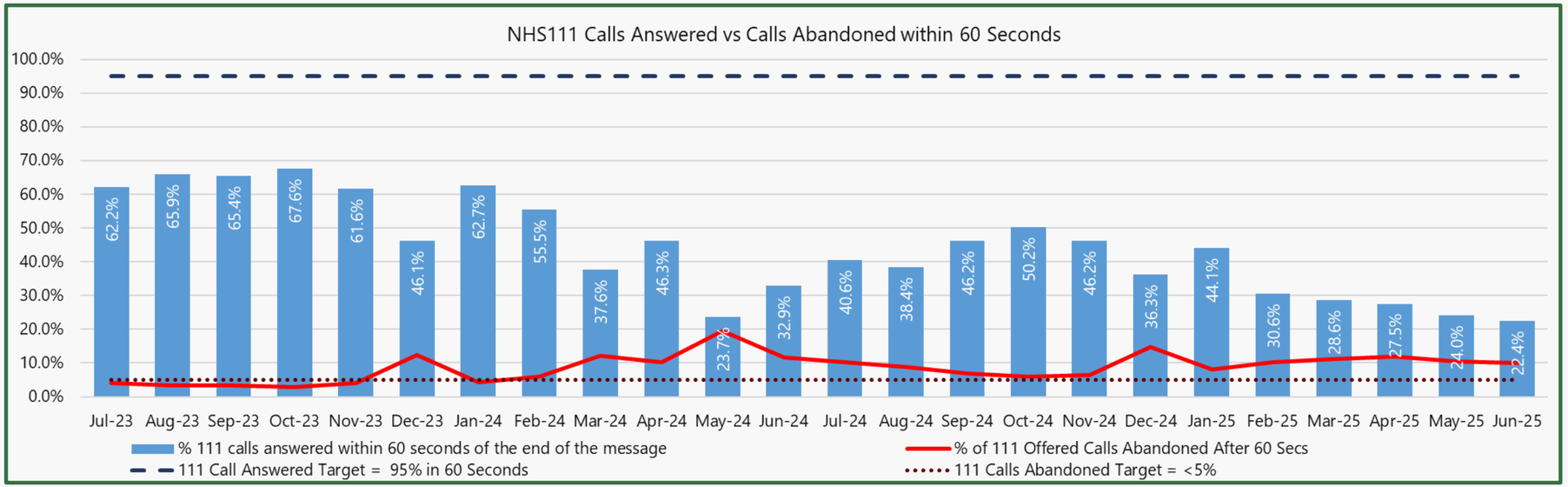
Our Patients: Quality, Patient Safety & Experience
111 Call Answering/Abandoned Performance Indicators

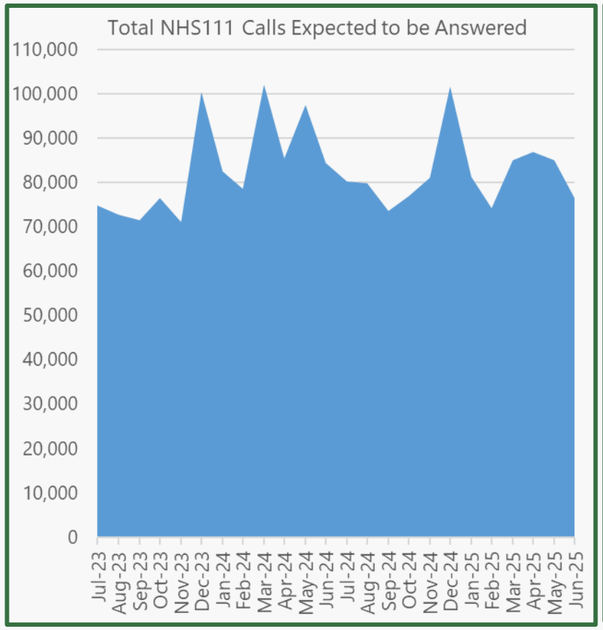
(Responsible Officer: Lee Brooks)

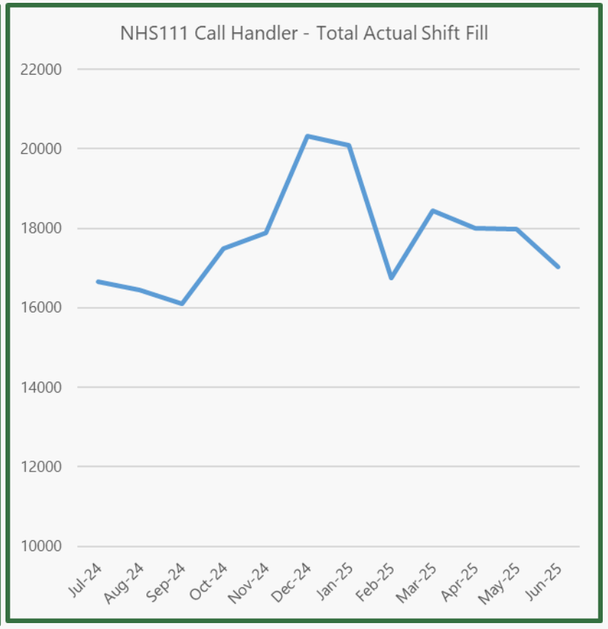
Abandonment Rate R

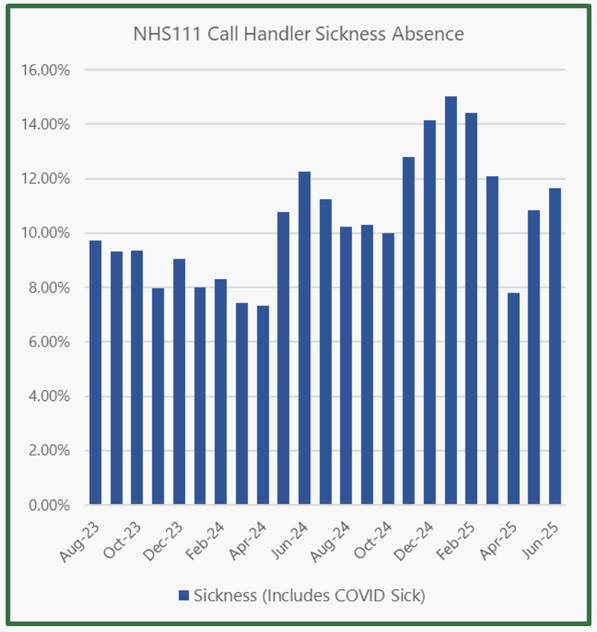
FPC

Influencing Factors – Demand and Call Handling Hours Produced









Analysis

The 111-call abandonment rate improved slightly to 10% in June 2025 from 10.5% in May 2025. However, the percentage of 111 calls answered within 60 seconds declined from 24% in May 2025 to 22.4% in June 2025 and continues to remain significantly below the 95% target.

Following a decline in performance during the middle of 2024, due mainly to the introduction of the new 111CAS system, performance did improve in October and November 2024. However, performance levels have continued to decline with the call answer rate within 60 seconds of 22.4% in June 2025, being the lowest seen in the past two years. This is at a time when UHP capacity for call handlers has continued to reduce compared with recent months and abstraction levels have increased, particularly in relation to Annual Leave and Secondments.

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 focus on realising the benefits of the new 111CAS;
A 111-re-roster pre-work review (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 might expect to see an improvement in performance in the summer, traditionally a period with lower demand and sickness. 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.

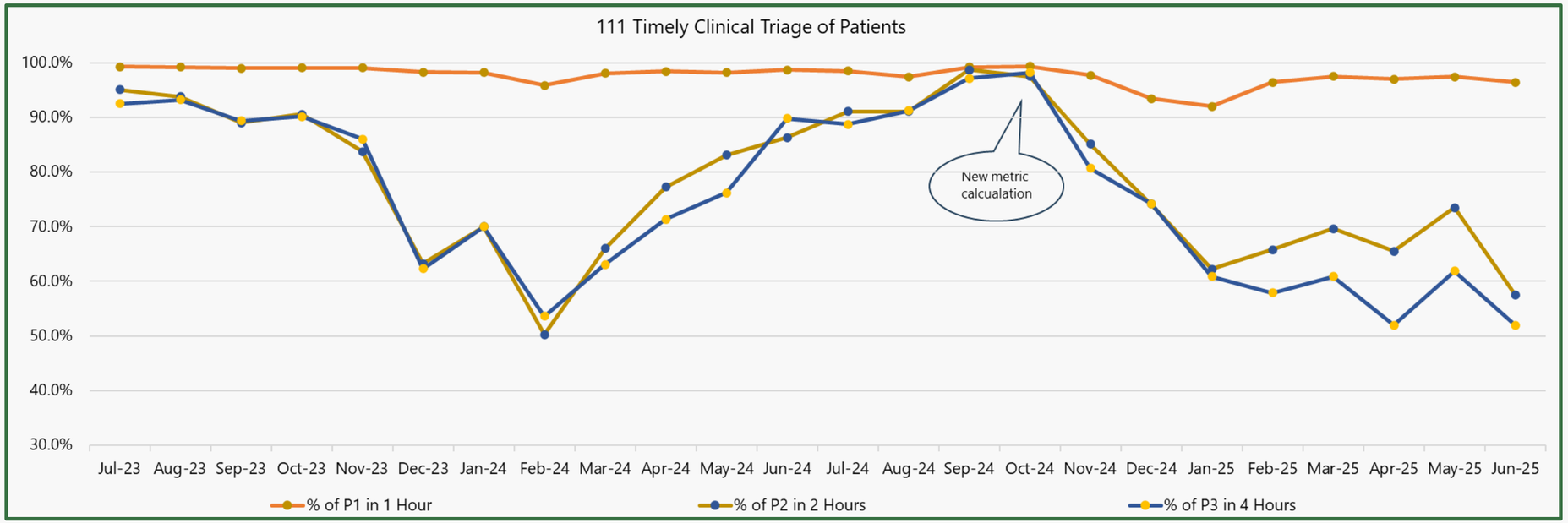
Our Patients: Quality, Safety & Patient Experience
111 Clinical Assessment Start Time Performance Indicators
Influencing Factors – Demand and Clinical Hours Produced

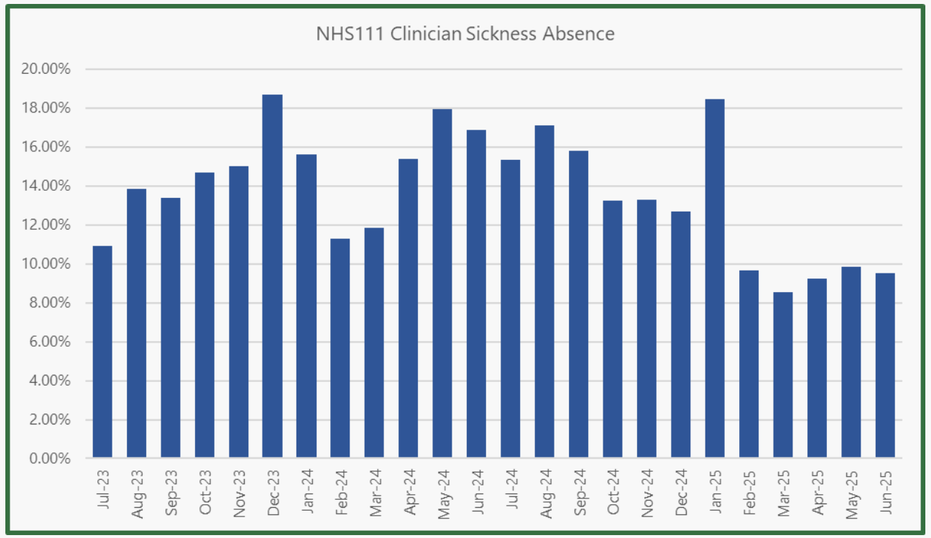
(Responsible Officer: Lee Brooks)

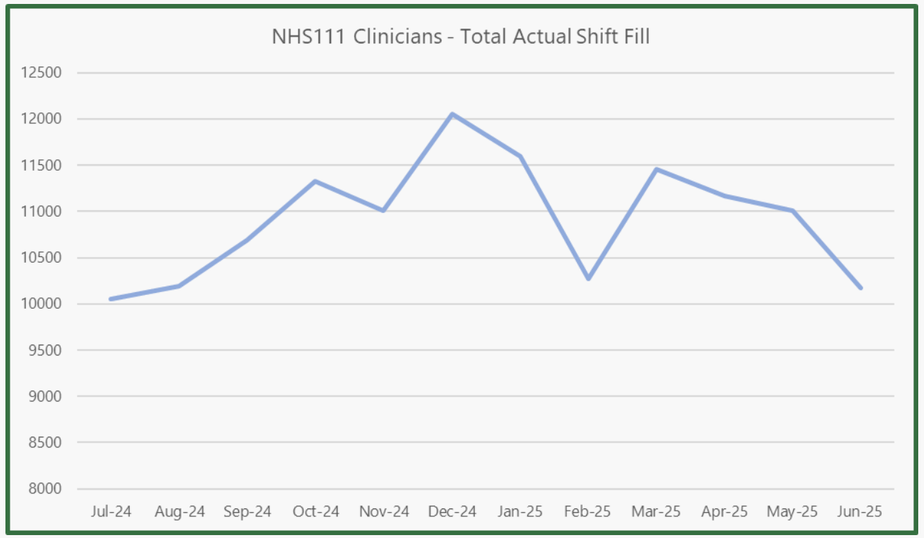
P1CT G

FPC

NB: Data quality issues have been identified in 111. These are currently being addressed.







Analysis

The highest priority calls, P1CT, achieved the 90% target, recording 96.4% in June 2025.

Ring back times for lower category calls decreased during June 2025, with P2CT calls at 57.5% and P3CT at 52%.

Numbers of clinician hours produced decreased again during June 2025, reducing from 11,004 hours in May 2025 to 10,173 hours in June 2025, albeit over one less day in the month. However, this was a 2.6% increase on the hours produced during June 2024. Clinician sickness absence decreased slightly during June 2025 at 9.50%.

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, this will be reversed in August,

Expected Performance Trajectory

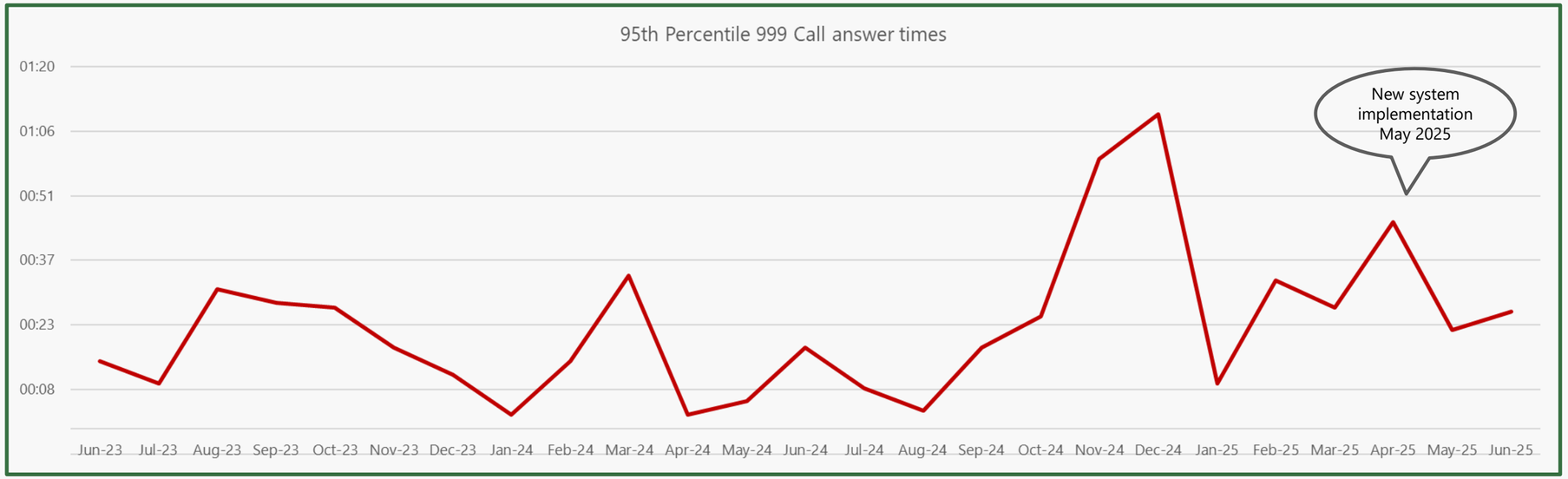
It is likely that there will be a performance improvement through the summer however the external rostering review suggests there is a demand and capacity gap within the current funded establishment and the Trust is therefore unlikely to reach performance without an increased workforce.

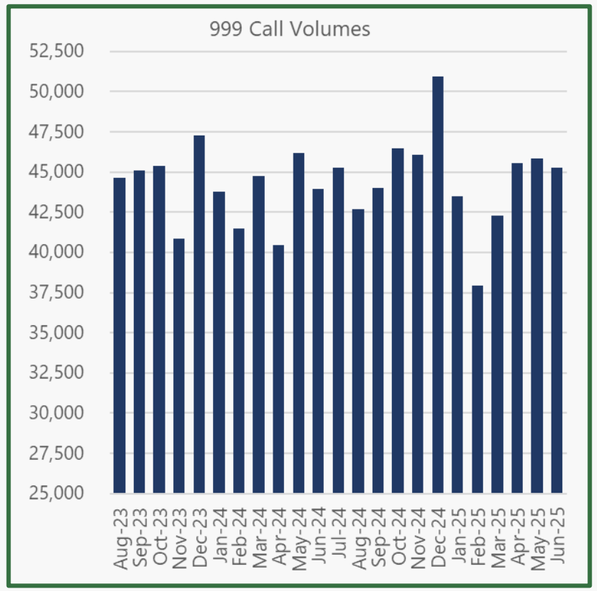
Our Patients: Quality, Safety & Patient Experience
999 Call Performance Indicators

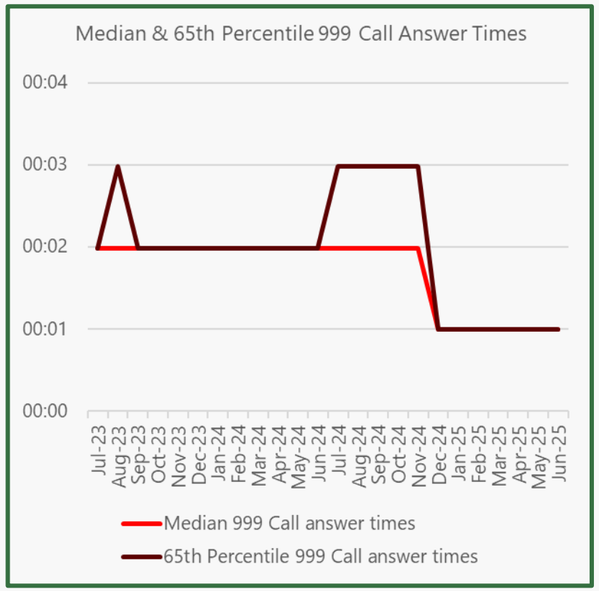
(Responsible Officer: Lee Brooks)

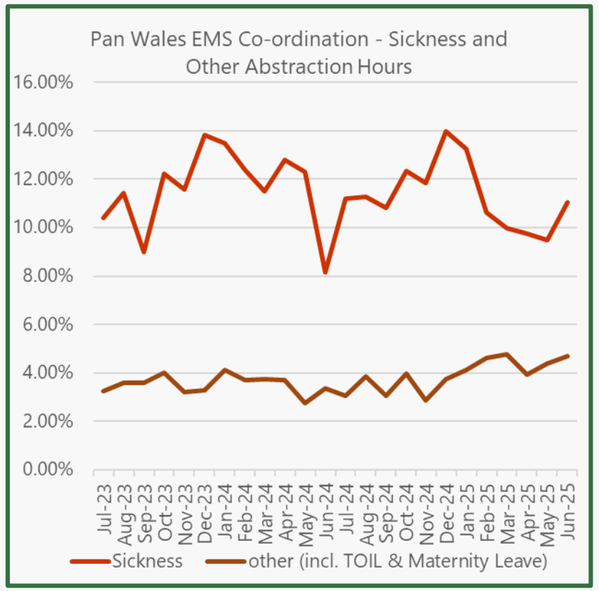
R FPC CI

Influencing Factors – Demand and Hours Produced









Analysis

The 95th percentile 999 call answering performance increased to 26 seconds in June 2025 and remaining 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 slight decrease in demand during June 2025 to 45,286 calls from 45,814 in May 2025.

Sickness levels saw an increase, from 9.48% in May 2025 to 11.05% in June 2025.

Remedial Plans and Actions

- Will continue to overrecruit for the next few months (as approved by the ADO and the EDoOps) which will also support potential losses from the Bryn Tirion move to Ty Elwy.
- Work is ongoing to identify what is contributing to high sickness via the Managing attendance at work 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 65th 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
Red Performance Indicators

Influencing Factors – Demand, Hours Produced and Hours Lost

(Responsible Officer: Lee Brooks)

8 Min

R

QUEST

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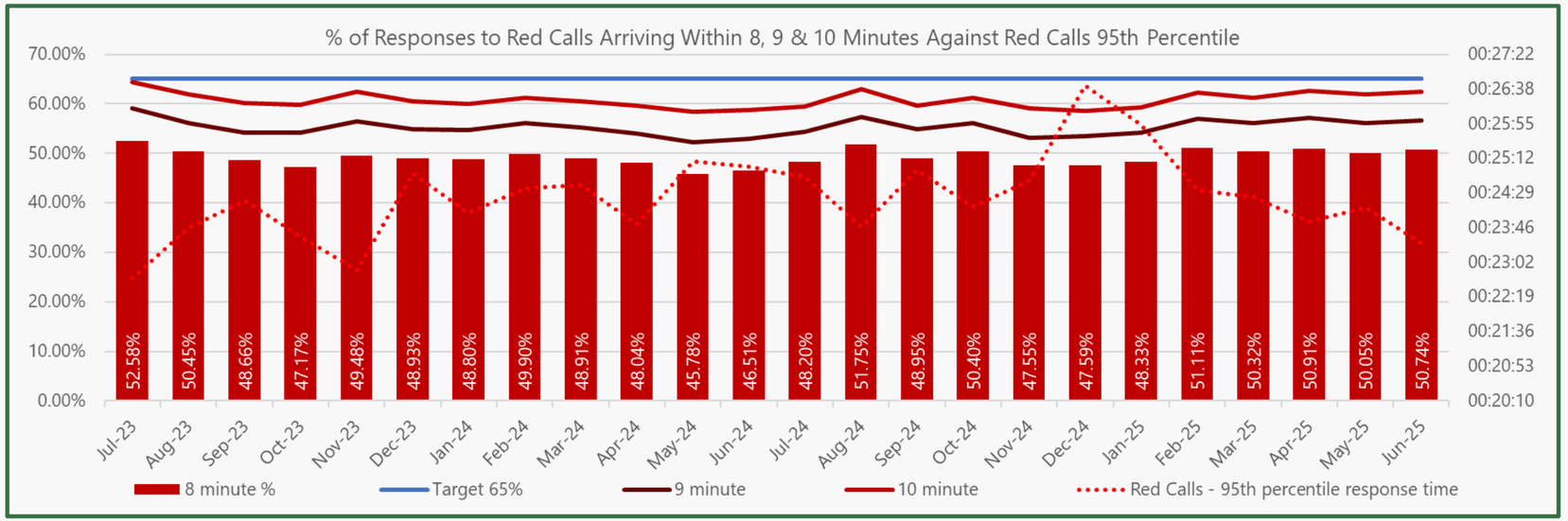
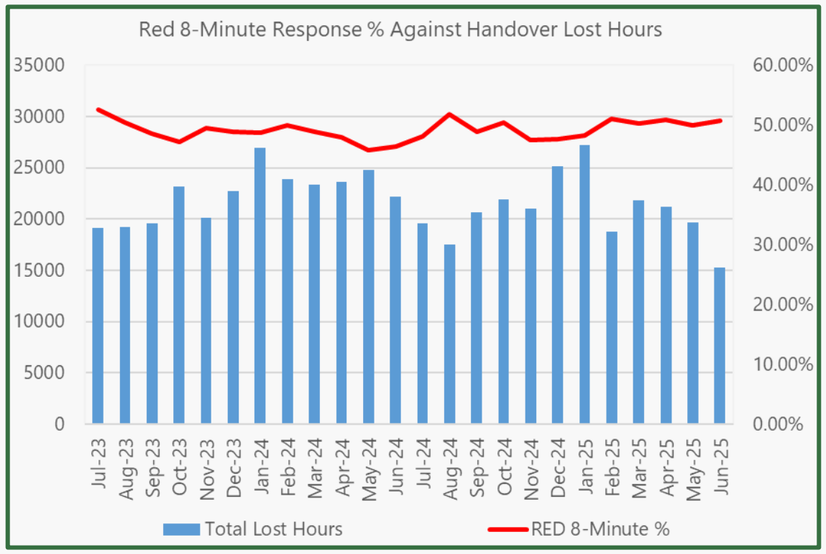
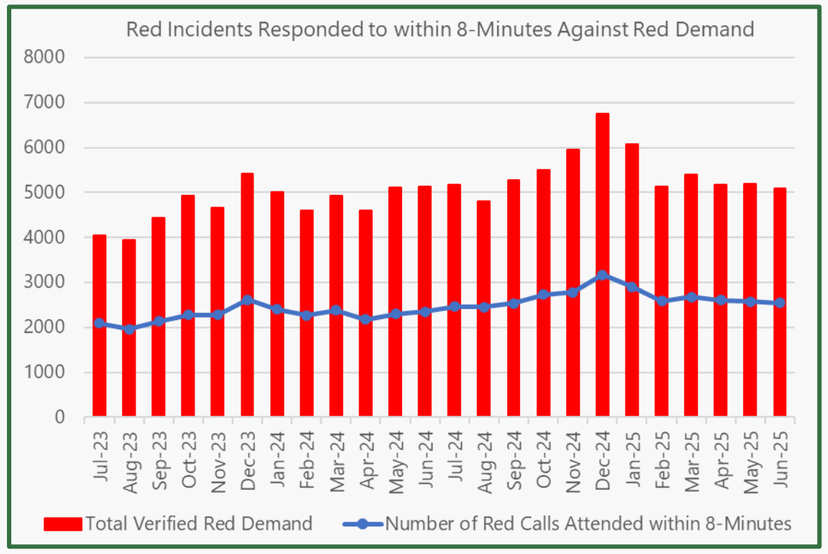
CI







Analysis

Red 8-minute performance improved slightly in June 2025 to 50.74% from 50.05% in May 2025 but remains below the 65% target.

Red 10-minute performance for June 2025 was 62.4%, which is marginally above the 2-year average (60.8%).

One of the main determinants is **red demand**, which has **increased** over the last few years, with red demand in June 2025 being 26.8% higher than that seen in June 2023. As red demand has increased, so too has the number of red incidents responded to within 8-minutes, with the figure for June 2025 of 2,547, being 18.2% higher than the figure for June 2023, i.e. the Trust is reaching more red calls in 8-minutes, but the denominator is also increasing.

The lower left graph demonstrates the correlation between overall Red performance and **hospital handover lost hours**, which shows that as handover rates decrease, so red performance improves. There were 15,278 lost hours during June 2025, which is the lowest figure recorded since September 2021.

Remedial Plans and Actions

The main improvement actions in the Trust's gift are:

- To maintain commissioned establishment in post levels overall: the Trust remains close to achieving its 95% UHP benchmark in June with 93.8% UHP (all resources);
- Full roll out of the Cymru High Acuity Response Unit (CHARU): the Trust achieved its highest ever CHARU UHP in January;
- The deployment of rapid clinical screening, as outlined in our IMTP (the Trust achieved this); and

Expected Performance Trajectory

On the 11th March 2025 the Cabinet Secretary for Health & Social Care announced that the current Red category will be replaced with a new arrest and emergency category which went live on 1st July 2025. This will see the focus moving to measures of the chain of survival and patient outcomes i.e. saving lives, rather than a hit/miss time targets.

Our Patients: Quality, Safety & Patient Experience
Amber Performance Indicators

(Responsible Officer: Lee Brooks)

R

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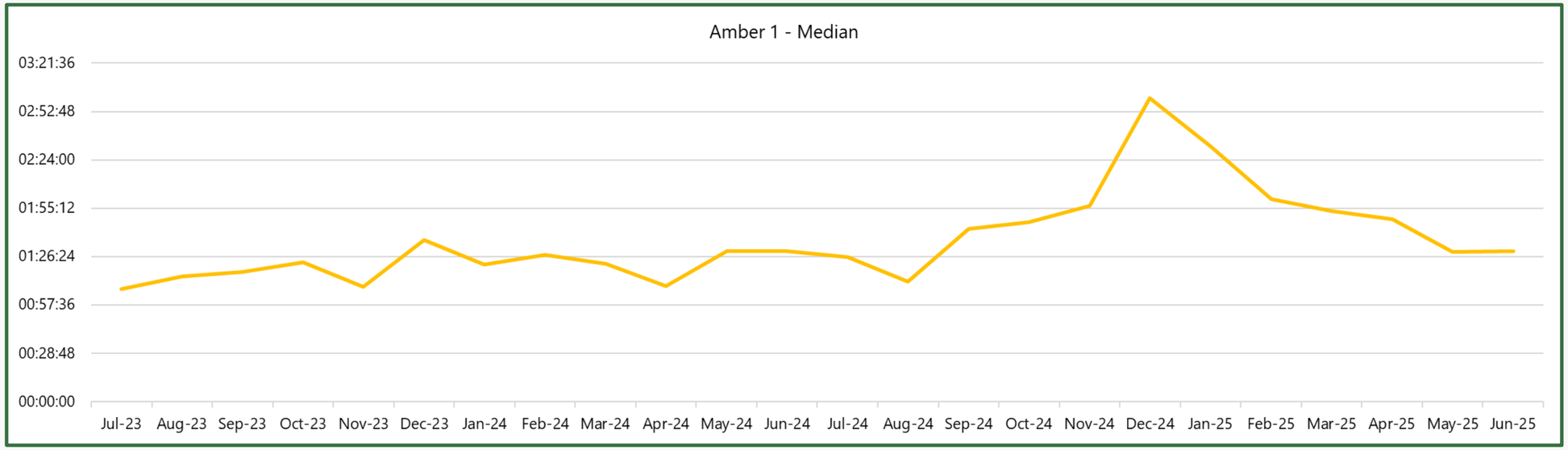
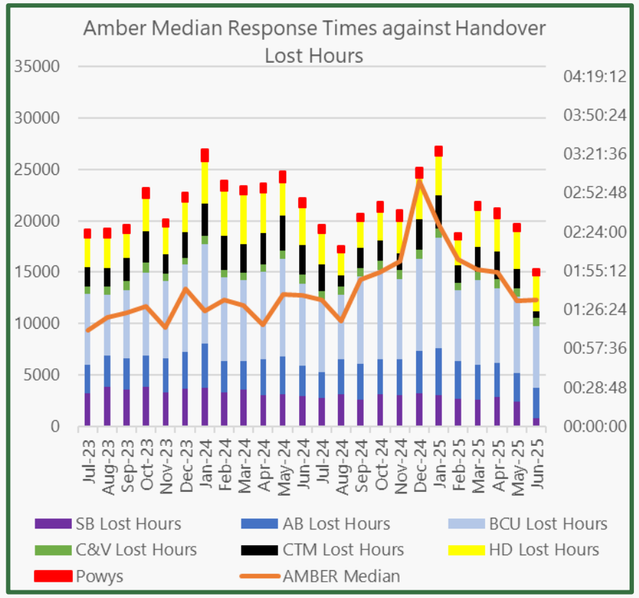
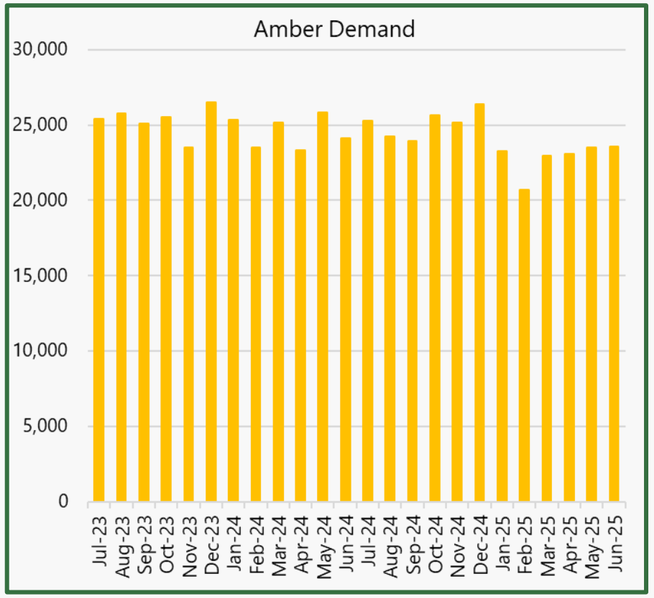
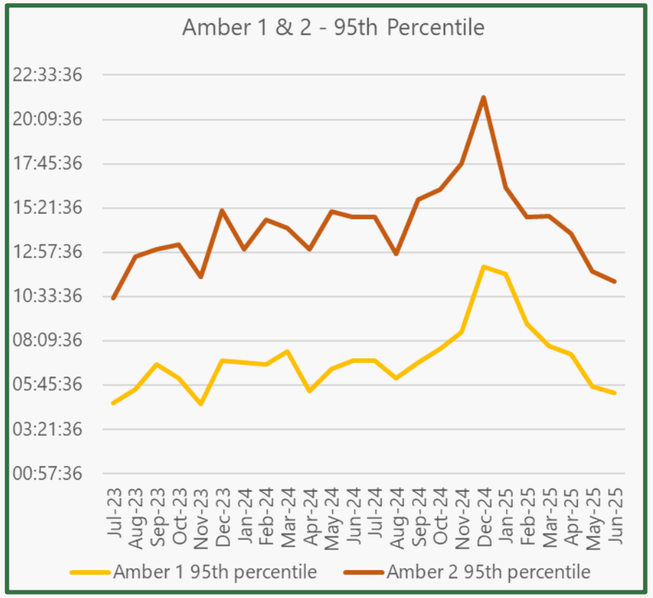
Influencing Factors – Demand, Hours Produced and Hours Lost









Analysis

The Amber 1 median performance time remained consistent during June 2025 at 1 hour and 29 minutes. The ideal Amber 1 median response time remains at 18 minutes.

The Amber 1 95th percentile decreased during June 2025 to 5 hours 18 minutes, down from 5 hours 40 minutes in May 2025. This time remains currently below the 2-year average figure of 7 hours 59 minutes.

As with Red, 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 improve further.

Remedial Plans and Actions

The actions being taken are largely the same as those related to Red performance on the previous slide. Welsh Government has recently announced further changes to the Ambulance Performance Framework that will affect the existing Amber category.

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 o 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.

Our Patients: Quality, Safety & Patient Experience

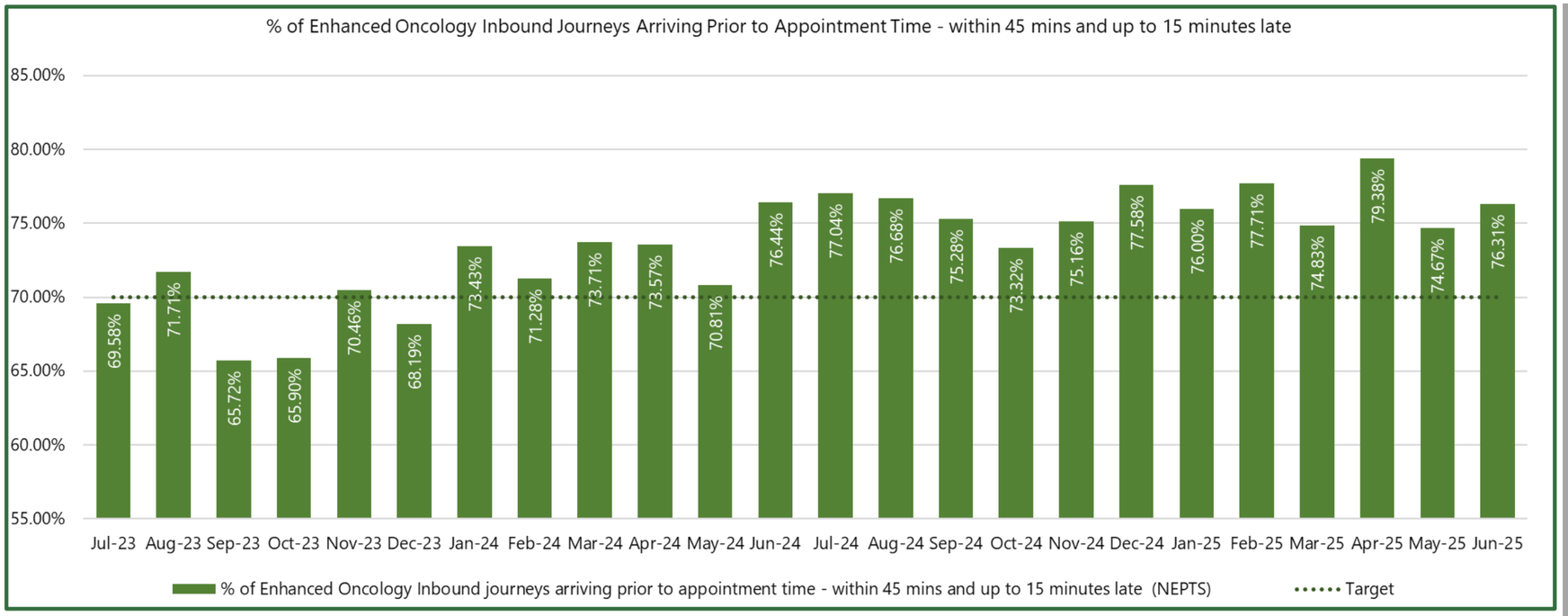
Patient Experience – Influencing Ambulance Care Indicators

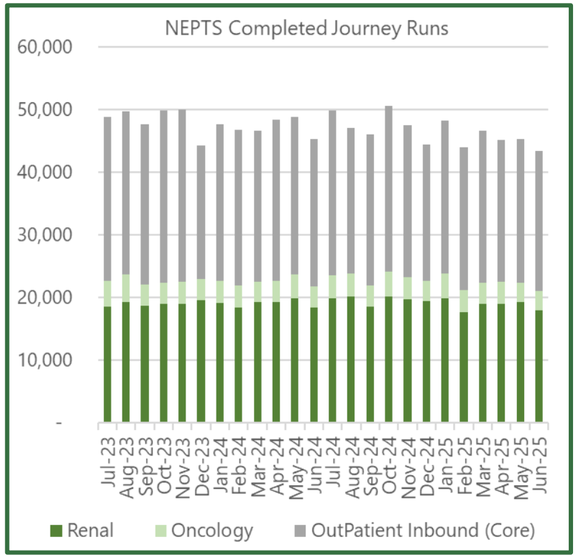
(Responsible Officer: Lee Brooks)

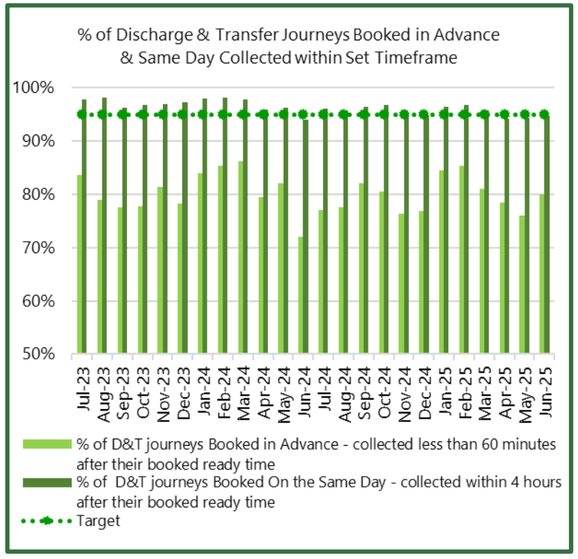
D&T	Oncology	Welsh Calls
R	G	G

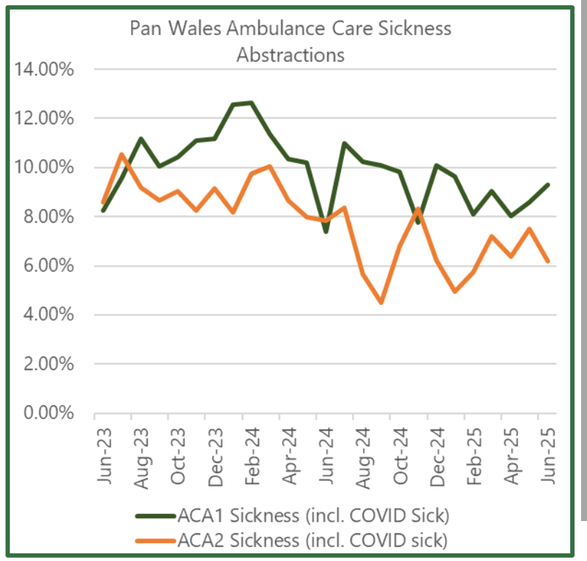
FPC

CI









Analysis

76.31% of enhanced Oncology journeys arrived within 45 minutes prior and up to 15 minutes late of their appointment time in June 2025, once again achieving the 70% target.

Discharge and Transfer journeys booked in advance and collected less than 60 minutes after their appointment improved in June 2025 to 80% but remains below the 95% target. Discharge and Transfer journeys booked on the same day achieved the 95% target in June 2025.

Renal journeys decreased marginally from 72.61% in May 2025 to 72.57% in June 2025, but achieving the agreed performance standard of 70% for only the seventh time since September 2024.

Call volumes answered decreased to 14,851 calls during June 2025, from 14,914 in May 2025; but the average speed of call answering increased from 12 minutes 47 seconds to 13 minutes 48 seconds.

ACA1 sickness remains above the 5.99% target, at 9.32% in June 2025. ACA2 sickness also remains above the 5.99% target at 6.20% in June 2025.

Remedial Plans and Actions

Increased focus on data management and journey recording times is underway, with enhanced focus on weekend performance and targeting hotspots. Projecting an improvement in performance over next few months, although caution on achieving the 95% figure as this was always an aspirational target that needs engagement and system change from Health Boards which is complex and challenging to achieve.

New rosters keys have been finalised based on updated demand with the roster review now commenced; however, the review is proving complex and is being reset once further modelling has been undertaken. Enhanced sickness monitoring has been implemented at the ADO/HoS level and all long term and complex cases are being reviewed regularly.

Expected Performance Trajectory

An improvement is expected in the next few months, although it is not anticipated that the target will be achieved without wider system change.

Our Patients: Quality, Safety & Patient Experience
Clinical Indicators

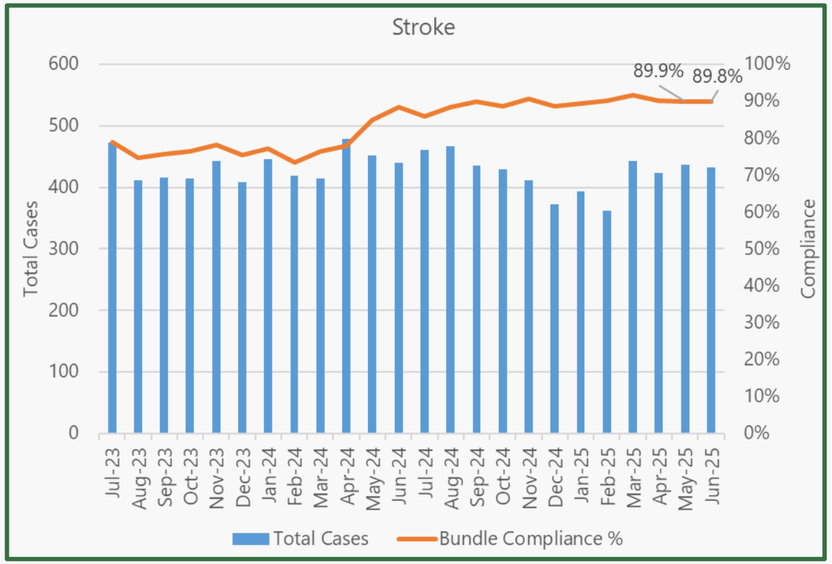
Suspected Stroke Patients with Appropriate Care, ST-elevation myocardial infarction (STEMI) with Appropriate Care and Time-Based metrics.

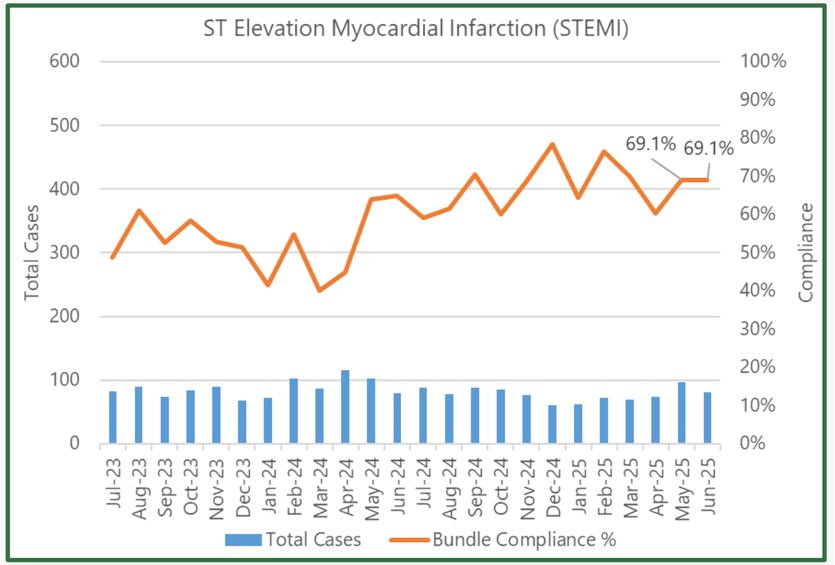
Stroke	Stroke Call to Door	STEMI
A	R	R

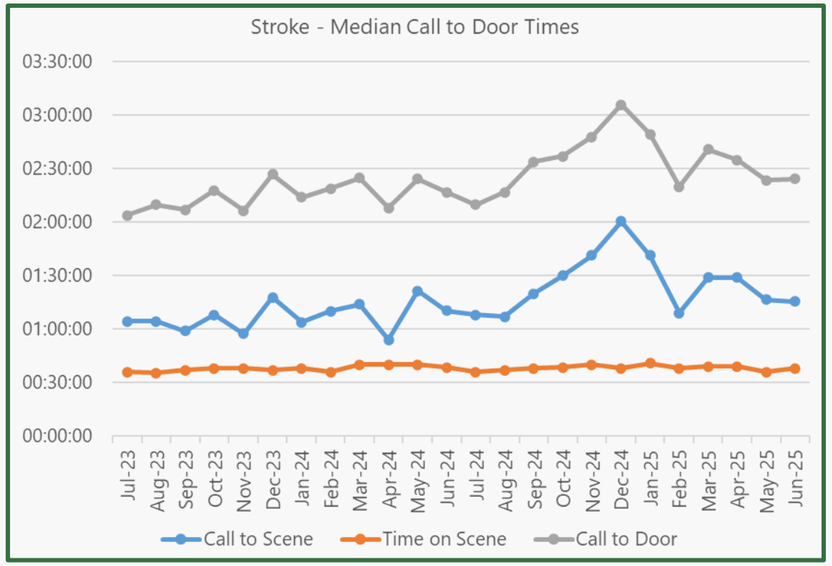
Self-Assessment: Strength of Internal Control: Moderate

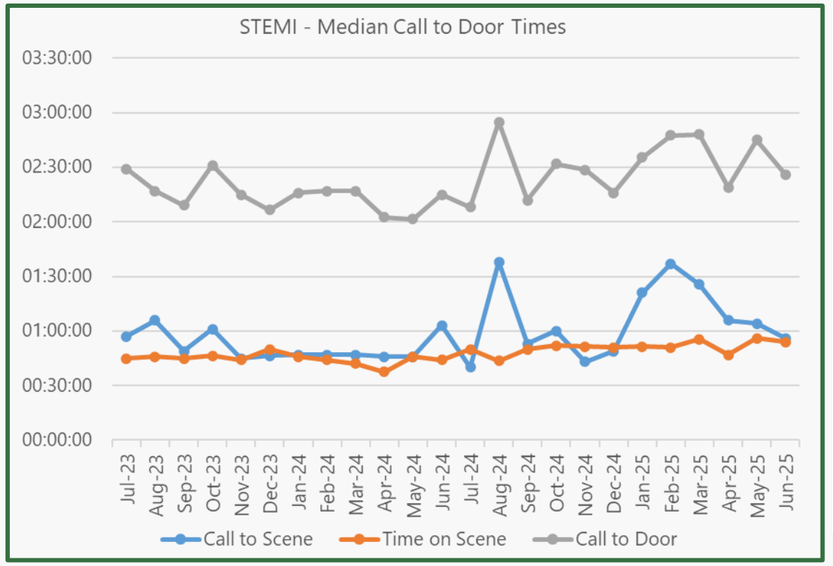
QUEST

(Responsible Officer: Andy Swinburn)









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

Stroke – 89.8% - Performance has remained consistent at around 90% for the past three months. There is a close correlation between documenting FAST (a test to detect symptoms of stroke) and care bundle compliance.

STEMI (heart attack) – 69.1%, a significant improvement from 60% in April 2025 but consistent with May 2025. There has been an increase in compliance across all elements of the care bundle. The number of cases remained low (81) therefore, increasing the volatility of the compliance data so this could be natural variance.

Call to door times for Stroke – Call to door times minimally increased for stroke in June (02:14:30). All three elements of the bundle have seen consistency on time.

Call to door times for STEMI – Call to door time has decreased since last month (02:26:00).

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 2025.

Our Patients: Quality, Safety & Patient Experience Clinical Indicators

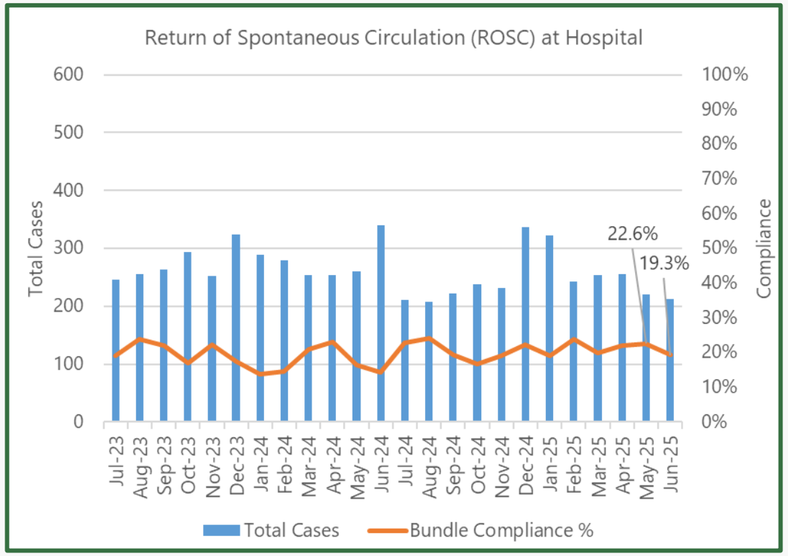
Return of Spontaneous Circulation, Hypoglycaemia, Fractured Neck of Femur (#NOF) and Time-Based metrics (#NOF)

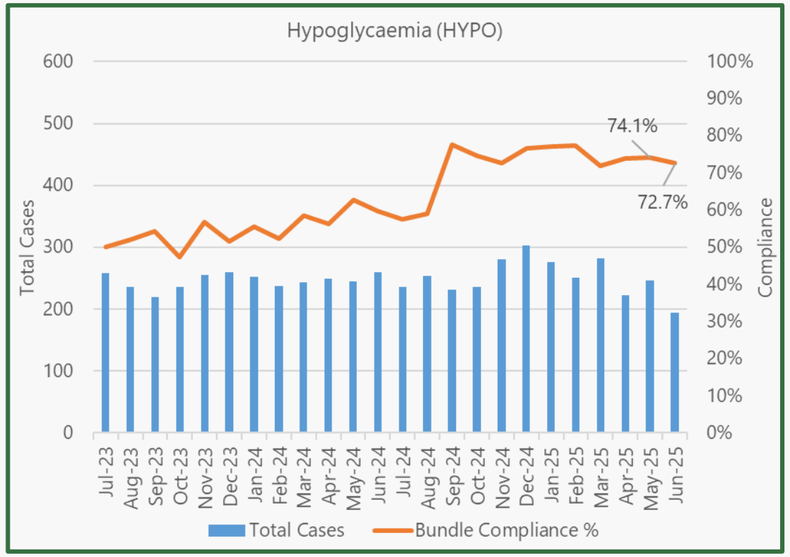
(Responsible Officer: Andy Swinburn)

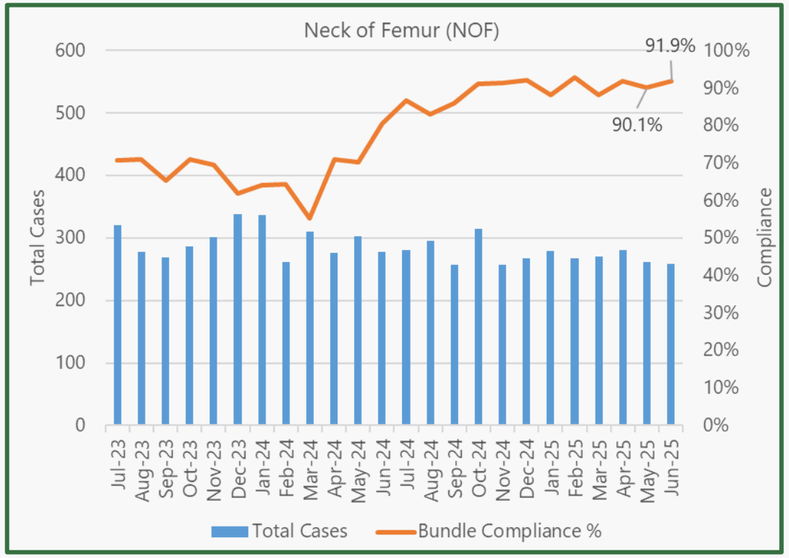
ROSC
A

Self-Assessment: Strength of Internal Control: Moderate

QUEST







#NOF Call 2 Door in development

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

Return of Spontaneous Circulation at hospital (from cardiac arrest) – 19.33%, a decrease from 22.6% in May. 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. Both December and January continued to see higher numbers of cases in this indicator.

Hypoglycaemia (diabetic patients with low blood glucose) – 72.7%, a slight decrease from last month. Compliance has remained quite static through Q1, although there has been a slight drop in compliance across the bundle.

Fractured Neck of Femur (hip fracture) – 91.9%, maintaining consistent performance from May. Only a slight increase in compliance which is evident across the care bundle.

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
Patient National Reportable Incidents & Duty of Candour

(Responsible Officer: Liam Williams)

Concerns.

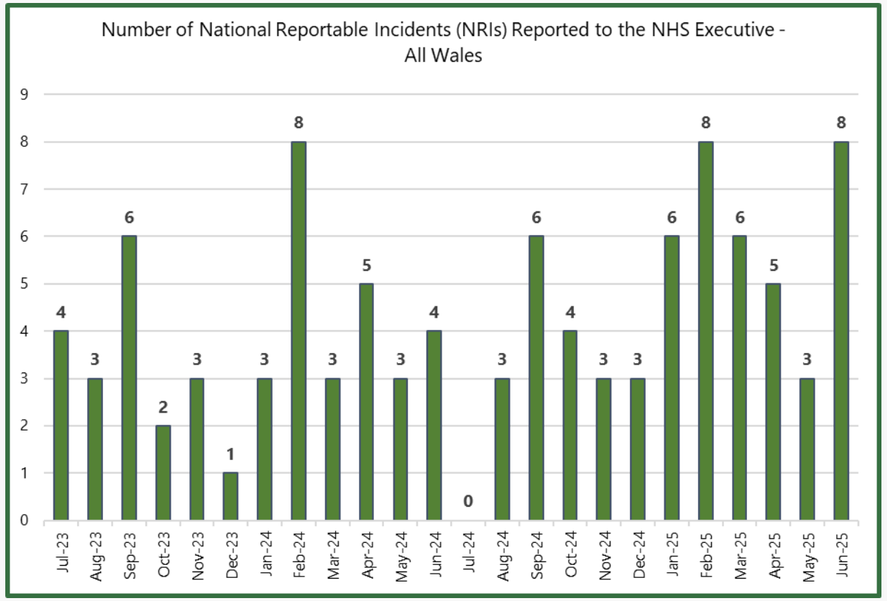
G

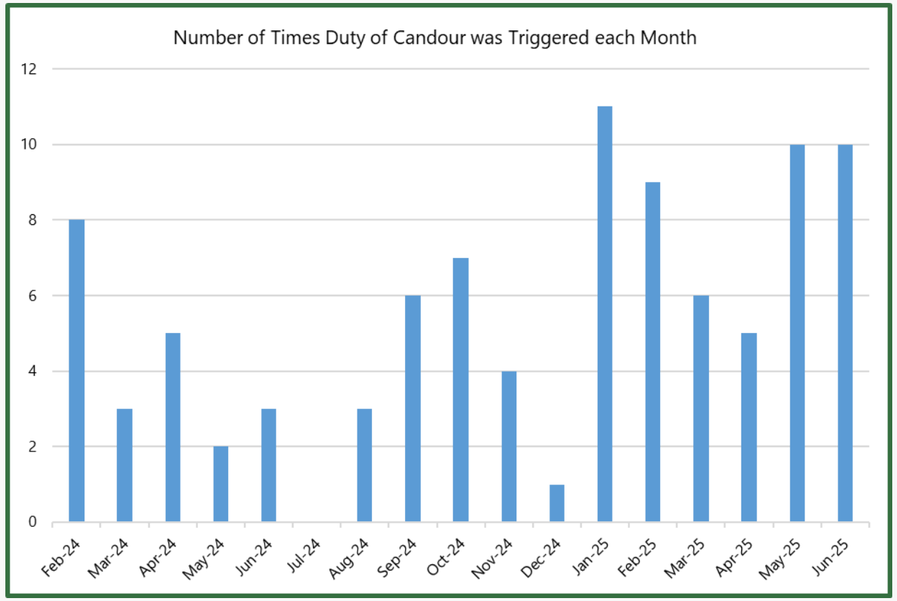
Self-Assessment: Strength of Internal Control: Moderate

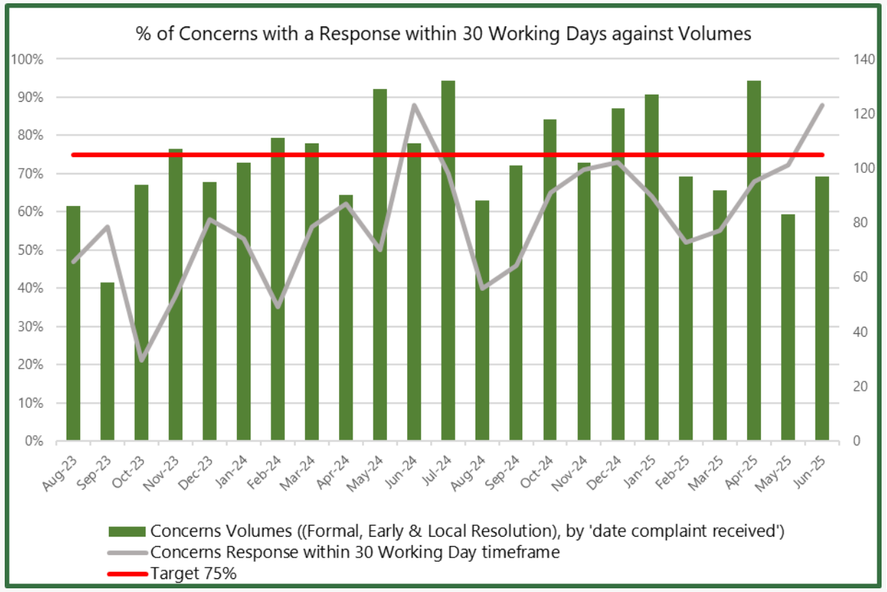
QUEST

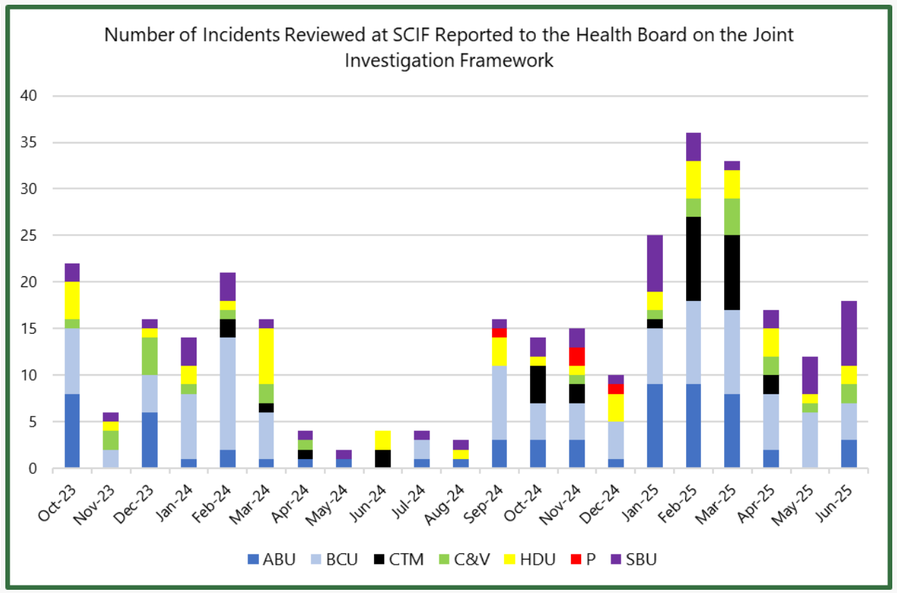
Health & Care Standard
Health - Safe Care / Timely Care

Responses Indicators









Analysis

Compliance with the 30 working day complaints target was achieved for the first time since May 2024. Performance for closed complaints however masks a concerning picture of a growing number of open and overdue complaints. This is due to increased complexity of investigations within the Trust, an increased volume of incidents that may have arisen from planned changes in the Clinical Safety Plan and the need to recruit 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 111Wales Integrated Care.

Remedial Plans and Actions

Ongoing monitoring of national incident reporting, enactment of the Duty of Candour and Complaints performance is monitored by team leads on a regular basis and all teams are working to achieve national timescales and a benchmarking position comparative to other NHS Wales.

The Trust has approved increased investment within the Operations Auditing Team and the Remote Care Education Team to support timeliness of complaint and incident investigations

Expected Performance Trajectory

An organisational PTR & Legal Services Recovery Plan is being developed and will be presented at the next QuESt Committee.

The complaints management process itself is well-assured, with families continuing to receive regular contact from the Trust.

*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

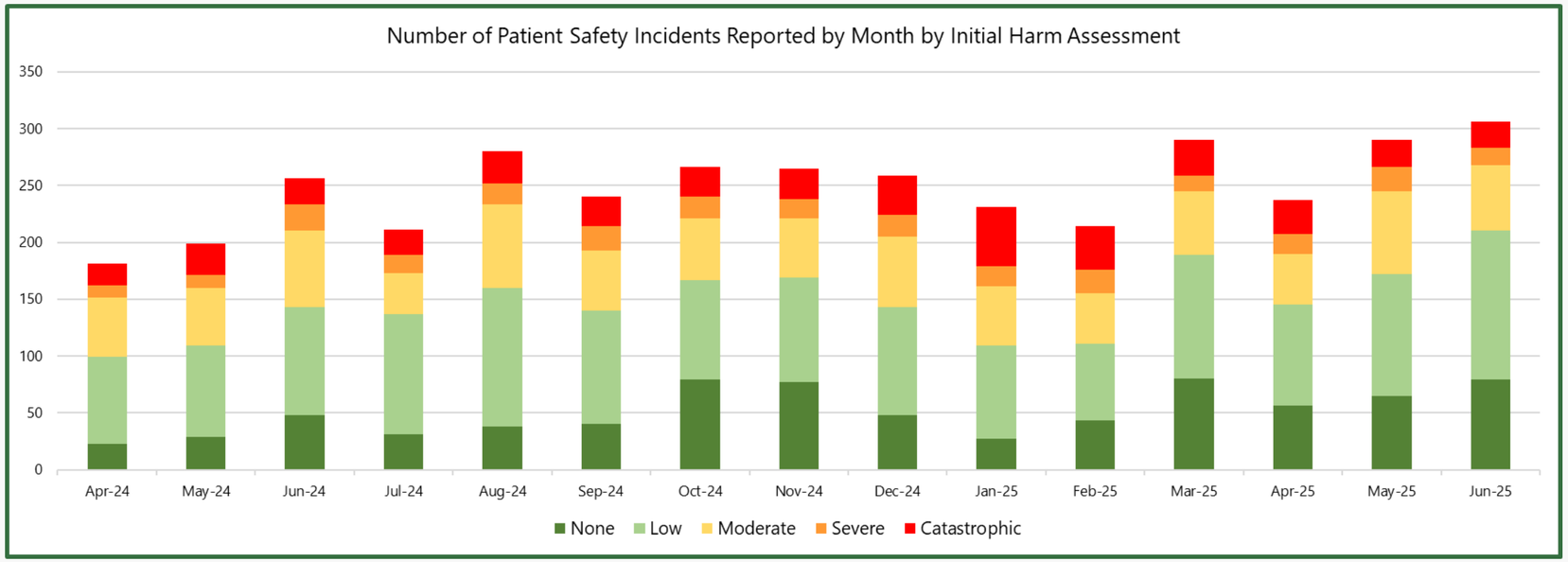
Our Patients: Quality, Safety & Patient Experience
Patient & People Safety Indicators

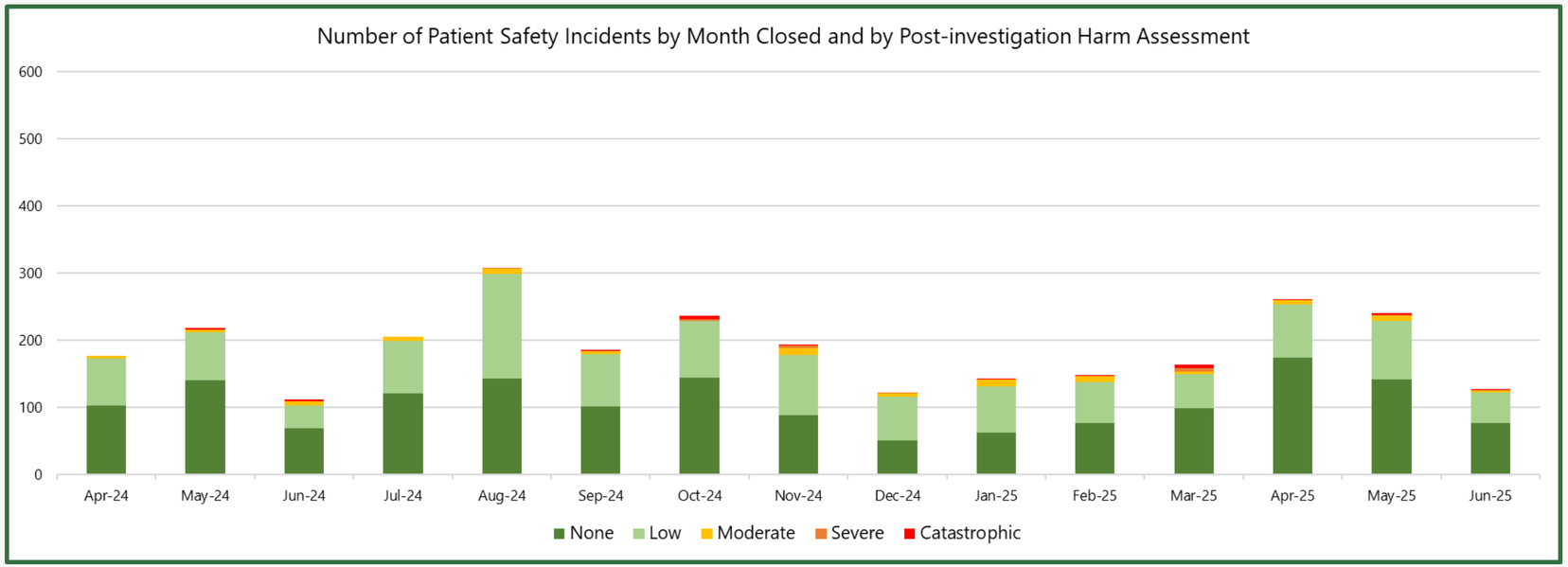
(Responsible Officer: Liam Williams)

Self-Assessment: Strength of Internal Control: Moderate

QUEST

Health & Care Standard
Health – Safe Care





Analysis

Incident reporting volumes have decreased back towards the organisational baseline. Incident closure rate however has shown a marked improvement in the number of investigations being completed and closed. This follows significant focus within service areas and improvement work of account permissions as part of the Datix Recovery & Improvement Plan. Near miss reporting is being encouraged during daily operational meetings to ensure we learn from all opportunities.

Closed incidents continue to demonstrate that validated levels of severe or catastrophic harm remain consistently low. NRI's that have been closed with the NHS Executive Wales have improved during the last month.

Remedial Plans and Actions

- Incident management culture is being supported through newly established Datix User and Datix Governance Groups (Datix Cymru is the electronic reporting software for incident reporting).

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.

Data source: Datix

Our Patients: Quality, Safety & Patient Experience
Coroners, Mortality and Ombudsmen Indicators

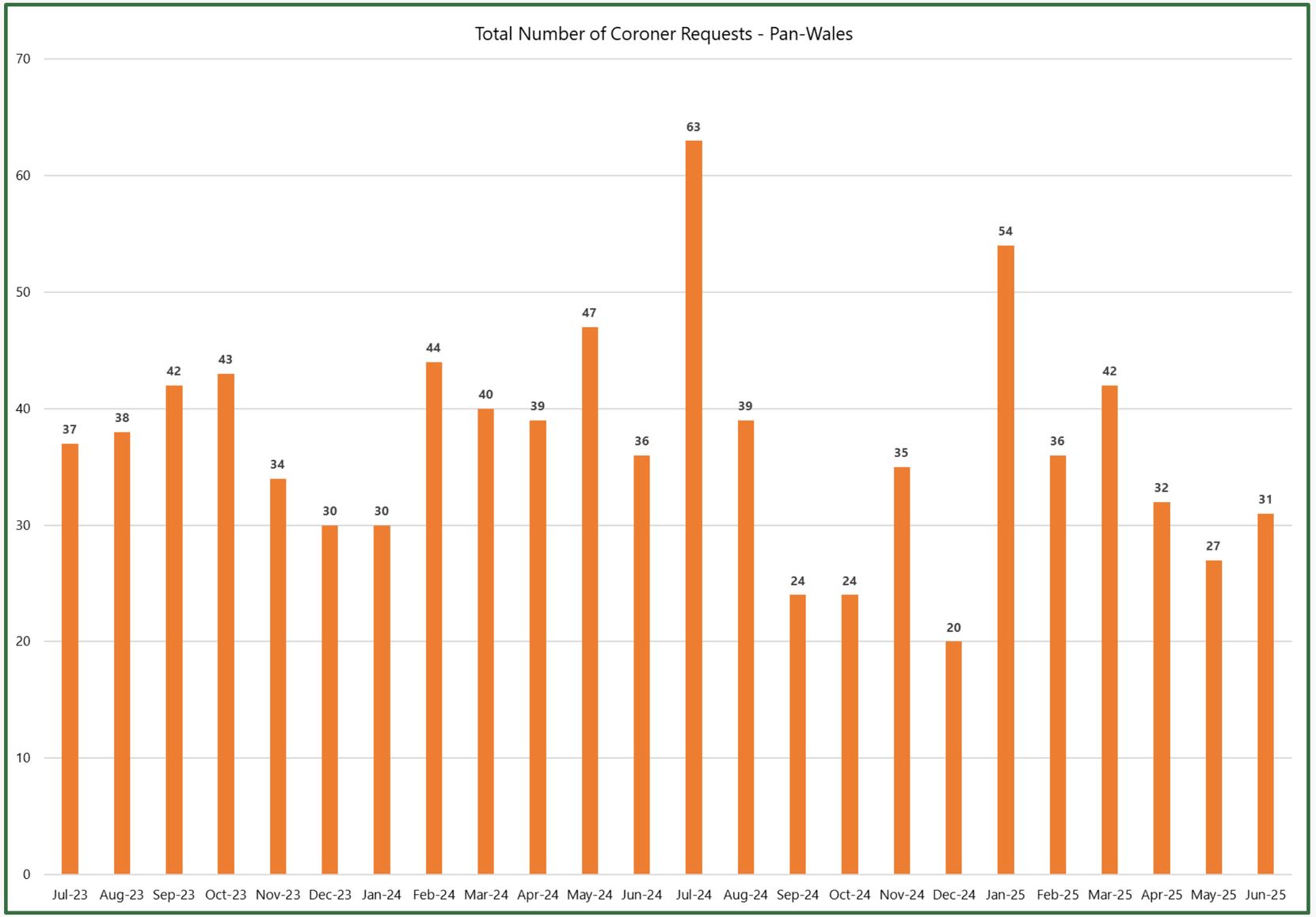
(Responsible Officer: Liam Williams)

Coroners Self-Assessment: Strength of Internal Control: Moderate

Mortality Self-Assessment: Strength of Internal Control: Moderate

QUEST

Health & Care Standard
Health – Safe Care



Analysis

The number of coroner approaches continues to bring a high level of activity to the Trust. 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.

Challenges to meet deadlines, in relation to EMSC with any form of remote Clinical decision-making involvement continue to require extension of deadlines and the Trust has received two Schedule 5 notices in May 2025.

From 1 May 2025 the additional support that has been in place since 16 Jan 2023 has ceased. The Trust will do less of our own representation, leading to more Barristers being instructed by the Trust.

Medical Examiner Level 1 triage occurs regularly, ensuring prompt recognition of cases where learning and/or potential harm are identified. The Level 2 Medical Examiner Learning Panel is now effectively reviewing the management and learning from cases.

Remedial Plans and Actions

Operations Quality have provided estimated completion dates for coronial deadlines, which will provide some assurance and expectations of completion dates to the coroner.

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.

The frequency of Level 2 Medical Examiner Learning Panels has been increased to weekly to address the high number of cases awaiting completion.

Expected Performance Trajectory

Short, medium and long-term plans continue to be developed to provide a solution to the challenges currently faced in timely completion of statements.

Mortality Reviews Data source: Internal Web Application

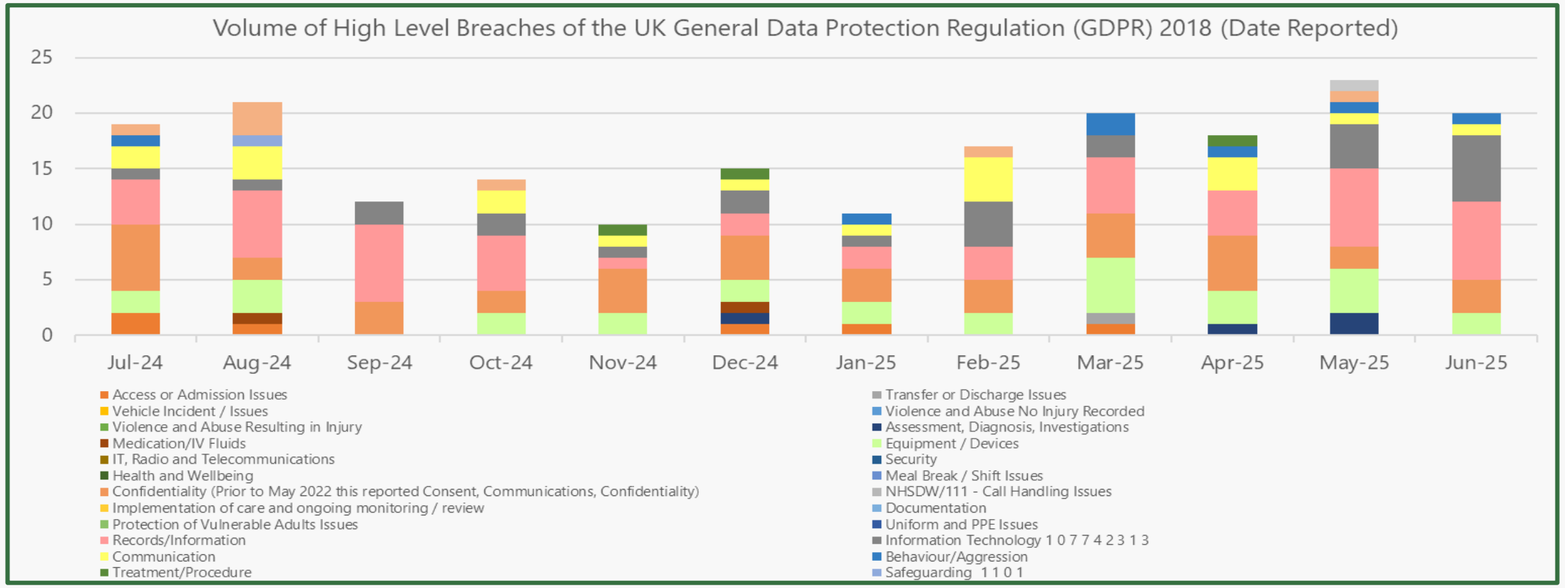
Our Patients: Quality, Safety & Patient Experience
Safeguarding, Data Governance & Public Engagement Indicators

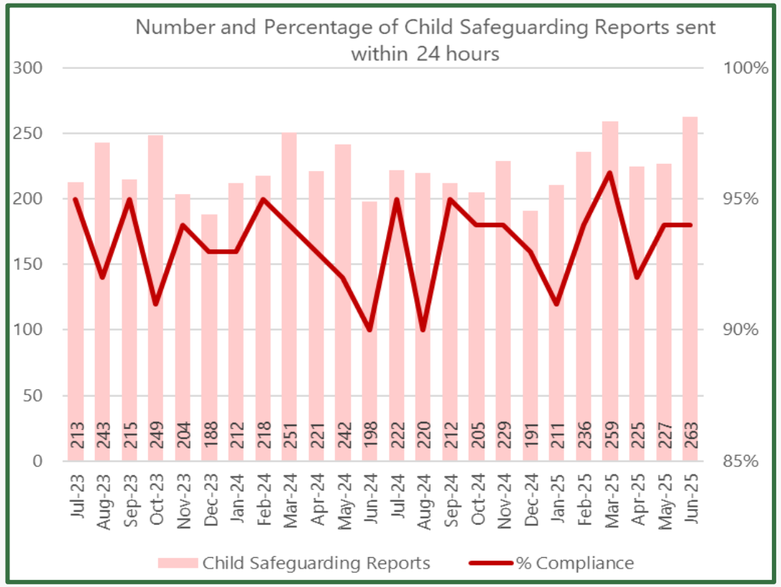
(Responsible Officers: Jonny Sammut & Liam Williams)

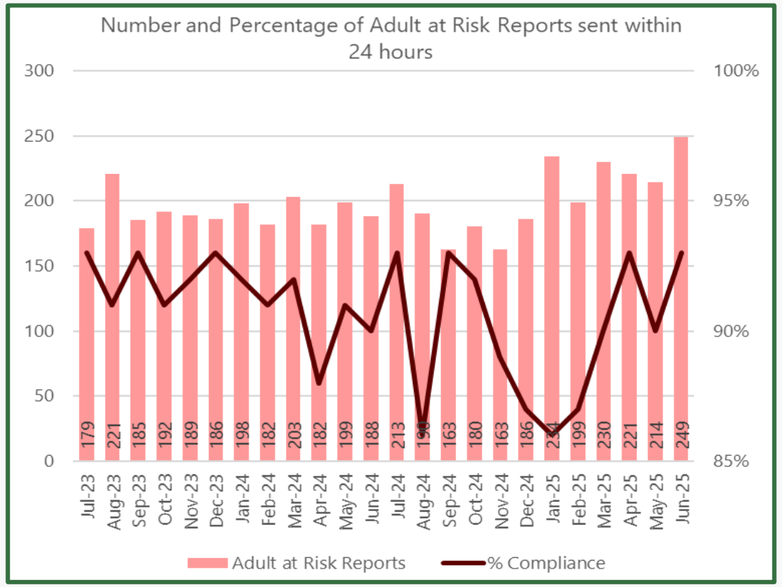
Health & Care Standard
Health – Safe Care

Self-Assessment: Strength of Internal Control: Strong

PCC







Analysis

Safeguarding: In June 2025 WAST colleagues submitted a total of 249 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); 790 reports were shared with local authorities across Wales during this reporting period. There have been 263 Child Safeguarding Reports submitted in June 2025, 94% of these were processed within 24 hours.

Data Governance: In June 2025, there were 20 information governance (IG) related incidents reported on Datix Cymru categorised as an Information Governance (IG) breach. Of these 20 breaches, 7 related to Records/Information, 3 IG/Confidentiality, 1 Communication, 2 Equipment, 1 Behaviour, and 6 Information Technology.

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 20-information governance related incidents reported on Datix, no incidents were reported to the Information Commissioner's Office (ICO). 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 IG Toolkit submission was completed on 31st March 2025. The next iteration of the IG Toolkit has now opened for FY25/25 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

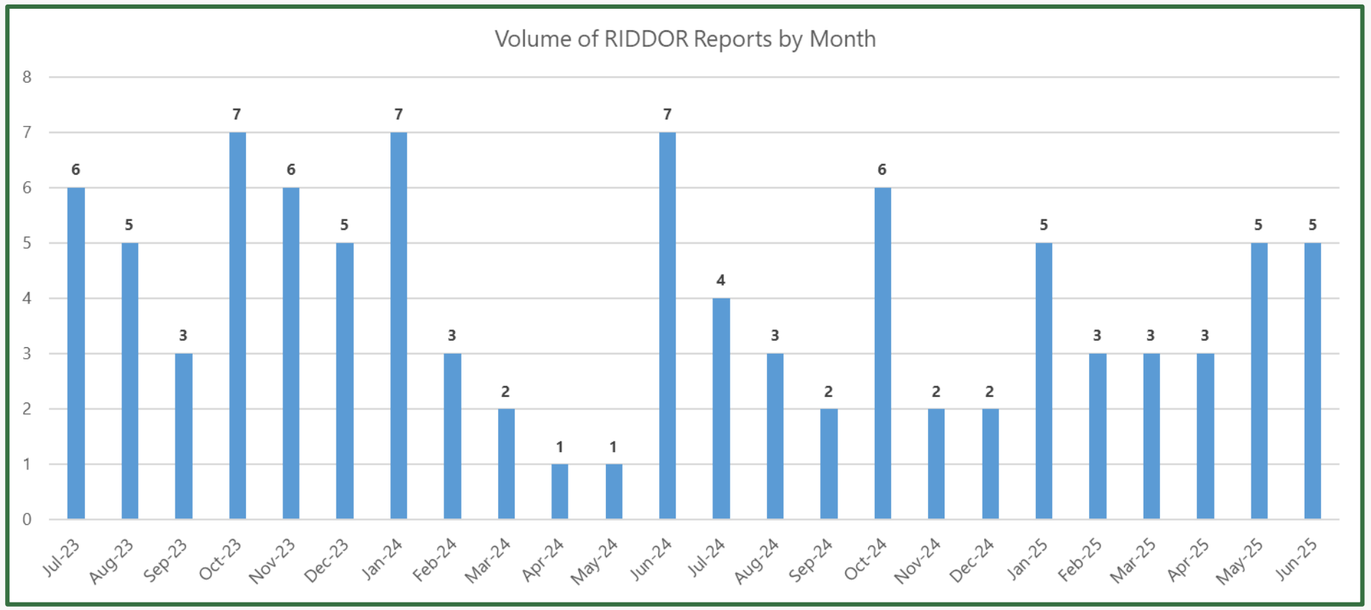
Our Patients: Quality, Safety & Patient Experience
Health & Safety (RIDDORS) Indicators

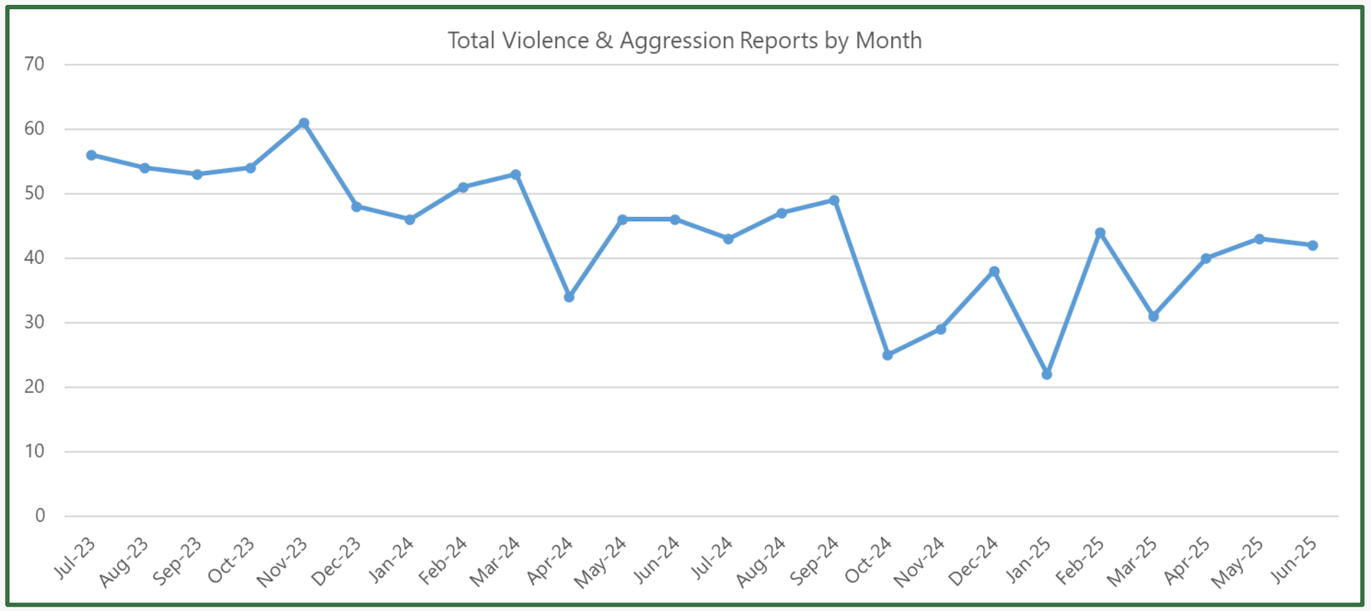
(Responsible Officer: Liam Williams)

Self-Assessment: Strength of Internal Control: Moderate

PCC

Health & Care Standard
Health – Safe Care





Analysis

RIDDOR: There were 5 incidents requiring reporting under RIDDOR during June 2025 all were for an injuries requiring over 7 days of work.

- 100% of the RIDDOR's were submitted within the HSE reporting timelines, due in part to the effort put into investigating incidents by line managers.
- 4 RIDDOR's reported during the month were as a result of manual handling incidents 1 whilst handling equipment and 3 whilst handling patients and 1 was a slip trip on the stairs of a patient's home.

Violence and Aggression:

- A total of 42 incidents have been reported of V&A in June.
- 6 physical assaults on staff was reported during the month with 6 incidents of verbal abuse all of which were incidents of swearing.
- 7 incidents were reported as moderate in harm and 19 noted as low harm with 15 cases being noted as causing no harm.
- The number of verbal assault incidents remained high during the month with aggressive and threatening behaviour accounting for 20 of the 42 incidents.

Remedial Plans and Actions

RIDDOR:

The weekly Datix incident meeting is being 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 managers is making improvements in causation and reporting to the HSE.

Violence and Aggression:

The challenges of the Right Care Right Person approach by Polices Services are being managed via the Risk Management process in partnership with the WAST Mental Health Team.

V&A Manager has met with TU partners to engage and explain workstreams aimed at reducing and preventing incidents advising on a process of risk assessment/incident reporting.

Work is underway with People Services and the V&A function in relation to recording sickness absences on staff electronic staff record (ESR) following being subject to an episode of V&A.

Expected Performance Trajectory

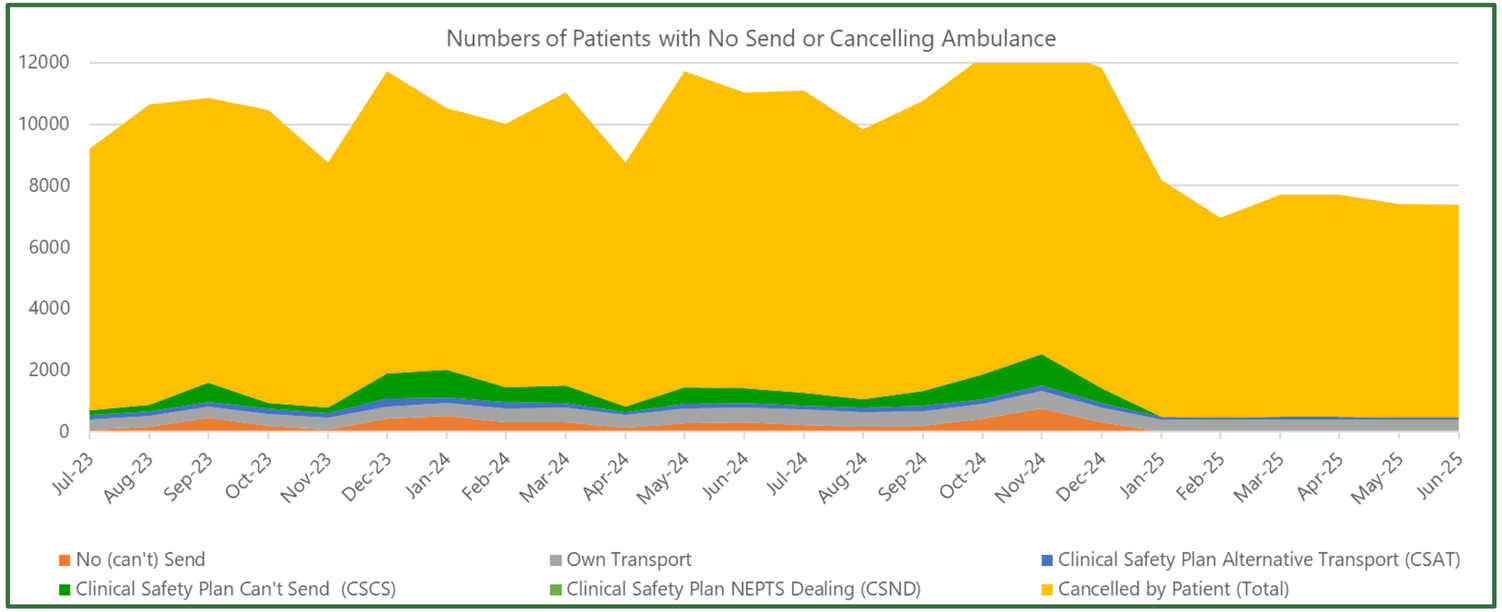
RIDDOR: The actions arising out of the recent deep dive into manual handling incidents aim to address the issues identified in the manual handling incidents this month.

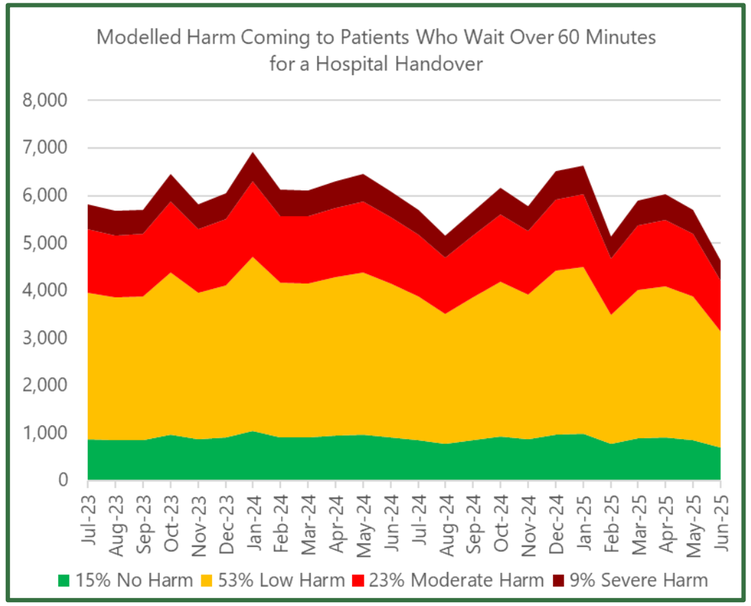
Violence and Aggression: There is a marked reduction in incidents reported over the last 12 months 29.8% which contradicts National reporting across the Sector, and this expected to be improved.

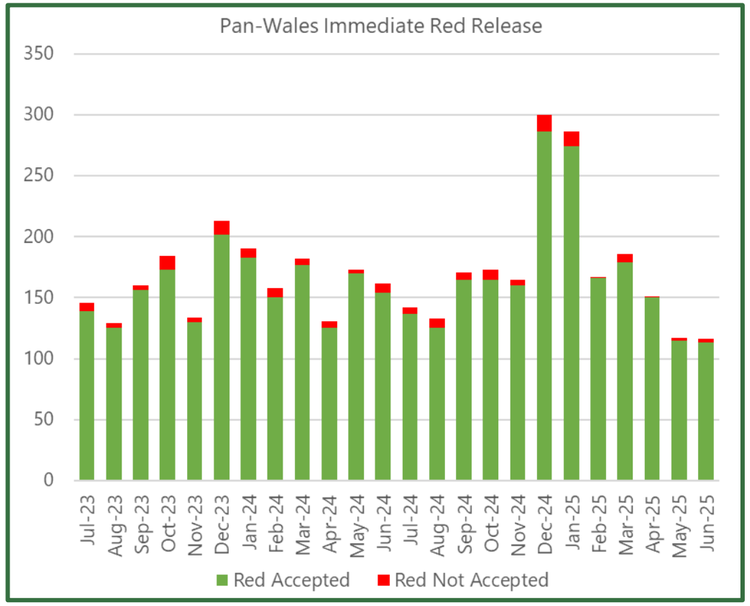
Data source: Datix

Our Patients: Quality, Safety & Patient Experience
Potential Patient Harm Indicators

(Responsible Officer: Andy Swinburn) G QUEST







Analysis

In June 2025, 78 ambulances were stopped due to Clinical Safety Plan alternative transport (CSPT). In addition, 6,926 ambulances were cancelled by patients (including patients refusing treatment at scene) a minimal decrease from the 6,962 in May 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.

There were 437 requests made to Health Board EDs for immediate release of Red or Amber 1 calls in June 2025. Of these 113 were accepted and released in the Red category, with 3 not being accepted and 131 ambulances were released to respond to Amber 1 calls, but 190 were not.

The graph in the bottom left shows the estimated level of patient harm during June 2025. Of the 4,625 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% (694 patients) would experience no harm, 53% (2,451 patients) would experience low harm, 23% (1,064 patients) would experience moderate harm and 9% (416 patients) would experience severe harm.

In June 2025 CSP levels for the Trust were:

Remedial Plans and Actions

Red 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 Red 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 from Q1. The NHS Wales Performance Delivery framework 2024/25 has a target of no handovers of more than one hour, this equates to 7,500 hours of handover lost hours.

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. See also slides on Red performance and Amber performance, in particular, remedial actions.

**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

PCC

Health & Care Standard
Health – Safe Care

May & June 2025 Combined		
NEPTS (503 responses)	Benchmark	Score
How long did you wait for your transport to take you home after your appointment.	85	85
Were you happy with the transport you received?	85	95
999 (43 responses)	Benchmark	Score
The 999-call taker who answered your call was reassuring.	85	79
The 999-call taker who answered your call explained what was going to happen next.	85	80
The length of time I waited for an ambulance to arrive was acceptable.	85	56
111 (29 responses)	Benchmark	Score
Do you feel your call to 111 Wales was helpful?	85	72
Did you follow the advice given to you by NHS 111 Wales?	85	87
Would you consider using NHS 111 Wales again?	85	91
WAST Overall - Friends & Family Test How was your overall experience with the service today?	Ranked from very poor to very good.	
o Ambulance care	92.22% Good	6.11% Poor
o Integrated Care (NHS 111 Wales Telephone line only)	53.85% Good	23.08% Poor
o EMS (including CSD)	63.34% Good	18.18% Poor
o NHS 111 Wales Online	32.43% Good	51.35% 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 May and June 2025, PECI attended 27 community engagement opportunities, engaging with approximately 496 people. Engagement this month included attending Pride Cymru, Cardiff Mela, All Wales People First Adfest and Swansea Disability Forum. At all these events we listened to people tell us about their experiences of using our services, answered questions and provided information about topics people wanted to know more about.

Throughout May and June, 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

The PECI Team are still waiting the progression of an OCP which will see the Team restructured and re-aligned to meet the Trust's ongoing strategic objectives. For now, the PECI Team continue to engage in an ongoing dialogue with the public about their experiences and expectations of using our services, though it is yet unclear how this will change and what Team will be responsible for public engagement in the future. As a result, the PECI Team are not committing to a diary of future engagement events and are considering each community engagement request on a case-by-case basis.

Response rates to some of our PREM's surveys continues to be disappointingly low and we acknowledge that this means we cannot report a truly reflective picture of what it feels like to be a user of some of our services. A DPIA was submitted to the ICO for consideration, which would allow us to contact certain 999 callers by SMS Text to ask them to provide feedback. The ICO has responded with 7 recommendations which will be presented to IGSG and from there it will be reported to ELT as an AAA.

Expected Performance Trajectory

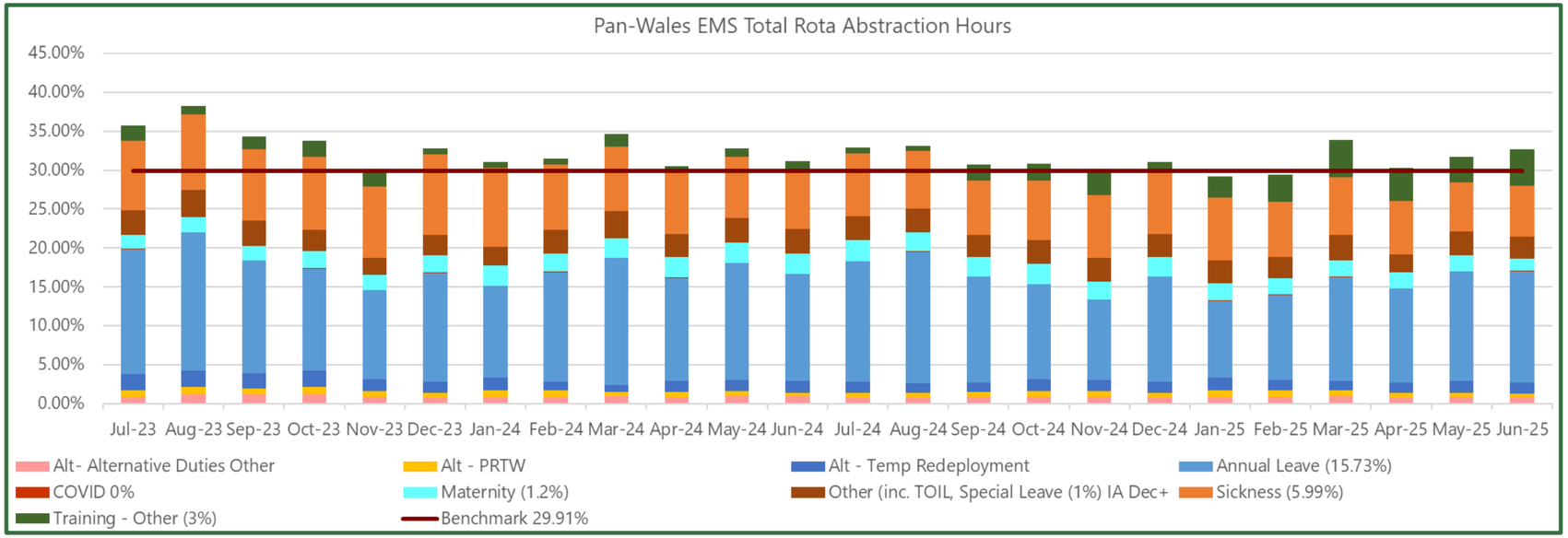
The Team has recently lost four members of staff to retirement or moving onto new positions elsewhere. The impending OCP means we are unable to back fill these posts. This will impact on our ability to support/attend community engagement opportunities.

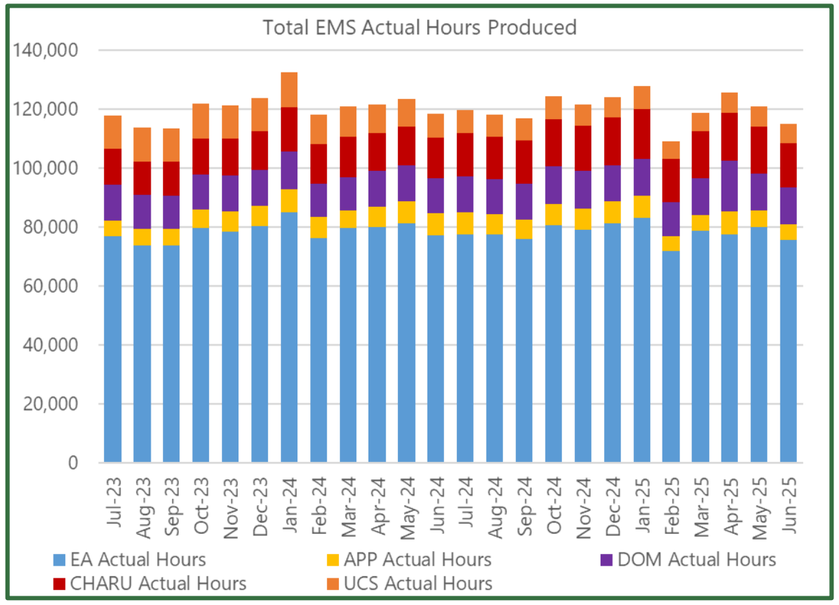
Our People
Capacity - Ambulance Abstractions and Production Indicators

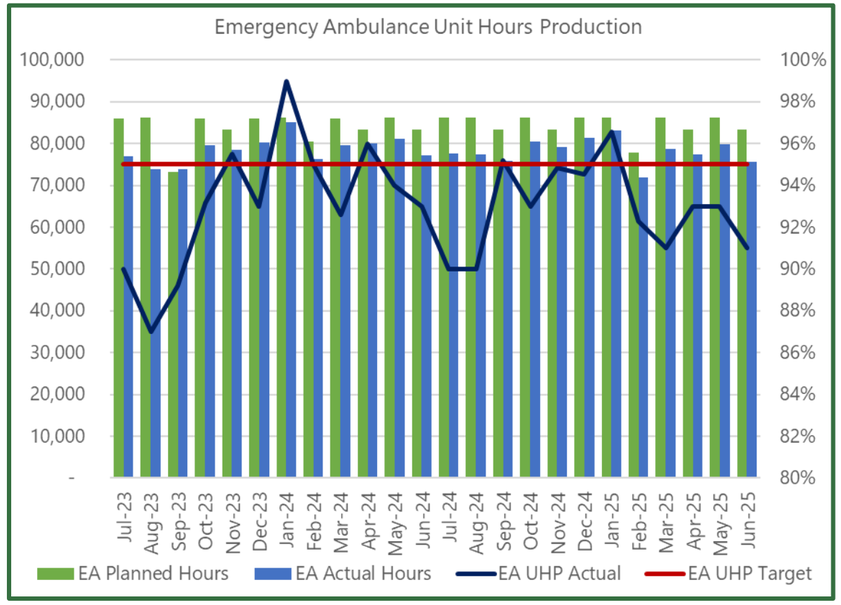
(Responsible Officer: Lee Brooks)

EA Production
A

CI PCC FPC







Analysis

Monthly abstractions from the rosters are key to managing the number of hours the Trust has produced, as are the total number of staff in post. June 2025, saw total EMS abstractions (excluding Induction Training) of 32.63%. This was a minimal increase on the 31.68% recorded in May 2025 and remains above the 29.91% benchmark. The highest proportion of abstractions was due to annual leave at 14.29% followed by sickness at 6.49%.

The total EMS hours produced is a key metric for patient safety. The Trust produced 115,205 hours during June 2025; a decrease compared to the 118,364 hours produced during June 2024. The Trust is delivering good levels of production.

Emergency Ambulance Unit Hours Production (UHP) achieved 91% in June 2025 which equated to 75,686 Actual Hours.

In June 2025 CHARU UHP was 85% against the full roll out requirement. A slight drop compared to the past seven months.

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.

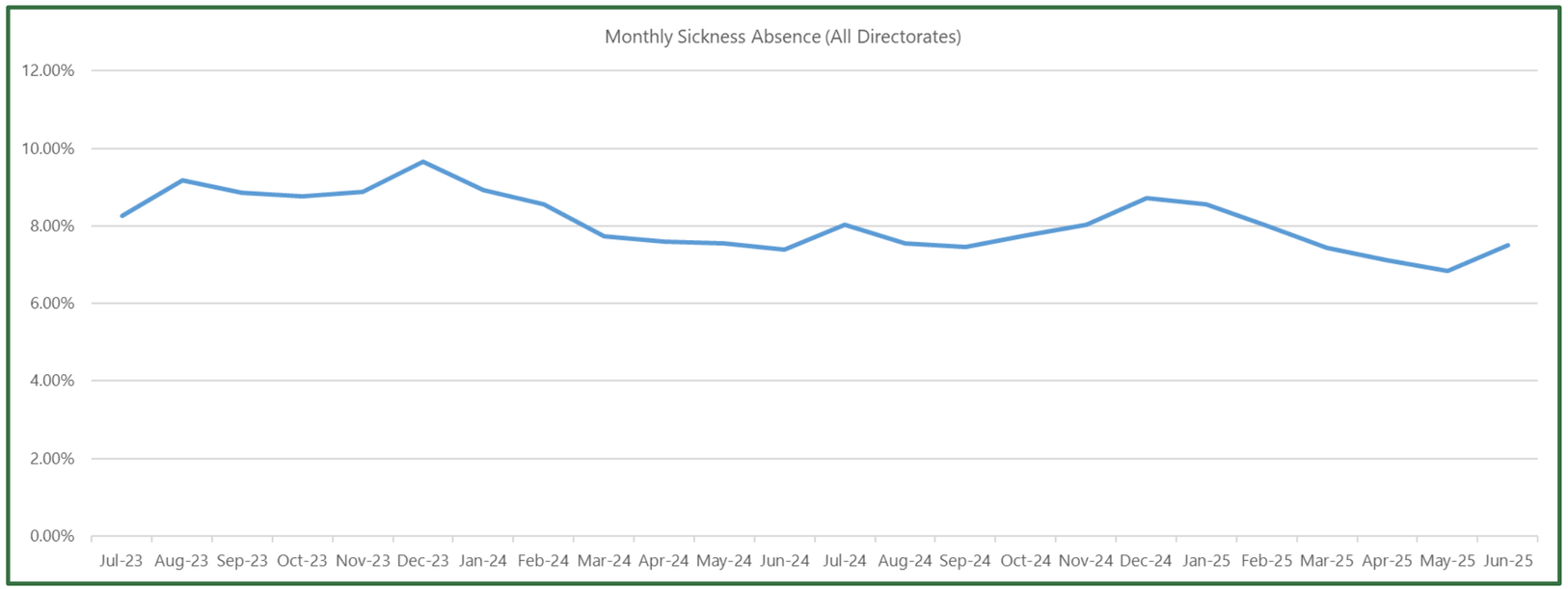
Our People
Capacity - Sickness Absence Indicators

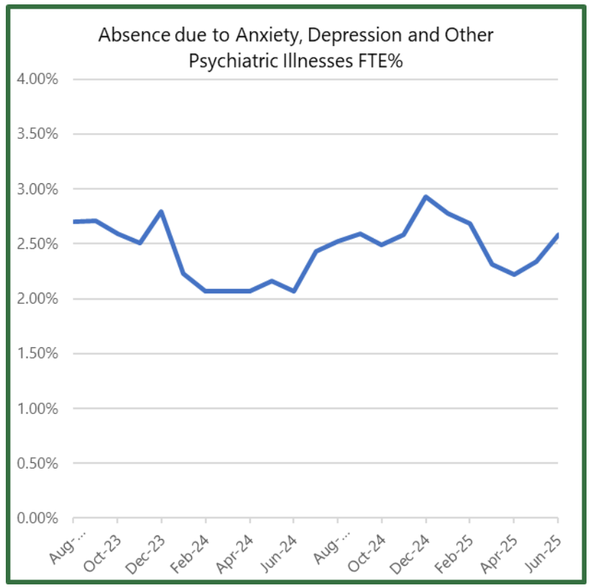
(Responsible Officer: Angela Lewis)

Sickness	Mental Health
R	R

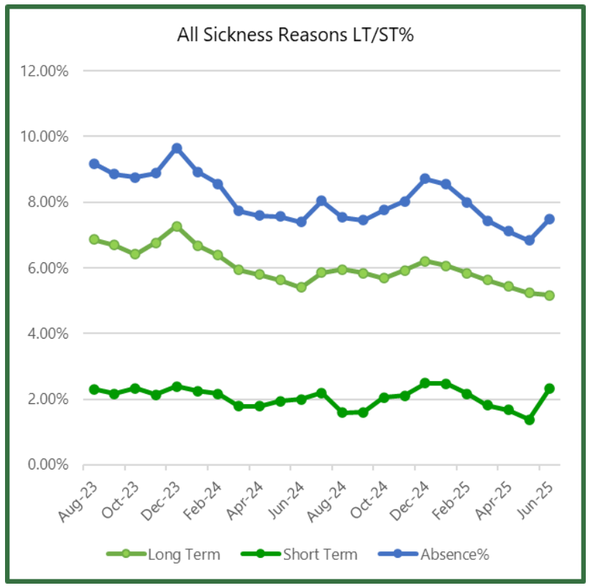
PCC

CI





Average working days lost per FTE (Annual)	
17.66 days	
Single month Absence %	
7.50%	
Long Term	**Short Term**
5.17%	2.33%
Mental Health	**Other MSK**
(S10 Stress/Anxiety) 2.58%	(excluding Back) 0.77%



June 2025

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

Analysis

There was a slight increase in overall sickness absence rates between May 2025 and June 2025, rising from 6.83% to 7.50%. Long term absence decreased from 5.25% in May 2025 to 5.17 % in June 2025, while short-term absence increased slightly to 2.33% (May 2025 - 1.38%).

The highest reasons for absence in June 2025 were Anxiety/ Stress/ Depression, other musculoskeletal problems, gastrointestinal problems, and injury fracture. Absence due to Mental Health increased slightly from 2.34% in May 2025 to 2.58% in June 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 June was 11.7 days.

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

Remedial Plans and Actions

- The Health and Wellbeing Plan for 2025-29 has been approved by the WAST Board and a delivery plan has been developed and implemented. The focus of the plan is to improve workplace relationships, increase the trauma-awareness of the organisation and address health and wellbeing challenges increasingly on a systemic level, in addition to providing support on an individual level.
- 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 programme plan for the pilot Health Check Programme, Health Diagnostics, (HD), has now started, and the team are scheduling clinics inviting staff to book screening appointments.

Expected Performance Trajectory

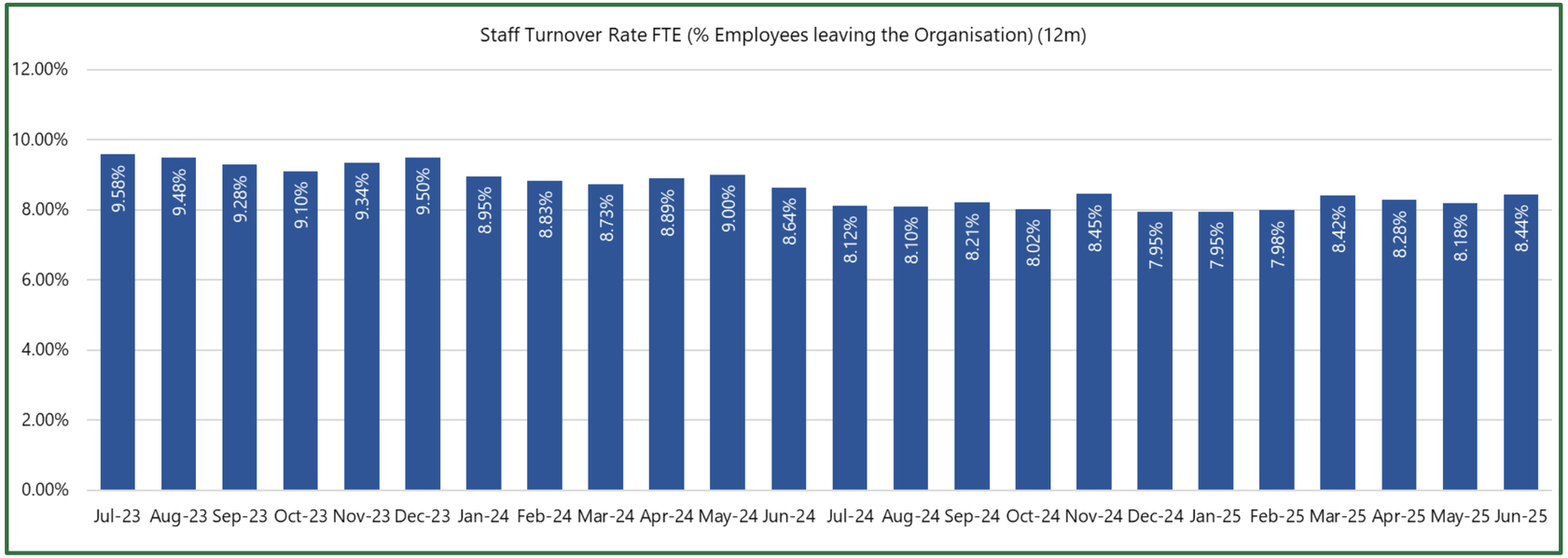
The Trust has indicated through its IMTP that sickness levels will fall in this financial year, but the Trust is unlikely to achieve the 6% target for the year given continuing system pressures.

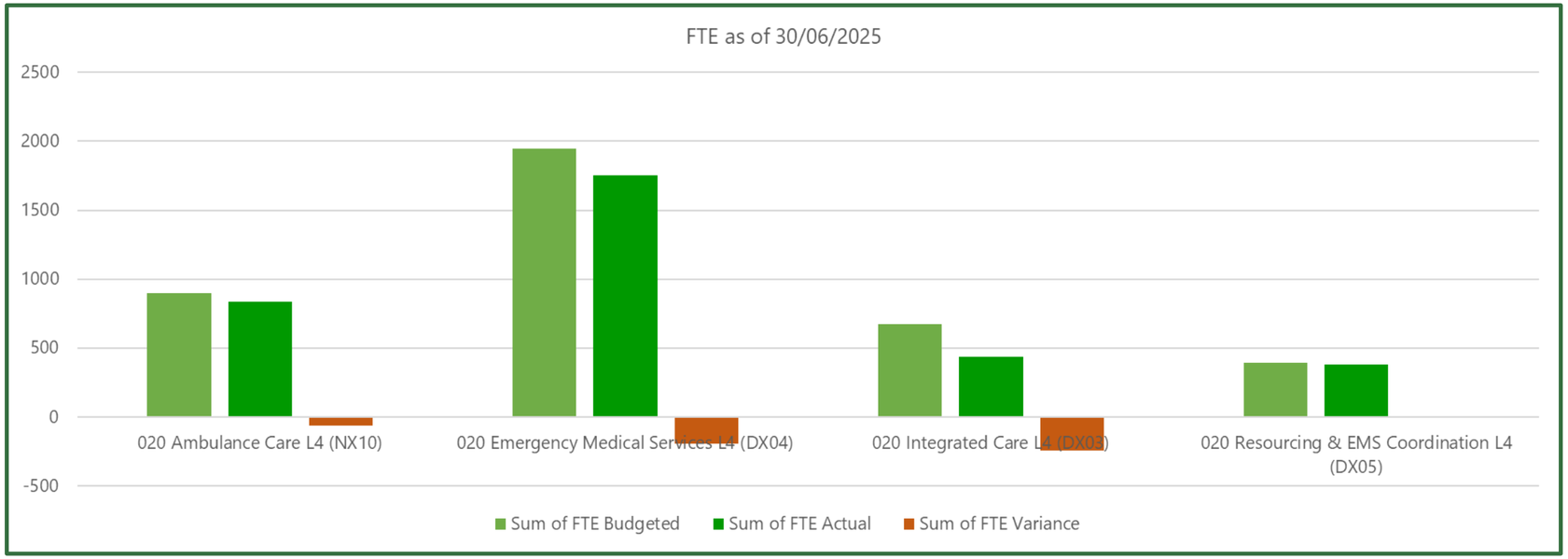
Our People
Capacity – Staff Turnover

(Responsible Officer: Angela Lewis)

G

PCC





Analysis

The staff turnover rate in June 2025 was 8.44%, minimally increasing from 8.18% in May 2025. June saw 31 leavers (27.03 FTE). Of those leaving, the greatest number were Operational and included;

- Technicians (6 people)
- Staff Nurses (5 people)
- Ambulance Care Assistants/Patient Transport Drivers (4 people)
- Emergency Call Handlers (3 people)

Current trends are being monitored via the leaver's questionnaires; however, these are not mandatory. Of the information shown for June, most leavers mention changes in personal circumstances, better work location, retirement, better work life balance or better hours.

In June, this was compensated by 39 joiners (36.88 FTE). A headcount of 1 person into Corporate roles and 38 people into Operational roles including:

- Staff Nurses (8 people)
- Emergency Call Handlers (7 people)
- Urgent Care Assistants (6 people)
- Paramedics (5 people)
- Non-emergency medical Dispatchers (3 people)

Remedial Plans and Actions

- The Trust is looking at longer term models to grow our APP cohort to support our future ambitions, which will include the recruitment of additional NQPs to support our B6 paramedics movement into APP roles.
- 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.

Our People
Capability - PADR and Training Rates Indicators

(Responsible Officer: Angela Lewis)

PADR: A

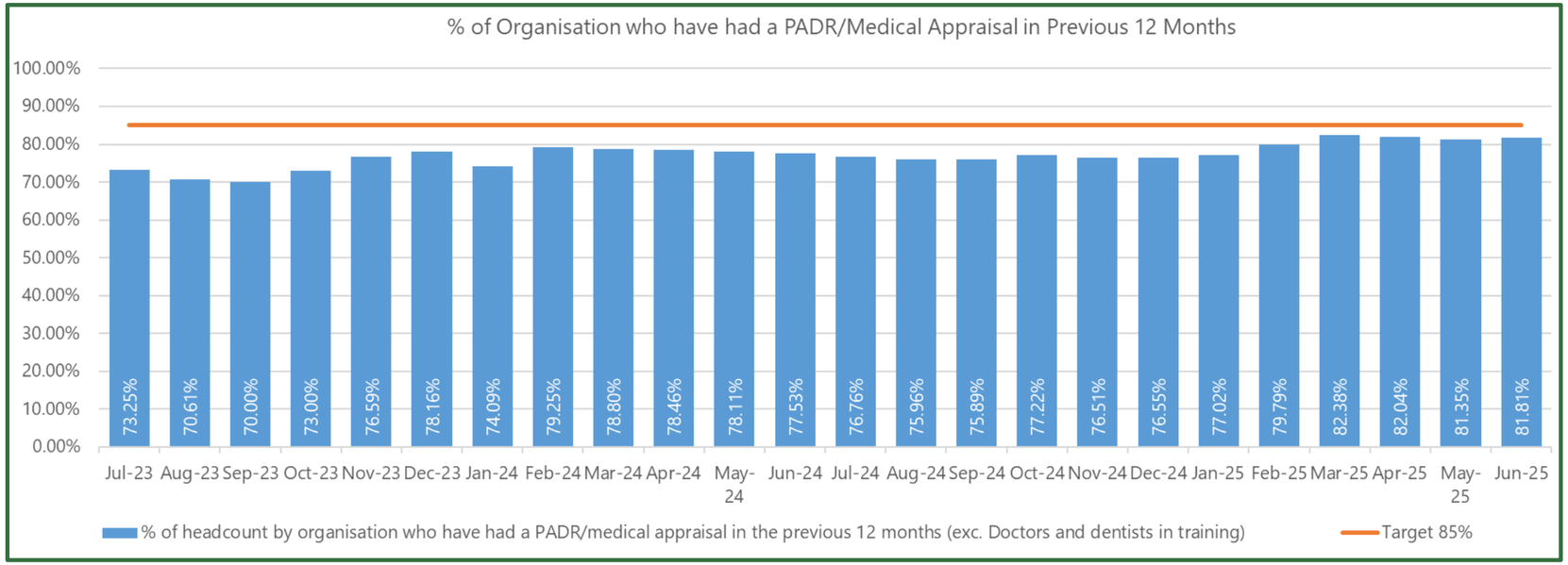
Stat & Mand: G

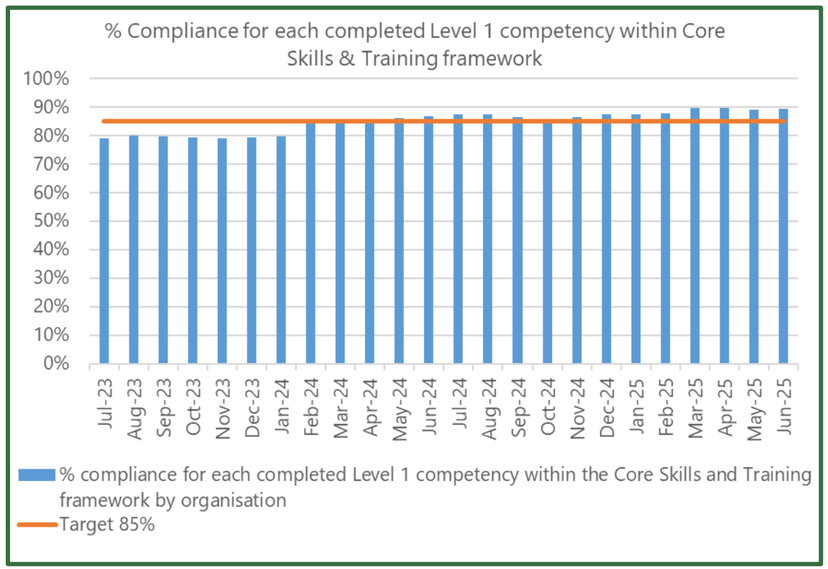
CI

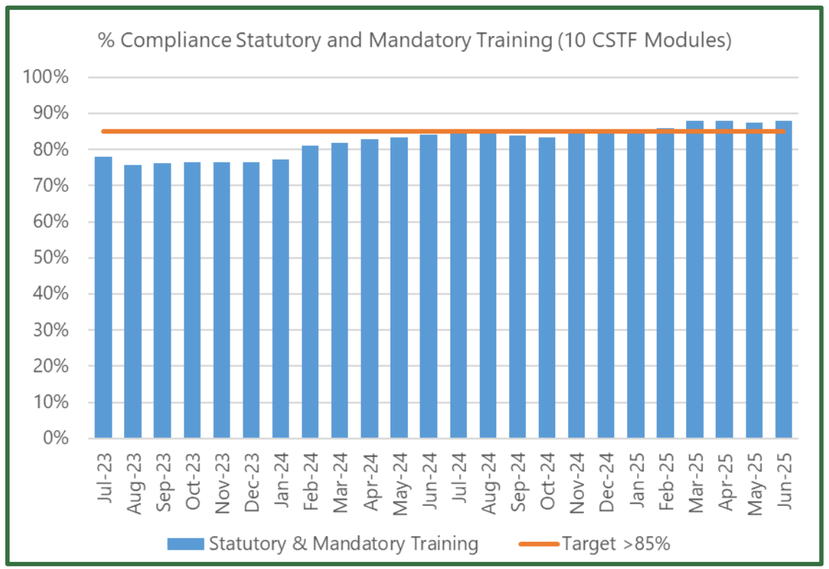
PCC

Health & Care Standard Health – Staff & Resources

Self-Assessment: Strength of Internal Control: Strong







Analysis

PADR rates minimally increased minimally from 81.35% in May2025 to 81.81% in June 2025 and remains close the 85% target. Over the reporting period this target has only been achieved once, in December 2022.

In June 2025 Statutory & Mandatory Training rates reported a combined compliance of 88.05% exceeding the 85% target for the seventh consecutive month. However, only Dementia Awareness (98.50%), Moving & Handling (95.93%) and Safeguarding Adults (95.61%), achieved the 85% target. Information Governance (88.11%), Equality & Diversity (84.53%), Paul Ridd (78.21%), Fire Safety (79.58%), Fraud Awareness (79.38%), Violence Against Women, Domestic Abuse & Sexual Violence (75.26%) and Welsh Language Awareness (73.40%) all remain below this target.

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
Enviroment, 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

Data source: ESR

Our People
Health and Well-being – Shift Overruns

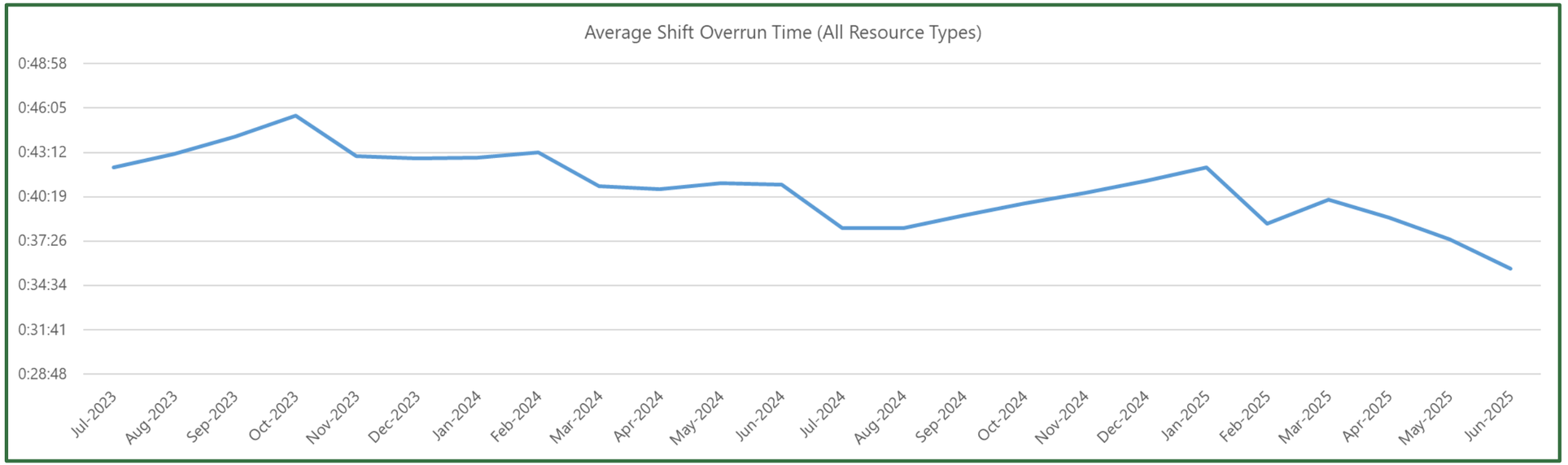
(Responsible Officer: Angela Lewis)

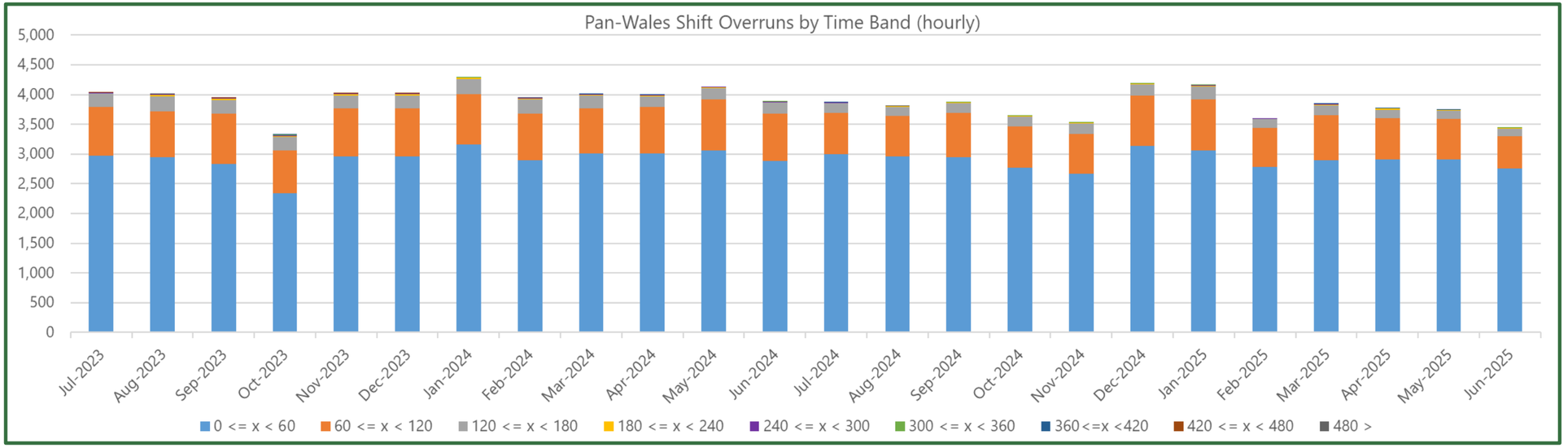
Overruns G

CI

PCC

FPC





Analysis

There were 3,441 shift overruns during June 2025.

The average overrun figure for June 2025 was 35 minutes and 38 seconds, a minimal decrease from May 2025 (37 minutes 32 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 76.5% of the total. 18.7% fall within the 61 to 120-minute category, 4.2% in the 121 to 180-minute category, 0.3% in the 181 to 240-minute category and 0.2% 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.

As part of the Trust's winter resilience planning, it introduced "pods" at some hospital locations to aid staff finishing on time. These are continuing, at this time, in 2025.

Expected Performance Trajectory

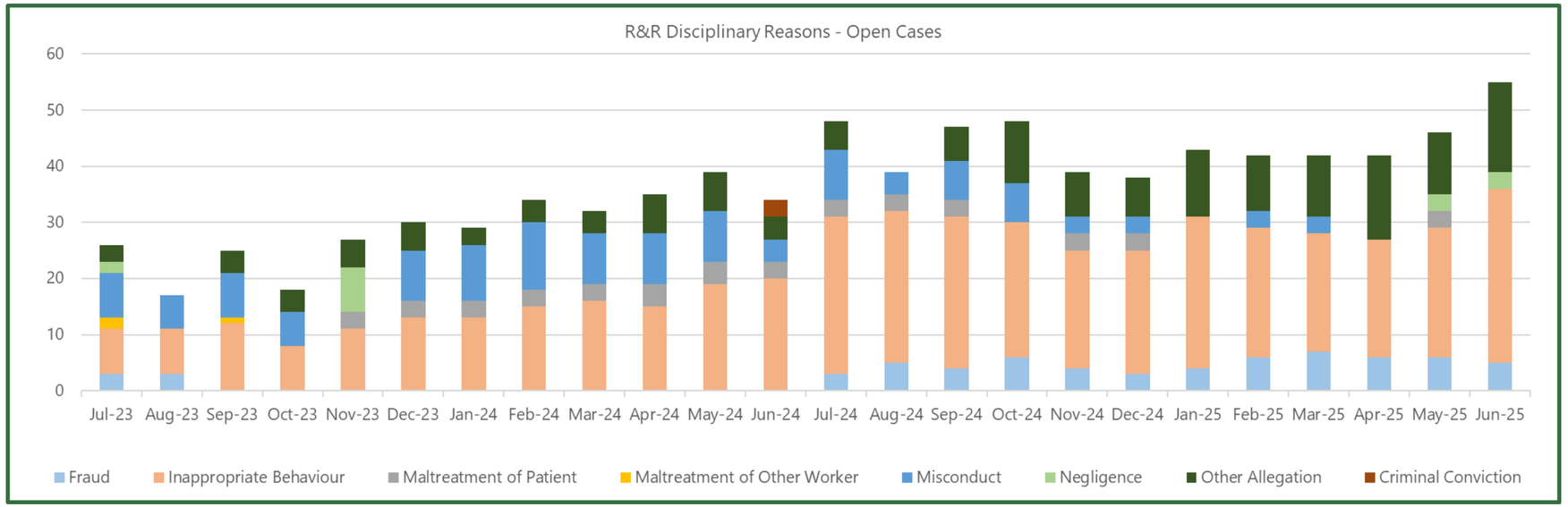
Overruns correlate with handover lost hours and may continue to increase.

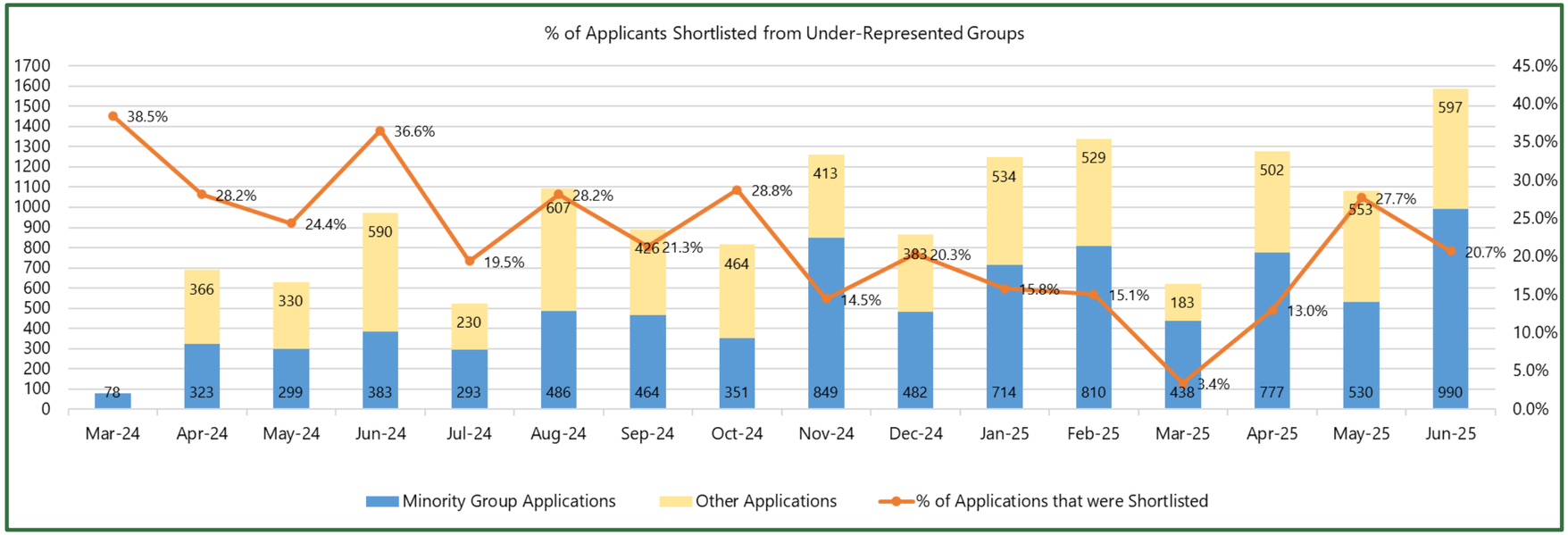
Our People
Culture – Number of R&R Disciplinary Hearings and Number of Applicants Shortlisted from Under-Represented Groups

(Responsible Officer: Angela Lewis)

Self-Assessment: Strength of Internal Control: Moderate

PCC





Analysis

There were 55 open formal disciplinary cases recorded at the end of June 2025, compared to 46 in May 2025. Of these Disciplinary cases, 56% are due to allegations of inappropriate behaviour.

There were 27 open formal Respect and Resolution cases in June 2025, an increase from 25 reported in May 2025. (increase due to R&Rs in relation to Roster Reviews)

The bottom graph shows that in June 2025, 1,587 job applications were processed, and 490 interviews planned.

Of the 1,587 applications, a total of 990 were from under-represented groups with 607 in the category of Ethnicity, 203 within Disability and 180 identifying within Sexual Orientation.

In June 2025, 20.7% (n=205) of all applications from under-represented groups made it through shortlisting and were invited for interview. This was a decrease from the 27.7% in May 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.

The work continues with the digital directorate and the ED&I team to host recruitment workshops for Black, Asian and Ethnically diverse applicants. The ED&I team are also hosting unconscious bias training for the managers within the digital directorate this is also being undertaken with the interviewers for our annual Graduate Paramedic recruitment. We have also set up support workshops for applicants that have a protected characteristic that have been invited to interview for the Graduate Paramedic position.

Expected Performance Trajectory

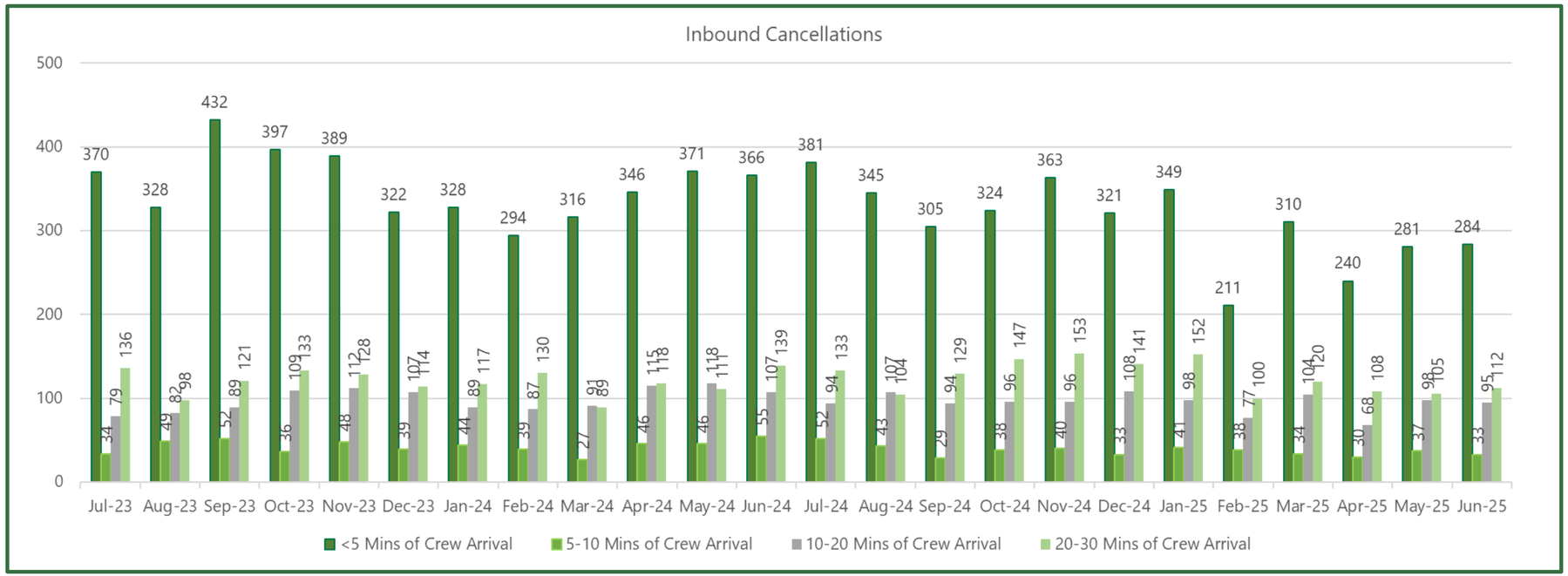
Continue to monitor levels, no trajectory for this measure.

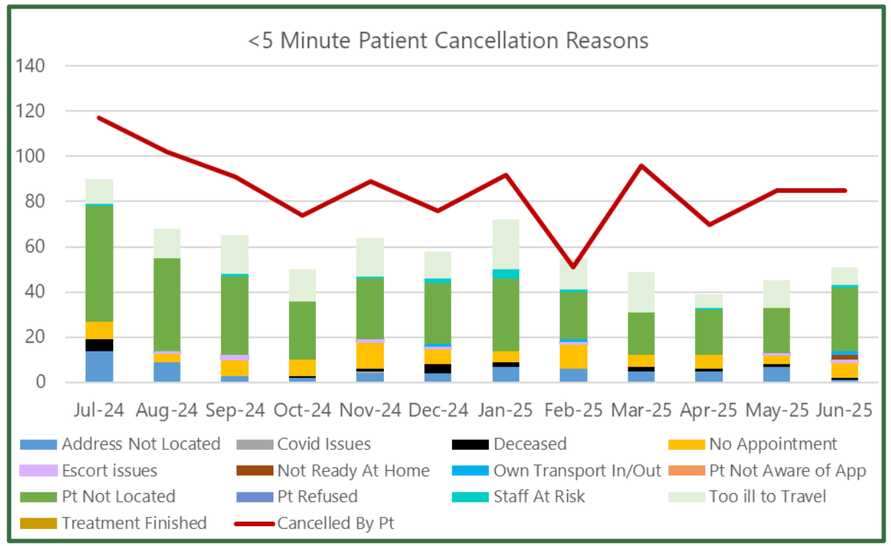
Finance, Resources and Value
Value: Ambulance Care Indicators

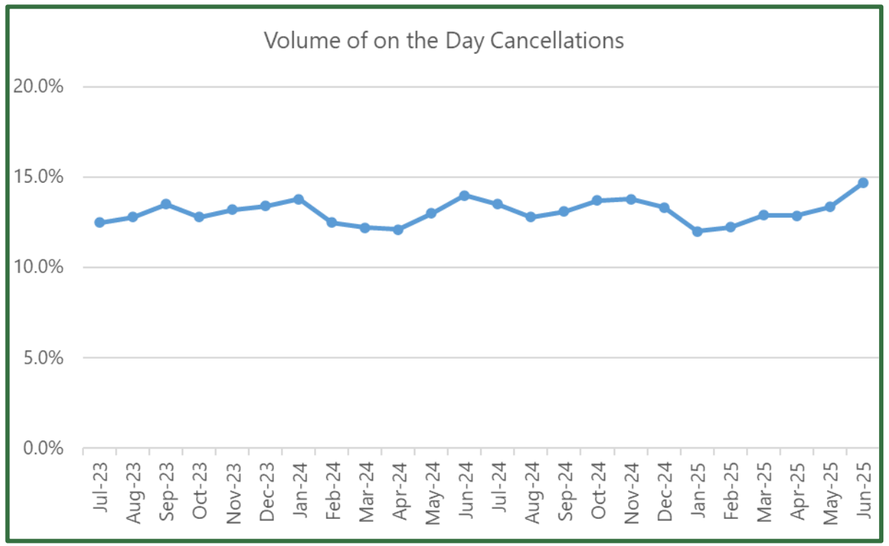
(Responsible Officer: Lee Brooks)

Cancellations
R

FPC







Analysis

Inbound cancellations of 5 minutes or less of the crew arrival time saw a minimal increase in June 2025 to 284, compared to 281 in May 2025. The total number of cancellations within 30 minutes also marginally increased from 521 in May 2025 to 524 in June 2025.

In June 2025 there were 85 travel bookings cancelled by patients (including via SMS), remaining consistent with May 2025. Further SMS improvements will go live in July that should continue the improving trend observed.

The other top reasons for less than 5-minute cancellations included: 28 patients not located, 8 unwell/too ill to travel and 7 no appointment.

Same day cancellations increased slightly in June 2025 to 14.7% compared to May 2025 (13.4%).

Remedial Plans and Actions

Work with Hywel Dda to develop a direct link between their PAS system and our CAD ,is imminent. Once in place this will allow for WAST to be notified once the health board cancels or alters an appointment, that requires WAST transport.

Work is also underway to enhance the service's text messaging options to improve notification to patients.

Expected Performance Trajectory

Until this work is completed, we do not anticipate a significant shift in the trajectory as many of the factors affecting this are outside of our direct control.

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

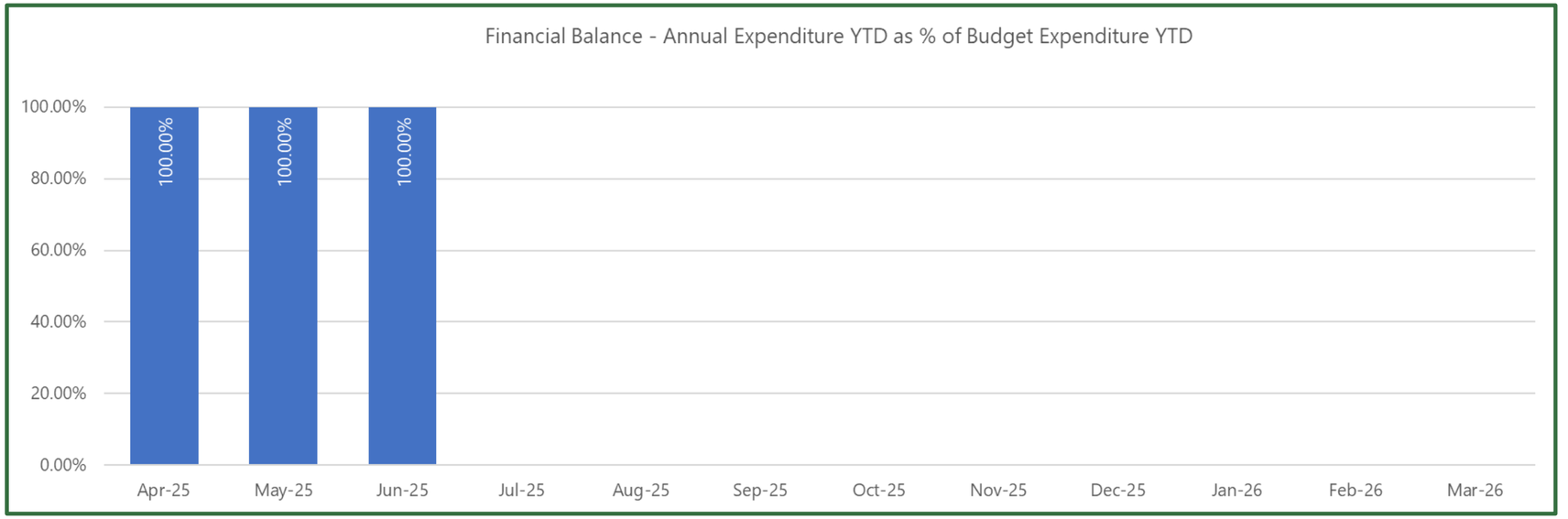
**Please note that MDTs do not appear to provide specific cancellation reasons for either inbound or outbound journeys. There are at present multiple and duplicated reasons both crews, control and the liaison desk can select.*

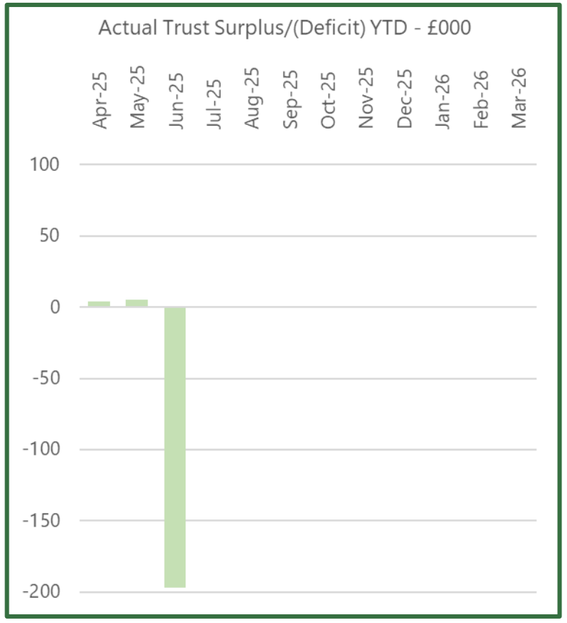
Finance, Resources and Value
Value - Finance Indicators

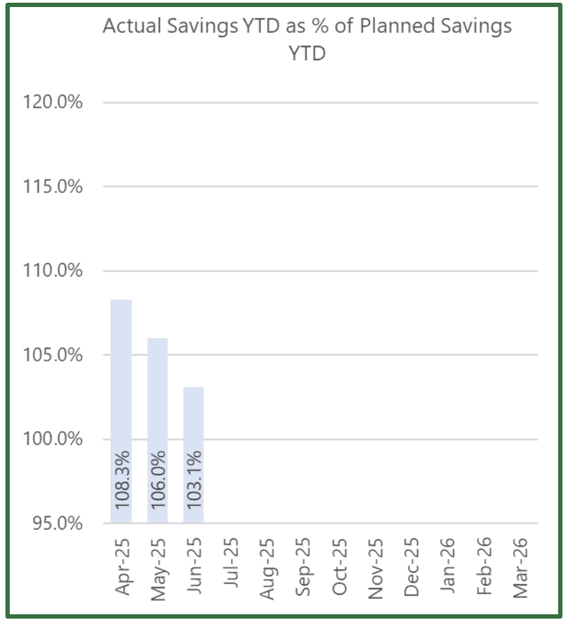
(Responsible Officer: Chris Turley)

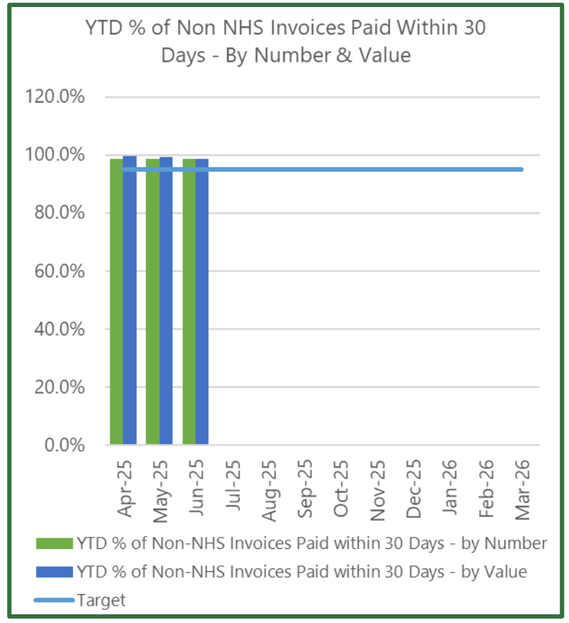
G

FPC









Analysis

The reported outturn performance at Month 3 is a deficit of £0.197m, with a forecast to the yearend of breakeven.

For Month 3 the Trust is reporting planned savings of £2.073m and actual savings of £2.137m (an achievement rate of 103.1%).

The Trust's cumulative performance against PSPP as at Month 3 is 98.7% against a target of 95%.

At Month 3 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.

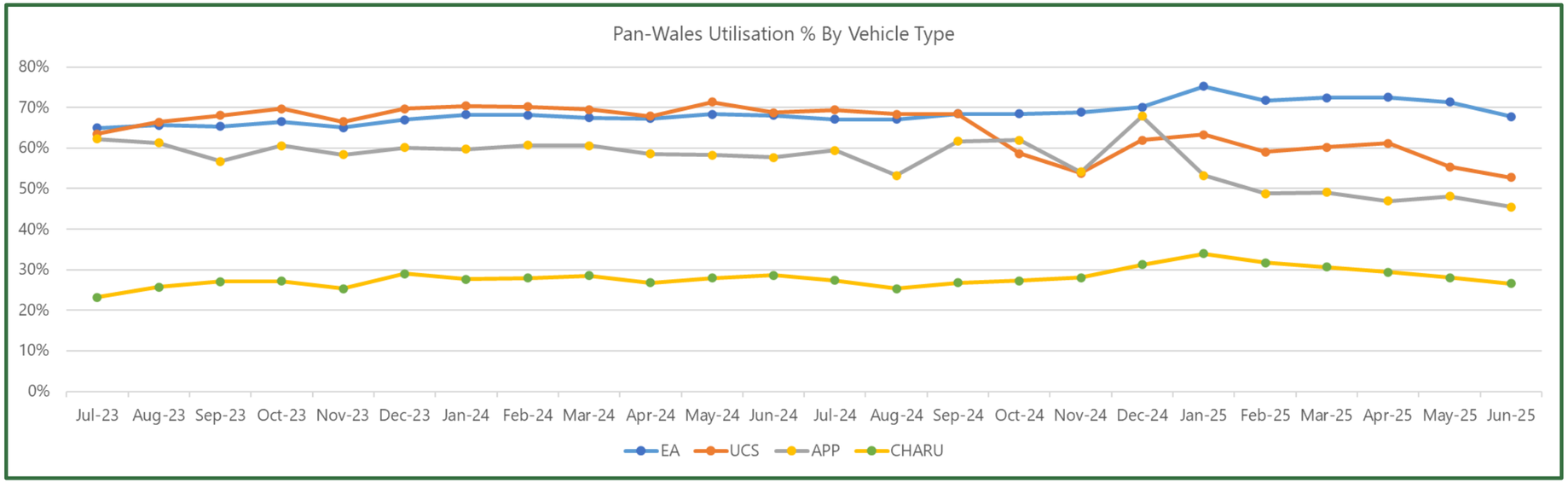
Finance, Resources and Value
EMS Utilisation

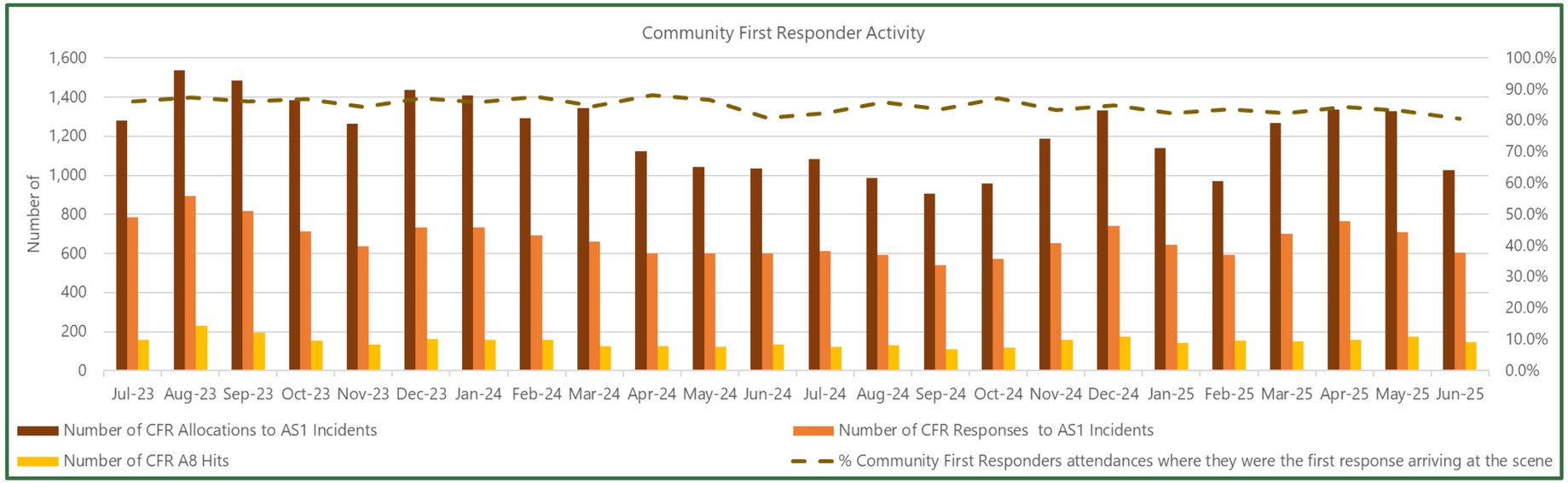
(Responsible Officer: Lee Brooks)

CHARU Utilisation G

FPC

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





Analysis

Pan Wales Utilisation metrics in June 2025 were 53.6% for all vehicles types, a decrease from 56.5% in May 2025. EA saw the highest rate during the month at 67.8%, a decrease compared to the upward trend over the previous months. 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 June we can see that CFRs were allocated to 1,025 EMS incidents and responded to 606. In June 2025 80.7% 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.

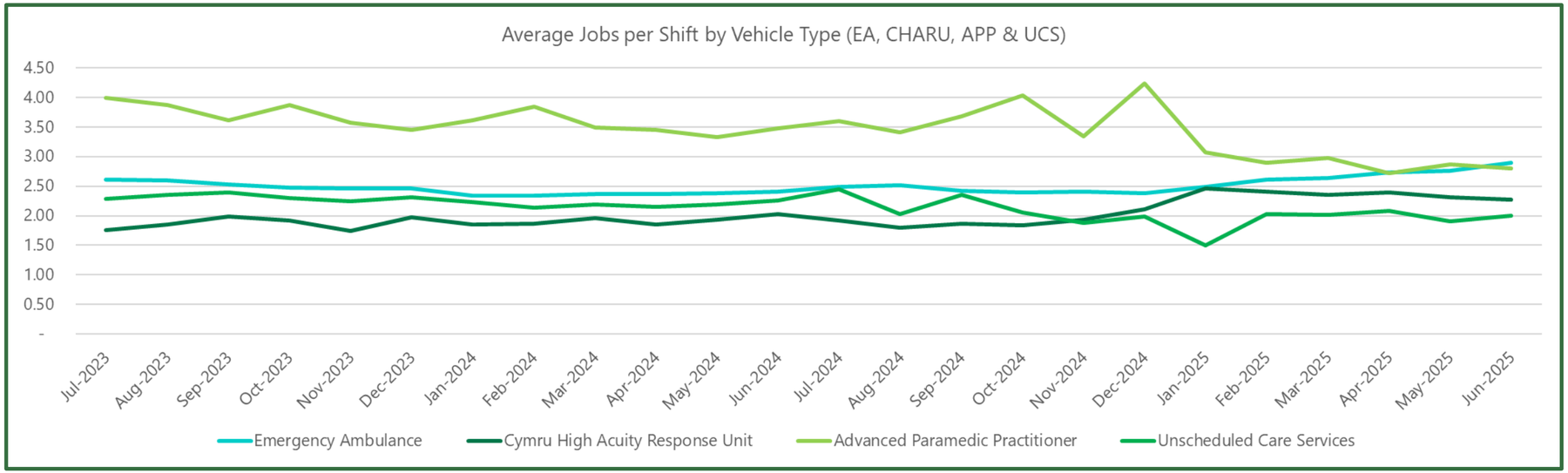
Finance, Resources and Value
Average Job/Shift Times

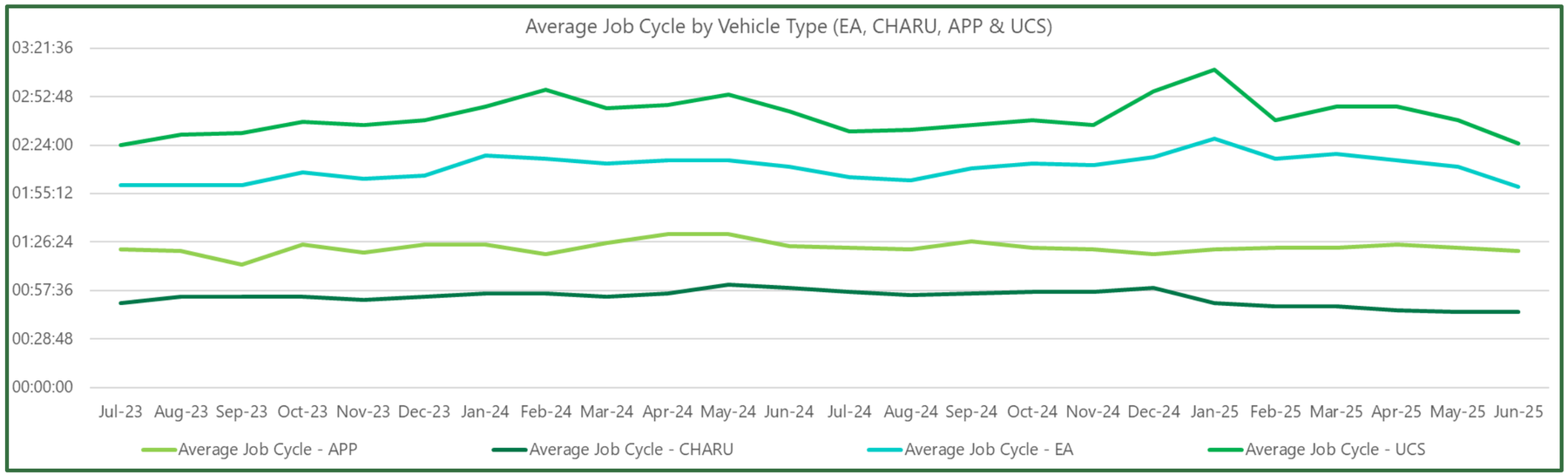
(Responsible Officer: Lee Brooks)

Jobs Per Shift
A

FPC

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





Analysis

Overall average jobs per shift was 2.33 in June 2025, a decrease from May 2025 (2.64). EAs averaged 2.89 jobs per shift and UCS crews 2.0. This is lower than what would be ideal and a product of handover delays.

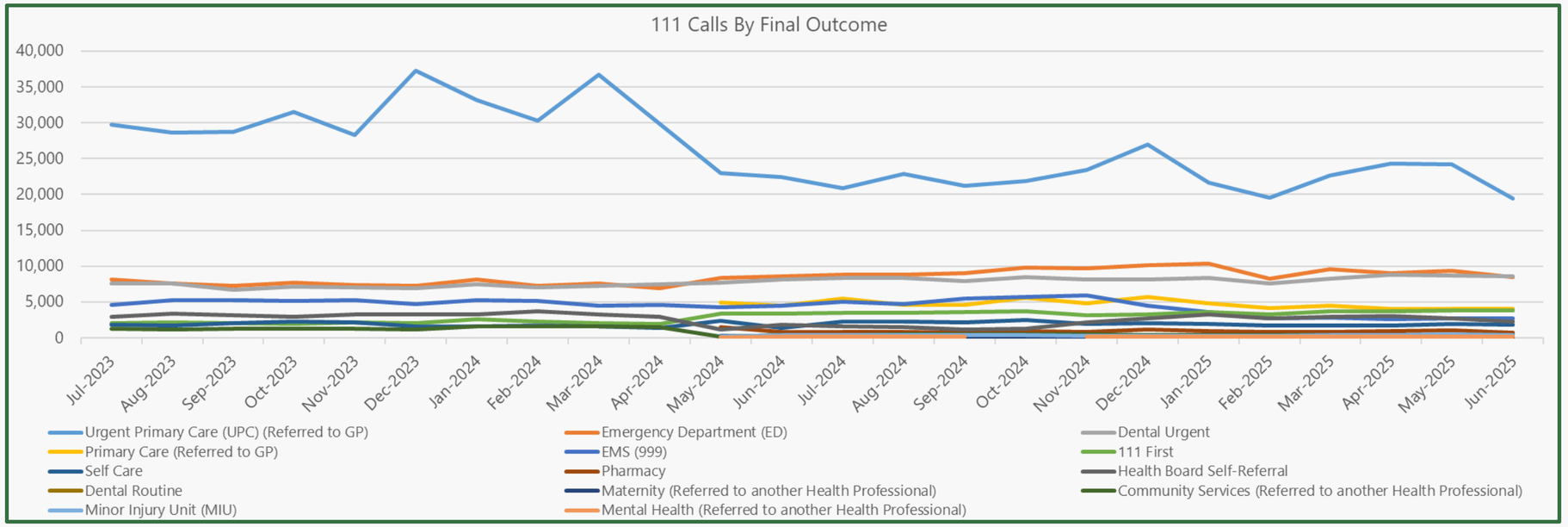
APPs attended on average 2.89 jobs per shift and CHARU's 2.80. However, both sets of data are under review.

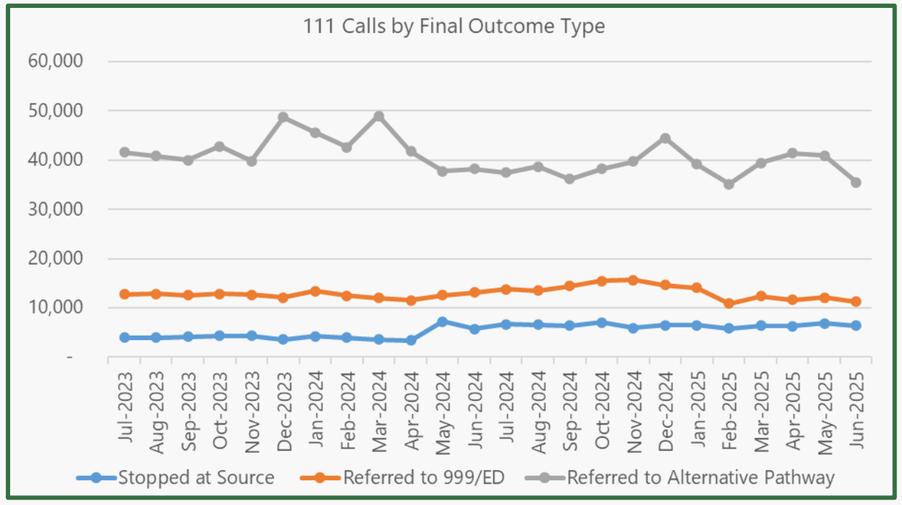
As demonstrated in the bottom graph, the average job cycle decreased slightly in June 2025 for EAs (1 hours 59 minutes) and APPs (1 hour 21 minutes) and UCS (1 hours 37 minutes). CHARU remained the same as the previous month (45 minutes).

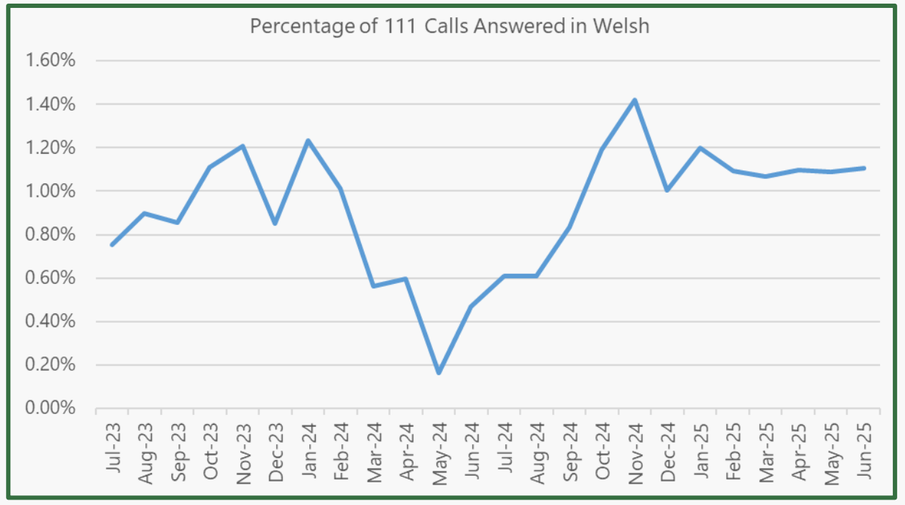
Partnerships / System Contribution
NHS111 Hand Off Metrics and NHS111 Consult & Close Indicators
Influencing Factors – Demand and Clinical Hours Produced

Dental G | C&C Volumes G | FPC

(Responsible Officer: Lee Brooks)







Analysis

During June 2025, 53,175 calls were allocated into the 14 categories displayed in the graph opposite; a decrease compared to the 59,815 seen during May 2025. However, data quality issues continue within 111 reporting which are currently being addressed.

Calls Referred to a General Practitioner (handover of care) continued to be the top outcome for NHS111 accounting for 31.81% of all calls during June 2025, but there has been a material drop since the implementation of the new 111CAS system.

As the bottom left graph highlights, in June 2025, 6,439 calls were 'Stopped at Source', with no onward referral, a slight decrease from 6,816 in May 2025. 11,260 calls were referred to 999/ED in June 2025.

The percentage of 111 calls answered in Welsh increased slightly from 1.09% in May 2025 to 1.10% in June 2025. This equated to 64.8% 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

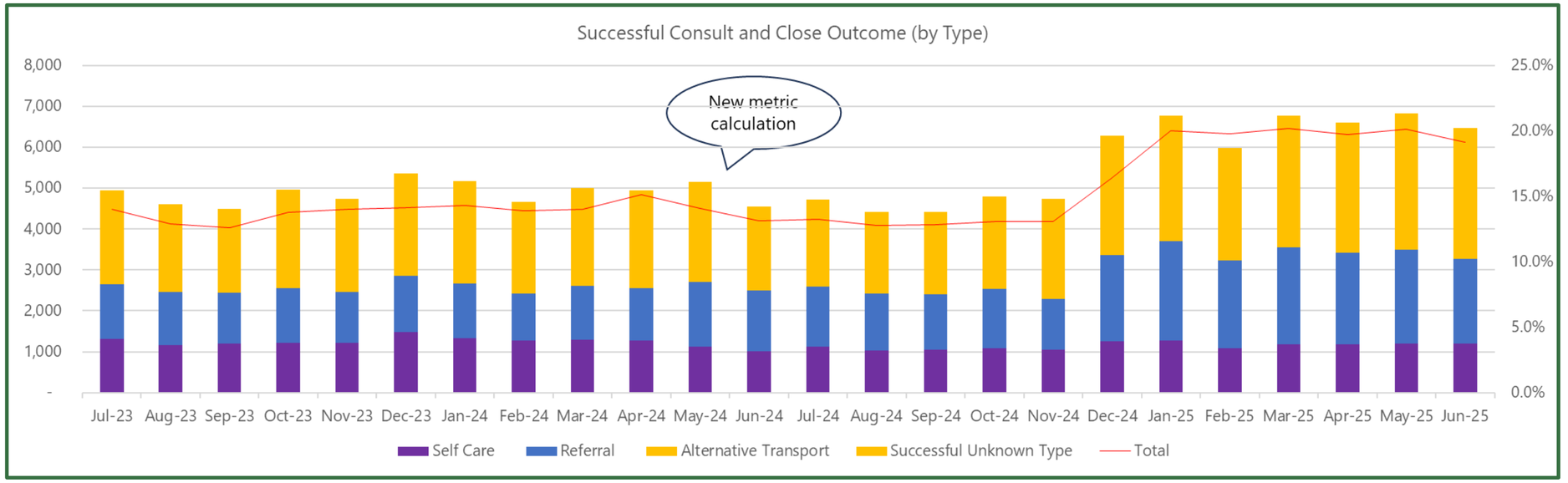
No performance trajectory is set at this time, as the Trust develops its measures and systems around these metrics. Once developed there will be an opportunity to develop benchmarks. The focus remains to shift left, where it is clinically safe and appropriate to do so.

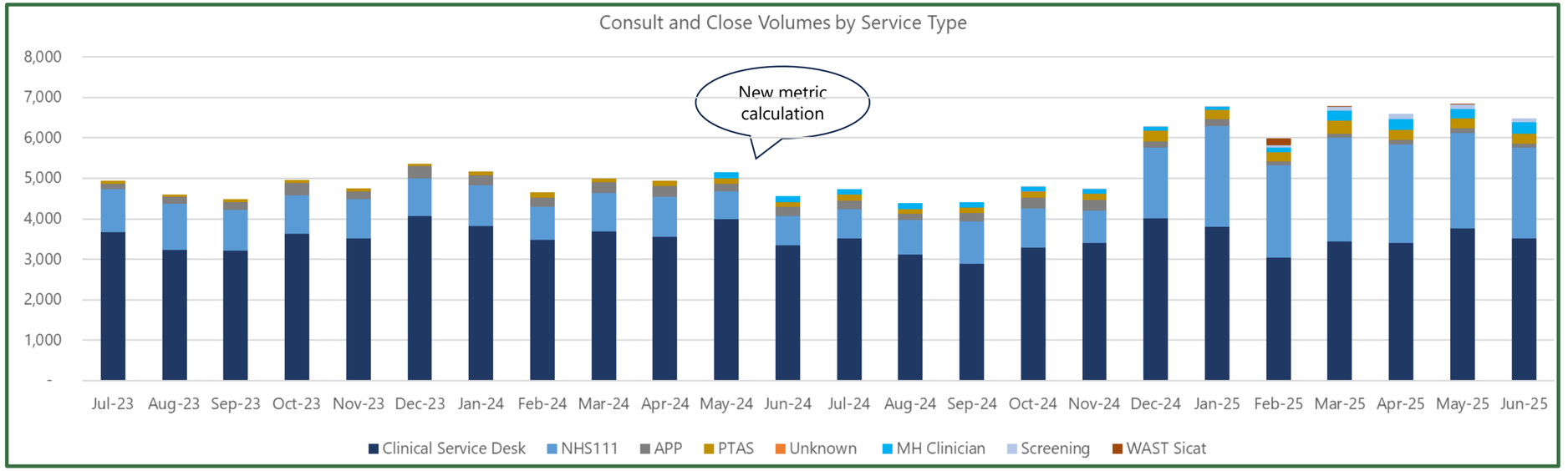
Partnerships / System Contribution
Consult & Close Indicators

(Responsible Officer: Lee Brooks)

C&C Outcomes: G

FPC





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) (10.4%), NHS111 (6.6%), WAST APP (0.3%), Health Boards using Physician Triage and Streaming Service (PTAS) (0.7%), Mental Health Clinician (0.8%) and Screening (0.3%) achieved 19.1% in June 2025, a decrease of 1.1% compared to May 2025, however achieving the 17% IMTP ambition for the sixth consecutive month. In June 2025, the number of 999 calls resulting in a Consult and Close outcome was 6,475, up from 4,555 in June 2024.

Of the calls successfully closed in June 2024, 62 patients received an outcome of self-care; 1,200 patients were referred to other services (including to Minor Injury Units and SDEC) and 976 were advised to seek alternative transport services to acquire treatment.

Remedial Plans and Actions

- Work underway reviewing processes, has yielded efficiencies in remote clinical support which is recognised by those calling.
- 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

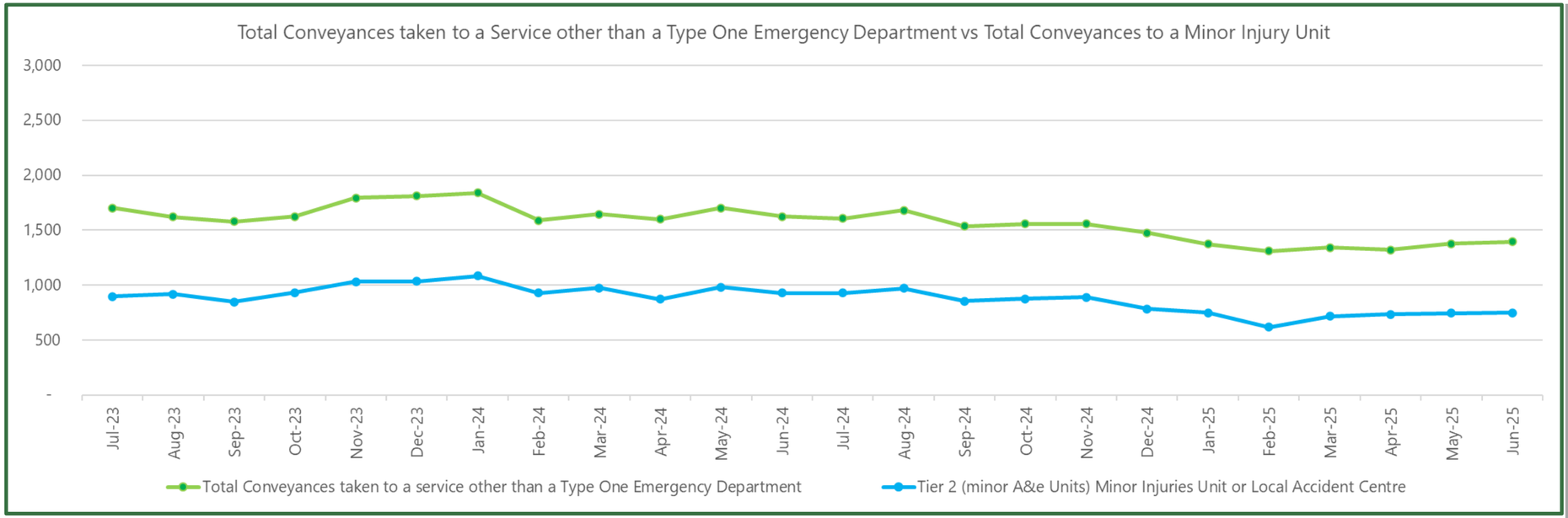
(Responsible Officer: Andy Swinburn)

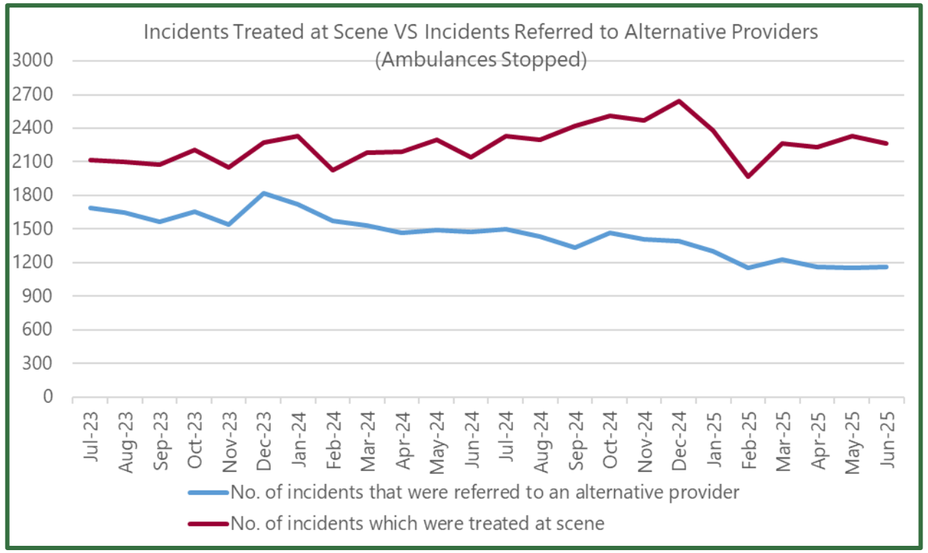
Conveyances R

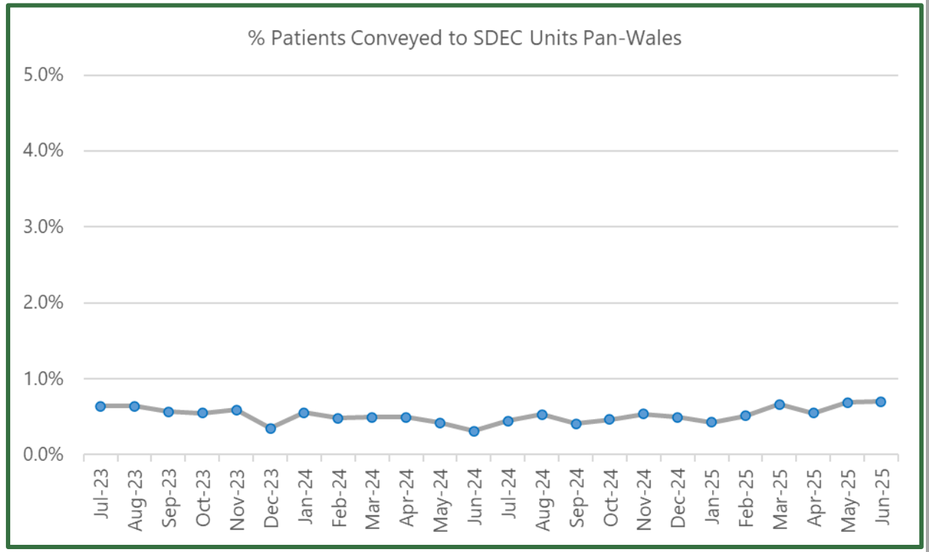
FPC

Ministerial Measure

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







Analysis

In June 2025 10.09% of patients (1,397) were conveyed to a service other than a Type One ED. 5.4% (749) were conveyed to a Tier two Minor Injuries Unit or Local Accident Centre while 36.81% 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 decreased, from 3,487 in May 2025 to 3,426 in June 2025.

Percentage of patients conveyed to SDEC units can remained consistent in June 2025 with the previous month (0.75).

Taxi conveyance has remained consistent for the past 12 months, averaging 832 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.

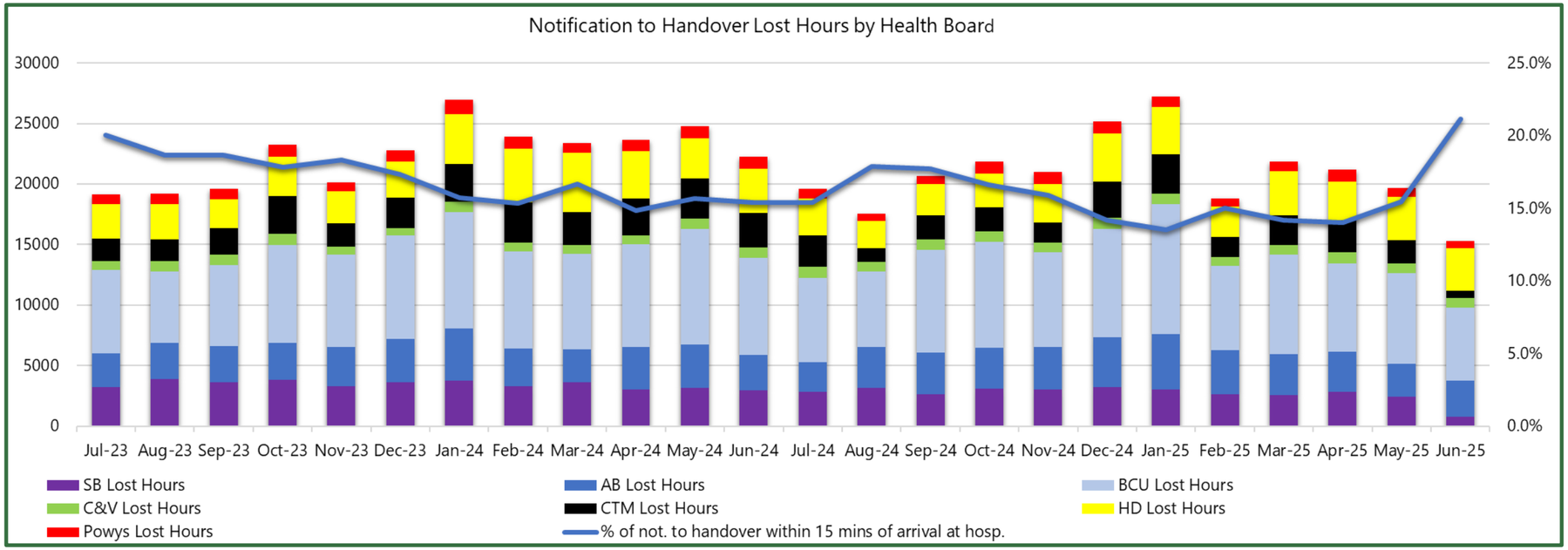
Partnerships / System Contribution Handover Indicators

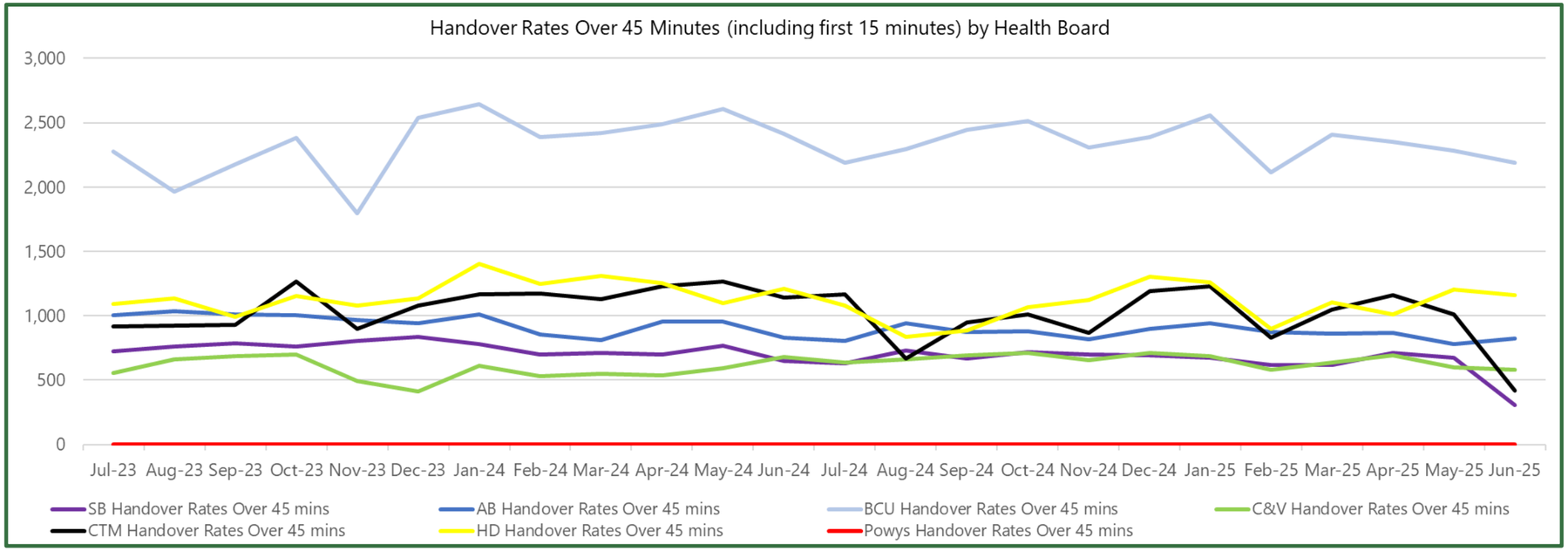
(Responsible Officer: Health Boards)

Lost Hours R

CI

QUEST





Analysis

249,911 hours were lost to Notification to Handover, i.e. hospital handover delays, over the last 12 months (Jul-24 to Jun-25), compared to 268,957 hours over the same timeframe the previous year. There were 15,278 hours lost in June 2025, which is 31.2% lower than the 22,229 hours lost during June 2024 and is the lowest monthly figure since September 2021. Cwm Taf Morgannwg and Swansea Bay in particular, have seen significant reductions, compared to last month, of 67% and 68%, respectively.

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

- Grange University Hospital (ABUHB) at 2,883 lost hours
- Ysbyty Maelor Hospital (BCUHB) at 2,288 lost hours
- Glangwilli Hospital (HDUHB) at 1,993 lost hours
- Ysbyty Glan Clwyd (BCUHB) at 1,902 lost hours
- Ysbyty Gwynedd Hospital (BCUHB) at 1,738 lost hours

Notification to handover lost hours averaged 509 hours per day during June 2025 (30 days) compared to 635 hours per day (31 days) in May 2025.

In June 2025, the Trust could have responded to approximately 4,819 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 too.

Expected Performance Trajectory

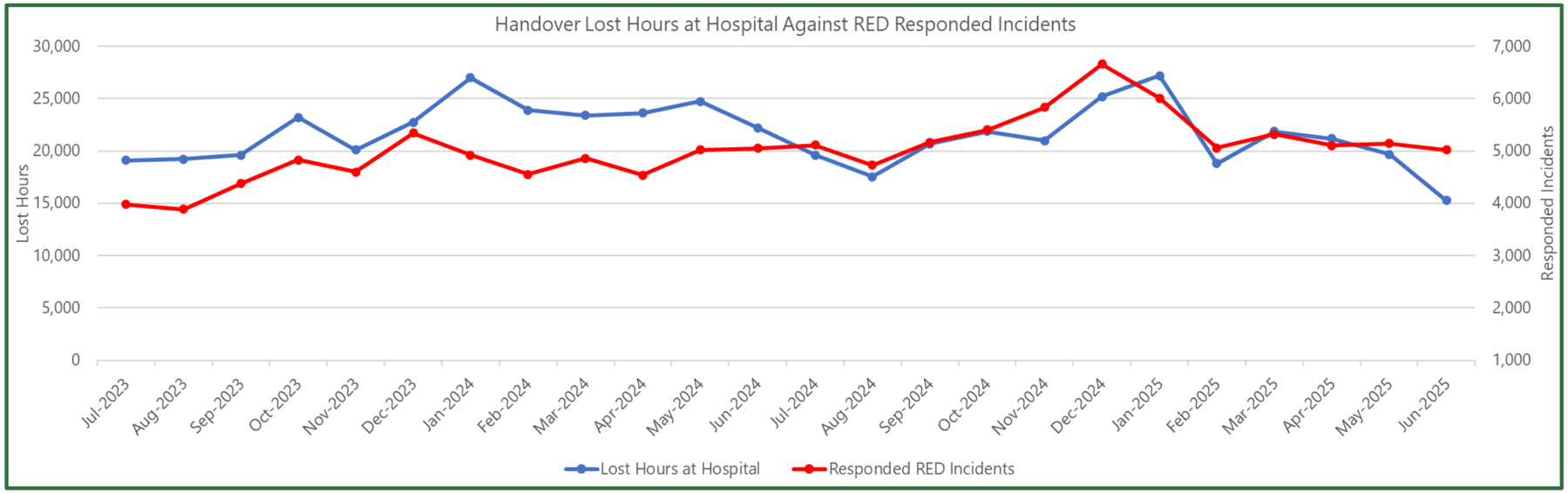
The likely expected ambition from Welsh Government is no waits over 45 minutes.

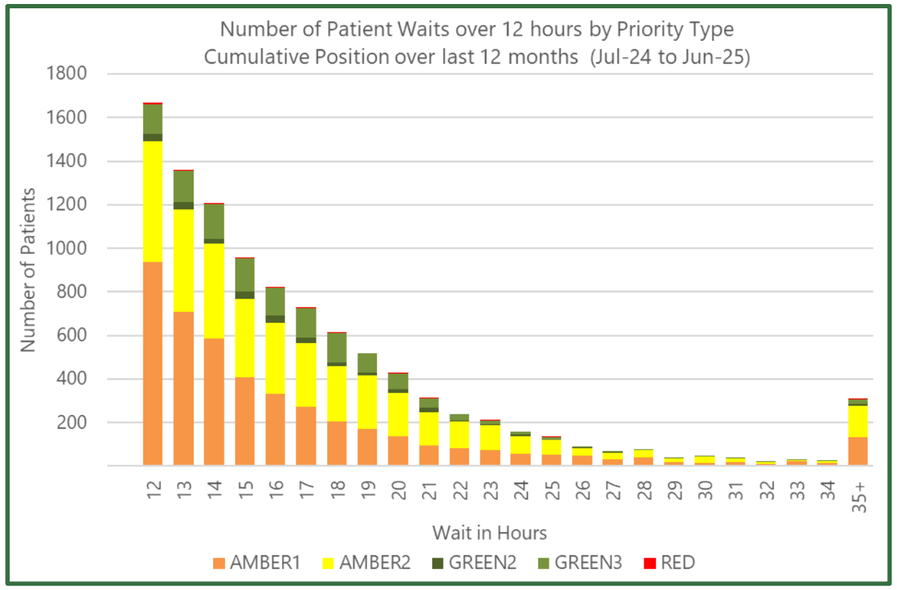
Partnerships / System Contribution

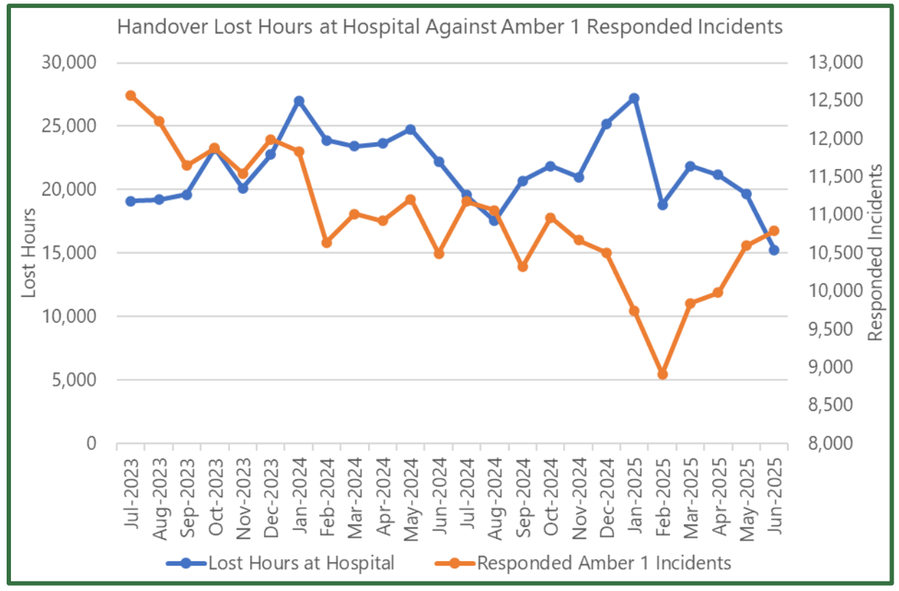
Handover Lost Hours Against Red & Amber 1 Responded Incidents

(Responsible Officer: Health Boards)

CI QUEST







Analysis

The top graph highlights that when handover lost hours have increased, so too do the number of Red 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 increasing and a decrease in the number of Amber 1 incidents being responded to, particularly at times of high demand, such as during December 2022. This is notwithstanding that some of these patients within the Amber 1 category will still be seriously ill.

In June 2025, 402 patients waited over 12 hours for an ambulance response.

Remedial Plans and Actions

Significant time has been spent by all Executives and non-Executives highlighting this patient safety issue to Commissioners, Health Boards and Welsh Government/Ministers, and this will continue through the year as we seek to influence and put pressure on the system to improve.

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
111 Abandoned Calls	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	**Hours Produced for Emergency Ambulances**	Proportion of hours produced within the calendar month for Emergency Ambulance Vehicles (Target 95%).
111 Patients Called back within 1 hours (P1)	(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.	**Sickness Absence (all staff)**	Staff sickness volumes as a percentage for all staff employed within the Welsh Ambulance Services NHS Trust.
999 Call Answer Times 95th Percentile	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.	**Frontline COVID-19 Vaccination Rates**	Volume of frontline (patient facing and non-patient facing) who have received a second COVID-19 vaccination.
999 Red Response within 8 Minutes	Percentage of 999 incidents within the Red (immediately life-threatening) category which received an emergency response at scene within 8 minutes.	**Statutory and Mandatory Training**	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).
Red 95th Percentile	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).	**PADR/Medical Appraisal**	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.
999 Amber 1 95th Percentile	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.	**Ambulance Response FTEs in Post**	Number of Emergency Medical Services, Full Time Equivalent (FTE) staff working for the Welsh Ambulance Services NHS Trust.
Return of Spontaneous Circulation (ROSC)	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.	**Ambulance Care, Integrated Care, Resourcing & EMS Coordination FTEs in Post**	Number of Ambulance Care, Integrated Care, Resourcing & EMS Coordination Full Time Equivalent (FTE) staff working for the Welsh Ambulance Services NHS Trust.
Stroke Patients with Appropriate Care	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 caret hat have a greater effect on patient outcomes if done together in a time-limited way ,rather than separately).	**Financial Balance – Annual Expenditure YTD as % of budget Expenditure**	Annual expenditure (Year to Date) as a proportion of budget expenditure.
Acute Coronary Syndrome Patients with Appropriate Care	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.	**Duty of Candour**	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.
Renal Journeys arriving within 30 minutes of their appointment (NEPTS)	Proportion of renal journeys which arrive at hospital appointments within 30 minutes (+/-) of their appointment time.	**111 Consult and Close**	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.
Discharge & Transfer journeys collected less than 60 minutes after booked ready time (NEPTS)	Proportion of journeys being discharged from and/or transferred between hospitals which were collected within 60 minutes of the hospital booked ready time.	**999 / 111 Hear and Treat**	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.
National reportable Incidents (NRI)	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.	**% Incidents Conveyed to Major EDs**	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).
Concerns Response within 30 Days	Proportion of concerns responded to by the complaints team within 30 working days of receiving the concern.	**Number of Handover Lost hours**	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.
EMS Abstraction Rate	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.	**Immediate Release requests**	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

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

AGENDA ITEM No	**8**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**4**

Revised Performance Update – Phase 1

MEETING	Quality, Patient Experience & Safety Committee (QuESt)
DATE	5 August 2025
EXECUTIVE	Andy Swinburn, Executive Director of Paramedicine
AUTHOR	Jonathan Chippendale, Asst Director of Clinical Development
CONTACT	jonathan.chippendale@wales.nhs.uk

EXECUTIVE SUMMARY

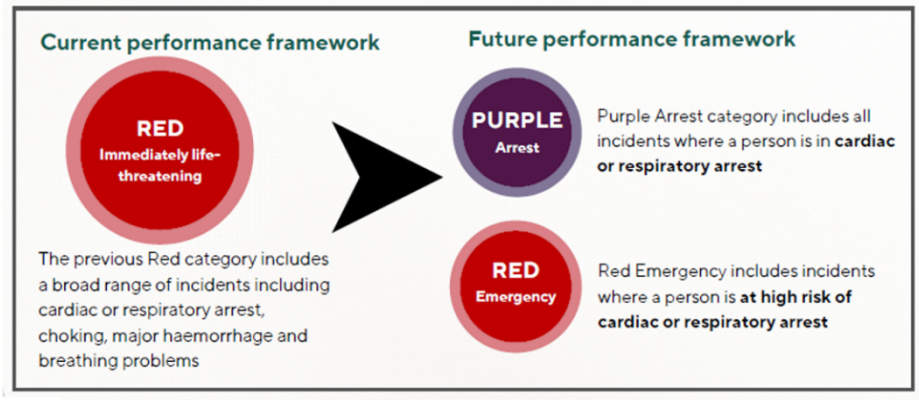
In October 2024 a Welsh Government led ambulance task and finish review group was established. The group was a mix of expert leads, commissioners, senior clinicians and statisticians.

The recommendations from the group were for replacement to the existing national 8-minute ambulance response target and as this was no longer appropriate in its current form. This group developed a series of metrics to replace the existing Red 8, these can be seen below.

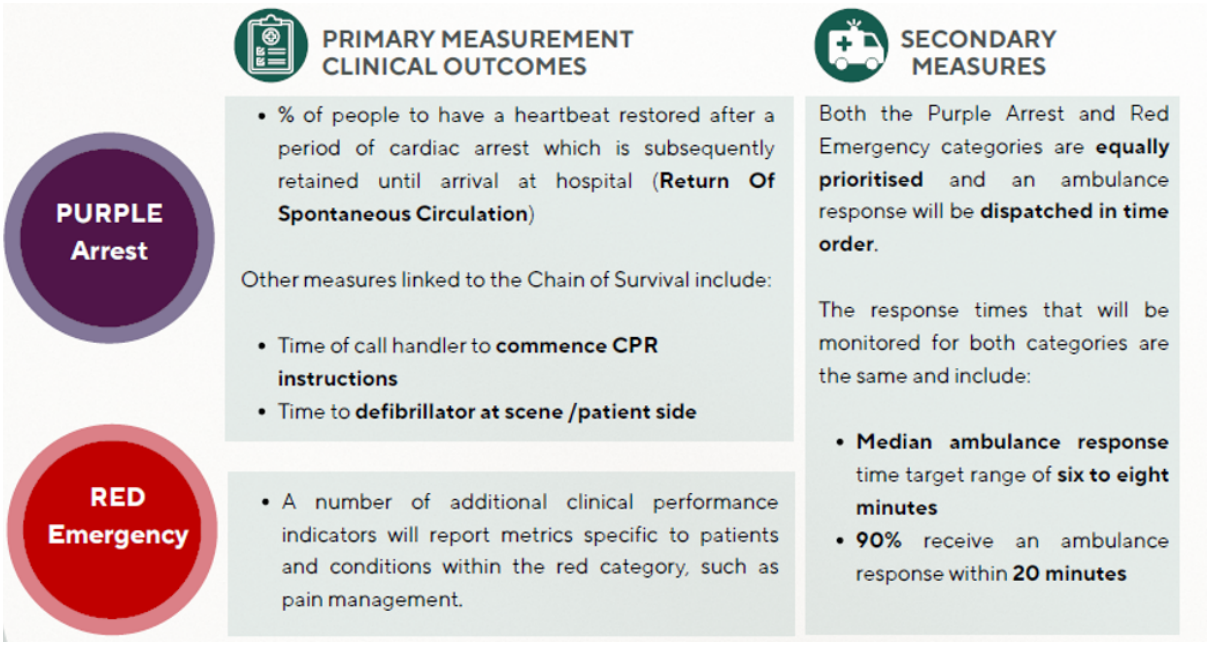
The cabinet secretary approved this recommendation in March 2025.

A new ambulance performance framework was developed for calls previously prioritised as a “red” 8-minute response incident and on the 1st July a 12-month pilot commenced.

The new performance framework recognises the need to establish two separate categories (purple and red) to allow the application of different clinical outcome measures aligned to patient specific condition.



The performance framework for these incidents can be divided into two elements, primary [clinical] outcomes and secondary measures.



Furthermore, an additional category, RCS0, has been introduced to include the remaining prioritisation codes from the previous "red" priority incidents to give opportunity for a clinician to review the call to decide if the patient would benefit from further assessment or an immediate face-to-face response.

Additionally, further clinical assurance indicator metrics for the "Red- Emergency" category have been proposed and agreed to be formulated with a planned reporting start date of the 1st October. Specifically, these will be:

Generic clinical indicators (CIs) across all EMERG category incidents (meeting agreed inclusion criteria)
Pain Management - Pain score change across the care episode (average)
Physiological scoring – Average NEWS(2) score change across the care episode (average)
Reporting of incident condition codes across the 12-month period (review at 6 months) to inform future condition specific CIs.

Condition specific CIs (meeting agreed inclusion criteria)
Maternity – Thermoregulation of the newborn/Assessment of the newborn
Anaphylaxis – Care bundle to include 1:1000 adrenaline
Breathing problems – Average oxygen saturation (SPO2) change across the care episode (average)
Major Trauma –Explore feasibility of reporting Trauma Desk consultation, pre-alert, use of triage tool, conveyance to major trauma centre.
Convulsions – Care bundle TBC.

Following the implementation of Phase 1, the Cabinet Secretary for Health and Social Care announced further proposed changes to the ambulance performance framework on the 16th July. (https://www.gov.wales/written-statement-further-changes-emergency-ambulance-performance-framework)

This announcement proposes three further new categories being orange, yellow and green.

Work to adopt these changes will be developed within the Trust and flow through current governance arrangements.

RECOMMENDATION

QuEST notes the update on the implementation of the new performance measures for phase 1 and notes the announcement for Phase 2.

KEY ISSUES/IMPLICATIONS

REPORT APPROVAL ROUTE

REPORT APPENDICES

REPORT CHECKLIST			
Confirm that the issues below have been considered and addressed		**Confirm that the issues below have been considered and addressed**	
EQIA (Inc. Welsh language)	NA	Financial Implications	NA
Environmental/Sustainability	NA	Legal Implications	NA
Estate	NA	Patient Safety/Safeguarding	NA
Ethical Matters	NA	Risks (Inc. Reputational)	NA
Health Improvement	NA	Socio Economic Duty	NA
Health and Safety	NA	TU Partner Consultation	NA

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

Cadeirydd
Chair: Colin Dennis

Prif Weithredwr
Chief Executive: Jason Killens

Swyddfa'r Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services Office

Ref: JK037/RW/KS

30 May 2025

Jeremy Griffiths
Director of Operations NHS Wales, Health, Social Care and Early Years Group
Welsh Government

Sent via e-mail:- Jeremy.griffiths001@gov.wales

Dear Jeremy

RE: New Performance Framework Response

Thank you for your letter (20 March 2025) confirming the approval by the Cabinet Secretary for Health & Social Care of the move to a new Emergency Ambulance Performance Framework on 1 July 2025.

You requested the development of clear and precise definitions for the new performance metrics together with proposed monitoring arrangements for assurance purposes by the end of May 2025. In addition, you required a rapid review of opportunities to support accelerated delivery of plans to improve outcomes for people in out of hospital cardiac arrest.

Please find attached three documents which set out our proposed definitions for Purple Arrest, Red Emergency and Rapid Clinical Screening (RCS0). These data definitions have been developed in line with the new ambulance performance framework standards and considerable thought has been given as to how the new framework can support improvements in patient outcomes and experience.

In relation to the monitoring arrangements for assurance purposes, the Trust has developed a specific action plan, which includes:

- Implementation of enhanced governance measures, including real-time data visibility and strengthened safety oversight, to ensure continuous situational awareness and proactive risk management for go-live and initial stages.
- A structured, command-led approach in place to support operational delivery at go-live.
- Immediate and longer-term evaluation of the changes, with planned reviews at key intervals and the commissioning of an independent assessment to ensure external assurance and shared learning.
- Deployment of a mechanism to gather staff feedback and provision of visible senior leadership presence at the front line.

There will be a range of internal and external accountability mechanisms. Internally, the Executive Director of Quality & Nursing will give a verbal update at the 5 August 2025 QUEST Committee. Whilst earlier updates will certainly be provided, there will be an opportunity at our IQPD on the 14 August 2025 to give Welsh Government a detailed update on progress. The Ambulance Services Indicators (ASIs) will be published on 21 August 2025, providing the first opportunity for the public and wider stakeholders to be informed on the quality and performance outcomes of the changes made.

To ensure that all relevant individuals and teams are informed and prepared for the upcoming change the Trust has developed an internal communications plan and an external communications plan, with the latter being in collaboration with the JCC and Welsh Government.

We have already started the collaboration and planning with SaLC after convening two joint workshops on improving survival from out of hospital cardiac arrest. We are currently finalising our joint plan and will report back to you with our recommendations by the end of June 2025, but in the meantime have attached our first draft for your consideration.

The Trust and Commissioners, via the JCC, are working in close collaboration on this programme of work and have jointly agreed both these data definitions and monitoring and assurance processes. If there are any questions, please let us know as soon as possible.

Yours sincerely

Jason Killens KAM
Chief Executive

Ross Whitehead
Director of Commissioning for Ambulance Services & 111

Encs.

cc. Rachel Marsh – Executive Director of Strategy, Planning and Performance
Andy Swinburn – Executive Director of Paramedicine
Lee Brooks – Executive Director of Operations

PURPLE ARREST
Data Definition Document

2025

Insight and Data Services

Version v1.1

May 2025

VERSION CONTROL TABLE

VERSION NUMBER	DATE	AUTHOR / REVIEWER / APPROVER	SUMMARY OF CHANGES
1.0	23/04/2025	Abigail Townsend Gregory Lloyd Hugh Bennett Call Flow Implementation Group	Creation of Definition Document.
1.1	01/05/2025	Abigail Townsend Gregory Lloyd Hugh Bennett CMT Metrics Group	1. Numerator for ARR3a expanded to detail the start and stop times for the three options listed. 2. Notes added to ARR3c to emphasise the measures intention is to measure when instructions are initiated by the Call Handler and does not measure “Hands on Chest”.
1.2	23/05/2025	Abigail Townsend Lee Brooks Call Flow Implementation Group	1. Correction to Page 10 which previously listed Time to Commence CPR Instructions as an Internal measure. It is intended as an External measure, page amended to reflect the audience is External. 2. Notes added to ARR3a, ARR4a and ARR5b for clarity, no change to definition.

DOCUMENT APPROVAL ROUTE

MEETING TITLE	MEETING DATE	VERSION	COMMENTS
CMT Metrics	30/04/2025	V1.0	Request for expansion on ARR3a Numerator and ARR3c Notes Section. Actioned and re-versioned as v1.1
CMT Board	06/05/2025	V1.1	No Comments. Approved for release to Commissioner.

CONTENTS

GREEN – EXTERNAL MEASURE BLUE – INTERNAL MEASURE

DEFINITIONS

ARR1a PURPLE ARREST Coded Calls

Description

How many calls received by the Welsh Ambulance Service are coded as ARREST verified incidents?

Data Definition

An ARREST verified incident is a call that has been coded as ARREST after being assessed by the call taker using the MPDS software. This dataset includes calls from both the public and Health Care Professionals, where the Health Care Professional has declared a cardiac or respiratory arrest.

Numerator:

Number of incidents with a final MPDS Code of ARREST or ARREST*.

Denominator:

n/a

Inclusions:

Final Priority = ARREST or ARREST*

Exclusions:

Out of area (England) incidents are excluded.

Calls taken by other ambulance services on WAST's behalf.

The following calls stopped are excluded:

- Calls made in error
- Duplicated calls
- Information calls
- Calls to other ambulance controls
- Test calls

Audience:

EXTERNAL

Notes:

See Appendix 1: ARREST MPDS Codes

ARR1b PURPLE ARREST Scene Attendance Time

Description

How many calls received by the Welsh Ambulance Service are coded as ARREST verified incidents resulting in an emergency response within 6-8 minutes?

Data Definition

An ARREST verified incident is a call that has been coded as ARREST after being assessed by the call taker using the MPDS software. This dataset includes calls from both the public and Health Care Professionals, where the Health Care Professional has declared a cardiac or respiratory arrest.

- The Median Response Time is the midpoint for all first ARREST responses arriving at the scene of the incident.
- The 90th percentile of Best Response Times for first ARREST responses arriving at the scene of the incident.

Numerator:

The time difference between Incident Clock Start and the time the first WAST Resource arrived on scene, stopping the clock.

Denominator:

n/a

Inclusions:

ARREST Coded Calls (see ARR1a) which resulted in an emergency response vehicle arriving at the incident scene.

Exclusions:

Out of area (England) incidents are excluded.

Calls taken by other ambulance services on WAST's behalf.

The following calls stopped are excluded:

- Calls made in error
- Duplicated calls
- Information calls
- Calls to other ambulance controls
- Test calls

Responses from the MEDIC, ACCTS and EMRTS Call Signs.

CFR and UFR Responses are excluded from the 90th Percentiles of the Best Response Times.

Audience:

EXTERNAL

Notes:

See Appendix 1: ARREST MPDS Codes

Subject to Clock Start Rules, see Appendix 2: PROPOSED CLOCK START – ARREST

ARR2 ROSC at Hospital

Description

Outcome from out-of-hospital cardiac arrest with attempted resuscitation, measured by documented return of spontaneous circulation (ROSC) at time of arrival of the patient to hospital. Recording of ROSC at hospital is the international Utstein standard and indicates the outcome of the pre-hospital response and intervention.

Data Definition

Outcome from out-of-hospital cardiac arrest where resuscitation is attempted, measured by documented return of spontaneous circulation (ROSC) at point of arrival at the emergency department door of the receiving hospital.

- Out-of-hospital refers to any arrest in public or private requiring an organised Emergency Medical Service (EMS) response.
- A cardiac arrest is defined as absence of signs of circulation.
- Resuscitation attempted is defined as when EMS personnel perform chest compressions or attempt defibrillation, or where bystander response has achieved a sustained ROSC.
- Return of spontaneous circulation 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.
- Point of arrival refers to point (time) of arrival of the patient at the emergency department door of the receiving hospital.
- Do Not Attempt Resuscitation (DNAR) order or other valid legal document (e.g. Advance Refusal of Treatment) is a signed written record of the patient's wishes with regards to resuscitation efforts.

Numerator:

Patients who had a documented resuscitation attempt by EMS with ROSC on arrival at hospital door following out-of-hospital cardiac arrest.

Denominator:

All patients who had a documented resuscitation attempt by EMS following out-of-hospital cardiac arrest.

Inclusions:

All patients who are documented as having had a cardiac arrest using the Out of Hospital Cardiac Arrest section of the electronic Patient Care Record (ePCR).

Exclusions:

Patients where resuscitation was not attempted (conditions unequivocally associated with death (obviously dead), written DNACPR or Living Will in place, or who were in the final stages of a terminal illness).

Audience:

EXTERNAL

Notes:

ROSC rates are calculated using electronic Patient Care Record (ePCR) counts, not verified ARREST incident counts. Thus, care is advised when comparing this measure to others in this pack.

ARR3a Time to Identify Cardiac Arrest

Description

How long does it take to identify a Cardiac Arrest?

Data Definition

The duration, measured in seconds, between the Incident Call Pickup and identification that the patient is in Cardiac Arrest, either by;

- Pre Alert: Is the Patient Breathing? Answer = No
- CPR Instructions are given by the Call Handler
- The establishment of the Final ARREST MPDS Code.

Numerator:

Depending on which occurs first between Pre-Alert, CPR Instructions or a Final ARREST MPDS Code;

- Incident Call Pickup (or Earliest Timestamp Available in the absence of Call Pickup) to Early Prioritisation (Pre Alert) Time.
- Incident Call Pickup (or Earliest Timestamp Available in the absence of Call Pickup) to Time CPR Commenced.
- Incident Clock Start to Final ARREST MPDS Code

Denominator:

n/a

Inclusions:
ARREST Coded Calls (see ARR1a)

Exclusions:

ARREST* Codes relating to Obstetric Emergencies with no indication of a cardiac or respiratory arrest.

Audience:

EXTERNAL

Notes:

- Subject to Clock Start Rules, see Appendix 2: PROPOSED CLOCK START – ARREST
- Calls can be recoded multiple times during the call life cycle as more information is provided by the call taker. Consequently, the first category applied is often not the same as the final one on the call.

ARR3b Time to Identify if the Patient is not Breathing

Description

How long does it take to identify if a patient is not breathing?

Data Definition

The duration, measured in seconds, between the Incident Call Pickup and the Pre Alert Time wherein a Response is given to the question “Is the Patient Breathing?” of “No”.

Numerator:

The time difference between Incident Call Pickup or Earliest Timestamp available if Pickup is unavailable, and Early Prioritisation (Pre Alert) Time.

Denominator:

n/a

Inclusions:
ARREST Coded Calls (see ARR1a)

Is the Patient Breathing = No

Exclusions:

n/a

Audience:

INTERNAL

Notes:

Subject to Clock Start Rules, see Appendix 2: PROPOSED CLOCK START – ARREST

ARR3c Time to Commence CPR Instructions

Description

How long does it take to commence CPR Instructions?

Data Definition

Depending on whether the arrest happens during the call or not, this is either calculated as the duration, measured in seconds, between the Incident Call Pickup and the ProQA instruction, for those identified as ARREST at first MPDS.

Otherwise, it is the duration, measured in seconds between the MPDS Established Date Time of the ARREST MPDS Code, and the ProQA instruction.

Numerator:

The time difference between Incident Call Pickup or Earliest Timestamp available if Pickup is unavailable and Time CPR Commenced if the Initial MPDS Code is an ARREST Code.

OR

The time difference between MPDS Established Date Time and Time CPR Commenced if the Initial MPDS Code was not an ARREST Code.

Denominator:

n/a

Inclusions:

ARREST Coded Calls (see ARR1a)

Incidents with a TimeCPRCommenced recorded.

Exclusions:

- Patients where resuscitation was not attempted (conditions unequivocally associated with death (obviously dead), written DNACPR or Living Will in place, or who were in the final stages of a terminal illness).

Audience:

INTERNAL

Notes:

- When a Call Handler goes into the ProQA, the CPR Commenced timestamp is automatically generated. Even if CPR instructions had already begun verbally, the Call Handler would still go through the ProQA. The TimeCPRCommenced timestamp indicates when the ProQA Instruction has been selected, it does not equivalent to “hands on chest”.
- Although CPR Instructions are provided verbally by the call handler, we are not able to capture if the bystander on scene carried out the instructions physically to deliver CPR as instructed.
- See Appendix 1: ARREST MPDS Codes

ARR3d Time to ARREST MPDS Code

Description

How long does it take to identify an ARREST Code?

Data Definition

The duration, measured in seconds, between the Incident Call Pickup and the establishment of the Final ARREST MPDS Code.

Numerator:

The time difference between Incident Call Pickup or Earliest Timestamp available if Pickup is unavailable, and the final Dispatch Code Established Date Time.

Denominator:

n/a

Inclusions:
ARREST Coded Calls (see ARR1a)

Exclusions:

n/a

Audience:

EXTERNAL

Notes:

Subject to Clock Start Rules, see Appendix 2: PROPOSED CLOCK START – ARREST

ARR4a Incidents with Bystander CPR

Description

How often does a Bystander perform CPR?

Data Definition

The percentage of patients documented as having an Out of Hospital Cardiac Arrest (OHCA) with EMS resuscitation attempts, who also received Bystander Compressions or CPR prior to EMS crew arrival.

Numerator:

Patients who had Bystander Compressions or CPR recorded as activity prior to EMS Staff Arrival as documented on the electronic Patient Care Record (ePCR).

Denominator:

All patients who had a documented resuscitation attempt by EMS following out-of-hospital cardiac arrest.

Inclusions:

All patients who are documented as having had a cardiac arrest using the Out of Hospital Cardiac Arrest section of the ePCR.

Exclusions:

- Patients where resuscitation was not attempted (conditions unequivocally associated with death (obviously dead), written DNACPR or Living Will in place, or who were in the final stages of a terminal illness).
- Compressions or CPR undertaken by a First Responder.

Audience:

INTERNAL

Notes:

Bystander CPR rates are calculated using electronic Patient Care Record (ePCR) counts, not verified ARREST incident counts. Thus, care is advised when comparing this measure to others in this pack. This aligns with other OHCA measures.

ARR4b Number of ARREST Calls with no Time to Commence CPR

Description

How many 999 calls received are coded as a verified ARREST incident, but have no record of CPR Instructions being given by the call handler?

Data Definition

The percentage of ARREST calls where no CPR instructions were provided by the call handler.

An ARREST verified incident is a 999 incident that has been coded as after being assessed by the call taker using the MPDS software. This dataset includes calls from both the public and Health Care Professionals, where the Health Care Professional has declared a cardiac or respiratory arrest.

When a Call Handler goes into the ProQA, the CPR Commenced timestamp is automatically generated. Even if CPR instructions had already begun verbally, the Call Handler would still go through the ProQA.

Numerator:

Number of 999 (AS1) incidents with a final MPDS Code of ARREST with no TimeCPRCommenced recorded.

Denominator:

Number of 999 (AS1) incidents with a final MPDS Code of ARREST.

Inclusions:

ARREST Coded Calls (see ARR1a)

Exclusions:

Patients where resuscitation was not attempted (conditions unequivocally associated with death (obviously dead), written DNACPR or Living Will in place, or who were in the final stages of a terminal illness).

Audience:

INTERNAL

Notes:

- When a Call Handler goes into the ProQA, the CPR Commenced timestamp is automatically generated. Even if CPR instructions had already begun verbally, the Call Handler would still go through the ProQA.
- See Appendix 1: ARREST MPDS Codes

ARR5a Incidents where a PAD was Available

Description

How many Incidents had an available public access defibrillator (PAD) within 500m of the incident location?

Data Definition

The percentage of verified ARREST Incidents which had a PAD located within 500m of the incident location which was available for collection at the time of the incident.

Numerator:

Number of 999 (AS1) incidents where an available PAD device was within 500m of the incident location entered by the call handler.

Denominator:

Number of 999 (AS1) incidents with a final MPDS Code of ARREST.

Inclusions:

ARREST Coded Calls (see ARR1a)

Exclusions:

- Defibrillators on WAST Vehicles or those held privately by members of the public or GoodSAM responders.
- PADs which are unavailable during the time of the incident due to being held within buildings with opening hours outside the time of the incident e.g. PADs located in schools closed during summer holidays.

Audience:

INTERNAL

Notes:

The measurement of a PAD being within 500m of an incident is calculated as a radius and represents a straight-line distance, as the crow flies. It does not account for actual travel distance via roads, pathways, or other routes, which may be longer due to geographical or infrastructural constraints.

ARR5b Incidents where a PAD was Allocated

Description

How many Incidents had an available public access defibrillator (PAD) within 500m, allocated to the incident?

Data Definition

The percentage of verified ARREST Incidents which had an available PAD allocated to the incident for collection.

Numerator:

Number of 999 (AS1) incidents where an available PAD device was within 500m of the incident and allocated to the incident.

Denominator:

Number of 999 (AS1) incidents with a final MPDS Code of ARREST.

Inclusions:

ARREST Coded Calls (see ARR1a)

Exclusions:

- Defibrillators on WAST Vehicles or those held privately by members of the public or GoodSAM responders.
- PADs which are unavailable during the time of the incident due to being held within buildings with opening hours outside the time of the incident e.g. PADs located in schools closed during summer holidays.

Audience:

INTERNAL

Notes:

- The measurement of a PAD being within 500m of an incident is calculated as a radius and represents a straight-line distance, as the crow flies. It does not account for actual travel distance via roads, pathways, or other routes, which may be longer due to geographical or infrastructural constraints.
- The instruction to retrieve a PAD device is only given if there is more than one bystander with the patient to ensure someone remains with the patient.

ARR5c Incidents where a PAD was Brought to Scene

Description

How many Incidents had an available public access defibrillator (PAD) within 500m of the incident location which was brought to scene?

Data Definition

The percentage of verified ARREST Incidents which had an allocated PAD collected and brought to the incident location.

Numerator:

Number of 999 (AS1) incidents where an available PAD device was within 500m of the incident and subsequently was collected and arrived on scene for use.

Denominator:

Number of 999 (AS1) incidents with a final MPDS Code of ARREST.

Inclusions:

ARREST Coded Calls (see ARR1a)

Exclusions:

- Defibrillators on WAST Vehicles or those held privately by members of the public or GoodSAM responders.
- PADs which are unavailable during the time of the incident due to being held within buildings with opening hours outside the time of the incident e.g. PADs located in schools closed during summer holidays.

Audience:

INTERNAL

Notes:

The measurement of a PAD being within 500m of an incident is calculated as a radius and represents a straight-line distance, as the crow flies. It does not account for actual travel distance via roads, pathways, or other routes, which may be longer due to geographical or infrastructural constraints.

ARR6a Time to Instruction to Retrieve an Available PAD

Description

How long does it take to instruct a caller/bystander to retrieve an available public access defibrillator (PAD)?

Data Definition

The duration between Clock Start and the first allocation of a PAD device to the incident, measured in seconds.

Numerator:

The time difference between Incident Clock Start and the Vehicle Allocation Date Time associated with the PAD device first allocated to the incident.

Denominator:

n/a

Inclusions:

ARREST Coded Calls (see ARR1a)

Incidents where at least one PAD was allocated.

Exclusions:

Defibrillators on WAST Vehicles or those held privately by members of the public or GoodSAM responders.

Audience:

INTERNAL

Notes:

- Where multiple PADs are allocated to an incident, the timestamps relating to the device which was allocated first is used.
- The instruction to retrieve a PAD device is only given if there is more than one bystander with the patient to ensure someone remains with the patient.

ARR6b PAD Retrieval Time

Description

How long does it take for a caller/bystander to retrieve an available public access defibrillator (PAD)?

Data Definition

The duration between the allocation time of a PAD device and its arrival on scene time, measured in seconds.

Numerator:

The time difference between Vehicle Allocation Date Time and the Vehicle Arrival at Scene Date Time associated with the PAD device arriving first on scene.

Denominator:

n/a

Inclusions:

ARREST Coded Calls (see ARR1a)

Incidents where at least one PAD arrived at scene.

Exclusions:

Defibrillators on WAST Vehicles or those held privately by members of the public or GoodSAM responders.

Audience:

INTERNAL

Notes:

- Where multiple PADs arrive on scene, the timestamps relating to the device which arrived at scene first is used.
- The instruction to retrieve a PAD device is only given if there is more than one bystander with the patient to ensure someone remains with the patient.

ARR6c Time to PAD Arrival

Description

How long does it take for a public access defibrillator (PAD) to arrive on scene?

Data Definition

The response time for the public access defibrillator which arrives first on scene, either brought by a bystander/member of the public, or a GoodSAM Responder. Measured in decimal minutes.

Numerator:

The time difference between Incident Clock Start and the On Scene Date Time of the first arriving PAD retrieved by a bystander/member of the public.

OR

The time difference between Incident Clock Start and the GoodSAMOnSceneDateTime where GoodSAMDefibObtainedDateTime is also populated.

The response time for whichever arrives on scene first is used.

Denominator:

n/a

Inclusions:

ARREST Coded Calls (see ARR1a)

Incidents where at least one PAD arrived at scene.

Exclusions:

Defibrillators on WAST Vehicles or those held privately by members of the public.

Audience:

EXTERNAL

Notes:

- Subject to Clock Start Rules, see Appendix 2: PROPOSED CLOCK START – ARREST
- Where multiple PADs arrive on scene, the timestamps relating to the device which arrived at scene first is used.

ARR7a Time to First Alert: WAST Resource

Description

How quickly was a WAST resource alerted?

Data Definition

The duration between Clock Start and the first alerting of a WAST Allocated Resource, measured in seconds.

Numerator:

The time difference between Incident Clock Start and the time of first WAST allocated resource.

Denominator:

n/a

Inclusions:

ARREST Coded Calls (see ARR1a)

All Resources Available for WAST Allocation, including CFR, UFR and EMRTS.

Exclusions:

GoodSAM Responders

Audience:

INTERNAL

Notes:

- Subject to Clock Start Rules, see Appendix 2: PROPOSED CLOCK START – ARREST
- Each incident may have multiple resources allocated to it including multiple WAST Vehicles.

ARR7b Time to First Mobilisation: WAST Resource

Description

How quickly was a WAST resource mobilised?

Data Definition

The duration between Clock Start and the first movement of WAST Allocated Resource, measured in seconds.

Numerator:
The time difference between Incident Clock Start and first movement of a WAST Allocated Resource.

Denominator:

n/a

Inclusions:

ARREST Coded Calls (see ARR1a)

All Resources Available for WAST Allocation, including CFR, UFR and EMRTS.

Exclusions:

GoodSAM Responders

Audience:

INTERNAL

Notes:

Subject to Clock Start Rules, see Appendix 2: PROPOSED CLOCK START – ARREST

ARR8a Time to First Alert: Paramedic Resource

Description

How quickly was a paramedic resource alerted?

Data Definition

The duration between Clock Start and the first alerting of a paramedic, measured in seconds.

Numerator:

The time difference between Incident Clock Start and the time of first paramedic resource allocation.

Denominator:

n/a

Inclusions:

- ARREST Coded Calls (see ARR1a)
- Vehicle Types:
    - Emergency Ambulance Paramedic
    - CHARU
    - APP
    - FRS2
    - HART

Exclusions:

GoodSAM Responders

Audience:

INTERNAL

Notes:

- Subject to Clock Start Rules, see Appendix 2: PROPOSED CLOCK START – ARREST
- Each incident may have multiple resources allocated to it including multiple WAST Vehicles.

ARR8b Time to First Mobilisation: Paramedic Resource

Description

How quickly was a paramedic resource mobilised?

Data Definition

The duration between Clock Start and the first movement of Paramedic Resource, measured in seconds.

Numerator:
The time difference between Incident Clock Start and first movement of a Paramedic Resource.

Denominator:

n/a

Inclusions:

- ARREST Coded Calls (see ARR1a)
- Vehicle Types:
    - Emergency Ambulance Paramedic
    - CHARU
    - APP
    - FRS2
    - HART

Exclusions:

GoodSAM Responders

Audience:

INTERNAL

Notes:

Subject to Clock Start Rules, see Appendix 2: PROPOSED CLOCK START – ARREST

ARR9a Time to First Alert: GoodSAM

Description

How quickly was a GoodSAM alert sent?

Data Definition

The duration between Clock Start and the first alerting GoodSAM responders, through a GoodSAM Alert Confirmation, measured in seconds.

Numerator:

The time difference between Incident Clock Start and the time the GoodSAM Alert is confirmed.

Denominator:

n/a

Inclusions:

ARREST Coded Calls (see ARR1a)

Exclusions:

GoodSAM Alerts which received no response (accept or decline).

Audience:

INTERNAL

Notes:

- Subject to Clock Start Rules, see Appendix 2: PROPOSED CLOCK START – ARREST
- Each incident may have multiple resources allocated to it including multiple GoodSAM Responders.
- GoodSAM Alerts are either Accepted or Declined by a GoodSAM Responder, or do not receive a response from a responder.
    - The GoodSAM Alert Confirmation Time has been taken from the first alert that was accepted by a GoodSAM Responder.

ARR9b Time to GoodSAM Acceptance

Description

How quickly was a GoodSAM responder mobilised?

Data Definition

The duration between Clock Start and the first movement of a GoodSAM Responder, measured in seconds.

Numerator:

The time difference between Incident Clock Start and the time the GoodSAM Alert is Accepted by a GoodSAM Responder.

Denominator:

n/a

Inclusions:

ARREST Coded Calls (see ARR1a)

Exclusions:

GoodSAM Alerts which received no response or were declined by the responder.

Audience:

INTERNAL

Notes:

- Subject to Clock Start Rules, see Appendix 2: PROPOSED CLOCK START – ARREST
- Each incident may have multiple resources allocated to it including multiple GoodSAM Responders.
- GoodSAM Alerts are either Accepted or Declined by a GoodSAM Responder, or do not receive a response from a responder.
    - The GoodSAM Alert Acceptance Time has been taken from the first alert that was accepted by a GoodSAM Responder.

ARR9c Response Time: GoodSAM

Description

How quickly was a GoodSAM responder on scene?

Data Definition

The duration between Clock Start and the arrival of a GoodSAM Responder on scene, measured in seconds.

Numerator:

The time difference between Incident Clock Start and the on-scene date time of the GoodSAM Responder.

Denominator:

n/a

Inclusions:

ARREST Coded Calls (see ARR1a)

Incidents where at least one GoodSAM Responder arrived at scene.

Exclusions:

GoodSAM Alerts which received no response or were declined by the responder.

Audience:

INTERNAL

Notes:

Subject to Clock Start Rules, see Appendix 2: PROPOSED CLOCK START – ARREST

ARR10a Time to Conveying Resource Response

Description

How quickly was a vehicle capable of conveying the patient on scene?

Data Definition

The response time for the first vehicle capable of conveyance arriving at scene, measured in decimal minutes.

Numerator:

The time difference between Incident Clock Start and the time the first vehicle with conveyance capacity arrived on scene.

Denominator:

n/a

Inclusions:

ARREST Coded Calls (see ARR1a)

Incidents where at least one conveyance capable vehicle arrived on scene.

Exclusions:

Incidents where a conveyance capable vehicle arrived at scene, but the patient was not conveyed to hospital e.g. Patient Treated at Scene or ROLE.

Audience:

INTERNAL

Notes:

- The first conveyance capable resource arriving at scene is not necessarily the first resource on scene, another non-conveyance vehicle may have arrived prior.
- The first conveyance capable resource arriving on scene is not necessarily the one which conveyed the patient to hospital.
- Subject to Clock Start Rules, see Appendix 2: PROPOSED CLOCK START – ARREST

ARR10b Time to Enhanced Care Response

Description

How quickly was an enhanced care response on scene?

Data Definition

The response time for the first vehicle capable of an enhanced care response arriving at scene, measured in decimal minutes.

Numerator:

The time difference between Incident Clock Start and the time the first vehicle capable of an enhanced care response arrived on scene.

Denominator:

n/a

Inclusions:

- ARREST Coded Calls (see ARR1a)
- Vehicle Types:
    - SP
    - CHARU
    - EMRTS
    - HART
    - BASICS
    - MEDSERVE

Exclusions:

n/a

Audience:

INTERNAL

Notes:

- Subject to Clock Start Rules, see Appendix 2: PROPOSED CLOCK START – ARREST

APPENDIX 1: ARREST MPDS CODES

Cont	Desp Code	Description	Org Col	Gov Col
DEF	03D01	Arrest	RED	ARREST
DEF	04D01	Arrest	RED	ARREST
DEF	04D01A	Arrest - Assault	RED	ARREST
DEF	04D01S	Arrest - Sexual assault	RED	ARREST
DEF	04D01T	Arrest - Stun gun	RED	ARREST
DEF	07D02	Arrest	RED	ARREST
DEF	07D02E	Arrest - Explosion	RED	ARREST
DEF	07D02F	Arrest - Fire present	RED	ARREST
DEF	07D02W	Arrest - Fireworks	RED	ARREST
DEF	08D01	Arrest	RED	ARREST
DEF	08D01B	Arrest - Biological	RED	ARREST
DEF	08D01C	Arrest - Chemical	RED	ARREST
DEF	08D01G	Arrest - Smell of gas/fumes	RED	ARREST
DEF	08D01M	Arrest - Carbon monoxide	RED	ARREST
DEF	08D01N	Arrest - Nuclear	RED	ARREST
DEF	08D01R	Arrest - Radiological	RED	ARREST
DEF	08D01S	Arrest - Suicide attempt (only carbon monoxide)	RED	ARREST
DEF	08D01T	Arrest - Suicide attempt (other toxic substances)	RED	ARREST
DEF	08D01U	Arrest - Unknown	RED	ARREST
DEF	09D01	INEFFECTIVE BREATHING	RED	ARREST
DEF	09D02	OBVIOUS or EXPECTED DEATH questionable (a through h; x through z)	RED	ARREST
DEF	09D02A	OBVIOUS or EXPECTED DEATH questionable (a through h; x through z) - Cold and stiff in a warm environment	RED	ARREST
DEF	09D02B	OBVIOUS or EXPECTED DEATH questionable (a through h; x through z) - Decapitation	RED	ARREST
DEF	09D02C	OBVIOUS or EXPECTED DEATH questionable (a through h; x through z) - Decomposition	RED	ARREST
DEF	09D02D	OBVIOUS or EXPECTED DEATH questionable (a through h; x through z) - Incineration	RED	ARREST
DEF	09D02E	OBVIOUS or EXPECTED DEATH questionable (a through h; x through z) - NON-RECENT death	RED	ARREST
DEF	09D02F	OBVIOUS or EXPECTED DEATH questionable (a through h; x through z) - Severe injuries obviously incompatible with life	RED	ARREST

DEF	09D02G	OBVIOUS or EXPECTED DEATH questionable (a through h; x through z) - Condition g (user-defined)	RED	ARREST
DEF	09D02H	OBVIOUS or EXPECTED DEATH questionable (a through h; x through z) - Condition h (user-defined)	RED	ARREST
DEF	09D02X	OBVIOUS or EXPECTED DEATH questionable (a through h; x through z) - Terminal illness	RED	ARREST
DEF	09D02Y	OBVIOUS or EXPECTED DEATH questionable (a through h; x through z) - DNR (Do Not Resuscitate) Order	RED	ARREST
DEF	09D02Z	OBVIOUS or EXPECTED DEATH questionable (a through h; x through z) - Condition z (user-defined)	RED	ARREST
DEF	09E01	Not breathing at all	RED	ARREST
DEF	09E02	UNCERTAIN BREATHING	RED	ARREST
DEF	09E03	Hanging	RED	ARREST
DEF	09E04	Strangulation	RED	ARREST
DEF	09E05	Suffocation	RED	ARREST
DEF	11E01	COMPLETE obstruction/INEFFECTIVE BREATHING	RED	ARREST
DEF	11E01C	COMPLETE obstruction/INEFFECTIVE BREATHING - Lolly/Candy/Sweets/Gum	RED	ARREST
DEF	11E01F	COMPLETE obstruction/INEFFECTIVE BREATHING - Food	RED	ARREST
DEF	11E01M	COMPLETE obstruction/INEFFECTIVE BREATHING - Milk/Liquid (non-toxic)	RED	ARREST
DEF	11E01O	COMPLETE obstruction/INEFFECTIVE BREATHING - Object/Toy	RED	ARREST
DEF	11E01U	COMPLETE obstruction/INEFFECTIVE BREATHING - Unknown	RED	ARREST
DEF	12D01	Not breathing (after Key Questioning)	RED	ARREST
DEF	12D01E	Not breathing (after Key Questioning) - Epileptic or Previous diagnosis of fitting	RED	ARREST
DEF	14D04	Just resuscitated and/or defibrillated (external)	RED	ARREST
DEF	14D04D	Just resuscitated and/or defibrillated (external) - DIVING injury (not underwater)	RED	ARREST
DEF	14D04F	Just resuscitated and/or defibrillated (external) - Floodwater rescue	RED	ARREST
DEF	14D04I	Just resuscitated and/or defibrillated (external) - Ice rescue	RED	ARREST
DEF	14D04S	Just resuscitated and/or defibrillated (external) - SCUBA accident (not underwater)	RED	ARREST
DEF	14D04W	Just resuscitated and/or defibrillated (external) - SWIFT water rescue	RED	ARREST
DEF	14E01	Arrest (out of water)	RED	ARREST
DEF	14E01D	Arrest (out of water) - DIVING injury (not underwater)	RED	ARREST
DEF	14E01F	Arrest (out of water) - Floodwater rescue	RED	ARREST
DEF	14E01I	Arrest (out of water) - Ice rescue	RED	ARREST
DEF	14E01S	Arrest (out of water) - SCUBA accident (not underwater)	RED	ARREST
DEF	14E01W	Arrest (out of water) - SWIFT water rescue	RED	ARREST

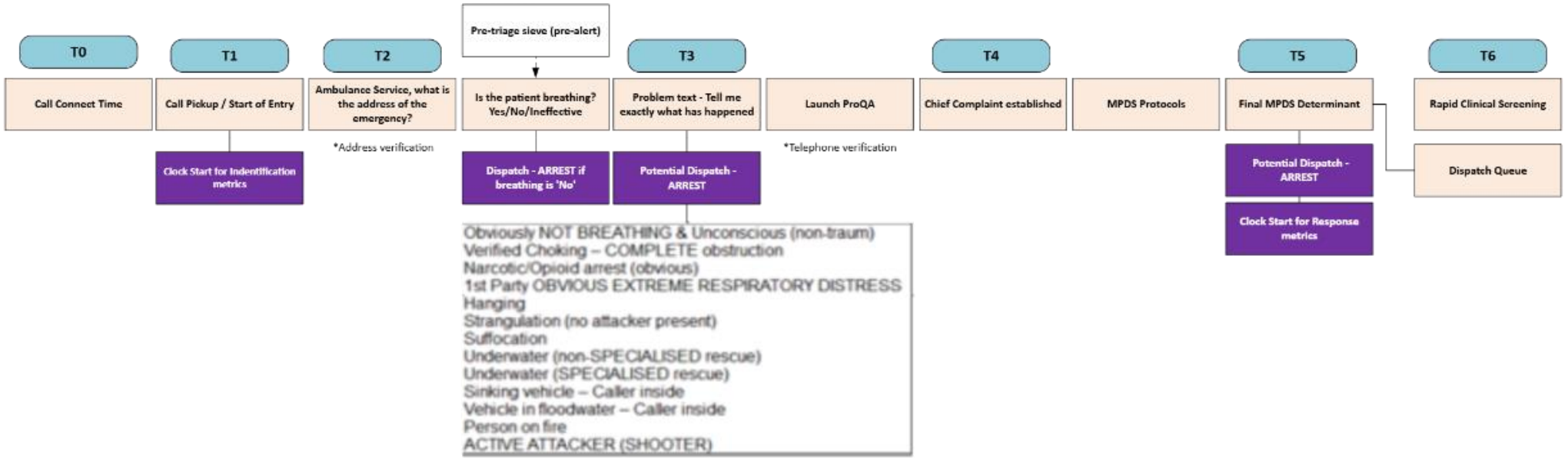
DEF	14E02	Underwater (DOMESTIC rescue)? Underwater (non-specialised rescue)	RED	ARREST
DEF	15E01	NOT BREATHING/INEFFECTIVE BREATHING	RED	ARREST
DEF	15E01E	NOT BREATHING/INEFFECTIVE BREATHING - Electrocution	RED	ARREST
DEF	15E01L	NOT BREATHING/INEFFECTIVE BREATHING - Lightning	RED	ARREST
DEF	17D02	Arrest	RED	ARREST
DEF	17D02A	Arrest - Accessibility concerns/difficulty	RED	ARREST
DEF	17D02E	Arrest - Environmental problems (rain heat cold)	RED	ARREST
DEF	17D02G	(OBSOLETE CODE) Arrest - On the ground or floor	Obsolete	ARREST
DEF	17D02J	Arrest - Jumper (suicide attempt)	RED	ARREST
DEF	17D02P	Arrest - Public place (street car park market)	RED	ARREST
DEF	19D05	Just resuscitated and/or defibrillated (external)	RED	ARREST
DEF	21D01	Arrest	RED	ARREST
DEF	21D01M	Arrest - MEDICAL	RED	ARREST
DEF	21D01T	Arrest - TRAUMA	RED	ARREST
DEF	23D01	Arrest	RED	ARREST
DEF	23D01A	Arrest - Accidental	RED	ARREST
DEF	23D01C	Arrest - Carfentanyl	RED	ARREST
DEF	23D01D	Arrest - Accidental and Fentanyl	RED	ARREST
DEF	23D01E	Arrest - Accidental and Carfentanyl	RED	ARREST
DEF	23D01F	Arrest - Fentanyl	RED	ARREST
DEF	23D01G	Arrest - Intentional and Fentanyl	RED	ARREST
DEF	23D01H	Arrest - Intentional and Carfntanyl	RED	ARREST
DEF	23D01I	Arrest - Intentional	RED	ARREST
DEF	23D01Q	Arrest - Violent or Combative and Fentanyl	Obsolete	ARREST
DEF	23D01R	Arrest - Violent or Combative and Carfentanyl	Obsolete	ARREST
DEF	23D01S	Arrest - Weapons and Fentanyl	Obsolete	ARREST
DEF	23D01T	Arrest - Weapons and Carfentanyl	Obsolete	ARREST
DEF	23D01V	Arrest - Violent or combative	Obsolete	ARREST
DEF	23D01W	Arrest - Weapons	Obsolete	ARREST
DEF	23E01	Narcotic / opioid arrest (obvious)	Obsolete	ARREST

DEF	23E01A	Narcotic / opioid arrest (obvious) - Accidental	RED	ARREST
DEF	23E01C	Narcotic / opioid arrest (obvious) - Carfentanyl	RED	ARREST
DEF	23E01D	Narcotic / opioid arrest (obvious) - Accidental and Fentanyl	RED	ARREST
DEF	23E01E	Narcotic / opioid arrest (obvious) - Accidental and Carfentanyl	RED	ARREST
DEF	23E01F	Narcotic / opioid arrest (obvious) - Fentanyl	RED	ARREST
DEF	23E01G	Narcotic / opioid arrest (obvious) - Intentional and Fentanyl	RED	ARREST
DEF	23E01H	Narcotic / opioid arrest (obvious) - Intentional and Carfentanyl	RED	ARREST
DEF	23E01I	Narcotic / opioid arrest (obvious) - Intentional	RED	ARREST
DEF	24D06	Baby born (complications with baby)	RED	ARREST
DEF	24D06M	Baby born (complications with baby) - Multiple birth	RED	ARREST
DEF	24D07	Baby born (complications with mother)	RED	ARREST*
DEF	24D07M	Baby born (complications with mother) - Multiple birth	RED	ARREST*
DEF	25D01	ARREST	RED	ARREST
DEF	27D01	Arrest	RED	ARREST
DEF	27D01G	Arrest - Gunshot	RED	ARREST
DEF	27D01I	Arrest - IMPALED currently	RED	ARREST
DEF	27D01P	Arrest - Penetrating wound (not IMPALED now)	RED	ARREST
DEF	27D01S	Arrest - Stab	RED	ARREST
DEF	27D01X	Arrest - Self-inflicted GSW (intentional)	RED	ARREST
DEF	27D01Y	Arrest - Self-inflicted knife/stab wound (intentional)	RED	ARREST
DEF	29D02R	HIGH MECHANISM (k through t) - Possible death at scene	RED	ARREST
DEF	29D06	Arrest	RED	ARREST
DEF	29D06U	Arrest - Unknown number of patients	RED	ARREST
DEF	29D06V	Arrest - Multiple patients	RED	ARREST
DEF	29D06X	Arrest - Unknown number of patients and Additional response required	RED	ARREST
DEF	29D06Y	Arrest - Multiple patients and Additional response required	RED	ARREST
DEF	30D01	Arrest	RED	ARREST
DEF	31D01	Unconscious – AGONAL/INEFFECTIVE BREATHING	RED	ARREST
DEF	31E01	INEFFECTIVE BREATHING	RED	ARREST
DEF	33D01P	Suspected cardiac or respiratory arrest - Palliative Care	RED	ARREST

DEF	33D01T	Suspected cardiac or respiratory arrest - Transfer/Interfacility	RED	ARREST
DEF	33D02P	Just resuscitated and/or defibrillated (external) - Palliative Care	RED	ARREST
DEF	33D02T	Just resuscitated and/or defibrillated (external) - Transfer/Interfacility	RED	ARREST
DEF	DX010	Emergency Ambulance Response Potential Cardiac Arrest	RED	ARREST
DEF	DX0101	Emergency Ambulance Response Potential Cardiac Arrest	RED	ARREST
DEF	DX01010	Emergency Ambulance Response Pre-arrest Anaphylaxis	RED	ARREST
DEF	DX0102	Emergency Ambulance Response Potential Cardiac Arrest Post Delivery	RED	ARREST
DEF	EMRC11	Emergency Response for a patient not Breathing/Cardiac Arrest	RED	ARREST
DEF	EMRC13	Emergency Response for a patient actively Choking	RED	ARREST

APPENDIX 2: PROPOSED CLOCK START – ARREST

REF: Call Flow & Categorisation Workshop v20



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

OUT OF HOSPITAL CARDIAC ARREST REPORT

Welsh Ambulance Service University NHS Trust and Save a Life Cymru Combined Action Plan

VERSION: 1

Out of Hospital Cardiac Arrest Action Plan

This action plan has been developed in direct response to the request from Welsh Government to undertake a rapid review of opportunities to accelerate improvements in outcomes for people experiencing an out-of-hospital cardiac arrest (OHCA) in Wales. It supports the implementation of the new Emergency Ambulance Performance Framework, which places an enhanced emphasis on clinical outcomes. In collaboration with the NHS Wales Save a Life Cymru (SaLC) programme, the actions outlined herein are aligned to the internationally recognised Chain of Survival, and are focused on strengthening community awareness, improving access to life-saving interventions such as defibrillators and CPR, and embedding robust data and analytical capabilities to drive continuous improvement. The plan reflects a clinically-led, system-wide approach that brings together NHS services, emergency responders, and community partners to give every individual the best chance of survival from OHCA.

Early Recognition and Call for Help

Strengthening public awareness and enabling prompt identification of cardiac arrest symptoms to ensure immediate engagement with emergency services.

Objective	Driver	Workstream	Identified Actions
Enhance public awareness and engagement through targeted digital campaigns to strengthen early response to out-of-hospital cardiac arrest.	To increase public awareness, confidence, and willingness to intervene during an out-of-hospital cardiac arrest by enhancing early recognition and bystander action.	**Early Recognition & Call for Help**	- Identification of high-impact stakeholder groups. - Development and delivery of bespoke, targeted video messaging.
Improve and expand CPR familiarisation and cardiac arrest awareness across community, educational, and workplace settings, focused on building public confidence to recognise	To improve early recognition of cardiac arrest and increase the likelihood of immediate bystander intervention.	**Early Recognition & Call for Help**	- System influencing around the integration of CPR awareness and training into the national curriculum, with a view to develop a longer-term action plan for primary to university CPR familiarisation. - Identification of priority stakeholder groups and targeted CPR familiarisation e.g. Cubs, Scouts, Guides, Sports Associations.

Objective	Driver	Workstream	Identified Actions
the signs of cardiac arrest and initiate bystander intervention.			- Explore opportunities to advocate for integrating CPR familiarisation into standard accreditation processes, such as driving licensing, to increase participation rates.
Enhance the confidence and capability of call handlers to recognise and respond to cardiac arrest incidents by reviewing our internal processes, infrastructure, and available support.	To ensure earlier recognition of cardiac arrest at the point of call and improve the quality and consistency of call handler-assisted CPR.	**Early Recognition & Call for Help**	- Review existing evidence base around call handling process and what actions can improve early recognition. - Improve the call handler process for provision of CPR advice, including the role of early clinical support. - Increase the frequency of CPR training from 3-yearly to annually for all call handlers. - Implement a robust feedback mechanism following audit to support learning and ongoing professional development. - Work with the Research & Innovation team to explore opportunities to use AI for the early identification of cardiac arrest and wider opportunities (i.e. identification of DNRs or instances where CPR would be ineffective).

Early Cardiopulmonary Resuscitation (CPR)

Empowering communities through widespread CPR training and support to initiate life-saving interventions before professional help arrives.

Objective	Driver	Workstream	Identified Actions
Achieve whole-organisation resuscitation readiness within WAST to lead by example and influence wider public sector adoption.	To establish WAST as a system leader in resuscitation preparedness, demonstrating organisational-wide commitment to saving lives and enabling WAST to advocate for the broader adoption of CPR training and GoodSAM participation across the wider public sector.	**Early CPR**	- Embed comprehensive CPR familiarisation and defibrillator awareness across all roles within WAST including non-clinical and corporate staff. This will include targeted training programmes, internal promotion of the GoodSAM app, and increased participation in the responder network. - Achieve 100% organisational readiness to support out-of-hospital cardiac arrest events, positioning WAST as a model of best practice within the public sector.
Strengthen public sector partnerships to promote strategic adoption of the GoodSAM app across community and emergency services.	To increase the number and distribution of active GoodSAM responders across Wales through organisational endorsement and structured promotion - enhancing real-time community response capability.	**Early CPR**	- Develop a prioritised public sector engagement strategy to increase adoption of the GoodSAM app among community and emergency services. - Targeted re-engagement with Health Boards and public services. - Use of compelling data-driven messaging, and structured communication plans to clarify usage expectations and operational flexibility for responders. - Implementation of engagement strategy with high impact, high influence stakeholders, and those with a high-level of buy-in. N.B. This objective is focused on system-level engagement and endorsement.

Early Defibrillation

Maximising public access and confidence in using Automated External Defibrillators (AEDs) to improve survival outcomes within the critical first minutes.

Objective	Driver	Workstream	Identified Actions
Build a mobile responder network by expanding GoodSAM participation and allocating defibrillators to frontline public sector workers.	To expand the reach and effectiveness of early defibrillation by equipping mobile responders with the tools and confidence to intervene.	**Early Defibrillation**	- Targeted allocation of Defibs to existing GoodSAM responders i.e. public-sector workers with public-facing roles that include community travel and outreach e.g. Police, District Nurses etc. - Targeted engagement with public sector to promote further uptake of the GoodSAM app and encourage adoption. N.B. This objective is focused on individual mobilisation and resource deployment.
Improve defibrillator guardian resilience by embedding Community First/Welfare Responders in the local maintenance and management of Public Access Defibrillators (PADs).	To ensure defibrillators across Wales are consistently maintained, accurately registered, and ready for use in emergencies - reducing barriers to timely defibrillation and enhancing system resilience in the early response to out-of-hospital cardiac arrest.	**Early Defibrillation**	- Integrate the CFR/CWR role into the PAD management network to strengthen resilience and operational readiness. - CFR/CWRs will provide an additional tier of support, undertaking routine maintenance checks, restocking equipment after use, and ensuring accurate updates to defibrillator registers. - A one-year pilot will evaluate the effectiveness of this support model, particularly in areas where defibrillators have not been strategically located.
Implement a national defibrillator repatriation process to maintain operational readiness and	To safeguard the resilience and readiness of defibrillators and ensure timely access to critical data for evaluating incident	**Early Defibrillation**	- Design, implement, and promote a standardised national process for defibrillator repatriation following deployment.

improve access to incident data.	management and system performance - thereby enhancing both community preparedness and continuous learning across the cardiac arrest response pathway.		- Rollout of standard messaging on every PAD with clear return instructions e.g. QR-coded 'luggage label' tags. - Establish a contingency protocol to monitor unreturned defibs, triggering temporary replacement measures where necessary to maintain operational coverage.

Advanced Life Support (ALS) and Post Resuscitation Care

Ensuring seamless transition to advanced medical care, including access to advanced specialist care, to support recovery and long-term health outcomes.

Objective	Driver	Workstream	Identified Actions
Enhance specialist responder readiness through structured CPD, training review, and clinical assurance in resuscitation practice.	To ensure consistent delivery of high-quality advanced clinical interventions during out-of-hospital cardiac arrests by maintaining excellence in specialist responder training, strengthening assurance mechanisms, and driving continuous professional development.	**ALS & Post Resuscitation Care**	- Undertake a comprehensive review of existing internal training provision for WAST specialist responders, including the CHARU team, with a focus on enhancing clinical competence in Advanced Life Support (ALS), Emergency Paediatric Life Support (EPALS), and Resuscitation in Special Circumstances (RiSC). - Develop and implement an action plan to bolster training provision, including a clinical audit programme and performance management process. - Implement an annual reaccreditation requirement as part of the CPD framework (currently 3-yearly).
Deliver robust audit, feedback and recognition for every PURPLE cardiac arrest call to drive learning, improvement and system excellence.	To enhance clinical quality, identify improvement opportunities, and recognise excellence by embedding a culture of continuous learning and positive reinforcement.	**ALS & Post Resuscitation Care**	- Implement a clinician-led audit process for 100% of PURPLE category cardiac arrest calls, where resuscitation attempts have taken place, supported by automated systems to capture, review, and report clinical performance. - Implement structured feedback for clinicians and call handlers, accessible crew-level performance data, and a formal recognition framework - including a pin badge and supporting letter from the Consultant Paramedic - for all staff contributing to successful return of spontaneous circulation (ROSC).

			- Introduce a dedicated audit role to maintain delivery capacity and oversight, supported by charitable donations.
Build clinician confidence and capability in cardiac arrest decision making through engagement, evidence, and supportive practice change.	To empower clinicians to make informed, evidence-based resuscitation decisions - supporting patient dignity, professional confidence, and the appropriate application of clinical resource, while addressing cultural factors that may undermine effective cardiac arrest management.	**ALS & Post Resuscitation Care**	- Undertake a qualitative, evidence-informed review of clinical decision making around the initiation and cessation of resuscitation attempts. This will include targeted engagement with clinicians to explore cultural and psychological barriers, particularly those affecting decisions to discontinue CPR. - Insights will inform the development of structured support mechanisms, training enhancements, and a forward plan to embed confidence in applying national protocols and clinical judgement in practice.
Maximise CHARU attendance at cardiac arrests by refining deployment processes and aligning practices to the new performance metrics.	To enhance the quality, consistency, and clinical outcomes of cardiac arrest responses by maximising the deployment of specialist resources capable of leading advanced resuscitation and coordinating scene-based care.	**ALS & Post Resuscitation Care**	- Review and refine CHARU deployment criteria and operational processes to increase attendance at PURPLE category cardiac arrest calls. - Identify and address barriers to deployment, with the aim of maximising specialist attendance at cardiac arrests to ensure enhanced clinical leadership at scene.

Data & Analytics

Harnessing high-quality, system-wide data to inform clinical practice, benchmark performance, and drive equitable, evidence-based improvements.

Objective	Driver	Workstream	Identified Actions
Implement PAD Map and geospatial analysis to optimise strategic placement and real-time visibility of public access defibrillators.	To increase the likelihood of defibrillator use in cardiac arrest incidents by ensuring devices are strategically placed in high-need locations, supported by intelligent mapping and data-driven deployment.	**Data & Analytics**	- Transition from the Defib Finder platform to the PAD Map system to enable real-time visibility, enhanced data accuracy, and improved management of PAD locations. - Implement a geospatial proof-of-concept overlaying OHCA incidence data with PAD locations to identify coverage gaps in underrepresented areas and prioritise targeted, defibrillator placement.
Develop a patient-centred reporting framework with robust metrics to evaluate cardiac arrest outcomes and system performance.	To improve transparency, accountability, and continuous improvement in cardiac arrest care by aligning performance reporting with patient-centred outcomes that reflect the true impact of the system response.	**Data & Analytics**	- Collaborate with the Joint Clinical Committee (JCC) to review existing cardiac arrest reporting processes and develop a more patient-centred suite of metrics. - Establish robust, shared definitions and identify outcome-based indicators - such as survival to hospital discharge - that are both clinically meaningful and accessible to stakeholders.
Strengthen cardiac arrest data quality by improving ePCR capture processes and responder understanding of data standards.	To ensure high-quality, reliable data informs performance monitoring, clinical audit, and continuous improvement.	**Data & Analytics**	- Collaborate with the Joint Clinical Committee (JCC) to review existing cardiac arrest reporting processes and develop a more patient-centred suite of metrics. - Establish robust, shared definitions and identify outcome-based indicators - such as survival to hospital discharge - that are both clinically meaningful and accessible to stakeholders.

RCS0
Data Definition Document

2025

Insight and Data Services

Version v1.0

April 2025

VERSION CONTROL TABLE

VERSION NUMBER	DATE	AUTHOR / REVIEWER / APPROVER	SUMMARY OF CHANGES
1.0	25/04/2025	Abigail Townsend Gregory Lloyd Hugh Bennett Call Flow Implementation Group	Creation of Definition Document. Seven metrics defined (RCS1-RCS4c), four further metrics in development to be submitted for approval at a later date.

DOCUMENT APPROVAL ROUTE

MEETING TITLE	MEETING DATE	VERSION	COMMENTS
CMT Metrics	30/04/2025	V1.0	No Comments
CMT Board	06/05/2025	V1.0	No Comments
Trust Board	07/05/2025	V1.0	No Comments

CONTENTS

GREEN – EXTERNAL MEASURE BLUE – INTERNAL MEASURE

DEFINITIONS

RCS1 RCS0 Categorised Calls

Description

How many calls received by the Welsh Ambulance Service are categorised as RCS0 verified incidents?

Data Definition

A RCS0 verified incident is a call that has been categorised as RCS0 after being assessed by the call taker using the MPDS software. This dataset includes calls from both the public and Health Care Professionals, where the Health Care Professional has declared a potentially life-threatening situation.

Numerator:

Number of incidents with an initial categorisation of RCS0.

Denominator:

n/a

Inclusions:

Initial Incident Categorisation = RCS0

Exclusions:

Out of area (England) incidents are excluded.

Calls taken by other ambulance services on WAST's behalf.

The following calls stopped are excluded:

- Calls made in error
- Duplicated calls
- Information calls
- Calls to other ambulance controls
- Test calls

Audience:

EXTERNAL

Notes:

See Appendix 1: RCS0 MPDS Codes

RCS2a Time of Final Code to Clinician Opens the Call

Description

How long does it take for a Clinician to open a call for review?

Data Definition

The duration, measured in seconds, between the Incident Clock Start and the time the call is selected for action (open or review).

Numerator:

The time difference between Incident Clock Start and the time the call is retrieved by the Clinical Navigator for review.

Denominator:

n/a

Inclusions:
Incidents Initially Categorised as RCS0 (see RCS1)

Clinical Navigator Type = Clinical Screening

Tags = Screening Started AND either Back to Dispatch or Passed to RICS

Exclusions:

Calls which exceeded the 60 second back stop waiting time for screening and are sent on to the dispatch queue.

Audience:

EXTERNAL

Notes:

Subject to Clock Start Rules, see Appendix 2: PROPOSED CLOCK START – RSC0

RCS2b How many Calls wait longer than 60 seconds for Screening?

Description

How many calls wait longer than the 60 second back stop for Clinical Screening and get sent through to dispatch?

Data Definition

The number of calls where the waiting time for clinical screening exceeds the 60 second backstop and the call is sent to dispatch without clinical screening occurring.

Numerator:

Number of incidents with a final MPDS Code of RCS0 with a Screening Time out Flag.

Denominator:

n/a

Inclusions:
Incident Initially Categorised as RCS0 (see RCS1)

Exclusions:

n/a

Audience:

INTERNAL

Notes:

n/a

RCS3 How long is the Clinician Engaged with the Incident?

Description

How long is the Clinician reviewing the call for to decide if it is suitable for ambulance dispatch or integrated care?

Data Definition

The duration, measured in seconds, between the time the Clinician has selected an incident for review and the final AQM action.

Numerator:

The time difference between the Call Retrieved Time and the time of the Final AQM Action completed by the Clinical Navigator.

Denominator:

n/a

Inclusions:

Incident Initially Categorised as RCS0 (see RCS1)

Exclusions:

Calls which exceeded the 60 second back stop waiting time for screening and are sent on to the dispatch queue (See RCS2b).

Audience:

EXTERNAL

Notes:

- A Clinical Navigator may join a call earlier than Incident Clock Start if the answer to “Is the Patient Breathing” is “Ineffective”. See Appendix 2: Proposed Clock Start.
- Completion of the AQM is independent of the Clinicians telephony activity, thus can be completed at any time during or after the call has finished.

RCS4a How many RCS0 calls are streamed to dispatch as ARREST or EMERG?

Description

How many calls received by the Welsh Ambulance Service are initially categorised as RCS0 and are sent to dispatch by the clinician as either ARREST or EMERG?

Data Definition

The number and percentage of verified incidents initially categorised as RCS0, that end Screening as an ARREST or EMERG priority.

Numerator:

Number of incidents with an Initial MPDS Category of RCS0, and an MPDS Category of ARREST or EMERG after Screening.

Denominator:

Number of incidents with an Initial MPDS Code of RCS0.

Inclusions:

Incident Initially Categorised as RCS0 (see RCS1)

Priority after Screening = ARREST or EMERG

Exclusions:

Calls which exceeded the 60 second back stop waiting time for screening and are sent on to the dispatch queue (See RCS2b).

Audience:

INTERNAL

Notes:

- See Appendix 1: RCS0 MPDS Codes
- Calls can be recoded multiple times during the call life cycle as more information is provided by the call taker. Consequently, the first category applied is often not the same as the final one on the call.

RCS4b How many RCS0 calls are streamed to dispatch as AMBER or GREEN?

Description

How many calls received by the Welsh Ambulance Service are initially categorised as RCS0 and are sent to dispatch by the clinician as either AMBER or GREEN?

Data Definition

The number and percentage of verified incidents initially categorised as RCS0, that end Screening as an AMBER or GREEN priority.

Numerator:

Number of incidents with an Initial MPDS Category of RCS0, and an MPDS Category of AMBER or GREEN after Screening.

Denominator:

Number of incidents with an Initial MPDS Code of RCS0.

Inclusions:

Incident Initially Categorised as RCS0 (see RCS1)

Priority after Screening = AMBER or GREEN

Exclusions:

Calls which exceeded the 60 second back stop waiting time for screening and are sent on to the dispatch queue (See RCS2b).

Audience:

INTERNAL

Notes:

- See Appendix 1: RCS0 MPDS Codes
- Calls can be recategorised multiple times during the call life cycle as more information is provided by the call taker. Consequently, the first category applied is often not the same as the final one on the call.

RCS4c How many RCS0 calls are sent to Integrated Care?

Description

How many calls received by the Welsh Ambulance Service are categorised as RCS0 and sent to Integrated Care for further assessment after screening?

Data Definition

The number and percentage of calls initially categorised as RCS0 verified incidents which are sent to Integrated Care for further assessment. Integrated Care may decide the patient still requires an ambulance, may benefit from an alternative pathway to care or may benefit from self-care advice.

Numerator:

Number of incidents with an Initial MPDS Code of RCS0 with a screening outcome of Integrated Care.

Denominator:

Number of 999 (AS1) incidents with an Initial MPDS Code of RCS0.

Inclusions:

Incident Initially Categorised as RCS0 (see RCS1)
Tags = Screening Started and Passed to RICS

Exclusions:

Calls which exceeded the 60 second back stop waiting time for screening and are sent on to the dispatch queue (See RCS2b).

Audience:

INTERNAL

Notes:

See Appendix 1: RCS0 MPDS Codes

APPENDIX 1: RCS0 MPDS CODES

Cont	Desp Code	Description	Org Col	Gov Col
DEF	02D00	Override	RED	RCS0
DEF	02D00I	Override - Injection administered or advised	RED	RCS0
DEF	02D00M	Override - Medication administered or advised	RED	RCS0
DEF	02D01	Not alert	RED	RCS0
DEF	02D01I	Not alert - Injection administered or advised	RED	RCS0
DEF	02D01M	Not alert - Medication administered or advised	RED	RCS0
DEF	02D02	DIFFICULTY SPEAKING BETWEEN BREATHS	RED	RCS0
DEF	02D02I	DIFFICULTY SPEAKING BETWEEN BREATHS - Injection administered or advised	RED	RCS0
DEF	02D02M	DIFFICULTY SPEAKING BETWEEN BREATHS - Medication administered or advised	RED	RCS0
DEF	02D03	SWARMING attack (bees wasps hornets etc.)	RED	RCS0
DEF	02D03I	SWARMING attack (bees wasps hornets etc.) - Injection administered or advised	RED	RCS0
DEF	02D03M	SWARMING attack (bees wasps hornets etc.) - Medication administered or advised	RED	RCS0
DEF	02D04	Snakebite	RED	RCS0
DEF	02D04I	Snakebite - Injection administered or advised	RED	RCS0
DEF	02D04M	Snakebite - Medication administered or advised	RED	RCS0
DEF	02E00	Override	RED	RCS0
DEF	02E00I	Override - Injection administered or advised	RED	RCS0
DEF	02E00M	Override - Medication administered or advised	RED	RCS0
DEF	03D00	Override	RED	RCS0
DEF	06E00	Override	RED	RCS0
DEF	06E00A	Override - Asthma	RED	RCS0
DEF	06E00E	Override - COAD (Emphysema/Chronic bronchitis)	RED	RCS0
DEF	06E00O	Override - Other lung problems	RED	RCS0
DEF	06E01	INEFFECTIVE BREATHING	RED	RCS0
DEF	06E01A	INEFFECTIVE BREATHING - Asthma	RED	RCS0
DEF	06E01E	INEFFECTIVE BREATHING - COAD (Emphysema/Chronic bronchitis)	RED	RCS0

DEF	06E01O	INEFFECTIVE BREATHING - Other lung problems	RED	RCS0
DEF	07E00	Override	RED	RCS0
DEF	07E00E	Override - Explosion	RED	RCS0
DEF	07E00F	Override - Fire present	RED	RCS0
DEF	07E00W	Override - Fireworks	RED	RCS0
DEF	08D00	Override	RED	RCS0
DEF	08D00B	Override - Biological	RED	RCS0
DEF	08D00C	Override - Chemical	RED	RCS0
DEF	08D00G	Override - Smell of gas/fumes	RED	RCS0
DEF	08D00M	Override - Carbon monoxide	RED	RCS0
DEF	08D00N	Override - Nuclear	RED	RCS0
DEF	08D00R	Override - Radiological	RED	RCS0
DEF	08D00S	Override - Suicide attempt (only carbon monoxide)	RED	RCS0
DEF	08D00T	Override - Suicide attempt (other toxic substances)	RED	RCS0
DEF	08D00U	Override - Unknown	RED	RCS0
DEF	09D00	Override	RED	RCS0
DEF	09D00G	Override - Condition g (user-defined)	RED	RCS0
DEF	09D00H	Override - Condition h (user-defined)	RED	RCS0
DEF	09D00X	Override - Terminal illness	RED	RCS0
DEF	09D00Y	Override - DNR (Do Not Resuscitate) Order	RED	RCS0
DEF	09D00Z	Override - Condition z (user-defined)	RED	RCS0
DEF	09E00	Override	RED	RCS0
DEF	09E00A	Override - Cold and stiff in a warm environment	RED	RCS0
DEF	09E00B	Override - Decapitation	RED	RCS0
DEF	09E00C	Override - Decomposition	RED	RCS0
DEF	09E00D	Override - Incineration	RED	RCS0
DEF	09E00E	Override - NON-RECENT death	RED	RCS0
DEF	09E00F	Override - Severe injuries obviously incompatible with life	RED	RCS0
DEF	09E00G	Override - Condition g (user-defined)	RED	RCS0

DEF	09E00H	Override - Condition h (user-defined)	RED	RCS0
DEF	09E00X	Override - Terminal illness	RED	RCS0
DEF	09E00Y	Override - DNR (Do Not Resuscitate) Order	RED	RCS0
DEF	09E00Z	Override - Condition z (user-defined)	RED	RCS0
DEF	10D00	Override	RED	RCS0
DEF	11D00C	Override - Lolly/Candy/Sweets/Gum	RED	RCS0
DEF	11D00F	Override - Food	RED	RCS0
DEF	11D00M	Override - Milk/Liquid (non-toxic)	RED	RCS0
DEF	11D00O	Override - Object/Toy	RED	RCS0
DEF	11D00U	Override - Unknown	RED	RCS0
DEF	11E00	Override	RED	RCS0
DEF	11E00C	Override - Lolly/Candy/Sweets/Gum	RED	RCS0
DEF	11E00F	Override - Food	RED	RCS0
DEF	11E00M	Override - Milk/Liquid (non-toxic)	RED	RCS0
DEF	11E00O	Override - Object/Toy	RED	RCS0
DEF	11E00U	Override - Unknown	RED	RCS0
DEF	12C00	Override	RED	RCS0
DEF	12C00E	Override - Epileptic or Previous diagnosis of fitting	RED	RCS0
DEF	12D00	Override	RED	RCS0
DEF	12D00E	Override - Epileptic or Previous diagnosis of fitting	RED	RCS0
DEF	13D00	Override	RED	RCS0
DEF	13D00C	Override - Combative or aggressive	RED	RCS0
DEF	14D00	Override	RED	RCS0
DEF	14D00D	Override - DIVING injury (not underwater)	RED	RCS0
DEF	14D00F	Override - Floodwater rescue	RED	RCS0
DEF	14D00I	Override - Ice rescue	RED	RCS0
DEF	14D00S	Override - SCUBA accident (not underwater)	RED	RCS0
DEF	14D00W	Override - SWIFT water rescue	RED	RCS0
DEF	14E00	Override	RED	RCS0

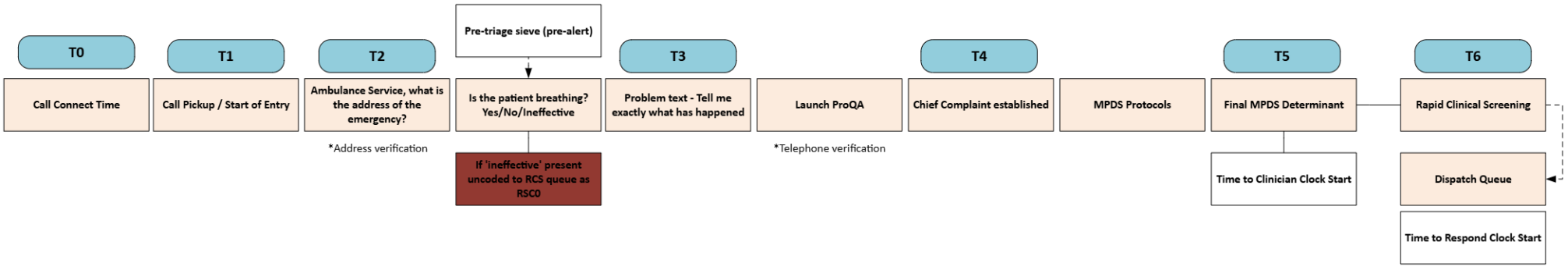
DEF	14E00D	Override - DIVING injury (not underwater)	RED	RCS0
DEF	14E00F	Override - Floodwater rescue	RED	RCS0
DEF	14E00I	Override - Ice rescue	RED	RCS0
DEF	14E00S	Override - SCUBA accident (not underwater)	RED	RCS0
DEF	14E00W	Override - SWIFT water rescue	RED	RCS0
DEF	15D00E	Override - Electrocution	RED	RCS0
DEF	15D00L	Override - Lightning	RED	RCS0
DEF	15E00E	Override - Electrocution	RED	RCS0
DEF	15E00L	Override - Lightning	RED	RCS0
DEF	19D00	Override	RED	RCS0
DEF	21D00M	Override - MEDICAL	RED	RCS0
DEF	21D00T	Override - TRAUMA	RED	RCS0
DEF	22D00	Override	RED	RCS0
DEF	22D00A	Override - Above ground	RED	RCS0
DEF	22D00B	Override - Below ground	RED	RCS0
DEF	22D00M	Override - Multiple victims	RED	RCS0
DEF	22D00X	Override - Both Above ground and Multiple victims	RED	RCS0
DEF	22D00Y	Override - Both Below ground and Multiple victims	RED	RCS0
DEF	23D00	Override	RED	RCS0
DEF	23D00A	Override - Accidental	RED	RCS0
DEF	23D00C	Override - Carfentanil	RED	RCS0
DEF	23D00D	Override - Accidental and Fentanyl	RED	RCS0
DEF	23D00E	Override - Accidental and Carfentanil	RED	RCS0
DEF	23D00F	Override - Fentanyl	RED	RCS0
DEF	23D00G	Override - Intentional and Fentanyl	RED	RCS0
DEF	23D00H	Override - Intentional and Carfentanil	RED	RCS0
DEF	23D00I	Override - Intentional	RED	RCS0
DEF	23D00Q	Override - Violent or Combative and Fentanyl	RED	RCS0
DEF	23D00R	Override - Violent or Combative and Carfentanil	RED	RCS0

DEF	23D00S	Override - Weapons and Fentanyl	RED	RCS0
DEF	23D00T	Override - Weapons and Carfentanil	RED	RCS0
DEF	23D00V	Override - Violent or combative	RED	RCS0
DEF	23D00W	Override - Weapons	RED	RCS0
DEF	23E00	Override - Accidental	RED	RCS0
DEF	23E00A	Override - Carfentanyl	RED	RCS0
DEF	23E00C	Override - Accidental and Fentanyl	RED	RCS0
DEF	23E00D	Override - Accidental and Fentanyl	RED	RCS0
DEF	23E00E	Override - Accidental and Carfentanyl	RED	RCS0
DEF	23E00F	Override - Fentanyl	RED	RCS0
DEF	23E00G	Override - Intentional and Fentanyl	RED	RCS0
DEF	23E00H	Override - Intentional and Carfentanyl	RED	RCS0
DEF	23E00I	Override - Intentional	RED	RCS0
DEF	23E00Q	Override	RED	RCS0
DEF	23E00R	Override - Violent or Combative and Carfentanyl	RED	RCS0
DEF	23E00S	Override - Weapons and Fentanyl	RED	RCS0
DEF	23E00T	Override - Weapons and Carfentanyl	RED	RCS0
DEF	23E00V	Override - Violent or combative	RED	RCS0
DEF	23E00W	Override - Weapons	RED	RCS0
DEF	24D00	Override	RED	RCS0
DEF	24D00M	Override - Multiple birth	RED	RCS0
DEF	25C00T	Override - Threatening self-immolation	RED	RCS0
DEF	25D00T	Override - Self Immolation	RED	RCS0
DEF	27D00G	Override - Gunshot	RED	RCS0
DEF	27D00I	Override - IMPALED currently	RED	RCS0
DEF	27D00P	Override - Penetrating wound (not IMPALED now)	RED	RCS0
DEF	27D00S	Override - Stab	RED	RCS0
DEF	27D00X	Override - Self-inflicted GSW (intentional)	RED	RCS0
DEF	27D00Y	Override - Self-inflicted knife/stab wound (intentional)	RED	RCS0

DEF	30D00	Override	RED	RCS0
DEF	31D00	Override	RED	RCS0
DEF	31E00	Override	RED	RCS0
DEF	33D00P	Override - Palliative Care	RED	RCS0
DEF	33D00T	Override - Transfer/Interfacility	RED	RCS0
DEF	34D00	Override	RED	RCS0
DEF	45D00	Override	RED	RCS0
DEF	45D00A	Override - Abdominal Pain / Problems	RED	RCS0
DEF	45D00B	Override - Allergies (Reactions) / Envenomations (Stings, Bites)	RED	RCS0
DEF	45D00C	Override - Back Pain (Non-Traumatic or Non-Recent Trauma)	RED	RCS0
DEF	45D00D	Override - Convulsions / Fitting	RED	RCS0
DEF	45D00E	Override - Diabetic Problems	RED	RCS0
DEF	45D00F	Override - Eye Problems / Injuries	RED	RCS0
DEF	45D00G	Override - Falls	RED	RCS0
DEF	45D00H	Override - Headache	RED	RCS0
DEF	45D00I	Override - Haemorrhage / Lacerations (Minor)	RED	RCS0
DEF	45D00J	Override - Traumatic Injuries (Non-Trauma Centre)	RED	RCS0
DEF	45D00K	Override - Unconscious / Fainting (Near)	RED	RCS0
DEF	99C01	Patient with care plan indicating CAT 1 response	RED	RCS0

APPENDIX 2: PROPOSED CLOCK START – RCS0 CODES

REF: Call Flow & Categorisation Workshop v20



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

AGENDA ITEM No	**10.1**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**2**

PUTTING THINGS RIGHT REPORT
QUARTER 1 2025/26, APRIL – JUNE

MEETING	Quality, Patient Experience & Safety Committee
DATE	5 August 2025
EXECUTIVE	Liam Williams, Executive Director of Quality & Nursing
AUTHOR	Wendy Herbert, Deputy Director of Quality and Putting Things Right Claire Appleton, Assistant Director - Putting Things Right
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EXECUTIVE SUMMARY

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.

In summary the Report for Quarter 1 2025/26 highlights:

- The impact of high demand across Trust Emergency and Non-Emergency Services
  - harm due to extensive response times in the community for emergency care
  - distress caused by cancellations of pre-booked transport
  - large volume of high harm cases shared with Health Boards for joint investigation.
  - increase in Nationally Reportable Incident (NRI) reporting and Duty of Candour cases

- Challenges in providing timely PTR responses and inquest statements.

- Seven Learning from Events Reports are overdue.

- Increasing avenues of internal assurance and benefits of national ambulance sector safety intelligence

- Learning around sepsis, high-risk overdoses and how we enquire about patient gender

RECOMMENDATIONS

- **That the Quality, Patient Experience & Safety Committee: receives the report for discussion**
- **identifies any additional assurance requirements**
- **assesses whether the current format and content of the report provides sufficient information and assurance on Low harm and Near-miss learning and improvement**

KEY ISSUES/IMPLICATIONS
(i) The performance challenges associated with timely PTR responses and inquest statements have led to the Trust being issued with five Schedule 5 notices from Coroners offices and additional contact from elected representatives relating to delayed PTR responses.
(ii) The distressing impact for all patients and families awaiting investigation findings or inquests is acknowledged and the Trust extends apologies to all affected.
(iii) The delay in providing evidence of learning to the Welsh Risk Pool risks financial and reputational penalties.
(iv) 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.
(v) The Trust is proactively responding to patient safety concerns about equipment identified through cross-border intelligence

REPORT APPROVAL ROUTE	
Clinical and Quality Governance Group	18 July 2025 (Virtual)
Quality, Patient Experience & Safety Committee	5 August 2025

REPORT APPENDICES
ANNEX 1 - SBAR Report
ANNEX 2 - PTR & Legal Quarterly Data

REPORT CHECKLIST			
Confirm that the issues below have been considered and addressed		**Confirm that the issues below have been considered and addressed**	
EQIA (Inc. Welsh language)	N/A	Financial Implications	YES
Environmental/Sustainability	N/A	Legal Implications	N/A
Estate	N/A	Patient Safety/Safeguarding	YES
Ethical Matters	N/A	Risks (Inc. Reputational)	YES
Health Improvement	N/A	Socio Economic Duty	N/A
Health and Safety	YES	TU Partner Consultation	N/A

ANNEX 1

REPORT ABBREVIATIONS			
AACE	Association of Ambulance Chief Executives	NRI	Nationally Reportable Incident
ACS	Ambulance Care Service	PFD	Prevention of Future Deaths
CCP	Complex Case Panel	PSOW	Public Service Ombudsman for Wales
CMT	Clinical Model Transformation	PTR	Putting Things Right
CQGG	Clinical Quality Governance Group	QMG	Quality Management Group
GP OOHs	General Practice Out Of Hours	SCIF	Serious Case Incident Forum
LFER	Learning From Events Report	WRP	Welsh Risk Pool

SITUATION

1. This Putting Things Right Report covers the period from 1 April 2025 – 30 June 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 elements:

   ANNEX 1: 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 2** as well as qualitative organisational intelligence flowing through the Trust's Quality and Safety Governance Groups.

   ANNEX 2: PTR and Legal data reporting. It 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).

ASSESSMENT

ASSURANCE

(i) ***External Assurance***

3. The Trust received a Section 27 non-Public Interest Report from the PSOW in April 2025. Report 202308948 findings were that the Trust's Clinical Support Desk clinicians should have reviewed the first 999 call, identified that the patient was at serious risk and then escalated the ambulance response category in line with the Trust's own guidance.

4. The Trust acknowledged the poor standard of complaint investigation at an early stage of PSOW involvement and accepted the recommendations issued by the PSOW. These actions have all been completed, with changes made through the revisions to the Performance Framework and CMT Programme contributing to strong controls to prevent a similar situation from reoccurring.

5. In addition to the recommendations made by the PSOW, the Trust acknowledges that the issues identified require the Trust to review our stance on liability and is in proactive contact with the family to support them through this process. The Trust apologises to family members that our concerns investigation has caused additional distress to them following their loss.

6. In recent months, delays in the Trust responding to complaints in a timely manner has resulted in contact being made by senior political representatives seeking confirmation of anticipated response timescales. Apologies have been offered in all cases and indicative timescales provided where possible. It is

recognised that our response times have deteriorated and a separate paper setting out a PTR and Legal Services Performance Organisation Recovery Plan is being considered by Committee.

7. During this quarter, the number of Coronial approached have remained static and the Trust has not received any Regulation 28 PFD Reports., However, some Senior Coroners have expressed dissatisfaction with timescales being taken to provide Statements. This has led to five Schedule 5 notifications being issued to the Trust, compelling the Trust to provide statements within a specified timeframe or risking a financial penalty.

   There is regional variation among Coroners offices, with four of the notifications received originating from South Wales Central area. The Trust recognises the impact adjourning inquests has on bereaved families and is working to respond to all Statement requests as promptly as possible.

8. The challenges in timely provision of inquest statements are presented in further detail within the PTR and Legal Services Performance: Organisation Recovery Plan

9. The NHS Wales Performance and Improvement (previously NHS Wales Executive) has agreed to undertake a national assurance exercise relating to joint investigations and enactment of the Duty of Candour / NRI reporting. WAST has provided data from January to June 2025.

(ii) ***Internal assurance***

10. Senior PTR leads have been heavily involved in the implementation and immediate safety monitoring of the new Ambulance Performance Framework and changes to call categorisations. This has included being part of the Incident Coordination Centre with an on-site presence to gather soft intelligence as well as daily monitoring of reported incidents and rapid learning through Rapid Incident Review and SCIF meetings. At the time of writing this report, the new Framework has been in place for two weeks and no patient safety incidents directly linked to the changes have been identified.

11. Timely review of near-miss incidents has allowed issues to be identified early on with adjustments being made swiftly to eliminate or manage risks. One example is learning around the 'accepted' status of calls and what staff should infer from this status. Technical subject matter experts have been able to resolve this promptly through CAD system changes to prevent any harm from occurring.

12. The Trust has been advised by colleagues in NHS England that following patient safety incident reports in other organisations, there is an under-recognised risk of the potential for significant harm and death due to delays in conveyance and critical treatment as a result of patient stretcher battery failure. Lack of knowledge by crews about of manual override functions was identified as a contributory factor. This is being discussed and addressed through the Ambulance Equipment Group

13. There is consideration being given as to whether to issue a Patient Safety Alert in England on this matter. The Trust is acting proactively to ensure all ambulance staff are made aware of the manual override function on battery powered stretchers and that battery checks (both those attached to the stretcher and any back-up batteries) are included in all 'make-ready' checklists.

14. In response to a cluster of significant patient safety incidents and safeguarding concerns, the Trust has established an internal Regional Integrated Intelligence Review. The purpose of the Regional Integrated Intelligence Review is to triangulate internal sources of organisational intelligence, including workforce, safeguarding, managerial perspectives, patient safety, complaints, legal matters, including inquests, and clinical standards of care. The review will also incorporate external intelligence, where we share an interface with their services.

15. This review aims to provide an integrated picture of intelligence and it will include aggregated data, contributions from multiple teams and directorates, and provide a holistic understanding of regional strengths and any concerns.

16. This approach to compiling and triangulating our organisational data is a new approach to assurance and learning for the Trust. Engagement from all areas involved has been positive towards the aims and approach being taken. It is anticipated that learning about the process through which the review is conducted will prove valuable in informing future integrated assurance and learning activities. It is also hoped that it will lend structure to future ambitions of an integrated quality dashboard.

(iii) ***Compliance heatmap***

17. This section provides an overarching analysis of the metrics within the compliance heatmap with detailed information on the positional context and improvement plans contained in the separate PTR and Legal Services Performance: Organisation Recovery Plan paper.

18. The overdue number of NRI investigations has begun to increase following previously successful efforts to reduce the number of open and overdue NRIs.

19. Complaint acknowledgement times dipped during May due to the PTR administration team development activities (8 complaints acknowledged just outside of the 5 working days timescale). The usual high compliance was restored the subsequent month.

20. Compliance to complaint response times are of significant concern. The Trust's high performance against the 30-working day target should be contrasted against the low number of complaint closures (approximately 50-75% of the number received during May and June), a very high number of open complaints (263) and the proportion of those that are overdue (60%).

21. The Trust's Patient Safety team has not been able to fully comply with the 5 five working day target for issuing Duty of Candour initial letters after the 'in-person' notification, due to sickness levels in the team. To provide assurance, these are relatively small numbers, and the target was out of compliance by no more than 2 days.

22. The Trust continues to achieve full compliance with National Patient Safety Alerts and Notices.

23. The Trust has received no Regulation 28 reports, although a number of requests have been received for further information and assurance post-inquest, all of which have been responded to within the requested timescales.

(iv) ***Assurance profile***

24. The variation in NRI reporting during May and June is largely due to a number of NRIs being identified during the last SCIF date in May and therefore not submitted as notifications to the NHS Executive until early June.

25. The number of incidents being finalised and closed on the Datix system has increased markedly in April and May 2025. This is mainly as a result of the training and support being offered by the Datix team and Patient Safety team and the focus placed on the number of open incidents during QMG.

26. The number of complaints received by the Trust spiked sharply during April. This appears to have been driven by an increased volume of complaints about Ambulance Care Services. 57% of complaints received that month related to the booking, delays, standard of driving or cancellations of non- emergency transport. Low staffing levels during March and April are likely to have compounded the existing dissatisfaction regarding short notice cancellations.

The Quality Improvement team have been working closely with the Ambulance Care team and a number of service improvements have taken place that are expected to improve the patient experience.

27. As a result of the transfer to a new digital case management system for claims has prompted review of all open claims cases. This has had positive benefits for the team, which has enabled them to identify several cases outside of the limitation period and subsequently close those cases, resulting in a significant reduction in open case numbers.

(v) ***Performance***

28. Due to the level of challenge being experienced, the timeliness of PTR responses for complaint and incident investigation, as well as submission of inquest statements, is covered in detail in an additional extraordinary paper in this Committee; PTR and Legal Services Performance: Organisation Recovery Plan

29. The sections on Compliance, Assurance and Performance have therefore been combined to provide an overarching analysis of the metrics presented in ANNEX 2, with detailed information on the positional context and improvement plans contained in the separate PTR and Legal Services Performance: Organisation Recovery Plan paper.

30. As of the beginning of June, the Trust had 5 deferred LFER cases. 4 of these were Amber deferred and 1 Red deferred case. Out of the new cases triggered, it has been identified that 6 Health and Safety-related cases have exceeded the submission deadline, risking financial penalties. A submission trajectory has been established and additional training arranged for Health and Safety colleagues.

(vi) ***Learning And Improvement***

Sepsis education and response

31. Improvement activity continues in response to several young people over recent years who have tragically died due to sepsis, with challenges and delays in sepsis recognition being a commonality among them. The Trust remains grateful for the courage and generosity with which their bereaved parents have shared their experiences with us and supported our improvement work.

32. Engagement is ongoing with the Sepsis Trust to collaborate on future learning packages, strengthening the online learning already available to staff. Sepsis

screening tools are being considered, proactive implementation of the revised National Early Warning Scores and a specialist learning and knowledge evaluation resource has been developed by the Education and Professional Practice team. We are engaged in awareness raising of the risks of sepsis at every opportunity, with a dedicated session at the Trust's successful 'WAST Q' Quality event.

Improving our approach to asking about gender

33. The Trust has, over the last year in particular, begun receiving a small volume of correspondence related to why and how we enquire about people's gender when undertaking remote consultations. This is likely reflective of wider societal engagement on this issue. Correspondence reflects opinions from a variety of positions on the issue and the Trust recognises the importance of ensuring our rationale for asking this information is understood and that we do so sensitively, understanding that this is a highly personal matter for some patients. The Trust's Head of Inclusion and Engagement is working with the NHS 111 Wales team to review the questions and wording within CPSS and provide training for staff to increase their fluency and confidence in asking this type of question. NASMED will be consulted to affirm that our position aligns with that of other ambulance services.

Improving identification of high-risk overdoses

34. Learning from a recent PSOW report has informed steps to enhance earlier recognition and prioritisation of high-risk overdose situations. Codes within the MPDS system have been comprehensively reviewed from early July the Overdose (23) codes aligned to V14 of MPDS will:
    - Stream the highest acuity overdose calls and Immediate Threat to life as ARREST category calls for emergency auto dispatch of a response to scene.
    - Stream the lowest priority overdose calls, without any priority symptoms at all, to 111 where the patient will be further assessed to determine their individual care needs.
    - Stream all the remaining overdose calls for early review and screening by a Clinical Navigator as part of the Rapid Clinical Screening. Clinicians working as Clinical Navigators will transfer patients to an ambulance response queue where appropriate, upgrading or allocating resources out of order if clinically indicated by way of an escalation process.

35. The Clinical Navigators will also be able to transfer patients to Integrated Care clinicians for a full clinical consultation, including the medications taken, timeframes involved, and the potential risk of lethality or likely harm. The Clinical Navigators can apply a priority review request and send these incidents to a new Rapid Assessment Queue for a timely assessment as an escalation process.

36. Significantly, all overdose calls which are assessed as needing an on-scene in-person response from the Trust will be categorised as Amber 1 calls from 1st July. Previously they may have been categorised as Amber 2 calls.

37. These positive steps to enhance early clinical oversight and increase the priority of overdose calls are designed to provide strong preventative control measures against the risk of undetected high-lethality overdoses. In support of this work, the Mental Health Team are seeking to recruit a specialist advisor to provide expert clinical care and leadership.

(vii) **Joint investigations**

38. 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.

39. An evaluation session has been arranged between the Trust, NHS Wales Performance and Improvement, Cardiff and Vale University Health Board and the national OfWCMS Programme team to review the pilot of a joint investigation module within Datix Cymru. Depending on the outcome of the evaluation, national engagement on the module is planned.

(viii) **National Reportable Incidents**

40. The incidents that have been reported as NRIs this quarter related to:

Call management - incorrect call categorisation and/or prioritisation, DX codes not being aligned to Falls Response and subsequent missed allocation opportunity, delay in providing pre-hospital Cardiopulmonary Resuscitation instructions
Remote clinical care - inappropriate clinical downgrade from Red to Amber 1, inappropriate outcome of GP OOHs instead of 999.
Clinical care – assessment: clinical reading of 12 lead ECG, treatment: airway management, incorrect use of defibrillator, unsafe management/supervision of oxygen resulting in burns; decision-making: decision to leave the patient without undertaking appropriate clinical assessments and a capacity assessment inadequate assessment of diabetic symptoms, inadequate assessment of head injury, staff acting outside of scope of practice.

(ix) **PTR & Legal Services Digital Quality, Safety and Experience systems**

Datix Cymru

41. The work of the Datix Recovery and Improvement Plan remains ongoing, with an annual review workshop arranged for September. Organisational engagement with the platform has increased, as demonstrated by the increased incident reporting and closure rates however organisational priorities related to CMT and resource constraints within both Patient Safety and Datix team mean the pace of achievement is conservative.

42. Progress has been made in relation to flowing Datix Cymru Incident and Feedback module data into the Trust's data warehouse with the first end-product in scope being automation of the MIQPR.

Civica i-Case

43. The Legal Services team have transferred case management for Road Traffic Accident, Personal Injury and Damage to Property onto a new system called i-Case. (Clinical Negligence claims remain on Datix Cymru). This system has also been procured by NHS Wales Legal and Risk Services and offers enhanced functionality and business intelligence tools, providing efficiency gains in the administrative elements of case management.

(x) **Horizon Scanning**

44. The Trust is awaiting updated Guidance from Welsh Government regarding proposed changes to the Concerns Regulations and the Putting Things Right Guidance process. Legislation is being laid before the Senedd over coming months with implementation date expected to be April 2026. Draft guidance has not yet been issued to NHS bodies and therefore implementation planning remains on pause until confirmation of the revisions is confirmed.

Welsh Ambulance Services University NHS Trust

PTR & Legal Services – Quarterly data

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

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

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?*

Thematic Learning – *where should we target our improvement efforts?*

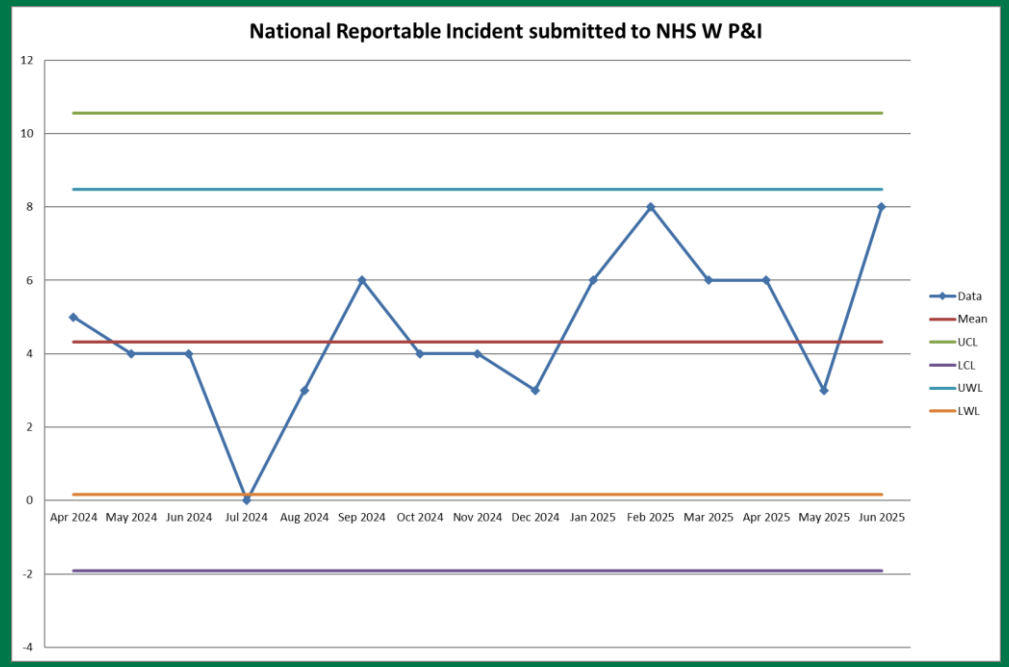
Data contained within this report is accurate at the time of reporting.

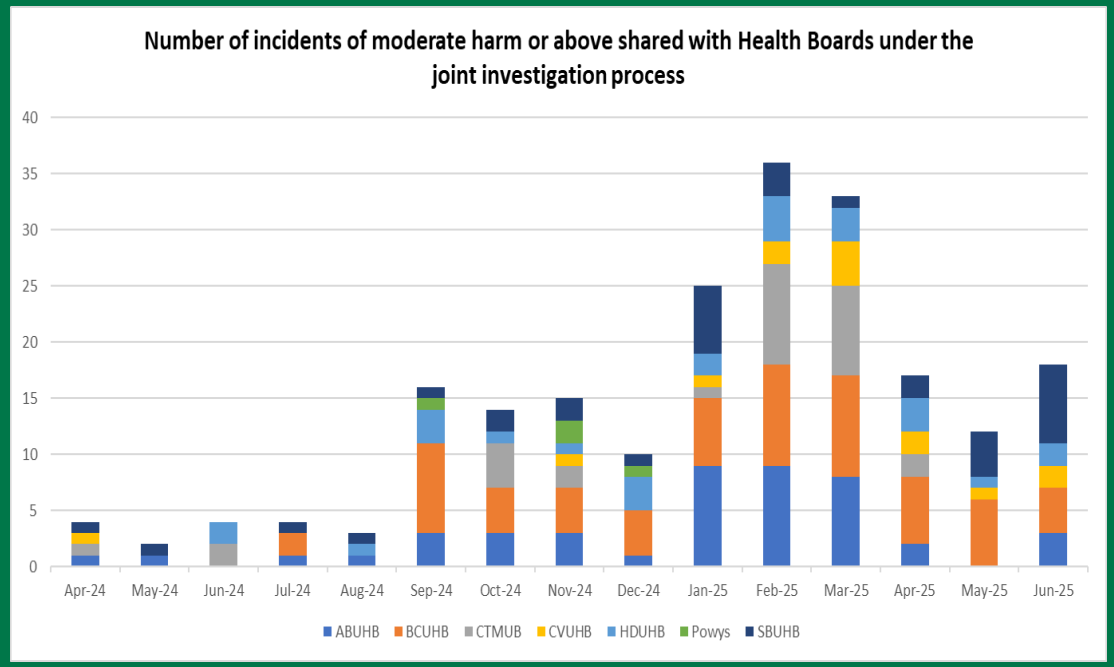
Data may be subject to change following validation, retrospective reviews and audits and ongoing clinical governance processes including regrading of incidents.

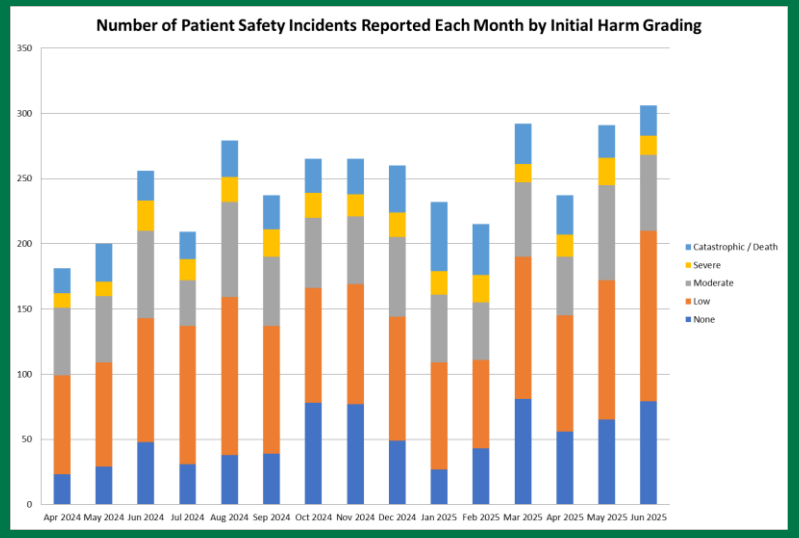
Compliance heat map

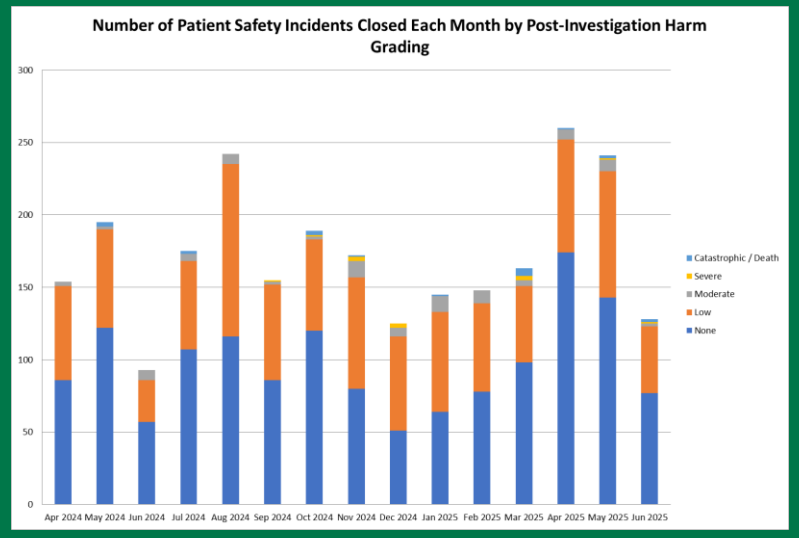
MEASURE	Scoring	Q1 2024-25			Q2 2024-25			Q3 2024-25			Q4 2024-25			Q1 2025-26		
		April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	June
Overdue NRIs	R: 10 A: 1 G: 0						40	34	29	30	28	29	29	30	32	34
Patient Safety Alerts/Notices overdue	R: 2 A:1 G: 0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Complaints ack'd within 5 working days	R: 80% A: 90% G: 98%	62%	87%	98%	100%	100%	100%	99%	95%	98%	99%	98%	100%	99%	89%	99%
Complaints responded to within 30 working days	R:<65% A: 65% G: 75%	62%	50%	88%	70%	40%	46%	65%	72%	73%	64%	52%	55%	68%	72%	89%
Duty of Candour letters issued within 5 working days	R: NO G: YES	NO	NO	YES	NO	YES	YES	NO	YES	YES	NO	YES	YES	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	0	0	0	2	0	0	0

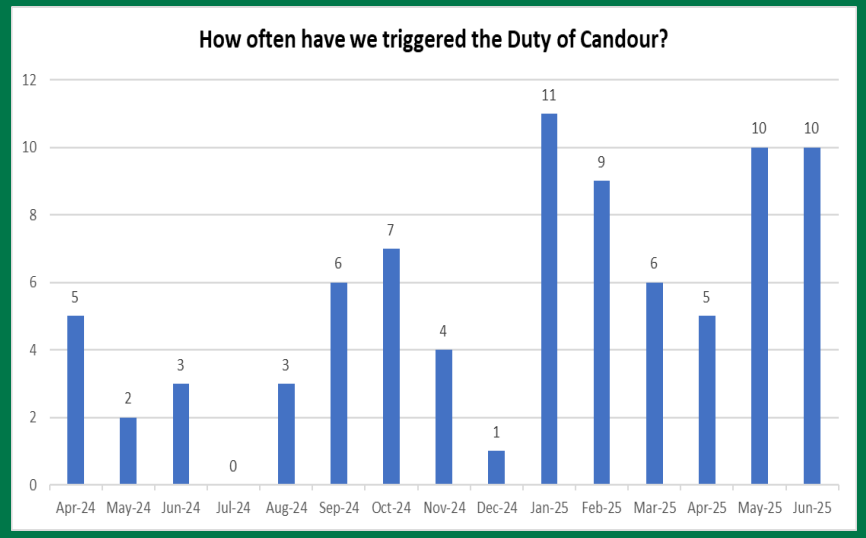
Assurance Profile – Incidents & Duty of Candour



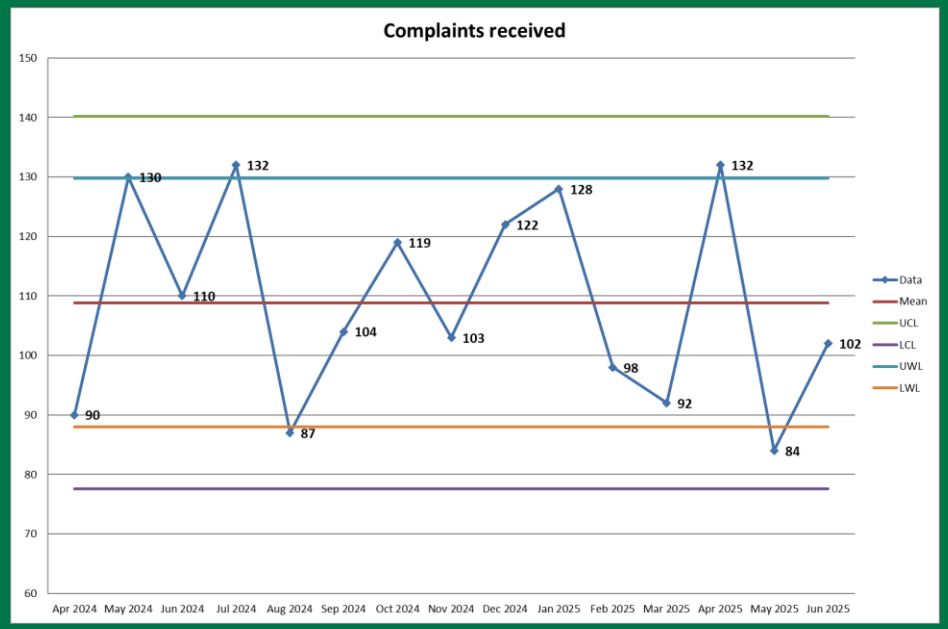


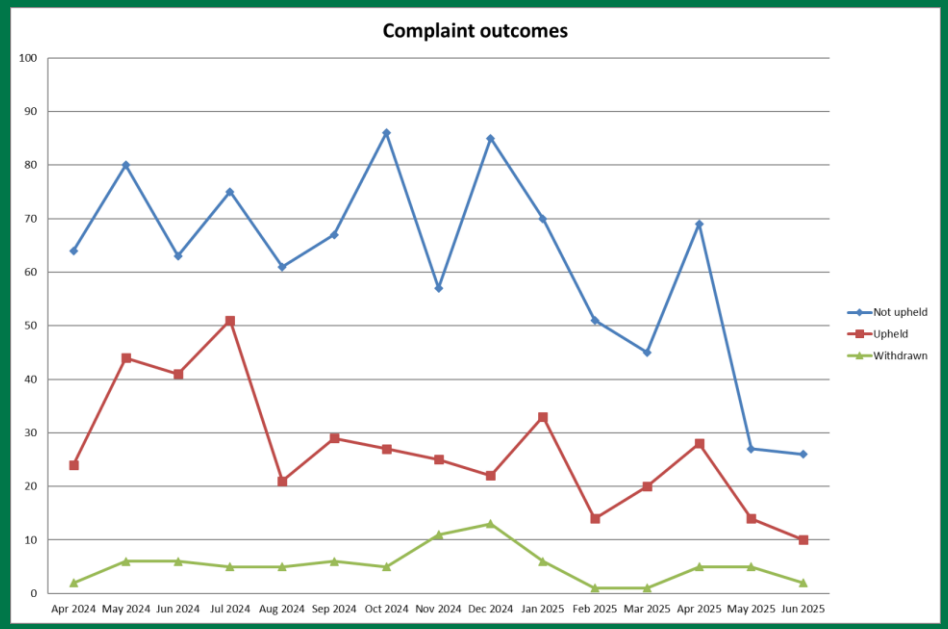


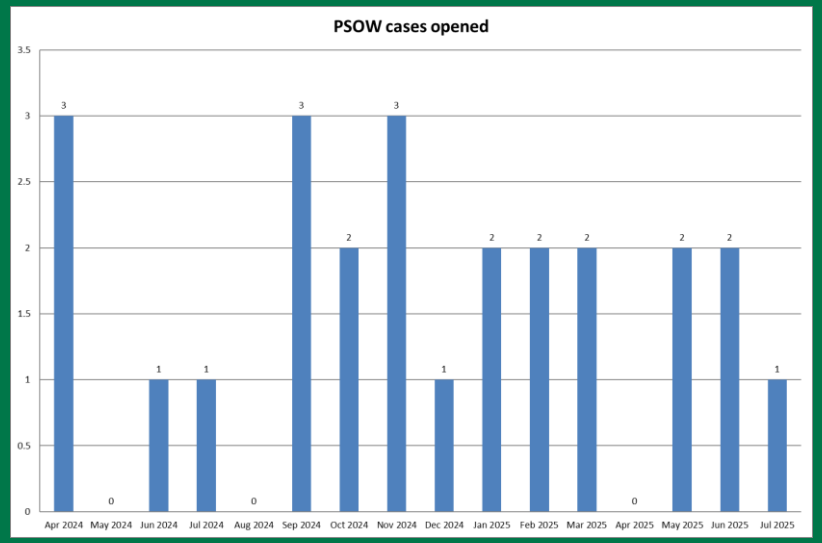


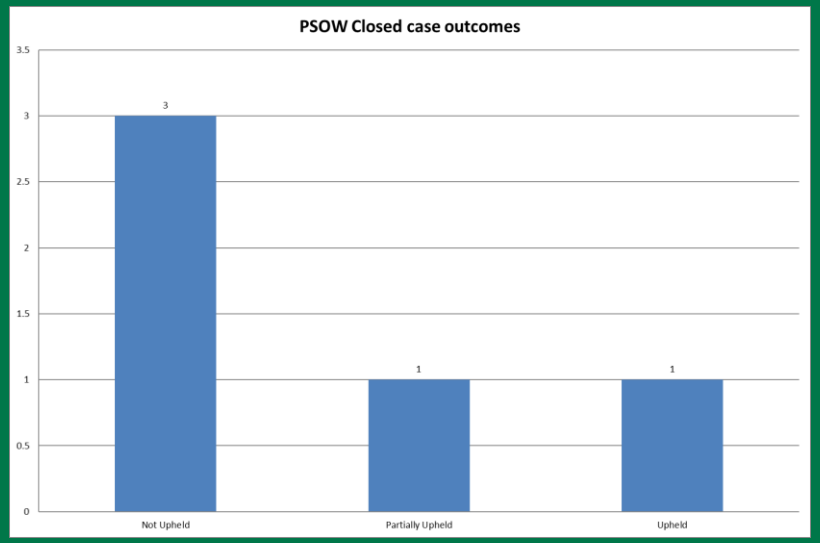


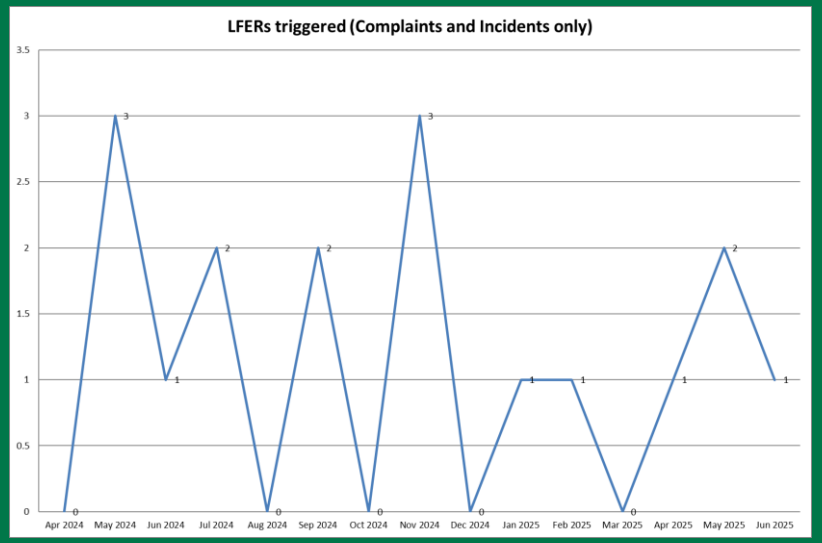
Assurance Profile – Complaints, PSOW and PTR outcomes







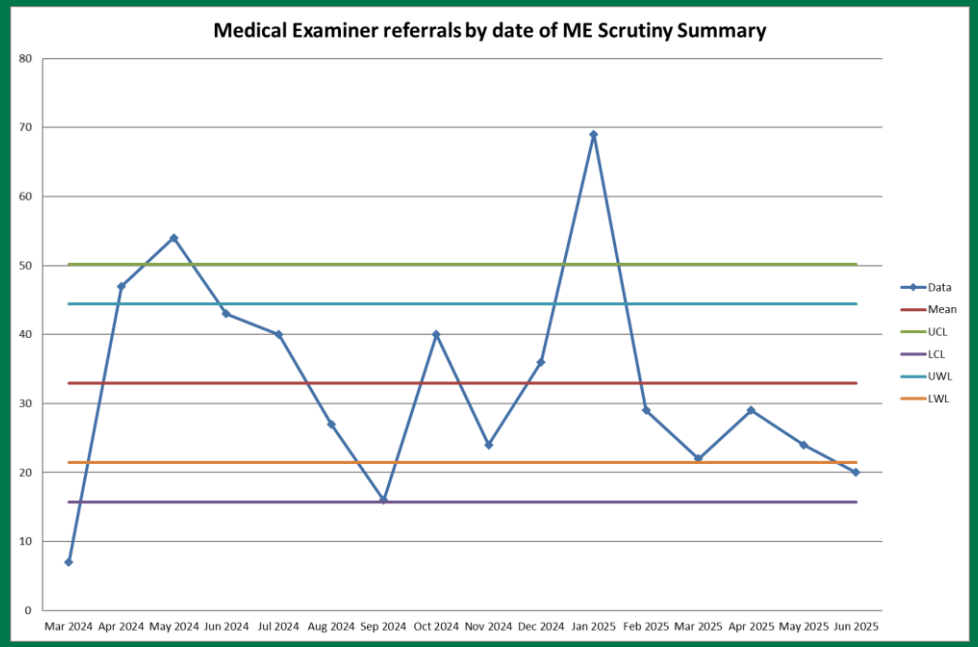


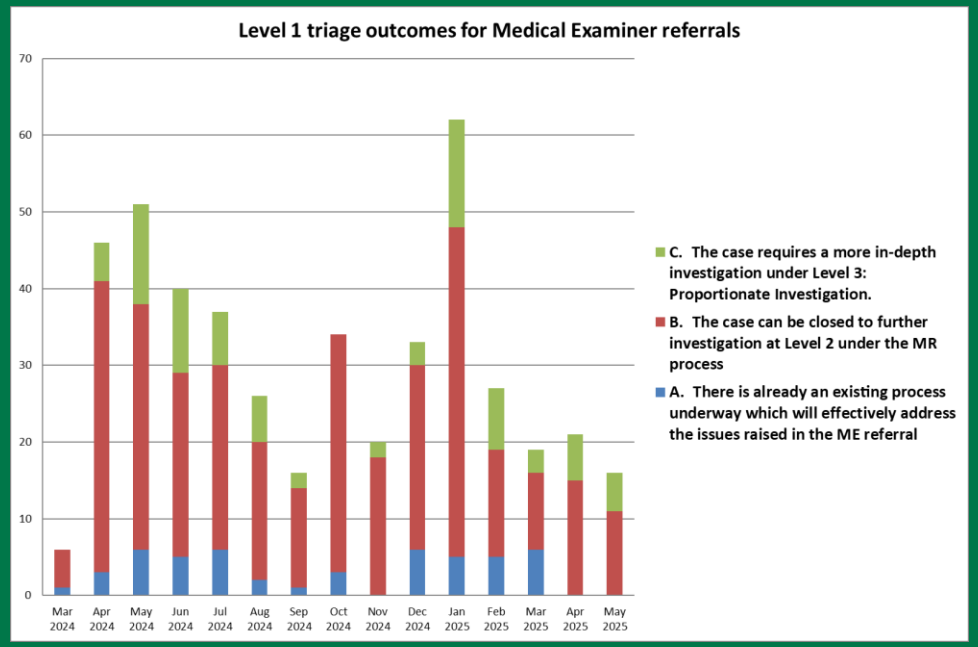


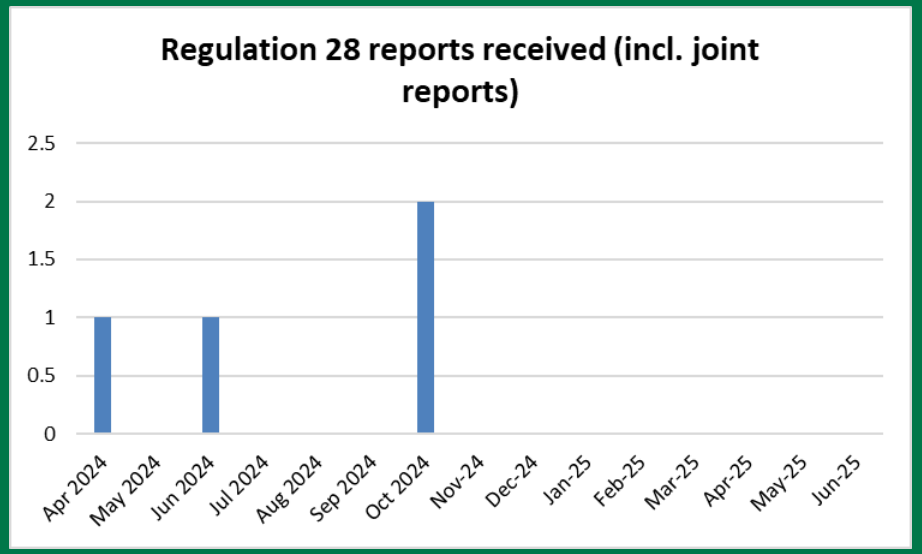
Assurance Profile –Legal Services

		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	June25
Claims opened	**Personal Injury (PI)**	2	0	1	1	2	0	3	1	2	4	2	2	5	1	3
	PI Road Traffic Accident	1	0	0	4	0	2	0	1	0	2	0	1	1	0	0
	Clinical Negligence	4	2	2	3	6	0	5	2	3	1	4	3	5	4	4
	Road Traffic Accident	19	23	19	14	30	14	26	16	14	23	11	19	21	17	28
	Damage to property	9	4	2	6	2	3	5	1	4	3	3	3	7	6	2
Claims closed	**Personal Injury (PI)**	0	0	0	0	0	2	0	6	8	9	2	0	--	30	9
	PI Road Traffic Accident	0	0	0	0	1	1	1	0	5	8	0	0	--	9	1
	Clinical Negligence	0	1	3	0	0	1	3	0	0	1	1	10	6	3	3
	Road Traffic Accident	17	13	13	18	29	43	30	27	9	12	27	11	--	39	58
	Damage to property	1	0	4	1	17	1	6	11	2	2	5	5	--	6	11
Claims open at the end of the month	**Personal Injury (PI)**	86	86	87	86	90	88	93	85	78	73	73	75	88	50	60
	PI Road Traffic Accident	64	64	64	68	67	68	67	56	51	45	45	46	46	37	44
	Clinical Negligence	171	172	172	175	181	180	182	184	186	186	189	178	174	176	177
	Road Traffic Accident	230	240	248	249	255	228	225	211	216	227	217	225	240	205	196
	Damage to property	30	34	33	37	22	24	23	13	14	15	18	16	19	13	10
		581	***596***	***604***	***615***	***615***	***588***	***590***	***549***	***545***	***546***	***542***	***540***	***567***	***486***	***487***

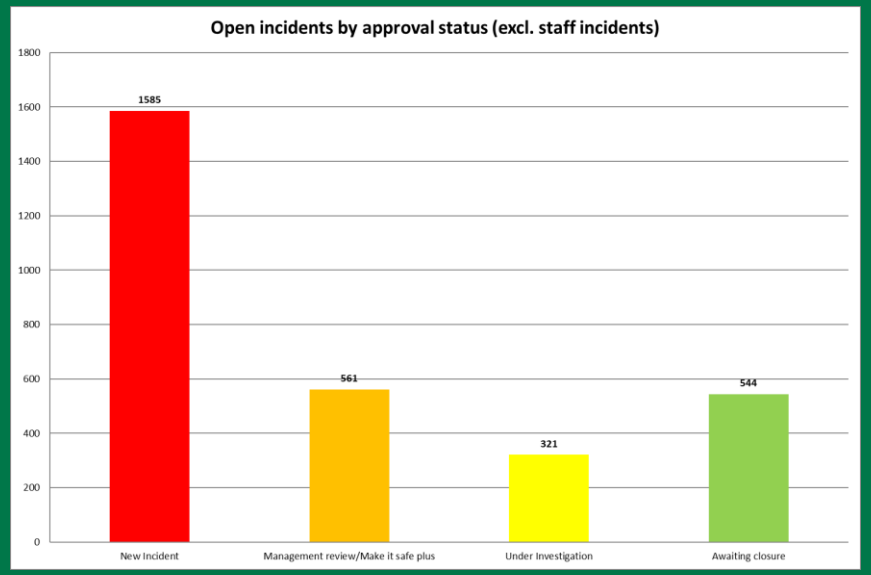
Assurance Profile – Mortality governance

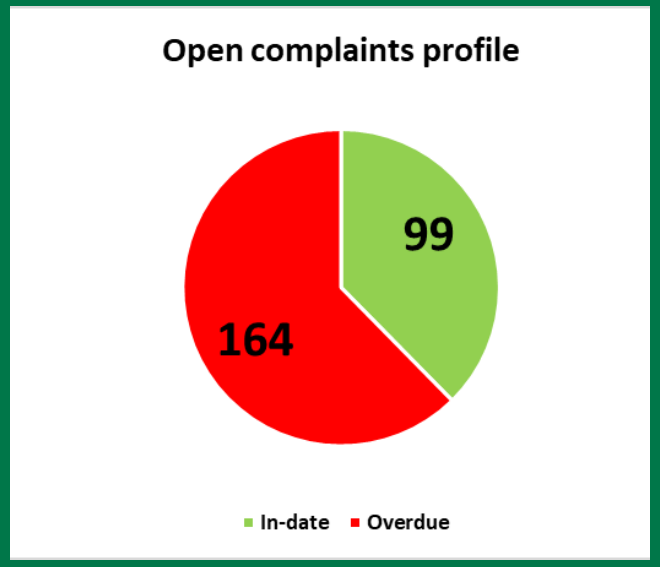


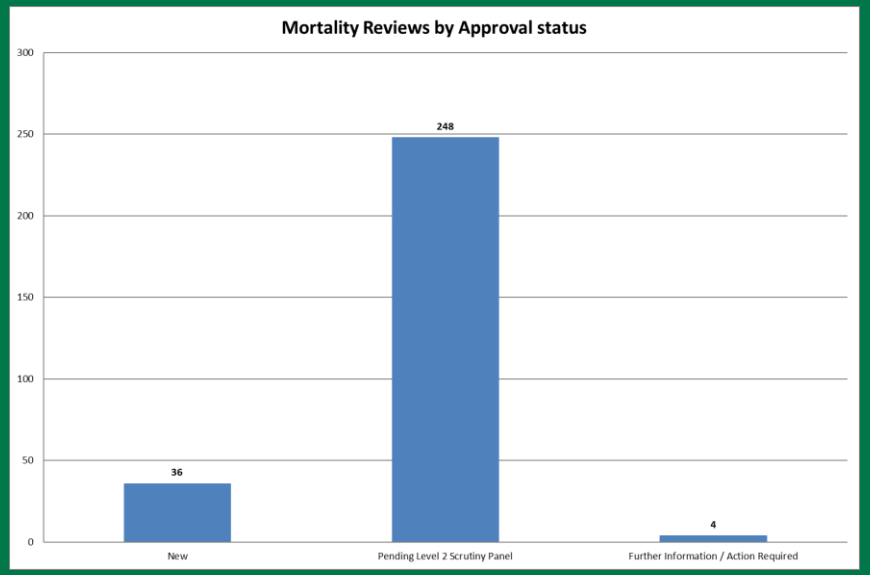


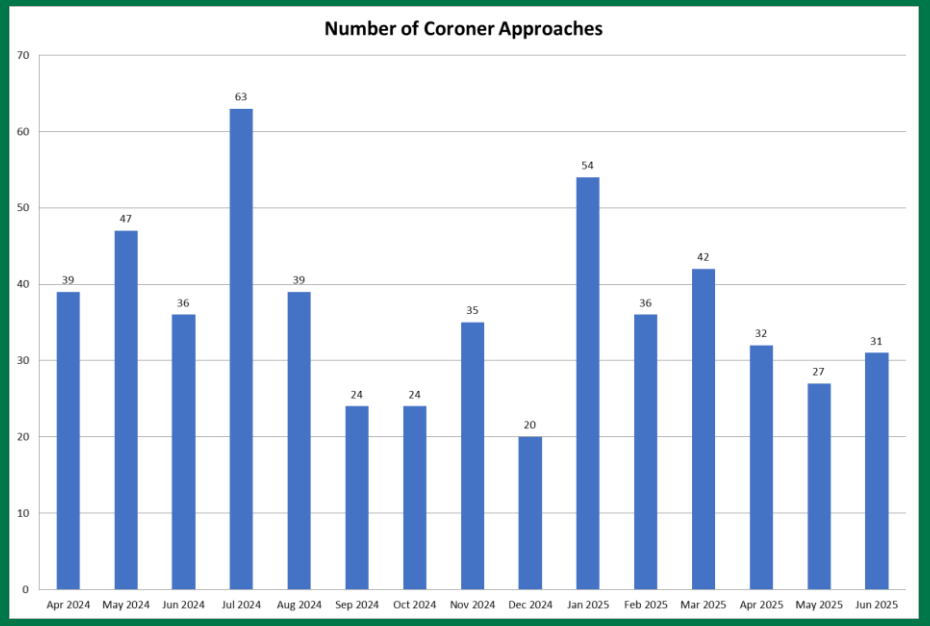


Performance Profile

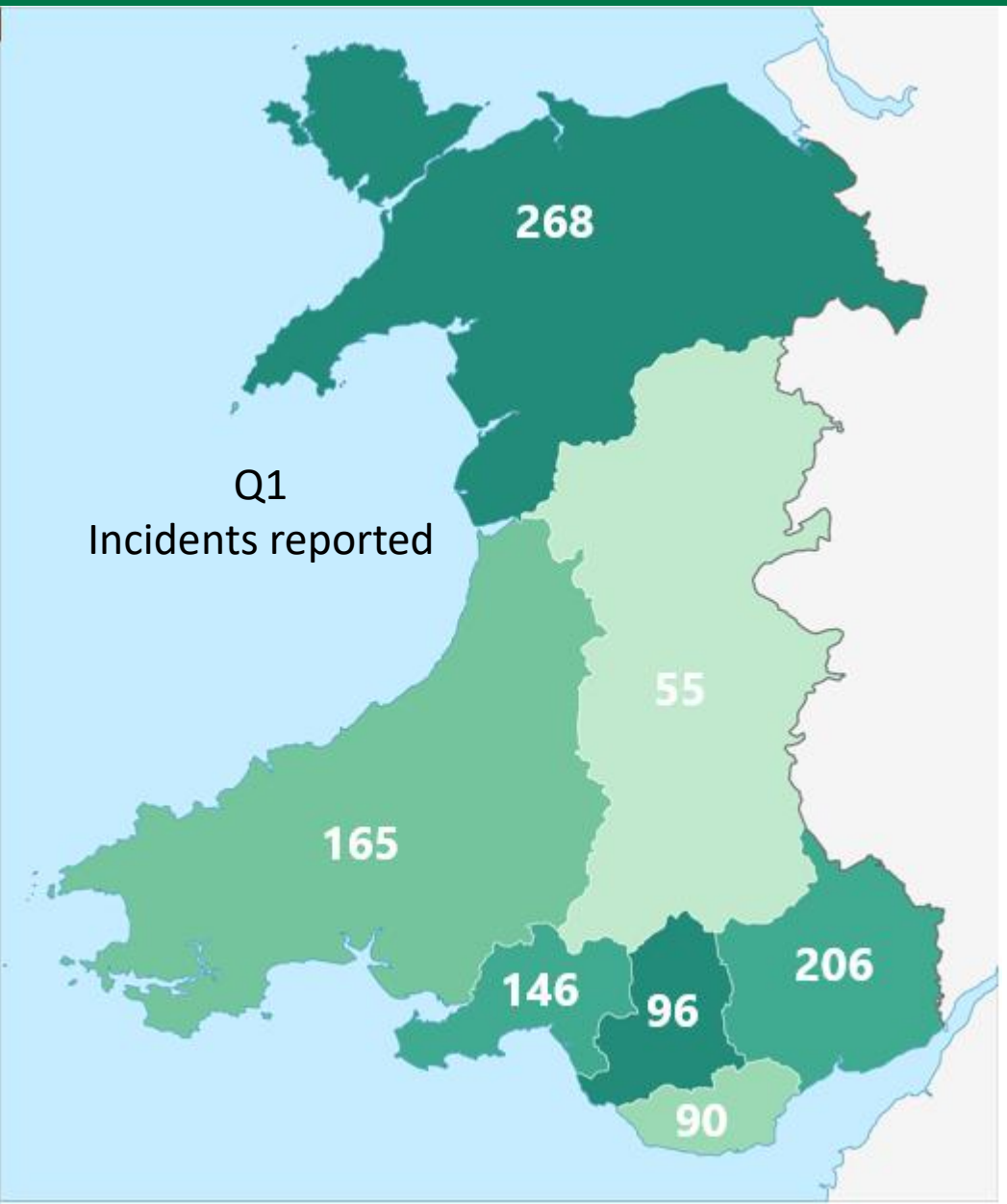








Thematic Learning - Incidents



Ambulance Care Service	**161**
999 Coordination Centre	**242**
Integrated Care	**265**
Emergency Medical Services	**415**

Thematic Learning -Incidents

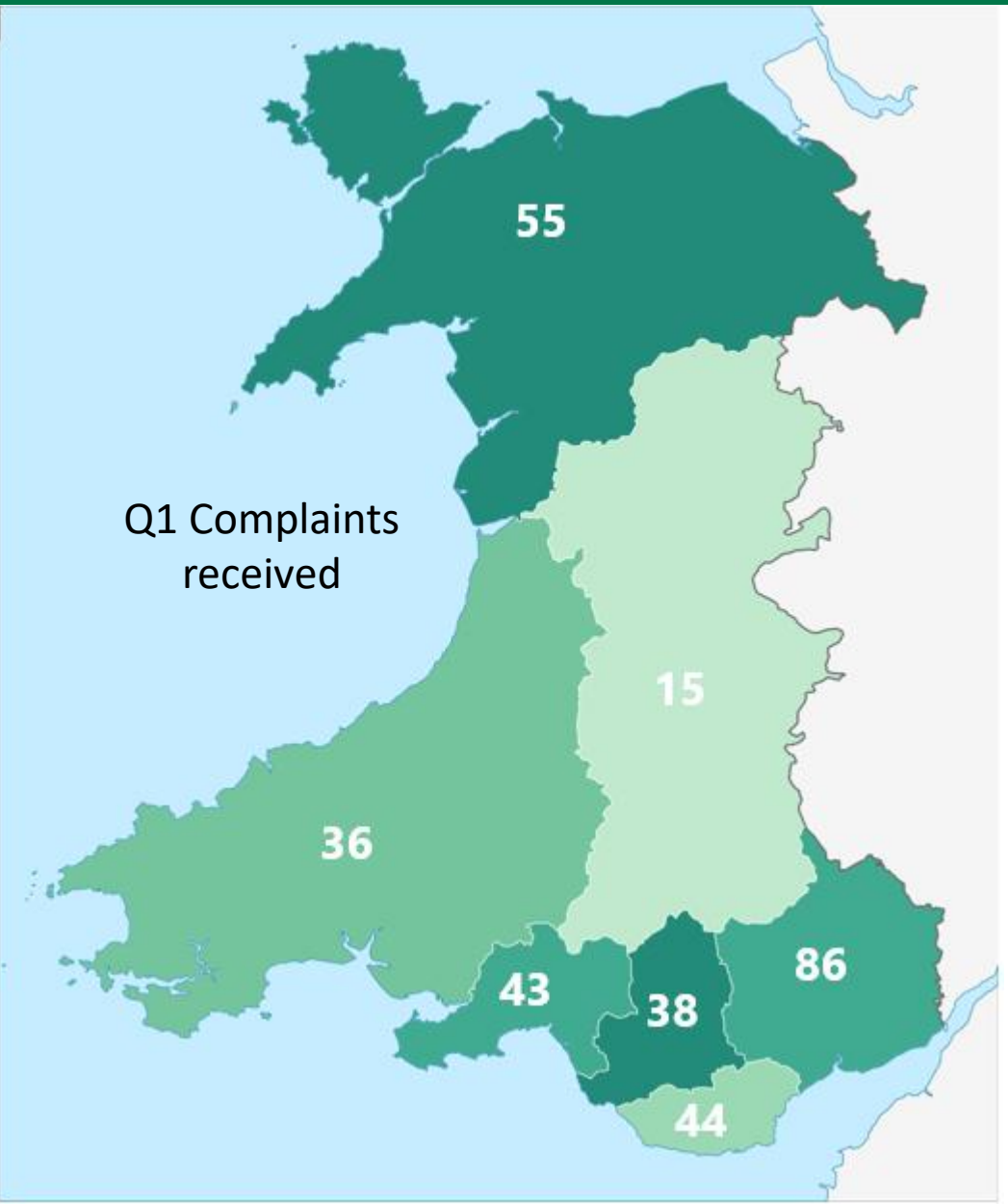
ACCESS & ADMISSION
Decreased number of incidents relating to delays

EQUIPMENT
Increase in equipment related incidents. No specific piece of equipment/supplier indicated. High reporting of vehicle and i-Pad damage but also of medical devices not being available or vehicles not sufficiently prepared.

ASSESSMENT, INVESTIGATION AND TREATMENT
High number of remote triage incidents identified through audits, coronial investigations, complaint investigations.

TREATMENT & PROCEDURE
Different thresholds and professional opinions relating to referral appropriateness / service access.

Thematic Learning -Complaints



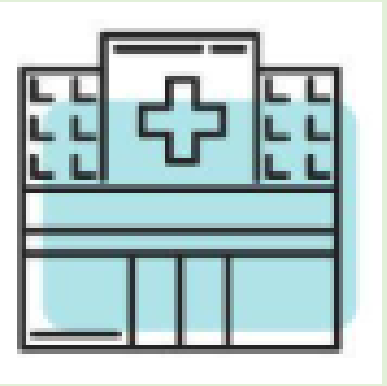
Ambulance Care Service	**162**
999 Coordination Centre	**74**
Integrated Care	**34**
Emergency Medical Services	**41**

Thematic Learning - Complaints

ACCESS TO SERVICES
Far fewer people this quarter complained about emergency ambulance delays or not being sent an ambulance

APPOINTMENTS
40% of our complaints related to people who had not been able to get to appointments and missed them as a result of short-notice cancellations of transport

ATTITUDE AND BEHAVIOUR
It is widely recognised that communicating with compassion and understanding when we reach people on scene is vital to how they feel about their experience, irrespective of the clinical care provided. Our complaints this quarter tell us we are not getting this right often enough.



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

AGENDA ITEM No	**10.2**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**2**

PUTTING THINGS RIGHT & LEGAL SERVICES PERFORMANCE: ORGANISATIONAL RECOVERY PLAN

MEETING	Quality, Patient Experience & Safety Committee (QuESt)
DATE	5 August 2025
EXECUTIVE	Liam Williams, Executive Director of Nursing & Quality
AUTHOR	Wendy Herbert, Deputy Director of Quality and Putting Things Right Claire Appleton, Assistant Director - Putting Things Right
CONTACT	Wendy.Herbert3@wales.nhs.uk Claire.appleton2@wales.nhs.uk

EXECUTIVE SUMMARY

The organisational performance of functions related to Putting Things Right (*Concerns Regulations*) and Legal Services is in a challenged position due to case volumes and increased complexity of patient management pathways through our services.

Following discussion of the emerging risk in this area at the last QuESt meeting, a refreshed Organisational Recovery Plan has been developed to provide assurance about future performance of this important portfolio of work.

The Organisational Recovery Plan details the background context and risks associated with reduced timeliness of performance. It then details areas of process, systems and workforce management changes that are already contributing towards increased efficacy as well as those with longer lead-in times where future benefit will be realised.

RECOMMENDED that the Quality, Patient Experience & Safety Committee note the information and assurance provided in the PTR and Legal Services Performance: Organisational Recovery Plan and advise on any additional assurance requirements

KEY ISSUES/IMPLICATIONS
• The Trust acknowledges the impact that delayed complaint, inquest and patient safety investigations are having on our patients and the public and affecting the pace at which we learn from adverse events. • Additionally there are financial and reputational risks for the Trust due to poor performance. • The Organisational Recovery Plan details measures that have already been taken to improve the current situation and encouraging signs of early improvement. However, some of the actions have longer-lead-in times and will take many months for benefits to be realised. • The current risk profile is therefore unlikely to change imminently, and timeliness-related performance is anticipated to improve gradually over the coming year.

REPORT APPROVAL ROUTE
Clinical Quality Governance Group

REPORT APPENDICES
ANNEX 1 - SBAR providing background information **ANNEX 2** - Putting Things Right & Legal Services Performance: Organisational Recovery Plan

REPORT CHECKLIST			
Confirm that the issues below have been considered and addressed		**Confirm that the issues below have been considered and addressed**	
EQIA (Inc. Welsh language)	NA	Financial Implications	Y
Environmental/Sustainability	NA	Legal Implications	Y
Estate	NA	Patient Safety/Safeguarding	Y
Ethical Matters	NA	Risks (Inc. Reputational)	Y
Health Improvement	NA	Socio Economic Duty	NA
Health and Safety	NA	TU Partner Consultation	NA

ANNEX 1

SITUATION

1. The organisational performance of functions related to Putting Things Right (Concerns Regulations) and Legal Services is reaching a position of unprecedented challenge due to open case volumes and increased complexity of patient management pathways through our services.

2. This is resulting in increased external concern being expressed by Coroners, political representatives on behalf of their constituents and compounding the distress and poor experience of complainants and those affected by patient safety incidents.

3. This position conflicts with the organisational ambitions of the PTR Recovery Plan and investment placed into QPSE during the previous year.

4. An Organisational Recovery Plan for PTR and Legal Services Performance has been developed collaboratively with key service areas, detailing the changes required to structures and staffing as well as improvements in systems and processes that will support the Trust to recover its performance position.

BACKGROUND

5. The investment into the Trust's PTR & Legal teams last year was anticipated to restore sufficient organisational capacity for effective and compassionate management of statutory and mandatory responsibilities within the PTR and Legal portfolio.

6. Effective corporate management of concerns and coroners caseloads has exposed capacity further gaps for undertaking concerns investigations and coronial work. Within QSPE the implementation of the new clinical models, the ongoing work to recruit senior clinicians and to complete an OCP has meant additional remote care investigation capacity has not yet been achieved. This in turn has impacted on the Clinical Directorate who have continued to provide significant support. Similarly, for Operations there has been significant change and this has further impacted on capacity to respond.

7. Of note, we have learned that the changes to our clinical model have also impacted significantly on the time to review, investigate and respond. The increased volume and complexity of work over the winter period has led to a position of unprecedented challenge for organisational PTR and Legal Services performance.

8. During the last QuESt Committee meeting, members requested a 'Recovery Plan' be developed to provide assurance of mitigating actions and information on when acceptable performance levels will be restored.

ASSESSMENT

9. ANNEX 2 *Putting Things Right & Legal Services Performance: Organisational Recovery Plan* provides full detail of the current challenges and the changes being implemented to address them. The improvements required fall broadly into the following areas: Structures and staffing, Systems and Processes.

10. Consideration is also given to areas of specific challenge such as Ambulance Care Service complaint management and Clinical Directorate capacity to support learning from mortality.

11. It has not been possible to include detailed improvement trajectories owing to several as-yet unrealised actions for which the benefit realisation is difficult to forecast. Potential risks to achievement are included which, if materialised, would also influence improvement delivery timescales.

12. Staff well-being is being adversely affected by the ongoing inability to meet demand in this important area of patient and public service. Organisational values are being used as guiding principles for interacting with colleagues under acute pressure and dedicated actions are being progressed to offer well-being support and enhance staff job satisfaction.

RECOMMENDATION

That the Quality, Patient Experience & Safety Committee:

NOTE the information and assurance provided in the Putting Things Right and Legal Services Performance: Organisational Recovery Plan

ADVISE on any additional assurance requirements

Putting Things Right & Legal Services Performance:

Organisational Recovery Plan

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

July 2025 v0.4

PTR & Legal Services Performance Organisational Recovery Plan

Performance challenges and risk

Current position	Unprecedented challenge due to case volumes and increased complexity of patient management pathways through our services. As of 12/07/25 2025 there are: 164 Open overdue complaints 34 Overdue NRIs 5 Schedule 5 notices received in Q1 2025
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.

PTR & Legal Services Performance
Organisational Recovery Plan

Contributory factors

Complexity	Increased service diversification: PTAS, APP,s 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 havent 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.

PTR & Legal Services Performance Organisational Recovery Plan

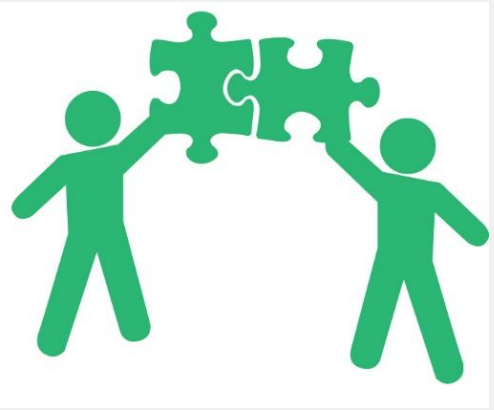
Assurance from PTR & Legal Services investment

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.	✓
Data recording and data quality has improved allowing foundational work towards automated PTR & Legal services reporting is being undertaken in conjunction with other QPSE and IDS colleagues. This will facilitate performance monitoring and thematic analysis in the long-term.	✓

Structures and staffing to support recovery

Investment	Investment in 16.74 FTEs worth of audit capacity has been agreed for Integrated Care. This additional capacity is intended to enable attainment of AACE accreditation for ECNS. The Trust's external accreditation through AACE for ECNS and MPDS will be temporarily deprioritised to provide sufficient audit capacity to respond to complaints, incident investigation and coronial matters. Funding for the new posts is due to be released from Q2 onwards and will require time for recruitment, onboarding and training before benefits begin to be seen. In the meantime, a 0.4FTE B6 is being funded at financial risk to support recovery. Through an OCP, the organisation will realign Integrated Care funding to the Operations Quality team in EMS. Whilst this does not provide additional capacity, it provides opportunities to review roles, responsibilities and efficiencies as detailed below.
Structure review and increased collaboration	Centralising Integrated Care concerns and audit management into Operations Quality will provide a single line of leadership and communication. A workflow review will be undertaken to identify inefficiencies that hinder productivity. The OCP will enable standardisation of responsibilities and ensure the structure provides sufficient capacity at all levels to eliminate bottlenecks with, for example, quality assurance of reports. The contributions of EMS and Integrated Care managerial staff to inquest preparation and attendance are being encouraged to build capacity and resilience in meeting coronial requirements. This provides succession planning opportunities, as well as ensuring an appropriate level of connectedness and ownership between service managers and coronial activity. Remote Integrated Care clinicians in the QPSE Directorate will also begin offering investigative capacity aligned to areas of clinical expertise and experience.



Systems & processes to support recovery

Proportionate, collaborative approaches

Teams of staff from QPSE, Integrated Care and EMSC have been working closely to increase efficiencies and introduce proportionate expert review in place of formalised audit where appropriate.

This includes processes to enhance prioritisation of resources towards areas of risk and learning such as a call management Rapid Incident Review (RIR) process. A similar approach is taken at the Remote Clinical Meeting towards Complaints Management and Inquest Management.

These initiatives have reduced MPDS audit requests significantly which is demonstrated in the outstanding audit requests graph on the next page. Additionally, 23 historical audit requests for SCIF have been cancelled following review at RIR. 10 audit requests were made for SCIF in May 2025 which is down from 81 requests in January 2025. The backlog of special audit requests has reduced from over 400 around March 2025 to 180 (as of 17 June 2025).

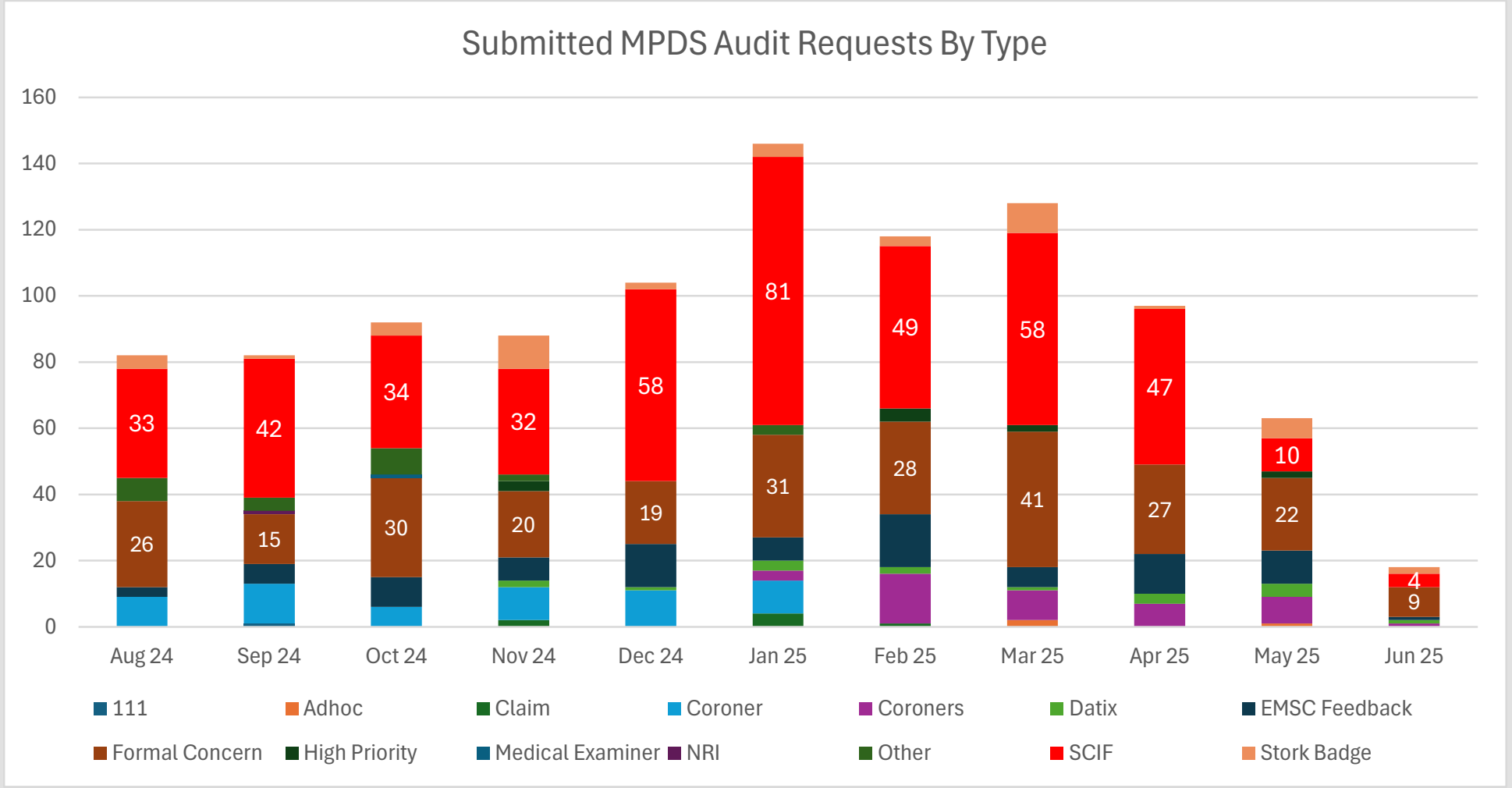
Proportionate approaches are aligned to England's existing Patient Safety Strategy and are the direction of travel for Welsh policy too. They enable staff to agree individualised methodologies from a suite of review and learning approaches dependent on the outcome, risk and potential for learning in each case.

Future opportunities to enhance confidence in applying proportionate approaches include strengthening the approach towards complaint gradings and inquest RAG ratings; both systems are intended to support organisations in deciding the depth of investigation required.

Current investigations take place using documentation across two CAD systems. As 999 and 111 are increasingly aligned, opportunities for providing services from a single CAD system are being explored. This offers operational benefits but also efficiency benefits to PTR and coronial investigations.

Systems & processes to support recovery - EMSC

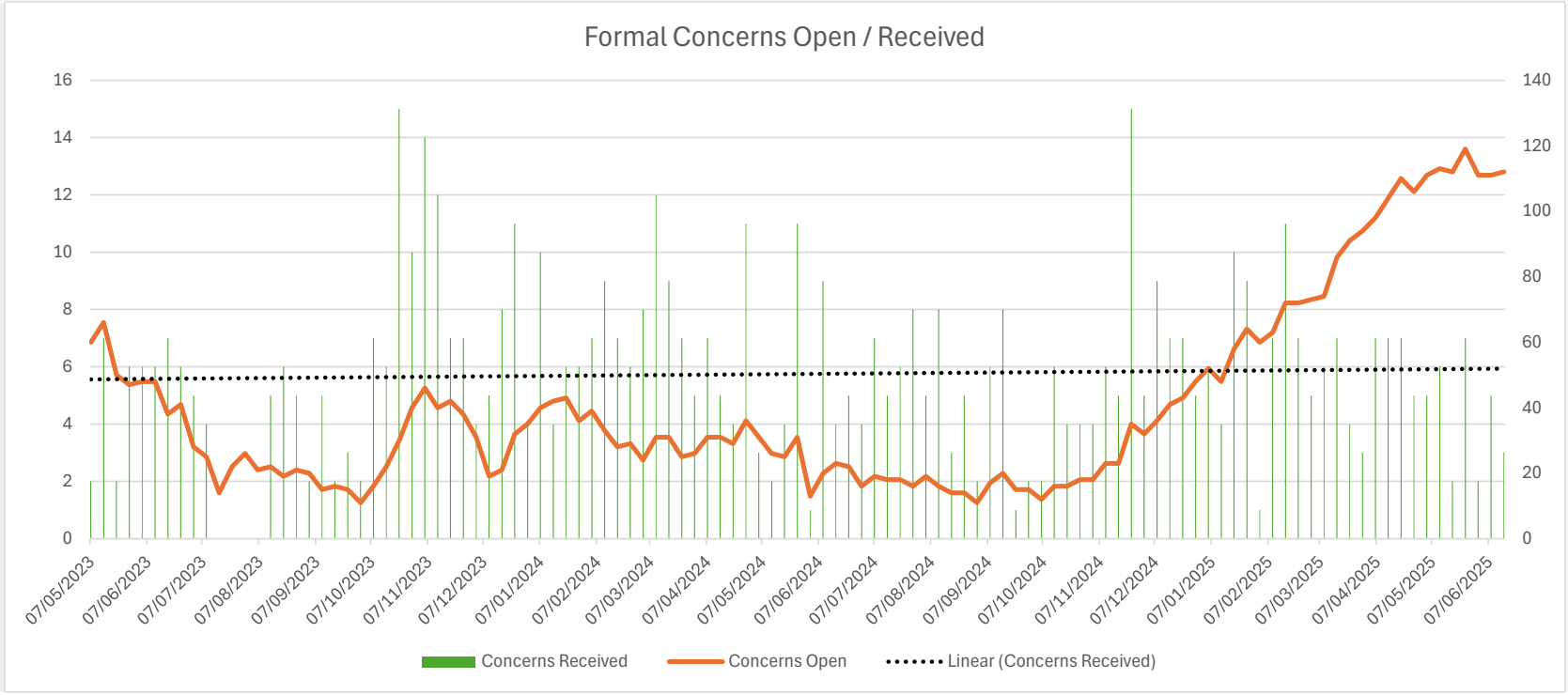
Proportionate, collaborative approaches



Improvement trajectory: Complaints - EMSC

Current position

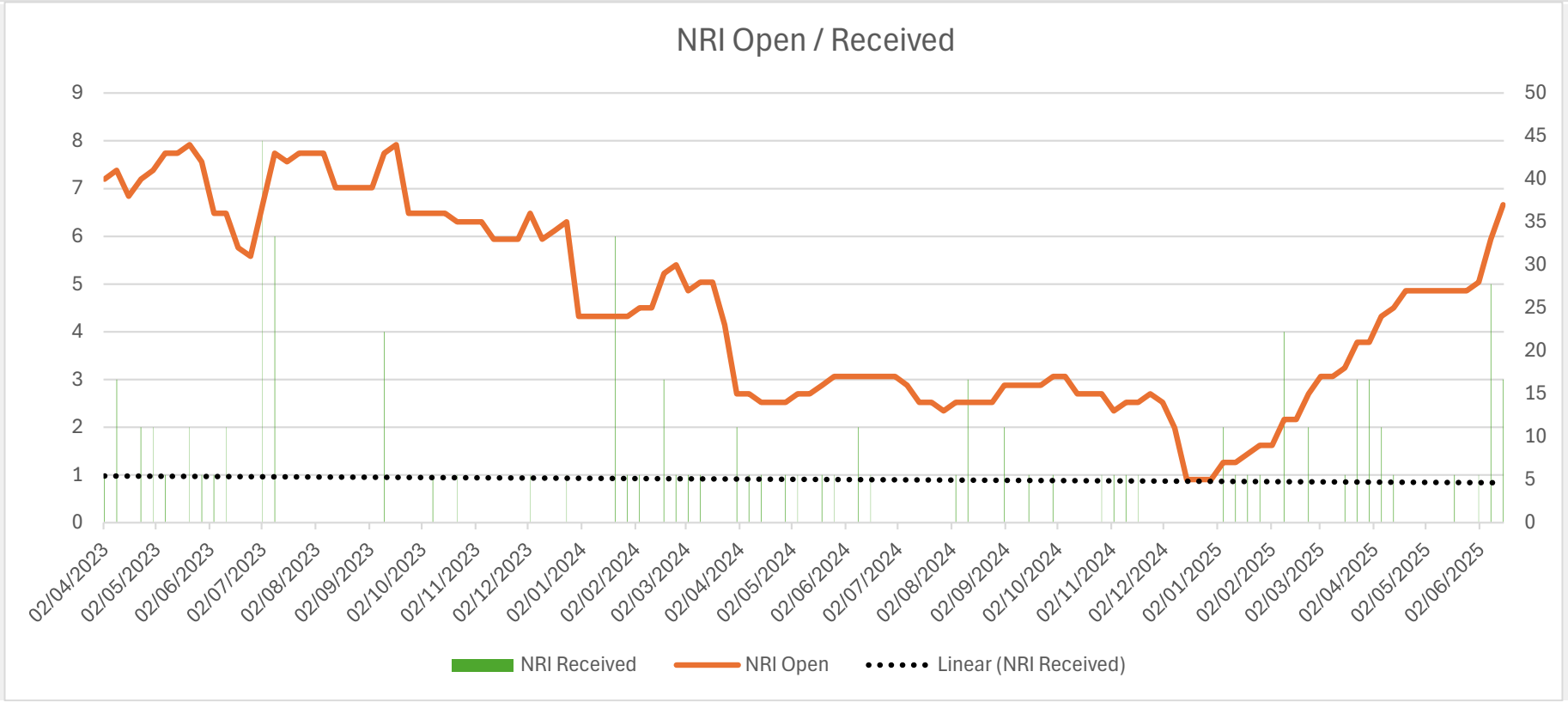
- Complaints being received by the Operations Quality department have remained relatively consistent since 2023, and the demand was being met following the investment as part of the PTR OCP in 2024. The reduction in completed investigations is a result of factors including delayed CSD input where required and MPDS audits rather than factors within the scope of the investigation team. It is important to note that investigations are becoming more complex with increasing clinical and other service area touch points resulting from CMT of which it is difficult to currently quantify.
- With the Operations Quality OCP aiming to introduce complaints and investigation capacity into the department, the focus will be on process mapping and refining processes and proportionate investigations to improve efficiencies and working practices. The department has previously addressed a significant backlog toward the end of 2023. Small improvements are already being made and partly rely on the delivery of the OCP which is anticipated around Q3-Q4.



PTR & Legal Services Performance
Organisational Recovery Plan

Improvement trajectory: Nationally Reportable Incidents - EMSC

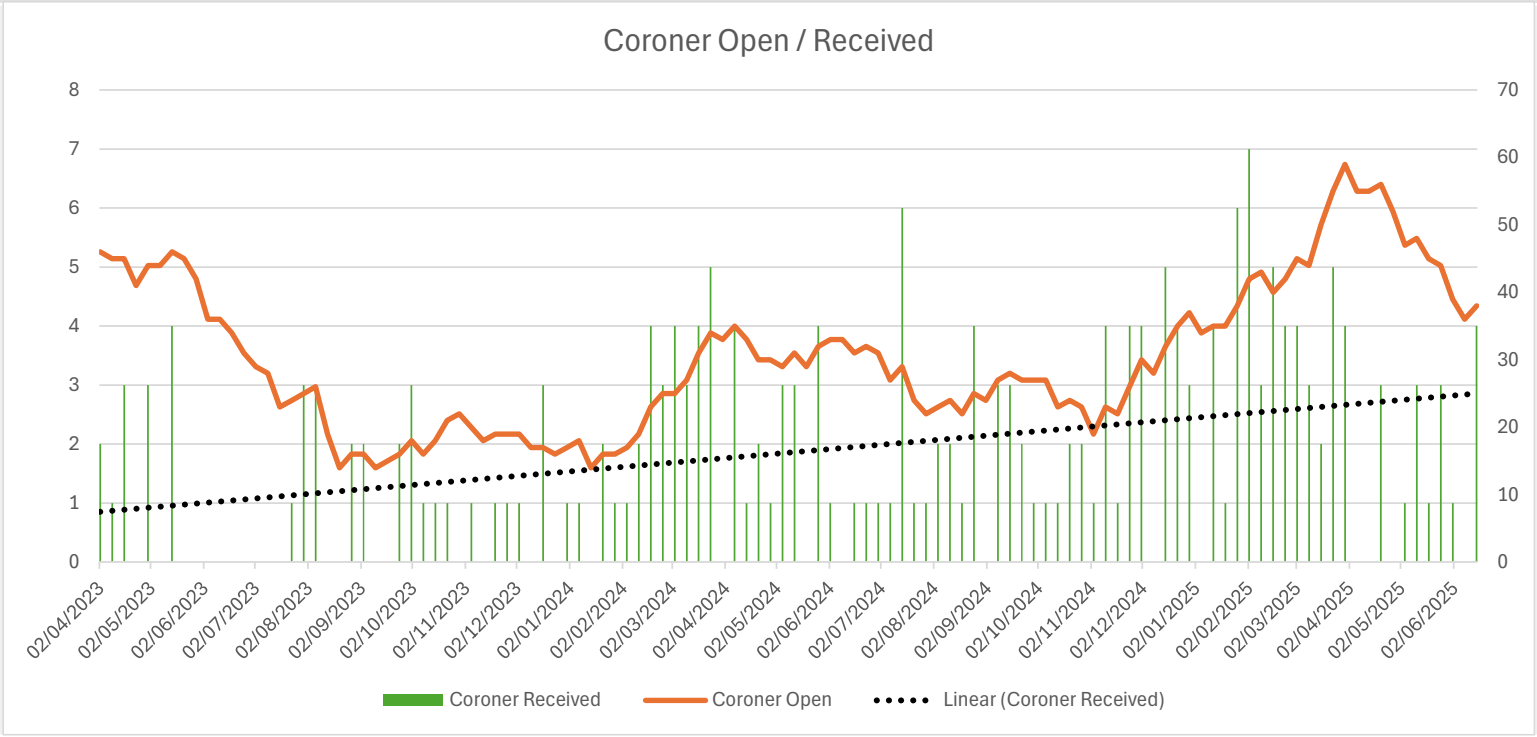
Current position	• NRIs being received by the Operations Quality department have remained relatively consistent since 2023, and the demand was being met following the investment as part of the PTR OCP in 2024. The reduction in completed NRI investigations is a result of factors including delayed CSD input where required and MPDS audits rather than factors within the scope of the investigation team. • Similarly to complaints, the focus will be on process mapping and refining processes and proportionate investigations to improve efficiencies and working practices and the delivery of the Operations Quality OCP Q3-Q4.



PTR & Legal Services Performance Organisational Recovery Plan

Improvement trajectory: Coronial Inquests - EMSC

Current position	• The volume of coroner requests has increased since 2023. Whilst there is a backlog, this has fluctuated for the past few years and is dependent upon some external factors such as capacity of EMS Coordination senior managers for appropriate sign-off. Investigations, like complaints, require external input from Integrated Care teams which the Operations Quality OCP should improve. • There has been an improvement in the position since April 2025, and it is anticipated that this trajectory will continue dependent on senior manager availability (there is currently some absence in the senior team within EMS Coordination). Prioritisation is dynamic based on coroner communications and schedule 5s, and the Legal Services and Operations Quality teams work collaboratively in this approach.



Ambulance Care Service: Complaint Reduction Plan

Current position is stable in terms of overall backlog, despite new concerns arriving. However, there is a focus on reducing, and closing older concerns.

Actions being taken to address:

QSPE colleagues attend Ambulance Care Monthly meeting to share the current position and identify hot spots. These are scrutinised at ADO/HoS level and actions agreed as required.

Power BI dashboard in development to support awareness/reporting.

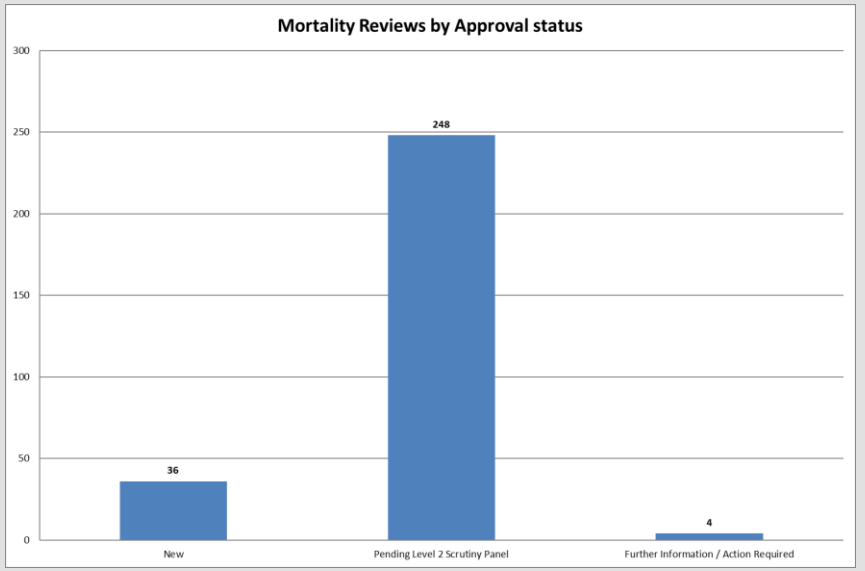
Each regional service area is required to submit a fortnightly update to their Head of Service setting out their current position and delivery plans to improve. This is discussed at 1:1 meetings.

Have assigned a dedicated person to progress chase a reduction in overall levels of delayed responses.

Developing a more proactive approach to preventing CMP cancellations, which form most of our concerns. This should minimise concerns raised and improve patient experience. Anticipated go-live is August 25.

PTR & Legal Services Performance
Organisational Recovery Plan

Learning from Mortality



- Organisational engagement in the Learning from Deaths agenda is pivotal to realising organisational IMTP ambitions for triangulated intelligence on mortality, clinical practice and population health.
- Clinical Directorate capacity to engage in Learning from Death meetings and in reviewing Medical Examiner referrals has been limited and achieving quoracy remains challenging.
- Increased attendance levels from a more diverse range of clinical staff will enable more thorough assurance to be provided and risks to be recognised in a timely way.
- Robotic Process Automation may offer efficiency opportunities around the administrative burden associated with the Medical Examiner process. Additional recruitment into IDS will allow exploration of possible advances in this area to commence in Q3.

PTR & Legal Services Performance
Organisational Recovery Plan

Workforce well-being

- Effective internal working relationships have been maintained despite the pressures on all teams involved. Increased collaboration across Directorates has led to enhanced job satisfaction and revealed opportunities for joint training and professional development.
- A bespoke well-being offer for PTR & Legal Services staff is being curated by the WAST Well-being team in response to staff survey results and feedback.
- Feedback from PTR administrators and Communications staff is being used to develop the Trust's public-facing contact offer. This will allow PTR staff to focus on supporting complainants and bereaved families.

Barriers & dependencies

- Achievement of the trajectories is dependent on external factors such as PTR and Legal case volumes received and coronial timescales.
- The lack of automated and accessible business intelligence related to these areas makes monitoring and performance management difficult, particularly at a granular level that would expose bottlenecks and obstacles to success. The time consuming nature of extracting data and calculating performance metrics mean progress or slippage is being reported anecdotally by teams involved rather than evidentially through robust and regular data. This shadows the issues to a degree from Executive and managerial scrutiny and support.
- Organisational pressures from CSP levels or increased REAP level would both increase the volume of work and reduce staffing available to manage them by redeployment to operational priorities.
- The commitment to further changes with the implementation of the new Ambulance Performance Framework and Phase 2 due after this means organisational capacity to continue absorbing changes, prioritise PTR & Legal work and devote time and energy to resolving the position whilst focused on the CMT Programme is limited.

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

AGENDA ITEM No	**11**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**1**

SAFEGUARDING ANNUAL REPORT 2024-2025

MEETING	Quality, Patient Experience & Safety Committee
DATE	5 August 2025
EXECUTIVE	Liam Williams, Executive Director of Quality and Nursing
AUTHOR	Vicky Maxwell, Assistant Director of Safeguarding
CONTACT	vicky.maxwell@wales.nhs.uk

EXECUTIVE SUMMARY

1. The Safeguarding Annual Report provides assurances to the Trust Board that statutory safeguarding duties have been met. It highlights the significant increase in safeguarding activity within the organisation, recognises safeguarding development and shares good practices.
2. The Executive Director of Quality and Nursing is the Executive Lead for safeguarding, while the Assistant Director of Safeguarding ensures compliance with statutory legislation and guidance
3. The report emphasises the importance of a strong safeguarding culture within the Welsh Ambulance Services University NHS Trust (WAST), which is driven by values and behaviours that foster professional curiosity, encourage scrutiny, and support actions to protect those at risk.
4. The Safeguarding Team collaborates with WAST colleagues and external partners to ensure effective and robust safeguarding practices.
5. The report details the increase in safeguarding reports submitted to Local Authorities, with neglect being the most common form of abuse identified.
6. It also highlights the launch of the 'Ask and Act' training under the National Training Framework, which enables practitioners to identify and support victims of domestic abuse and sexual violence.
7. The Safeguarding Team's pathway facilitates contact with the Live Fear Free helpline, providing support to victims of domestic abuse and sexual violence. The team also works with the Fire Risk Referral Pathway to support vulnerable individuals within the community.
8. The report highlights the Senior Team's involvement in the management of safeguarding allegations against WAST colleagues, and the establishment of a bespoke allegations safeguarding mailbox to support centralised communication and maintain confidentiality.
9. Training and education are key components of the safeguarding strategy, with various Continuous Professional Development (CPD) sessions and mandatory

training achieving high compliance rates. These safeguarding learning opportunities are shaped from themes and trends identified both as a single agency and across the wider safeguarding community in Wales, and support WAST colleagues to have a good understanding of key safeguarding topics.

10. The report concludes by emphasising the team's commitment to promoting excellence in safeguarding interactions, meeting statutory responsibilities, and protecting the people served by WAST.
11. The Safeguarding Team looks forward to driving the safeguarding agenda in alignment with WAST priorities across the coming year.

RECOMMENDED that the Quality, Patient Experience & Safety Committee:

(1) Approves the Safeguarding Annual Report 2024/2025, and
(2) Note and considers the sustained increase in demand and the cumulative impact on the Safeguarding Team

KEY ISSUES/IMPLICATIONS
(i) The Safeguarding Annual Report (**Annex 1**) provides evidence on how the Trust has performed during the 2024-2025 period in relation to safeguarding people in our care. It aims to give the Trust Board information on WAST safeguarding activities, engagement and collaborative working with our partner agencies; as well as the necessary assurances that the statutory duties under the relevant safeguarding legislation and guidance are being fulfilled.

REPORT APPROVAL ROUTE	
Clinical & Quality Governance Group	24 July 2025
Quality, Patient Experience & Safety Committee	5 August 2025

REPORT APPENDICES
ANNEX 1 - Safeguarding Annual Report 2024/2025

REPORT CHECKLIST			
Confirm that the issues below have been considered and addressed		**Confirm that the issues below have been considered and addressed**	
EQIA (Inc. Welsh language)	N/A	Financial Implications	N/A
Environmental/Sustainability	N/A	Legal Implications	YES
Estate	N/A	Patient Safety/Safeguarding	YES
Ethical Matters	N/A	Risks (Inc. Reputational)	N/A
Health Improvement	N/A	Socio Economic Duty	N/A
Health and Safety	N/A	TU Partner Consultation	N/A

Welsh Ambulance Services University NHS Trust

Safeguarding Annual Report 2024-2025

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

Amb_wastsafeguarding@wales.nhs.uk

01792 315884

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University NHS Trust

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01792 315884

Introduction

The safeguarding annual report provides the Trust Board with the necessary assurances that the statutory duties have been met in accordance with legislation.

Priority is given within the report to evidence the significant increase in safeguarding activity within the organisation; to celebrate the success and achievements of the dedicated Safeguarding Team, as well as sharing the good practice of WAST colleagues, our improved safeguarding systems and processes, and how we have learned from our experiences.

The Executive Director of Quality and Nursing is the executive lead for safeguarding within WAST. The Assistant Director of Safeguarding has responsibility as Named Professional for Safeguarding Children as well as Adults at Risk. This role ensures the Trust's compliance with statutory legislation and guidance above.

The Assistant Director of Safeguarding takes the organisational strategic lead on all safeguarding-related issues. This includes working with the Regional Safeguarding Boards on topics of regional and national importance. This engagement supports the objectives of Welsh Government, Public Health Wales, the Community Safety Partnerships, the Older People's Commissioner, and the Children's Commissioner for Wales. Whilst Local Authorities hold an overarching Corporate Parenting role to safeguard and promote the rights and life chances of care-experienced children and young people, WAST is dedicated to ensuring this role effectively safeguards all who have contact with our service.

WAST success in safeguarding continues to be driven by an effective organisational culture; one with values and behaviours that foster professional curiosity, encourage scrutiny, and support the actions required to protect those at risk of abuse or in need of care and support.

The Safeguarding Team collaborates with all WAST colleagues to foster a safeguarding culture, at each level in the organisation. External partnership working is also integral to the team's role; WAST's contribution to the work of our partner agencies will be highlighted in this report.

VISION

To create a safe and supportive environment where every individual in our care is protected from harm and empowered to thrive. We are committed to fostering a culture of vigilance, compassion, and continuous improvement in safeguarding practices.

1. Reporting Safeguarding Concerns

Safeguarding Team's priority is to ensure that WAST colleagues provide safe and effective care which protects people at risk of abuse and neglect as well as those in need of care and support.

WAST compliance with the requirements from the Children Act 2004, Social Services and Well-being (Wales) Act (SSWA) 2014, Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 (VAWDASV), as well as the Health and Care Quality Standards – Safe, is demonstrated by this activity.

Reporting Numbers

Table 1
Annual Safeguarding Report Numbers Since 2021/22

Report Type	2022/23	2023/24	2024/25
Child at Risk	1,303	1,698	1,856
Child in need of care and support	853	929	1,029
Adult at Risk	1,106	2,210	2,440
Adult in need of care and support	3,785	6,287	7,005
Total	**7,047**	**11,124**	**12,330**

2024/25 evidences a continued increase in the annual safeguarding reports submitted to Local Authorities.

Increased number may be attributed to the growing inequalities in Wales noted by Public Health Wales, heightened awareness of safeguarding concerns among WAST colleagues and the digitalisation of the reporting process.

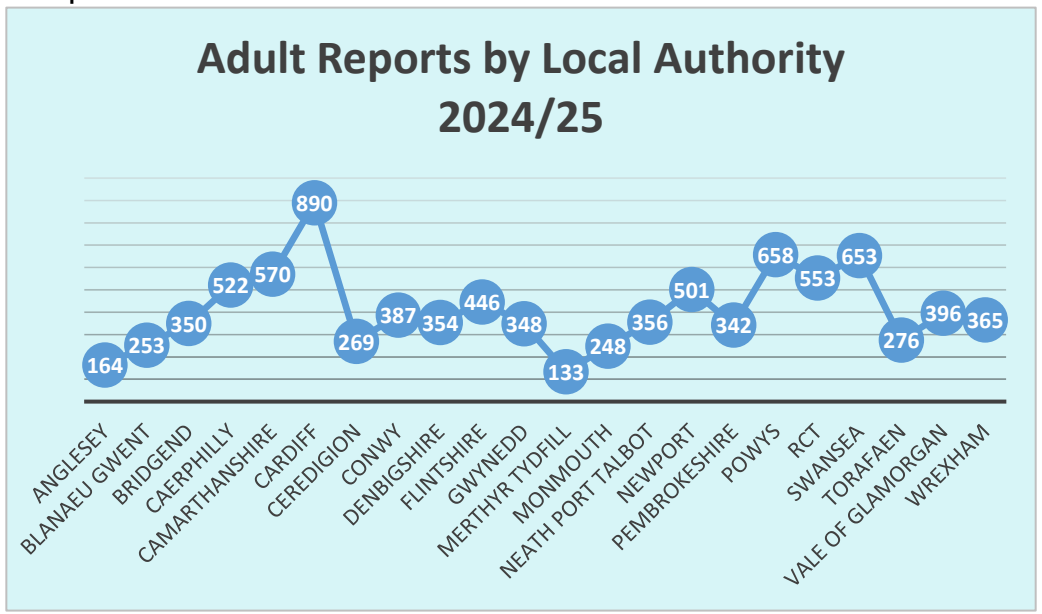
NEGLECT was the most common form of abuse identified in child & adult at risk reports in 2024/25.

In addition to the reports made to Local Authorities within Wales; WAST colleagues also reported **70** concerns for children, an increase of **42** from the previous year, and **137** for adults to the other relevant Local Authorities in the UK (**115** increase from 2023/24).

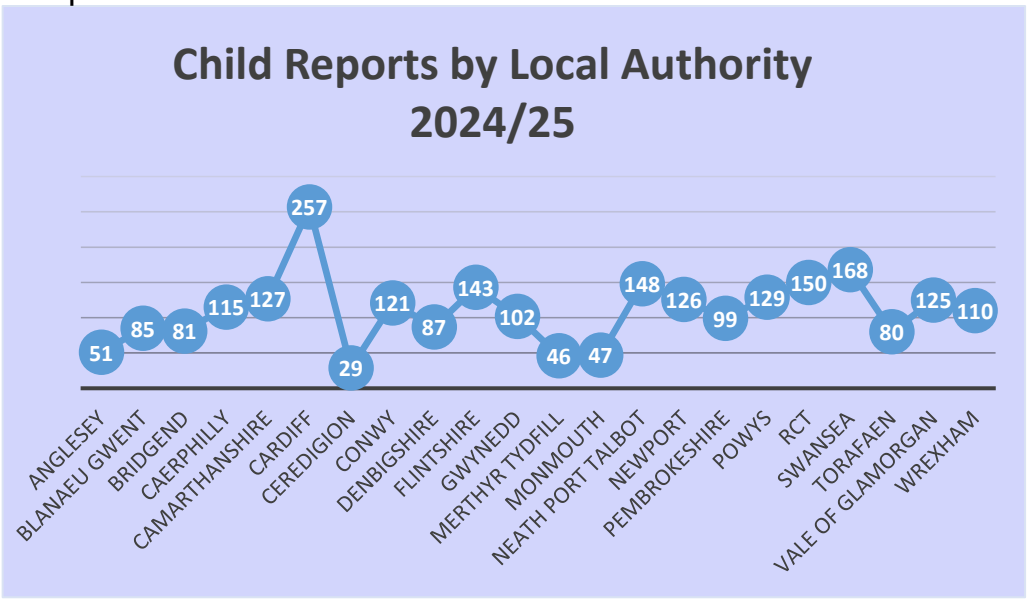
Reports per LA and HB Area across Wales

Local Authorities

Graph 1

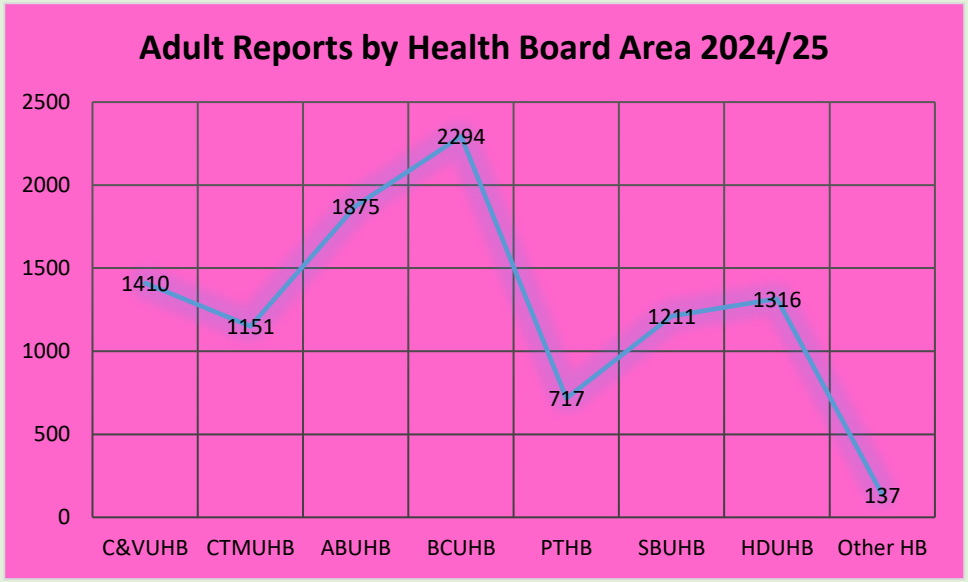


Graph 2

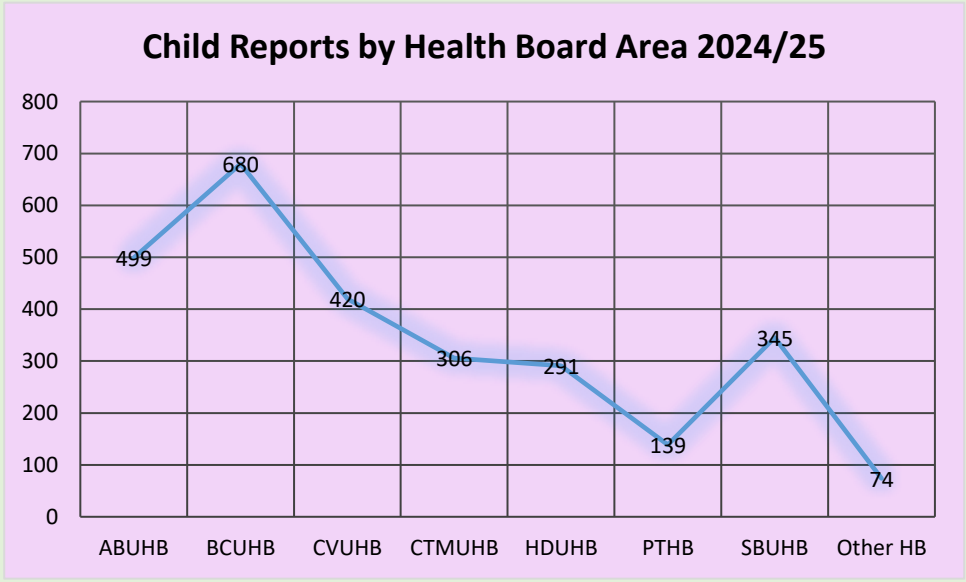


Health Boards

Graph 3



Graph 4



Reports to Local Authorities across Wales

Our priority is to ensure that WAST colleagues provide safe and effective care which protects people at risk of abuse and neglect as well as those in need of care and support.

This involves reporting concerns appropriately to the relevant agencies and utilising appropriate pathways which further support victims of domestic abuse and sexual violence following contact with our service.

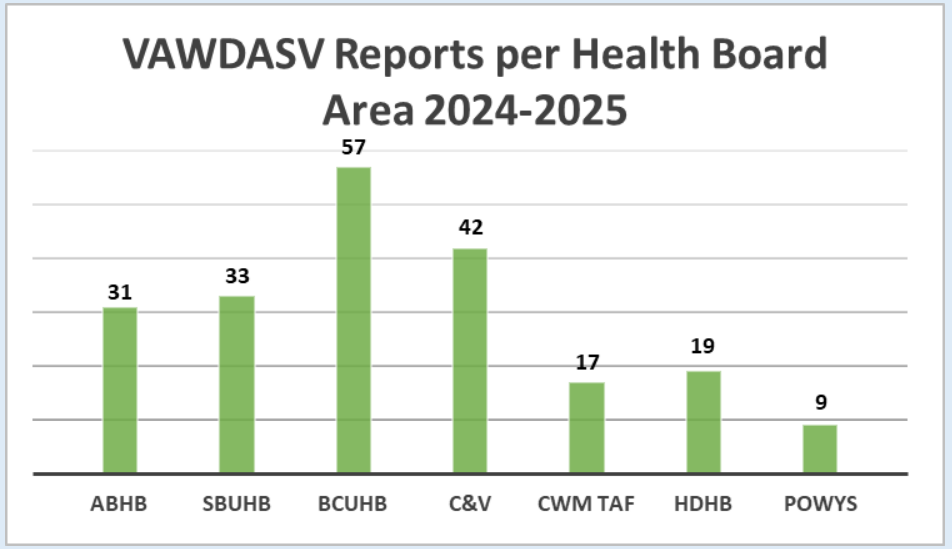
Graph 1 illustrates WAST reports made per Health Board area across Wales during this reporting period (**219** reports).

Chart 1 illustrates the reports made for adults and children

In addition to this WAST utilises a Pathway to facilitate contact with the specialist services of the Live Fear Free helpline which supports the aim of early identification, intervention and support for persons involved in these issues.

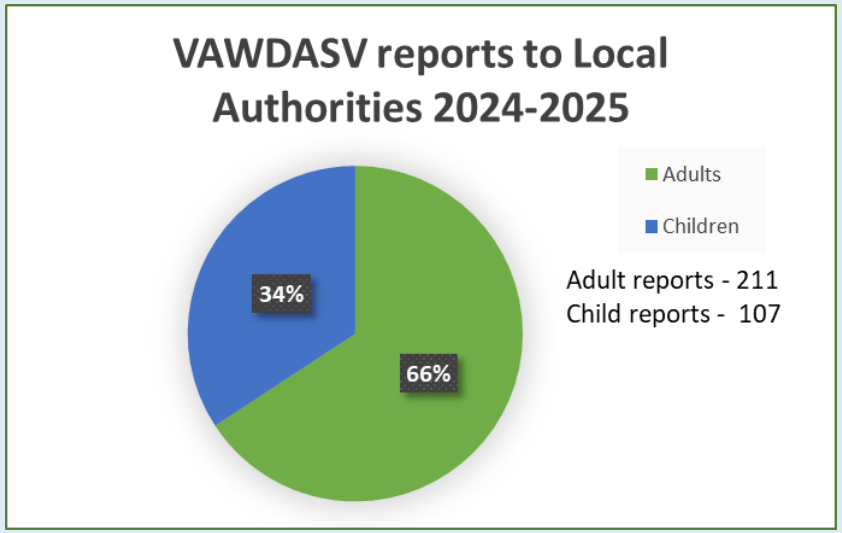
The Safeguarding Team's launch of Group 2 "Ask and Act" training as required under the National Training Framework enables practitioners to utilise the Pathway as appropriate to the circumstances of the person involved.

Graph 5



In addition to the above data 11 reports were also made where no HB identified

Chart 1



Live Fear Free Pathway

The WAST Safeguarding Team's existing pathway facilitates contact with the specialist services with the Live Fear Free helpline. Regular contact and pathway review meetings are held with support the helpline manager.

Pathway is embeded and accessible to all WAST collegues to use via Doc-works Scribe. This provides a bespoke mechanism to support victims and survivors of domestic abuse and sexual violence.

93 Referrals Submitted During 2024/25

These figures do not capture the contacts where WAST colleagues provide service users with the helpline number.

"The Live Fear Free Helpline has worked in partnership with WAST since November 2013 to ensure that victims of Domestic Abuse and Sexual Violence in Wales are given a wraparound service to keep them safe.

Statistics and the type of victims both our services come across show us that our communities, and the people who live in them, are extremely fragile. As a result, any initiative such as the working partnership between the Live Fear Free Helpline and WAST is invaluable and can prove to be a much- needed lifeline for some. These are the people who may otherwise fall under the radar of support services.

It should also be noted that by raising the awareness of this initiative that WAST personnel have also been made aware of their own responsibilities towards their colleagues and over the course of 24/25 we've received several contacts where WAST Line Managers or peers have been looking to the Helpline for advice and support.

The "can do" attitude between both WAST and the Live Fear Free Helpline has been instrumental in making this partnership a success and constant dialogue means issues are resolved as soon as the occur. Long may this continue."

Live Fear Free Helpline Manger

Fire Risk Referral Pathway

Gwasanaeth Tân ac Achub Canolbarth a Gorllewin Cymru
Mid and West Wales Fire and Rescue Service

Gwasanaeth Tân ac Achub De Cymru
South Wales Fire and Rescue Service

Gwasanaeth Tân ac Achub Fire and Rescue Service

Due to the nature of our service WAST are in a unique position to identify home fire risks.

Making every contact count with our service users.

332 Fire Risk Referrals

Chart 2

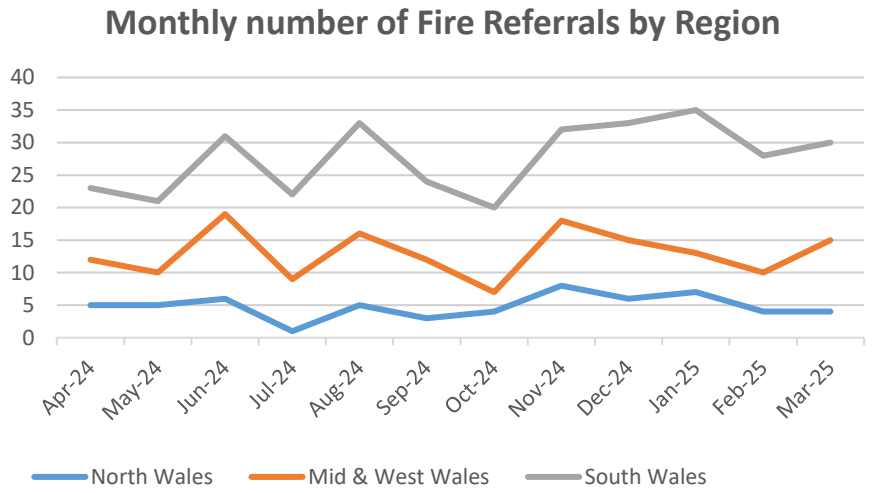
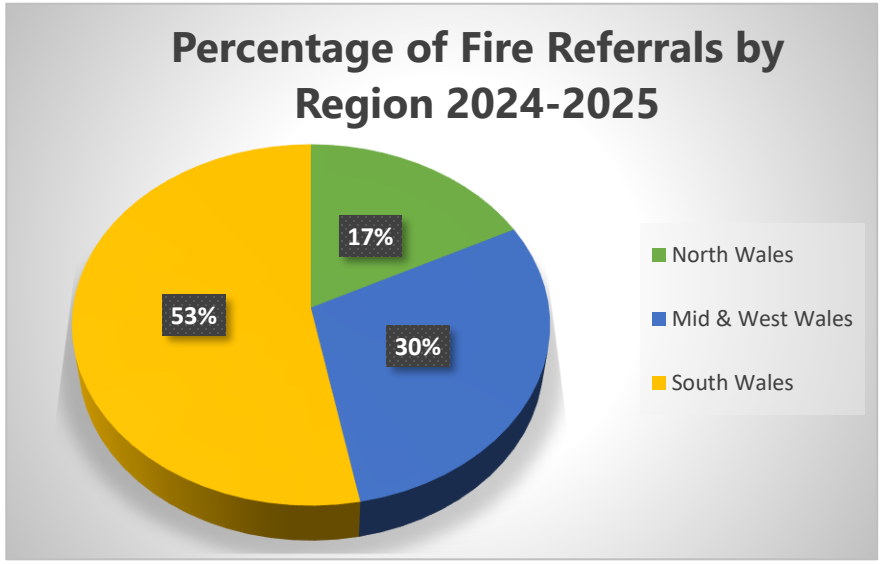


Chart 3



- Fire Risk Referrals have been consistent this year with a further slight overall increase (320 in 2024/25)
- The referral process enables WAST colleagues to request that the local FRS get in contact to **offer support** or conduct a **home safety check**
- Colleagues complete a referral on Doc-works, and it is e-mailed directly to the relevant FRS
- Streamlined and time-efficient collaborative referral process to protect some of the most vulnerable individuals within our communities in Wales

Expansion of Services available through Doc-works Scribe

Dementia Referrals

149 Dementia referrals were shared with Alzheimer's Society Cymru.

We understand from our partnership working with Alzheimer's Society Cymru that our referrals are supporting people affected by dementia through the diagnostic process, where families are being given support and advice around early detection and are guided through the diagnosis pathway.

Safeguarding Records

Doc-works is currently supporting the team to develop an innovative new bespoke digital platform for recording all safeguarding enquiries (internal & external) which will automatically collect data and produce data reports. This advanced system will provide a secure platform to maintain records whilst capturing data to provide clear case management governance, providing assurance the corporate safeguarding responsibility is being discharged.

A dashboard function to support team case management, data capture which can be analysed to review themes and trends.

Doc-Works Scribe App Update

Development on an app update has been completed.

What will this mean?

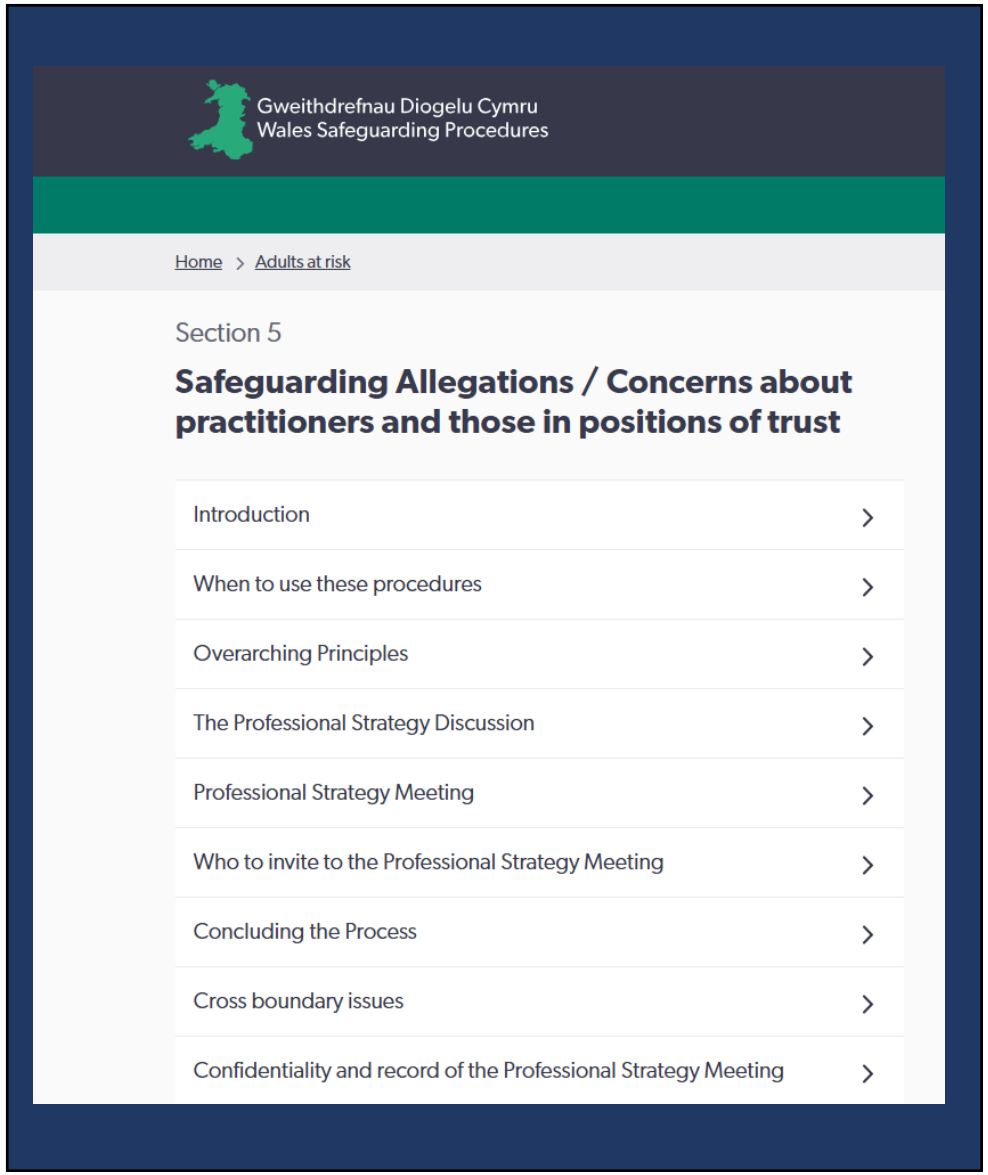
Update designed to meet the growing needs of healthcare professionals. It will be introducing a range of new functionality such as seamless integration with a range of medical devices, allowing for more efficient and accurate patient capture process.

What else?

Introduce a background task processing, which means processing will continue after the home button has been pressed. This function will allow reports/referrals to be processed immediately even when the app has been closed down prematurely, resulting in a reduction in held reports.

Implementation Coming Soon

Safeguarding Allegations



2022/23	2023/24	2024/25
37	34	100

- During 2024/25 there was involvement in **100 safeguarding allegation cases.** This increase reflects the commitment that WAST have made to improving culture within the organisation, resulting in staff feeling more empowered to speak up safely.

Section 5 Threshold Met by LA	Police Involvement	Clinical	Allegation relates to incident when representing WAST
63	52	10	31

- On 31st March 2025 there were **54 open safeguarding allegation** cases
- Of the open cases **12** involved **sexual misconduct** elements (22%)
- 5 open cases involved **stalking or harassment**

Bespoke Safeguarding Mailbox Created to Support Managers & Maintain Highest Levels of Confidentiality

Amb_wastsafeguardingallegations@wales.nhs.uk

2. Education and Training

The Trust's annual training plan continues to support statutory safeguarding requirements. Working in partnership with our dedicated training teams across WAST to establish a robust training program for all aspects of safeguarding.

Level 2 Safeguarding Training

The Safeguarding Team currently delivers face-to-face or virtual sessions to all CCC, ACA, CSD, EMS and NHS111 Wales colleagues across the Trust.

We delivered safeguarding training sessions to 46 to induction groups. This is an increase of 15 % more than last year when we delivered 31 sessions.

Mandatory Safeguarding Training

WAST has achieved **92%** compliance for child safeguarding and **91%** for adult safeguarding training during this reporting period.

It is acknowledged that some data was not captured on ESR. This will be addressed during the next reporting period.

CPD

A variety of CPD sessions have been offered during this reporting year, including 3 bespoke face to face sessions for Senior Paramedics on induction programmes and a locality CPD event. Training opportunities provided by partners are circulated widely on Trust platforms, i.e.. Non-fatal Strangulation and Sexually Harmful Behaviour webinars.

SWAY Training package on Child Sexual Exploitation

Since the introduction of the virtual CPD training package on Child Sexual Exploitation (CSE) in March 2024, over **51** colleagues have accessed and completed the training.. The training re-enforces the importance of professional curiosity when encountering children and young people who may have been subjected to CSE.

WAST National Training Framework progress

WAST "is required to incorporate training for Groups 1, 2, 3 and 6 into their existing learning and development framework and submit to the Welsh Ministers their own training plan, training needs analysis and annual plan based on this".

Group 1

Group 1 has continued to be delivered on induction and as a 3 yearly mandatory refresher within our organisation.

Table 1 illustrates total G1 completions up until March 31st 2025

The number of colleagues who have completed Group 1 training has been determined by the WAST Online Learning Management and training department records which are recorded on WAST electronic staff records at the time of this report.

Table 1

Reporting period	Total per Group	Total completed	% completed
2024/25	4,418	4,213	95%

Group 2

Group 2 training under the NTF focusses on "Ask and Act"- a principles-based approach of targeted enquiry.

The objective of this is to enable practitioners to "Ask" potential victims and survivors when concerns relating to VAWDASV are identified ; and "Act" so that suffering and harm is prevented or reduced. This training is only approved for face-to-face delivery and is currently delivered by the safeguarding teams accredited trainers.

WAST current annual target is to train **300** colleagues per year, **284** colleagues received training (95%) WAST total Group 2 colleagues employed **3027.** Total trained by April 1st, 2025, **1905** (63%)

Group 3

Individuals who are required to do more than "Ask and Act"; those who perform a "Champion" role. The training will enable people to:

Support colleagues as they make decisions in relation these subject areas, help offer services to all family members affected by violence against women, domestic abuse and sexual violence and act as a champion within their organisation.

14 G3 colleagues are currently trained within WAST.

Learner Feedback

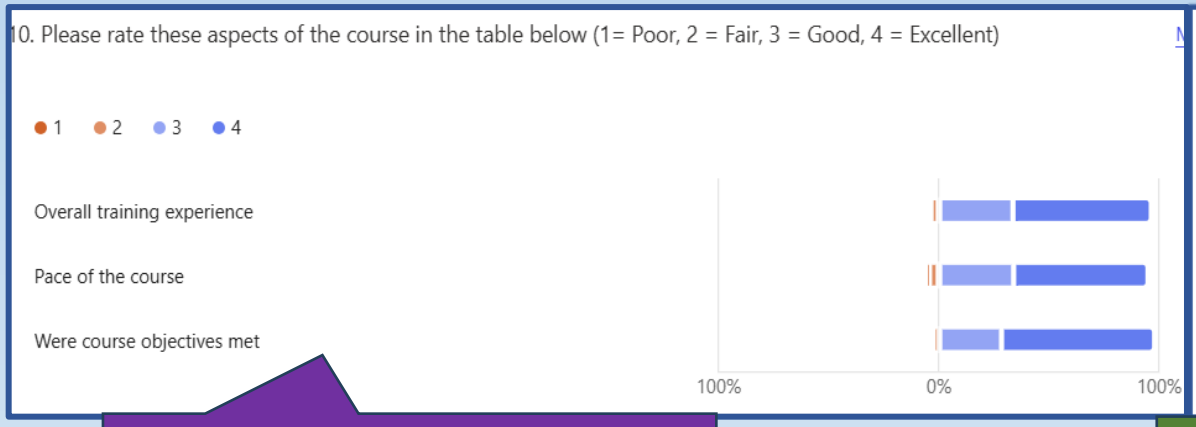
"A good outline on how to spot and help individuals that may be suffering from abuse in this area of their lives"

"Helpful for everyone who is operational"

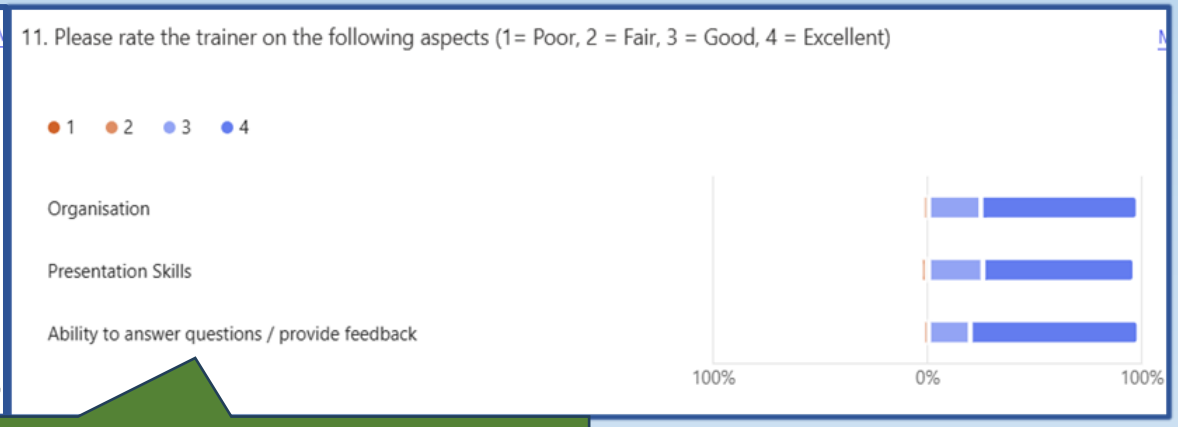
"Gives you the ability to help others so that they can feel safe"

"Fantastic amount of information put across from the trainer well presented"

"This training course is paramount for any patient-role within the ambulance service, along with any other healthcare professionals. In addition to this, it is vital to understand the procedures to follow, and when to report an adult/ child at risk".



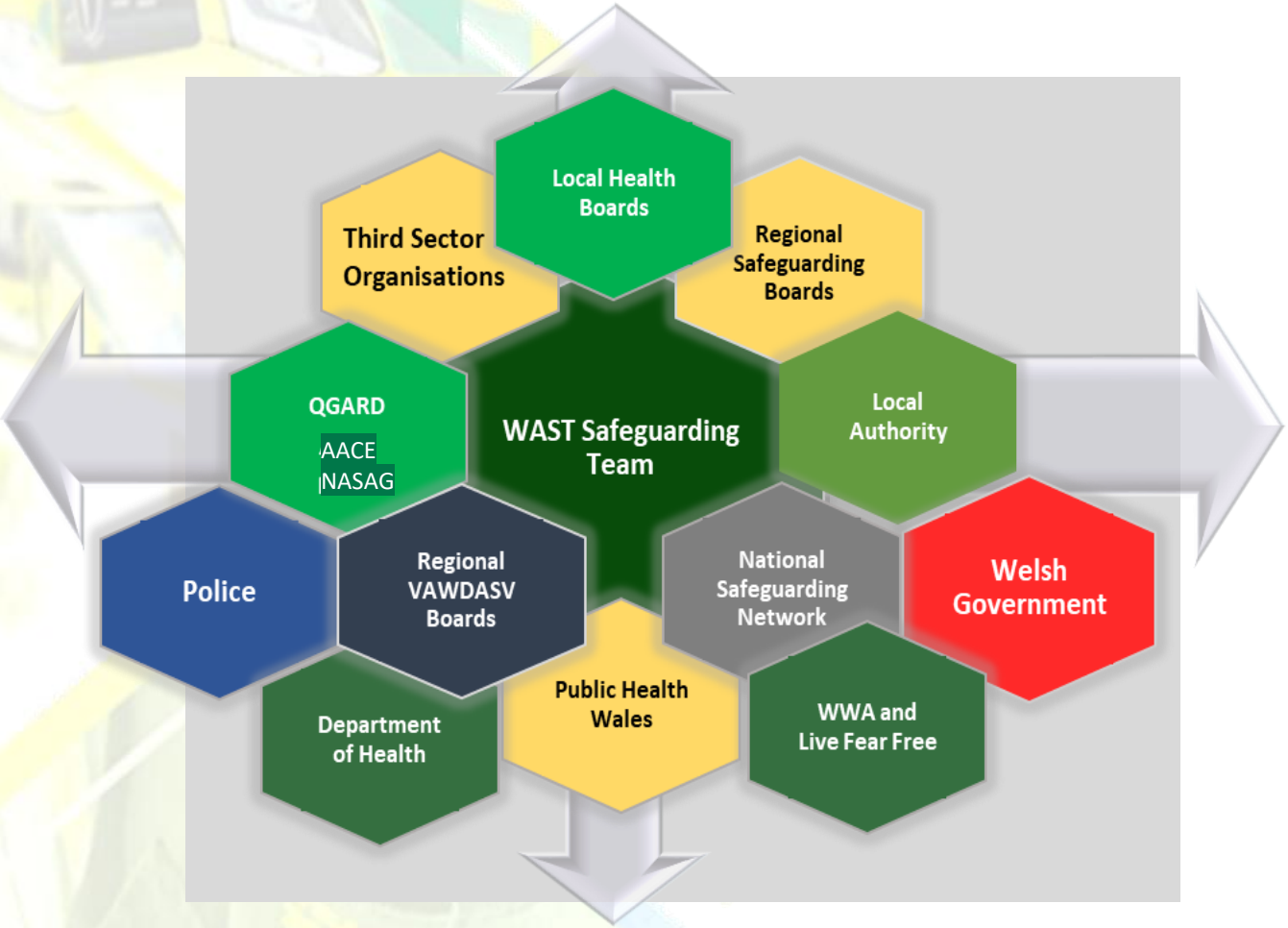
88% of learners evaluated their training experience as good or excellent



95% of learners evaluated the trainer as good or excellent

Welsh Ambulance Services University NHS Trust

3. Partnership Working



The Safeguarding Team sits within the Quality, Safety and Patient Experience Directorate. The team are essential to fulfil WAST's corporate safeguarding responsibilities, whilst also assisting with the directorate's specific objectives.

Success is founded on impactful leadership, management, empathy, compassion and innovation.

Safeguarding objectives are achieved by effectively working together with a wide range of services and professionals, ensuring good outcomes for service users.

The team ensures robust connections across all relevant partner agencies, to actively engage with safeguarding arena across Wales.

Our achievements obtained through improved knowledge, skills and attitudes as well as the promotion of our engagement with safeguarding multiagency activity has fortified our working relationships both at an operational and strategic level.

The Wider Safeguarding Arena

Complex Case Review

Under the Social Services and Well-being (Wales) Act 2014, there is no specific provision addressing self-neglect. Self-neglect has become an increasingly concerning issue and has been highlighted in numerous Adult Practice Reviews across Wales.

However, all six Regional Safeguarding Boards in Wales have developed distinct self-neglect policies and toolkits to enable professionals to effectively support individuals facing significant self-neglect issues.

The WAST Safeguarding Team regularly participates in Multi-agency Complex Case Meetings, working collaboratively with other agencies to support individuals and develop solutions to complex issues.

National Ambulance Safeguarding Advisory Group (NASAG)

The purpose of this group is to promote a consistent approach to safeguarding across the UK Ambulance Services. It connects, supports and guides the safeguarding practice of its practitioners across the UK.

Vicky Maxwell, the Assistant Director of Safeguarding for WAST chairs this group. Vicky is committed to developing and sharing good practice, whilst providing a space for Ambulance Safeguarding leads to access peer support.

The WAST Safeguarding Team contribute to the work of the group and are currently part of the NASAG working group who are reviewing all the safeguarding sections of JRCALC. 2024/25 has seen the Children's Safeguarding information being reviewed. This is an ongoing piece of work that the team will continue supporting.

ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES
NASaG
National Ambulance Safeguarding Group

Welsh Government
Single Unified Safeguarding Review (SUSR)

After WAST's active participation in the task and finish groups during last year's SUSR consultation process, we can confirm that the SUSR process is live since 1st October 2024.

All WAST Safeguarding Team members have now completed the SUSR training.

The new single review process in Wales will provide affected families with a swift, rigorous approach, eliminating multiple reviews, reducing trauma, and enabling faster multi-agency learning and action.

Section 126 Enquiries

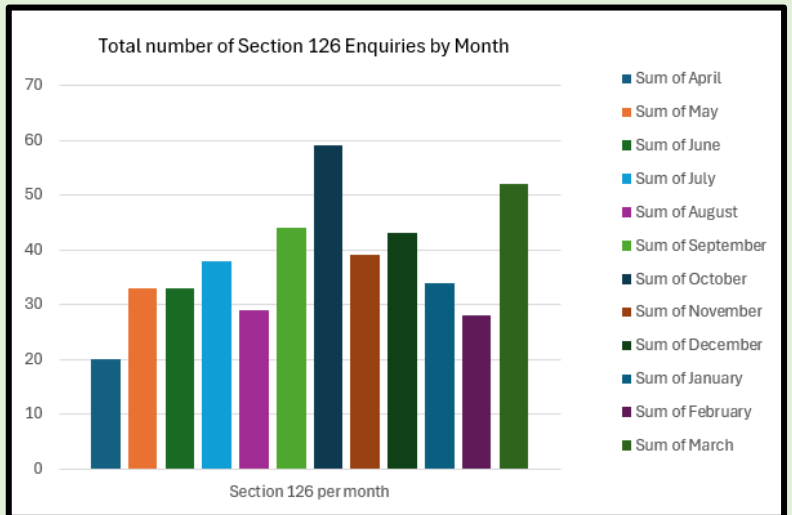
Local Authorities are required to conduct enquiries under Section 126 of the Social Services and Wellbeing (Wales) Act 2014. A recognised "*relevant partner*" of the Local Authority, WAST has a legislative obligation to participate in any enquiries or strategy meetings/discussions that may be undertaken.

The aim of this process is to prioritise the needs of a vulnerable individual, enabling agencies to share information appropriately, identify risks, and take specific actions.

The Safeguarding Team accesses various WAST systems and collaborates with multiple directorates within WAST to gather the necessary information to support this process.

This activity has seen a significant increase during this reporting period, rising from 374 cases last year to **452 cases this year**, illustrated below.

Graph 6



WAST Colleague Enquiries

The Safeguarding Team work collaboratively with colleagues within WAST and external agencies to ensure positive outcomes for children and adults at risk of harm.

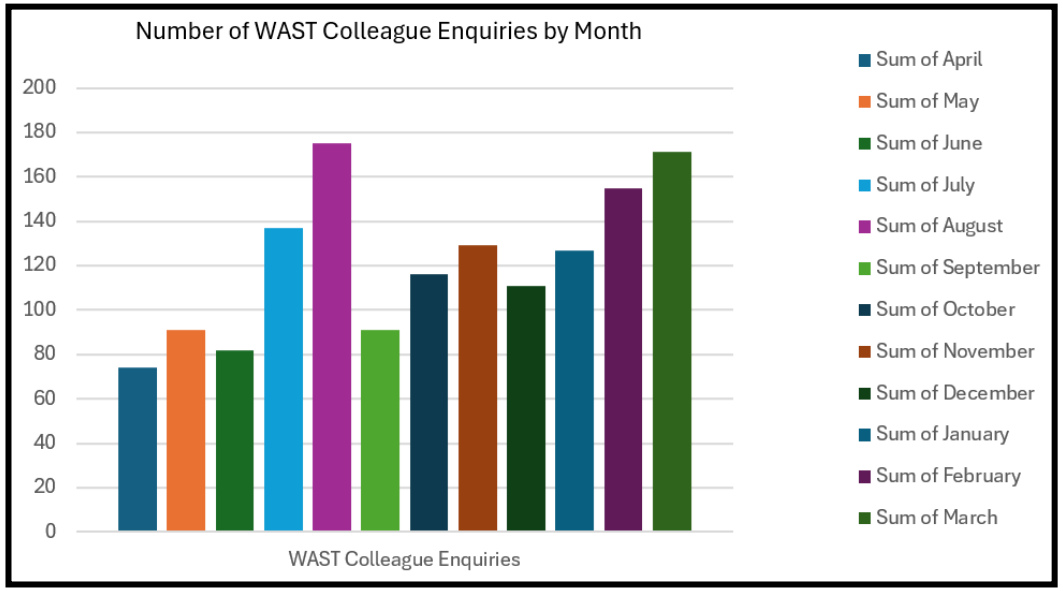
Colleague enquiries includes responding to all enquiries related to safeguarding, as well as providing feedback to inform future practice.

1,459 WAST colleague enquiries were recorded, most common reasons were:

- Doc-works Scribe Support
- Reflective / Retrospective Safeguarding Advice

Most received via e-mail

Graph 7



Regional Safeguarding Board's Activity

The WAST Safeguarding's Team support six Regional Safeguarding Board across Wales, including; Cardiff and Vale, Cwm Taf Glamorgan, Gwent, Mid and West Wales, North Wales and West Glamorgan Safeguarding Board. WAST have a duty to co-operate which is part of our core business. The Assistant Director of Safeguarding and Senior Safeguarding Specialists have ensured strategic engagement at the board level, whilst the Safeguarding Specialists engage as panel members during panel reviews.

See the figure below regarding our engagement with ongoing reviews in the reporting period 2024 -2025:

Adult Practice Review (APR)

Table 2

2022 - 2023	2023 -2024	2024 – 2025
4	3	7

Child Practice Review (CPR)

Table 3

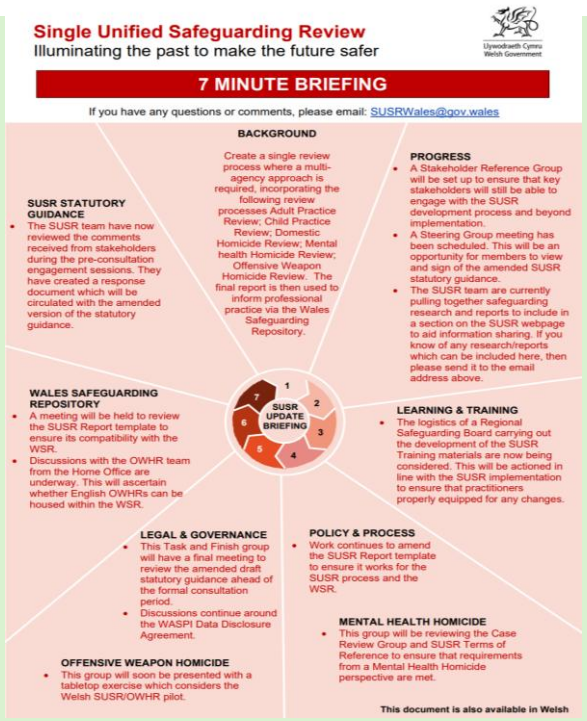
2022 - 2023	2023 - 2024	2024 – 2025
5	2	6

Domestic Homicide Review (DHR)

Table 4

2022 2023	2023 - 2024	2024 – 2025
6	4	5

Adult Practice reviews, Child Practice reviews and Domestic homicide reviews have been replaced by the Single Unified Safeguarding Review (SUSR) process in Wales since 1st October 2024.



The SUSR brings agencies and individuals connected to the incident into safe learning environment.

The purpose of the SUSR:

- Build a greater understanding of what happened and why.
- Improve the understanding of the impact of the actions of organisations
- Look into whether different actin would have had different outcomes for the child or adult at risk
- Identify any learning opportunities for the future
- Provide a clear action plan on how to improve service provision.

Procedural Response to Unexpected Deaths in Childhood (PRUDiC)

The PRUDiC guidance sets a minimum standard of response to unexpected deaths in childhood. It applies following the death of a child which was not anticipated as a significant possibility 24 hours before (PHW 2022). During **2024/25** WAST were involved with **58** PRUDiC's (66 in 2023/24).

- **11** involved infants
- **2** road traffic collisions
- **3** possible drownings
- **2** possible non-accidental injuries

Graph 8

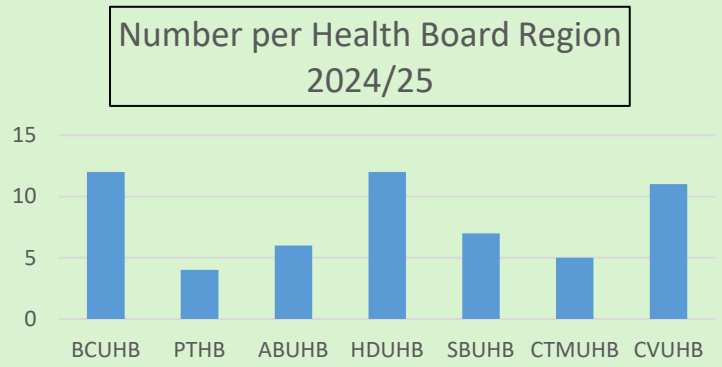
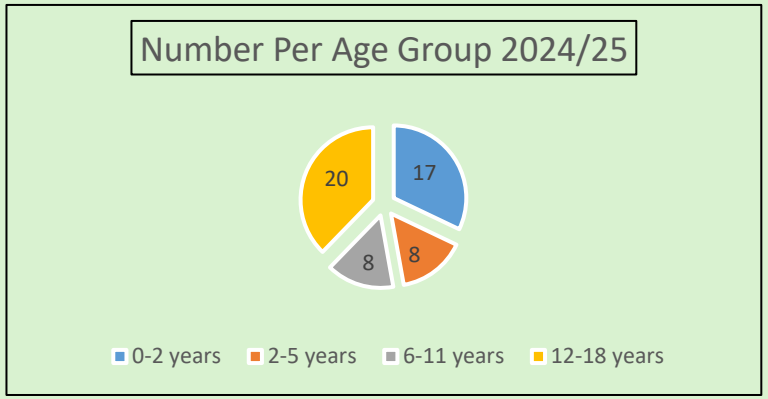
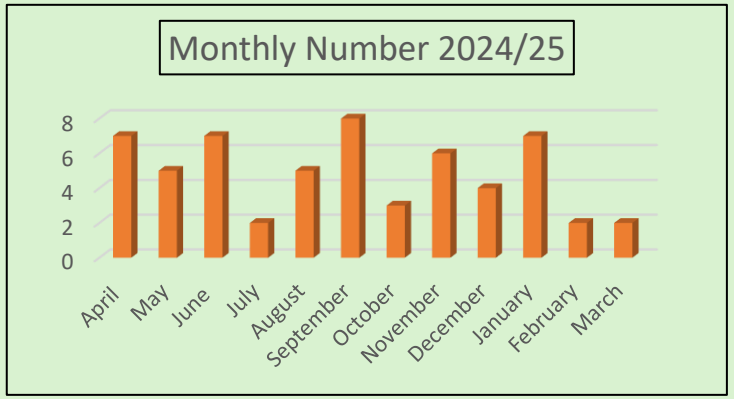


Chart 4



Graph 9



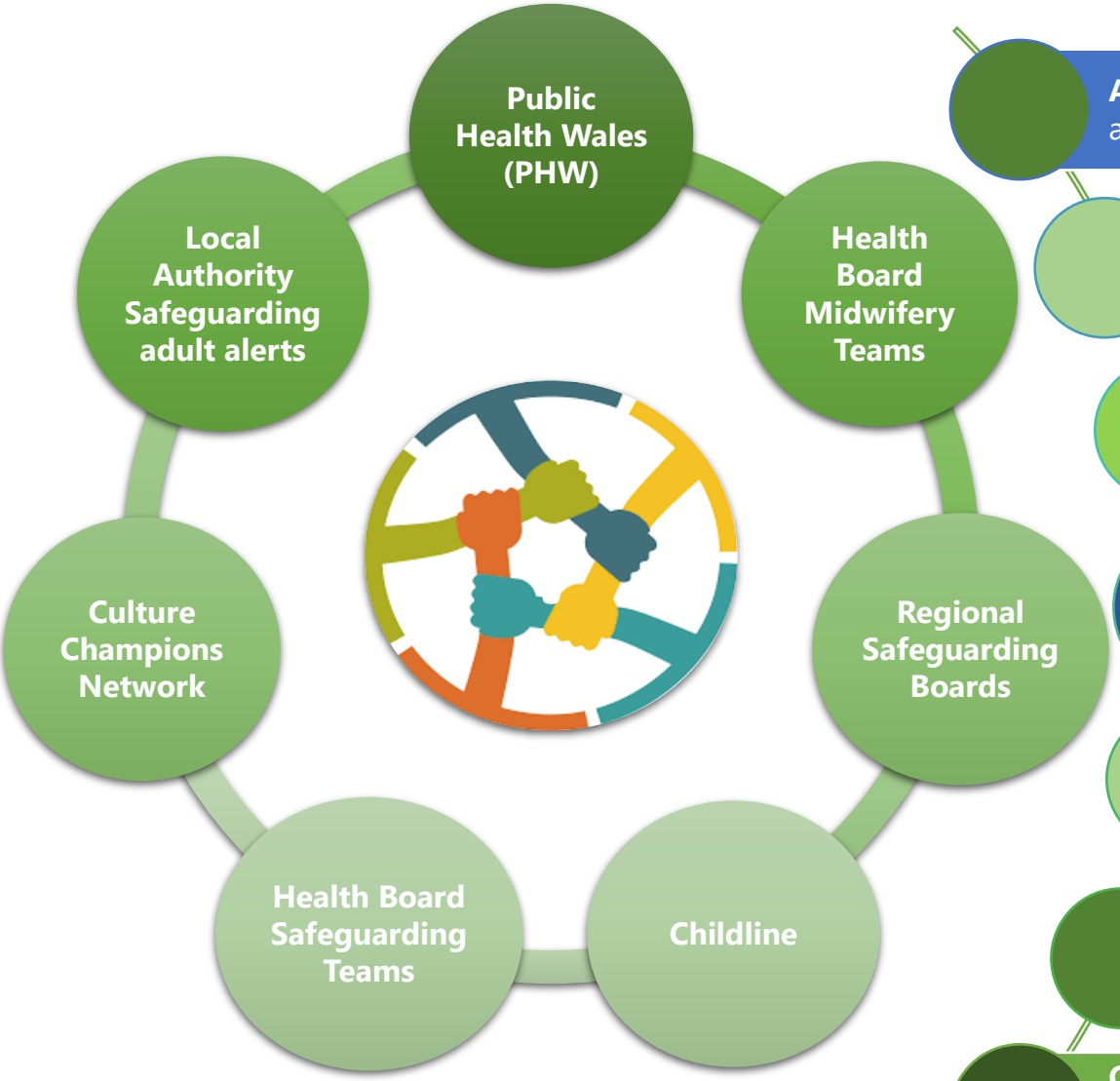
- **9** involved children with pre-existing health issues
- **8** completed suicides (all within 12–18-year age group)

WAST is a key contributor to Public Health Wales (PHW) in recognising themes and trends across Wales. The data can be used to identify trends and recurring themes across Wales, with the intention of preventing future deaths e.g. an example of this is Safer Sleep guidance for families with young babies.

There were **8** deaths due to completed suicide, although it is not always clear if the young person wished to end their life. PHW notes that suicide often reflects the complex interactions between adverse childhood experiences, mental health issues and social and emotional challenges for young people

It is recognised that these can be traumatic incidences and every effort is made to ensure colleagues are supported, in addition to the usual supporting mechanisms 2Wish provide specialist support to anyone involved in a PRUDiC incident.

WAST Additional Partnership Working



Adult Safeguarding Alerts Specific information is shared relating to specific safeguarding arrangements/needs. **8** alerts relating to adults were placed on our alert system in 2024/25

WAST Safeguarding Team are committed to **championing culture change**, helping to build an environment which is inclusive, positive and compassionate.

Child Protection Alerts Specific information is shared relating to the safeguarding arrangements in place for families with children who may have contact with our service. **8** child alerts were placed on our alert system in 2024/25.

Protecting the unborn Specific information is shared and a pre-warning given to practitioners the aim of which is to give responding crews prior information on the existence of an agreed plan of care or safeguarding requirement. **114** midwifery alerts actioned by WAST in 2024/25

Thematic Reviews – WAST Safeguarding Team engage with the thematic reviews instigated by the PHW child death review panel. The information obtained from each review is then utilised to formulate National health or safety campaigns to help protect the public.

Annual Partnership Reports – WAST Safeguarding Team contribute to the Partnership Reports to the Boards across Wales as requested. This ensures wider understanding of the safeguarding activity and experiences of our organisation.

Childline offers a unique service to help young people in the UK**.** WAST Safeguarding Team works with Childline when we have provided care for a child who has contacted them. Responded to **40 Childline** enquiries during this reporting period

Case Example of Robust Safeguarding Practices

EMS colleagues attended a 999 call for a 16-year-old female who had overdosed on Sertraline, cocaine, and alcohol. Upon arrival, the young female was found lying on her friend's sofa, reluctant to interact, pushing them away, and resisting any care they attempted to provide. Her friend disclosed to the crew that the young girl might be a victim of sexual exploitation.

Despite the initial resistance, the crew's ability to engage with the 16-year-old, who was undoubtedly scared and unsure of whom to trust, was evident when completing the safeguarding report. The information shared by the young girl was distressing for both her and the crew, but the crew's compassionate engagement was crucial.

The Safeguarding Team was invited to a strategy meeting concerning the young girl. Thanks to the robust documentation provided by the crew, the safeguarding team had access to extensive information that other agencies were unaware of, ensuring that appropriate measures were implemented to protect the individual. This is an excellent example of effective safeguarding practices.

Diolch yn Fawr

The WAST People's Voices Network plays an important role in ensuring that lived experience informs strategic thinking and frontline practice throughout WAST.

Its contributions help the safeguarding team to remain person centred, particularly in understanding in how our services are experienced by those most at risk.

WAST VOICES

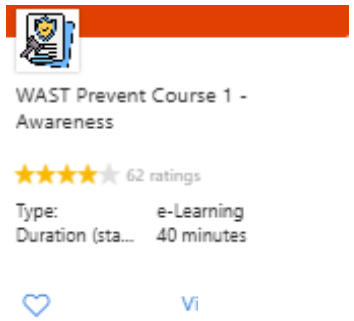
OUR PEOPLE, OUR NETWORK, OUR VOICES

Prevent

Significant increase in the annual referrals this year, **5 Prevent referrals** shared with the Counter Terrorism Team.

Most of these referrals required significant input from the Safeguarding Team, with discussions with Local Authorities and separate 101 Police reports.

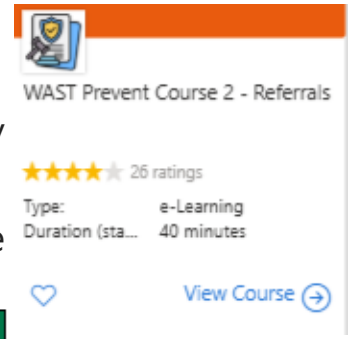
5 Prevent Referrals



Training

Prevent training now forms part of WAST statutory and mandatory training.

The UK Home Office Training on Prevent has been made available on LMS 365.



	Prevent Awareness	Prevent Referrals
Number of WAST Colleagues Completed to Date	2,365	1,557

Coming Soon

NEW POLICY 2025/26

Currently developing its inaugural Prevent Policy, which is expected to be finalised by the end of 2025.

NEW WAST PREVENT FORM

During 2025/26 there will be a new updated Prevent Referral form, which aligns with the recently updated All Wales Prevent Partners Referral Form.

4. Quality Improvement

The Safeguarding Team's approach to quality and quality improvement for this reporting period has been to focus on achieving the requirements set within the Safeguarding work plan 2024/25. The team have participated in internal quality meetings.

WAST is required to report on the safeguarding position of the organisation both internally and externally. The safeguarding work plan provides the focus for improving quality as part of the organisation's internal strategy but also incorporates the requirements included in standards and outcomes set by external reporting mechanisms. The safeguarding work plan & assurance framework is mapped to the Health and Care Quality Standards (2023), specifically relating to the domain "Safe". The outcome of which is to ensure *our service users are protected from harm and protect themselves from harm.*

The principles of Prudent Healthcare are considered throughout, recognising continued progress is always required to integrate the principles into our safeguarding operational framework.

Safeguarding Priorities 2024/25

Reporting Safeguarding Concerns	Training and Education	Policy and Procedure	Safeguarding Processes

Reporting Safeguarding Concerns
- Monthly data provided
- Quarterly reports completed and approved by Safeguarding Strategic Group

Training
- Safeguarding Training level 2 delivered as required
- Bespoke sessions delivered utilising Eventbrite

Policies and Procedures
- 2 policies reviewed and approved
- 1 policy review started

Safeguarding Processes
- Continue Doc-works Scribe expansion and development

Improving the Service We Provide

WAST Safeguarding Team work closely with the Patient Safety Team and participate in the WAST Serious Case Incident Forum (SCIF) to address any safeguarding issues identified within concerns and adverse incidents. Thus, ensuring all necessary collaboration with stakeholders to support and protect our colleagues, patients and service users.

We fully embrace the Trust's Duty of Candour and 'Putting Things Right' process. Our goal is to provide a supportive framework for staff to learn from safeguarding incidents and inform our continual improvement of safeguarding processes within WAST.

The Terms of Reference for our Safeguarding Strategic Group (SSG) were refreshed in 2024 to build on an established framework providing influence, strategic direction, leadership and governance to provide assurance WAST meets all safeguarding statutory duties.

The terms of reference now also reflect the group's commitment to the Welsh Government Corporate Parenting Charter, ensures robust management and completion of recommendations and action plans from statutory review processes, and the group's commitment to oversee safeguarding risks ensuring they are robustly managed at all organisational levels.

Safeguarding Maturity Matrix

The Safeguarding Maturity Matrix (SMM) is an annual self-assessment tool used by Health Boards and Trusts across Wales to report on safeguarding activities, demonstrate improvements, and identify risks. It helps organisations showcase their strengths and plan for future priorities through peer review, feedback and collaborative working with the national Safeguarding Service.

The WAST SMM submission highlighted areas of good practice such as the refreshed Terms of Reference for SSG, shared learning from audits and statutory reviews, and the creation of bespoke training packages on child sexual exploitation; and child and adolescent self-harm behaviours. It also identified areas of focus to improve compliance with statutory and mandatory safeguarding training and to review safeguarding-related policies within WAST, both of which have been achieved during this reporting period.

Policy Reviews

The Safeguarding Children and Adults at Risk of Harm policy and associated Standard Operating Procedures (SOPs) have been reviewed and approved through full internal processes.

The Violence Against Women, Domestic Abuse, and Sexual Violence Ask & Act policy and associated SOPs have been reviewed and approved through full internal processes.

MS Forms was utilised in the consultation process to collate and evidence responses. This proved a new and innovative way to complete a Trust wide consultation with the Policy Team expressing interest in attempting the method with other consultations.

Work to review the Management of Allegations Policy has begun and the aim is to proceed through internal processes during 2025/26.

All updated policies and SOPs are readily accessible on the Safeguarding SharePoint pages.

5. Support, Advice and Guidance

The Safeguarding Team within WAST appreciates that working to ensure good outcomes for children and adults at risk, and victims of domestic abuse/sexual violence can be demanding and distressing work.

Supporting colleagues requires a collaborative approach which facilitates the promotion of good standards and ensures confident and competent practitioners who can make sound professional judgements. The Safeguarding Team supported 1,459 internal colleague enquiries.

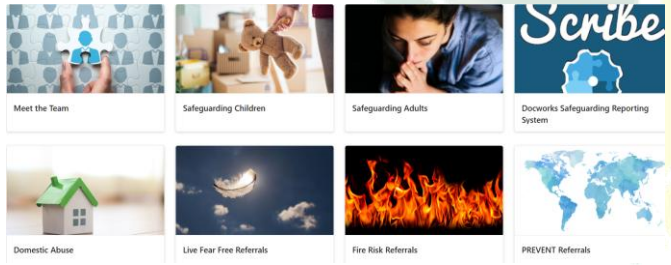
Safeguarding Supervision

The Safeguarding Team has begun a series of team supervision sessions. Supervision is a process of formal professional support, reflection and learning that contributes to development.

This gives the team a forum to discuss challenging or interesting cases, for the group to give advice and share opinions. It is a forum to learn from experiences and to reflect on safeguarding processes. This is also an opportunity to share good practise, where colleagues have made excellent safeguarding reports, and this has led to the individuals involved being safeguarded from further harm.

The introduction has been highly beneficial, with the team valuing the opportunity to discuss cases and outcomes while reflecting on policy and procedure. The team aims to build on this success by initiating supervision for other colleagues within WAST.

Safeguarding SharePoint Page



Allegations: The Safeguarding Team has established a dedicated email inbox for receiving allegations within WAST, ensuring that sensitive information is reviewed directly by the senior team.

Shadowing

The team continue to welcome WAST colleagues who request to spend time working alongside them as they conduct everyday core safeguarding activities.

Datix

In January 2025, the Safeguarding Team conducted an audit of all Datix submissions that indicated **'Yes'** or **'Don't Know'** in relation to safeguarding concerns. The goal was to identify any missed opportunities to protect vulnerable adults and children within the community who were possibly at Risk of Abuse and Neglect or had needs for care and support.

Over **90** Datix entries were reviewed during January by the Safeguarding Team...

Out of the **90** reviewed **45** Datix entries that indicated **'YES'** to safeguarding concerns, only **40%** had actually submitted a safeguarding report to the Local Authority for review.

Additionally, **15%** of the missed safeguarding reports involved significant safeguarding concerns.

41 of the Datix incidents reviewed which were highlighted as **'Don't Know'** in relation to safeguarding concerns, on review **10%** were found to have significant safeguarding issues, yet no report was submitted to the Local Authority for review.

Moving forward managing Datix with safeguarding concerns

Further audits will be conducted over the coming months, along with ongoing training to ensure safeguarding concerns are identified and managed appropriately. Your unwavering dedication to safeguarding our community is immensely valuable

Building the Team

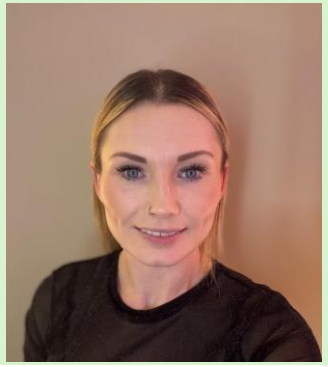
"My background is in Paediatric Nursing. I qualified in 2013 and worked in theatres before undertaking a further year at university to obtain my Specialist Community Public Health Nursing Degree.

I then went on to work a special care baby unit before joining the community to work as a Health Visitor in 2016.

My first safeguarding role was community based for BCUHB. Here I gained real insight and experience of safeguarding issues, which I can now share within the WAST arena.

Joining the Safeguarding Team at WAST has been a real learning experience. I enjoy working with such a friendly and supportive team. Since joining I have started to develop a training package for Level 3 Inflicted Injury and disguised compliance as this supports our objectives alongside the wider safeguarding agenda.
I currently cover Aneurin Bevan Health Board whilst continuing to work in my Health Visiting Role. Throughout my careers I have continued to work on a Children's Unit in BCU as a paediatric nurse. I am excited to develop within my WAST Role and support staff across the service."

Natasha Carson
Safeguarding Specialist



"I am a Registered Nurse (Adult) with a secondary qualification as a Specialist Community Public Health Nurse. I have worked initially in acute surgical nursing but spent the majority of my career working in the community with vulnerable children & young people and their families.

I started work in the ambulance sector five years ago and came to WAST in May 2024.
I am committed to working with colleagues across WAST to shape and lead the direction of safeguarding, within a workforce that is privileged to support people when they are at their most vulnerable.

I lead the Corporate Safeguarding Team in WAST to discharge the statutory safeguarding duties on behalf of the organisation. I am proud to have a team of highly skilled Safeguarding Specialists who champion the delivery of high quality safeguarding across the workforce. I work closely with safeguarding leaders across Wales to ensure that the Ambulance Service is a key partner in safeguarding planning and delivery at a national level.

I chair the National Ambulance Safeguarding Advisory Group (NASAG) and have a close group of peers who shape, guide and support safeguarding across UK Ambulance Services."

Vicky Maxwell
Assistant Director of Safeguarding

"I qualified as an Adult Nurse in 1997 going on to obtain a secondary qualification as Specialist Community Nurse. Seeking a new challenge, I joined WAST in 2019 and joined NHS 111 Wales, where I then moved over to the Clinical Support Desk . My previous experience in Community Nursing and Remote Clinical Triage has provided me with good insight and understanding of the demands crew and remote clinicians face daily in both clinical and safeguarding situations.

I joined the safeguarding team in 2024. My new team is so supportive and has given me plenty of experience to shadow experienced members of the team in some challenging situations. Enabling myself to gain excellent experience, skills and knowledge within a specialist's role. My nursing background especially within the community setting has helped me recognise the impact of health inequalities and how as healthcare professionals we can make a difference when safeguarding situations are identified and how we can make a positive difference to many individuals.

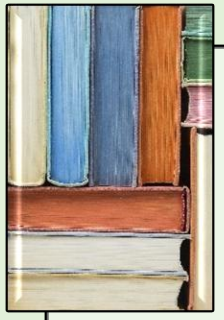
I currently cover SBUHB and BCUHB but I welcome any colleagues from any area to get in touch should they have any safeguarding inquiries."

Michelle Davies
Safeguarding Specialist

Moving Forward 2025/26

Further develop the Doc-Works Scribe digital reporting process to implement efficient and accurate safeguarding record keeping

Provide assurance using quality reporting measures, which reflect the safeguarding activity across WAST, which can be used to evidence change



Continue creating tailored safeguarding training that incorporates current themes and trends. Empowering WAST colleagues to identify and escalate concerns effectively and timely

Work collaboratively with partner agencies to ensure WAST meet requirements of key themes such as Welsh Government Corporate Parenting Charter, Prevent, trauma informed care and homelessness

Revise the 'Management of Safeguarding Allegations' policy and related safeguarding risk assessment process to ensure consideration of safeguarding in relevant cases

Contribute to the People & Culture Directorate's 'WAST Way'. An initiative which will shape how leaders are supported to act consistently and safely in accordance with safeguarding legislation.

Conclusion

This report demonstrates the Safeguarding Team's commitment to promoting excellence in safeguarding interactions across the organisation, to meet our statutory responsibilities and protect the people we serve.

The increase in safeguarding activity reflects a professionally curious organisation able to identify and escalate safeguarding risk and inequality. It also reflects the changing landscape of modern safeguarding.

Comprehensive safeguarding training is prioritised to enable WAST colleagues develop knowledge and confidence in recognising and responding to safeguarding concerns.

The Safeguarding Team are proud to representing WAST at multi-agency forums that place patient and WAST colleague safety at the heart of discussions.

As the volume and complexity of safeguarding casework continues to grow, particularly with the ongoing Speaking Up Safely work, it will be important to explore how future resourcing models can further support the Safeguarding Team in maintaining both its operational delivery and wider strategic impact.

We look forward to shining a light on key safeguarding issues during the coming year and are excited to proactively drive the safeguarding agenda in alignment with the wider WAST priorities.

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01792 315884

AGENDA ITEM No	**13**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**2**

Clinical Audit Plan & Action Tracker Q1 (update) 2025/26

MEETING	Quality, Patient Experience and Safety Committee
DATE	5 August 2025
EXECUTIVE	Andy Swinburn, Director of Paramedicine
AUTHOR	Vince Baglole
CONTACT	vince.baglole@wales.nhs.uk

EXECUTIVE SUMMARY

Following an Audit Wales review of WAST's Quality Governance Arrangements, one of the recommendations was for the Clinical Audit Plan to be monitored on a quarterly basis at QuEST.

This is the Q1 2025-26 update to highlight progress with audits (the plan) and also to actions from the completed audits (action tracker).

The Q1 2025-26 Clinical Audit Plan contains 13 audits covering a range of topics including clinical conditions, medicines, and compliance to documentation. This is a dynamic plan which allows for additional audits to be added, however, since the Q4 update, no further audits were requested or added.

Of those indicated on the plan:

- 3 have been completed, one in Q1, one in Q2 three in Q3 and two in Q4.
- 4 are progressing as planned
- 6 are yet to start, some are reliant on ePCR User Interface changes being implemented**,** some are not due to start until Q2.

There are currently four completed clinical audits on the Action Tracker, with a total of 17 actions. Of those:

- 10 have been completed
- 2 are on track as planned
- 5 are delayed *(with mitigating / recovery actions taken)*

Clinical Indicators:
The Clinical Intelligence and Assurance Team (CIAT), in collaboration with the Clinical Intelligence Advisory Group (CIAG), continues to monitor performance against Clinical Indicator Care Bundles. Significant performance variations are reviewed with Regional Clinical Leads, and appropriate mitigating actions are agreed.

Interim Performance Measures:
As of 1 July 2025, the RED call categorisation has been replaced by three new categories:

- **PURPLE** (Cardiac Arrest)
- **RED** (Emergency)
- **RCS0** (Rapid Clinical Screening)

The PURPLE category retains time-based metrics, while the RED (EMERG) category will require performance measures focused on clinical care as well as response times. CIAT is developing a suite of interim performance measures for EMERG calls, based on case mix.

Development of these measures will include defining appropriate inclusion and exclusion criteria, to be proposed by CIAG and reviewed via AAA for approval by CQGG. CIAT will report progress to CIAG and provide updates at future QuEST meetings when measures are ready for testing or modelling.

RECOMMENDED: That the committee:

- **Note the Q1 2025-26 Clinical Audit Plan and Action Tracker update.**

KEY ISSUES/IMPLICATIONS

Many of the audits and re-audits can be undertaken solely by the Clinical Intelligence & Assurance Team. However, support is required for some topics where subject matter experts are needed as authors, and the support of sponsors to ensure completion of the audits and subsequent actions.

REPORT APPROVAL ROUTE

Quality, Patient Experience and Safety Committee - 09/05/2025

REPORT APPENDICES
Appendix 1 Clinical Audit Plan 2025/2026 Quarter 1 Appendix 2 Action Tracker July 25

REPORT CHECKLIST			
Confirm that the issues below have been considered and addressed		**Confirm that the issues below have been considered and addressed**	
EQIA (Inc. Welsh language)	NA	Financial Implications	NA
Environmental/Sustainability	NA	Legal Implications	NA
Estate	NA	Patient Safety/Safeguarding	NA
Ethical Matters	NA	Risks (Inc. Reputational)	NA
Health Improvement	NA	Socio Economic Duty	NA
Health and Safety	NA	TU Partner Consultation	NA

SITUATION:

1. Following an Audit Wales review of WAST's Quality Governance Arrangements, one of the recommendations was for the Clinical Audit Plan to be monitored on a quarterly basis at QuEST.
2. This is the Q1 2025-2026 update to highlight progress with audits (the plan) and also to actions from the completed audits (action tracker).

BACKGROUND:

3. 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 tailor the plan so that it is realistic, achievable and that expectations are not overreached.
4. The plan is developed in consultation with the Clinical Intelligence & Assurance Team, Clinical Intelligence & Assurance Group, and senior clinical, and non-clinical managers within the Trust. Consideration is given to linking audit topics to the IMTP, LDPs, and risk registers where possible.
5. Care, treatment, and decision making should reflect best practice based on evidence to ensure that people receive the right care and support to meet their individual needs.
6. 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 or have been completed. Various groups and committees receive quarterly updates for the clinical audit plan, and it is made available on the Trust's Intranet.
7. This plan and the subsequent action tracker to monitor learning from each of the completed audits is monitored by the Clinical Intelligence & Assurance Group, and an update noted at Clinical Directorate Business meetings.
8. Following an Internal Audit report issued in May 2024 on Clinical Audit, of the four objectives, three resulted in 'Reasonable Assurance' (Clinical Audit Strategy, Clinical Audit Planning & Clinical Audit Outcome Reporting). The fourth resulted in 'Substantial Assurance' (Benefits Realisation and Lessons Learned).
9. The Clinical Intelligence & Assurance Team are progressing with the recommendations from the Internal Audit relating to the Clinical Audit Plan.

- Where possible clinical audits are linked to the IMTP, LDPs and risk registers. Specific fields for IMTP/LDP/Risk are now included on the audit proposal form. In addition, the decision log contains further information to justify the inclusion of audits.
- More detailed information is now contained in the Clinical Audit Delivery Plan in relation to audits being included, and delays and issues if required. This is reported monthly to the Clinical Intelligence & Assurance Group.

ASSESSMENT:

10. The Q1 2025-2026 Clinical Audit Plan contains 13 audits covering a range of topics including clinical conditions, medicines, and compliance to documentation. This is a dynamic plan and since the Q4 update, the STEMI follow up audit and ROLE Form Images in ePCR follow up audit have been completed. In addition, a CIAT report into missing St John PCRs posing a data breach risk has been undertaken and was presented at CIAG in July.

11. Of those indicated on the plan:
    - 3 have been completed, one in Q1, one in Q2 three in Q3 and two in Q4.
    - 4 are progressing as planned
    - 6 are yet to start, some are reliant on ePCR User Interface changes being implemented, some are not due to start until Q2.

12. The Clinical Audit Action Tracker is a dynamic document used to monitor and progress the actions as a result of learning from clinical audits. Progress with actions is monitored and supported by the Clinical Intelligence & Assurance Group, and at the Clinical Directorate Business meetings.

13. There are currently four completed clinical audits on the Action Tracker, with a total of 17 actions. Of those:
    - 10 have been completed
    - 2 are on track as planned
    - 5 are delayed (with mitigating / recovery actions taken)

RECOMMENDATION:

The committee:

Note the Q1 2025-2026 Clinical Audit Plan and Action Tracker update.

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Clinical Audit Plan

2025/2026
Quarter 1

Draft v0.2 Last Updated 03rd June 2025

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://nhswales365.sharepoint.com/sites/AMB-Intranet-Medical/SitePages/Clinical-Audit-Programme.aspx)

Head of Clinical Intelligence & Assurance

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			
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					
TBC	1	Clinical Frailty Scale (CFS) – follow-up audit (action from CIAT23_003)	Clinical Intelligence & Assurance Team	Head of Clinical Intelligence & Assurance	TBC	N/A	N/A			

TBC	1	Use of Magnesium Sulfate	Clinical Intelligence & Assurance Team	Head of Medicines Management	Indicative Q3 2025/26	N/A	N/A			
25_002	1	CI Care bundle compliance in Interhospital (IHT) patients	Clinical Intelligence & Assurance Team	Head of Clinical Intelligence & Assurance	Indicative Q1 2025/26	N/A				
TBC	1	Non-medical prescribing	Clinical Intelligence & Assurance Team	Head of Medicines Management	Indicative Q2 2025/26	N/A	N/A			
TBC	1	Trauma in older people Tool	Clinical Intelligence & Assurance Team	TBC	Indicative Q4 2025/26	N/A	N/A			
25_003	1	Appropriate use of antimicrobials	Clinical Intelligence & Assurance Team	Head of Medicines Management	Commenced Q1 2025/26	N/A				
25_004	1	Appropriate use of Ketamine	Clinical Intelligence & Assurance Team	Regional Clinical Lead – Consultant Paramedic	Commenced Q1 2025/26	N/A				
25_005	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
						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". Further decisions made to align reporting with Warwick, Welsh Registry and Joint Commissioning Committee (JCC). In the interest of efficiency CIAG to determine if this should be undertaken together with JRCALC and CFR subset QA work.
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	SQL developed. 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. Audit completed, presented to CIAG 20 03 25
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	TBC	Clinical Intelligence & Assurance Team	TBC	Required UI changes presented to ePCR CRG

Ref	Clinical Audit Title	Rationale/Drivers	Clinical Audit Author	Clinical Audit Contact/Support	Audit Start Date	Comments
		would assist in identifying areas for improvement for patient care and avoid unnecessary admission to Emergency Departments.				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.
TBC	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	Indicative Q1 25/26	
TBC	Use of Magnesium Sulfate	PGD being developed in 2025, potential need for audit when embedded into practice.	Clinical Intelligence & Assurance Co-ordinator	Clinical Intelligence & Assurance Team	Indicative Q3 2025/26	Indications for use, severe asthma in adults and children Pre-eclampsia, Eclampsia, Torsade de Pointes. CIAT will be notified when online training of Magnesium sulfate has reached 50% In the interim CIAT will

Ref	Clinical Audit Title	Rationale/Drivers	Clinical Audit Author	Clinical Audit Contact/Support	Audit Start Date	Comments
						supply monthly data on its use to Regional HBCL
25_002	CI Care bundle compliance in Interhospital Transfer (IHT) patients.	CIAG approved change to global IHT metric encompassing many more cases which would have previously been included in a Clinical Indicator. 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.	Clinical Intelligence & Assurance Co-ordinator	Clinical Intelligence & Assurance Team	Indicative Q1 2025/26	Audit commenced in Q1 as planned.
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
TBC	Trauma in older people Tool	Trauma in Older People Tool is a rebranding and is due for re-launch Potential need for audit once embedded into practice.	Clinical Intelligence & Assurance Co-ordinator	Clinical Intelligence & Assurance Team	TBC	

Ref	Clinical Audit Title	Rationale/Drivers	Clinical Audit Author	Clinical Audit Contact/Support	Audit Start Date	Comments
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
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	Indicative 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.

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Welsh Ambulance Services NHS Trust
Clinical Audit Action Tracker

Last updated 25th July 2025

High
Medium
Low

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		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	
				2		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 repesentation from operational staff 23/08/2024 - T&F group inaugaural meeting scheduled for 26/9/24 08/08/2024 - KC/RS/RT to meet in August to agree T&F group membership and scope	
				3		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	
				4		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	
				5		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.	
				6		Develop, quality assure, and implement the CI.	Kath Charters	31/12/2025	To follow all previous actions. Implementation to include education and awareness.	
B	09/01/2025	CIAT24_002	Tranexamic Acid Administration 2023/24	1		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	
				2		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	
				3		Issue a Clinical Notice with infographic to highlight key findings, recommendations, areas of good practice and areas for improvement.	Kevin Webb	28/02/2025	03/07/25 Clinical notices commenced and in working draft 03/06/25 - RT to draft clinical notice 29/4/25 - GL confirmed communication of audit findings by clinical notice 13/2/25 - Draft clinical notice dependent on clarification of flush guidance from HJ & SF, and any insights gained from staff feedback e.g. on gender disparity. 10/1/25 - RT to draft clinical notice for CP/TA comments and GL approval	
				4		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	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	
				4a		Additional action arising from CIAG TXA SBAR presented 13 12 24 Exploration required around the gender disparity in TXA administration	Vince Baglole	13/06/2025	04 06 25 KC advised CCIO via email of work undertaken by CIAT to explore use of nudge facility within ePCR. However this is not feesable and a tool tip has been suggested (as per email) with suggested wording 13 06 25 TXA gender disparity SBAR presented to CIAG	
C	09/01/2025	CIAT24_003	Major Trauma Triage Tool	1		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	
				2		Review and feedback to staff as required where patients were positive on the South Wales MTTT and a call to the trauma desk was not documented.	Carl Powell	28/02/2025	03/07/2025 CP confirmed that all cases have been reviewed and he will feed back to SPs imminently 25/04/25 CP confirmed that cases are being reviewed prior to feedback 14/04/25 RS email to CP for update 02/04/25 CP advised feedback is a work in progress 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	
				3		Issue a Clinical Notice with infographic to highlight key findings, areas of good practice and areas for improvement.	Kevin Webb	28/02/2025	03/07/25 Clinical notices commenced and in working draft 29/4/25 - GL confirmed communication of audit findings to be by clinical notice 13/2/25 - Draft clinical notice dependant on any insights gained from staff feedback 10/1/25 - RT to draft clinical notice for CP/TA comments and GL approval	
				4		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	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	

D	20/03/2025	CIAT24_005	Drug administration documentation in ePCR	1		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	
				2		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, inlcuding link to the report and infographic. 14/04/25 RS emailed Regional Clinical Leads reminding of action and request for confirmation as complete.	
				3		This clinical audit to be included on the agenda of the Medicines Management Group (when convened TBC) to discuss findings and implications for the Medicines Management Policy e.g. information recording requirements for medical gases and flushes.	Vince Baglole	**TBC**	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.	

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AGENDA ITEM No	**14**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**1**

Clinical Plan (Proof of Concept/Draft) 2025-2030

MEETING	Quality, Patient Experience & Safety Committee (QuESt)
DATE	5 August 2025
EXECUTIVE	Andy Swinburn, Executive Director of Paramedicine
AUTHOR	Jen Lloyd, Clinical Directorate Business Manager
CONTACT	Jen.lloyd@wales.nhs.uk

EXECUTIVE SUMMARY

The Clinical Plan is due a rewrite for 2025-2030 and the accompanying powerpoint presentation provides an outline of the format that will be used to develop and present the plan.

Led by Lisa Coghlin, Health Board Clinical Lead (Cardiff & Vale), the Clinical Directorate Leads have been developing content in the form of scripts for animation, podcasts, film and infographics to provide an interactive and user-focussed approach to the plan format.

The team are working with an independent design agency to develop the proof of concept with animation style, example pages and user journey flow included in the presentation.

KEY ISSUES/IMPLICATIONS

As part of the next phase following sharing of the plan with ELT, the team will be looking to have the following discussions to determine the upkeep and engagement for the report:

- Hosting and maintenance of the site holding the interactive clinical plan
- Branding and message alignment with other Trust documentation
- Engagement with wider Trust colleagues for content development and feedback
- Options regarding Welsh translation and how it can be utilised in the plan

REPORT APPROVAL ROUTE

- Clinical Directorate Task and Finish Group
- ELT

REPORT APPENDICES
Powerpoint demonstration of Clinical Plan Proof of Concept

REPORT CHECKLIST			
Confirm that the issues below have been considered and addressed		**Confirm that the issues below have been considered and addressed**	
EQIA (Inc. Welsh language)	NA	Financial Implications	Y
Environmental/Sustainability	NA	Legal Implications	Y
Estate	NA	Patient Safety/Safeguarding	Y
Ethical Matters	NA	Risks (Inc. Reputational)	Y
Health Improvement	NA	Socio Economic Duty	NA
Health and Safety	NA	TU Partner Consultation	NA

Welsh Ambulance Services University NHS Trust

Clinical Plan 2025–2030

GIG CYMRU NHS WALES

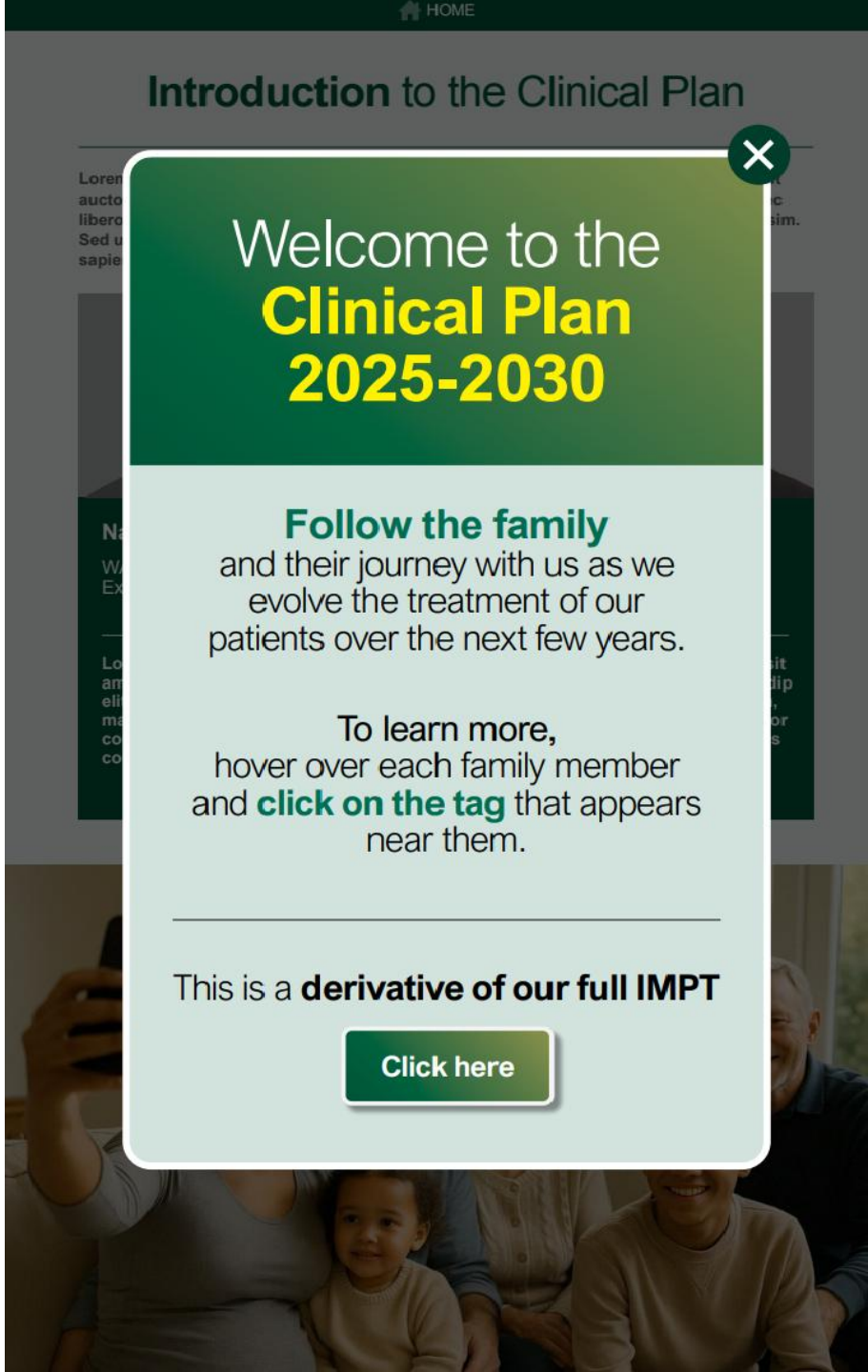
Ymddiriedolaeth Brifysgol GIG
Gwasanaethau Ambiwlans Cymru

Welsh Ambulance Services
University NHS Trust

Lisa O'Sullivan
Health Board Clinical Lead
Cardiff and The Vale

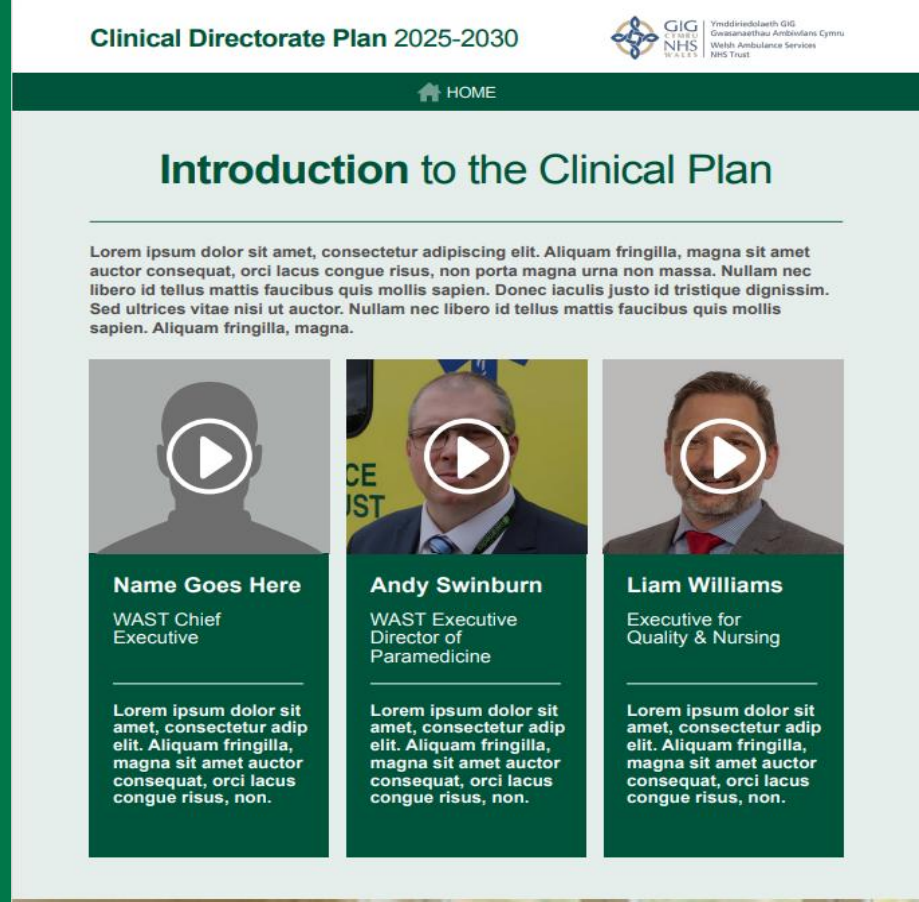
Purpose of the Interactive Website

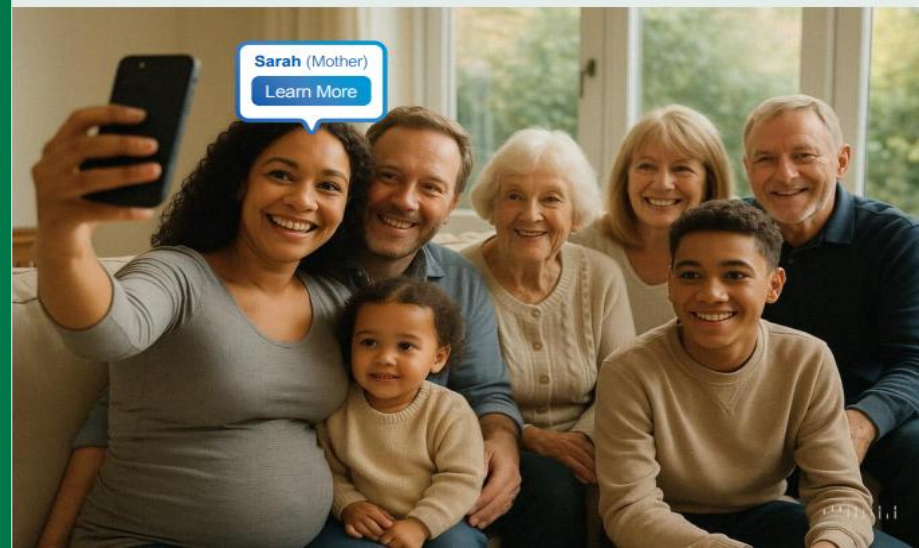
- Web-based platform developed with Fresh Communications.
- Outlines WAST's 5-year strategic clinical direction.
- Engages patients, staff, and stakeholders.
- Explains how WAST is transforming care delivery



The Jones Family- Storytelling

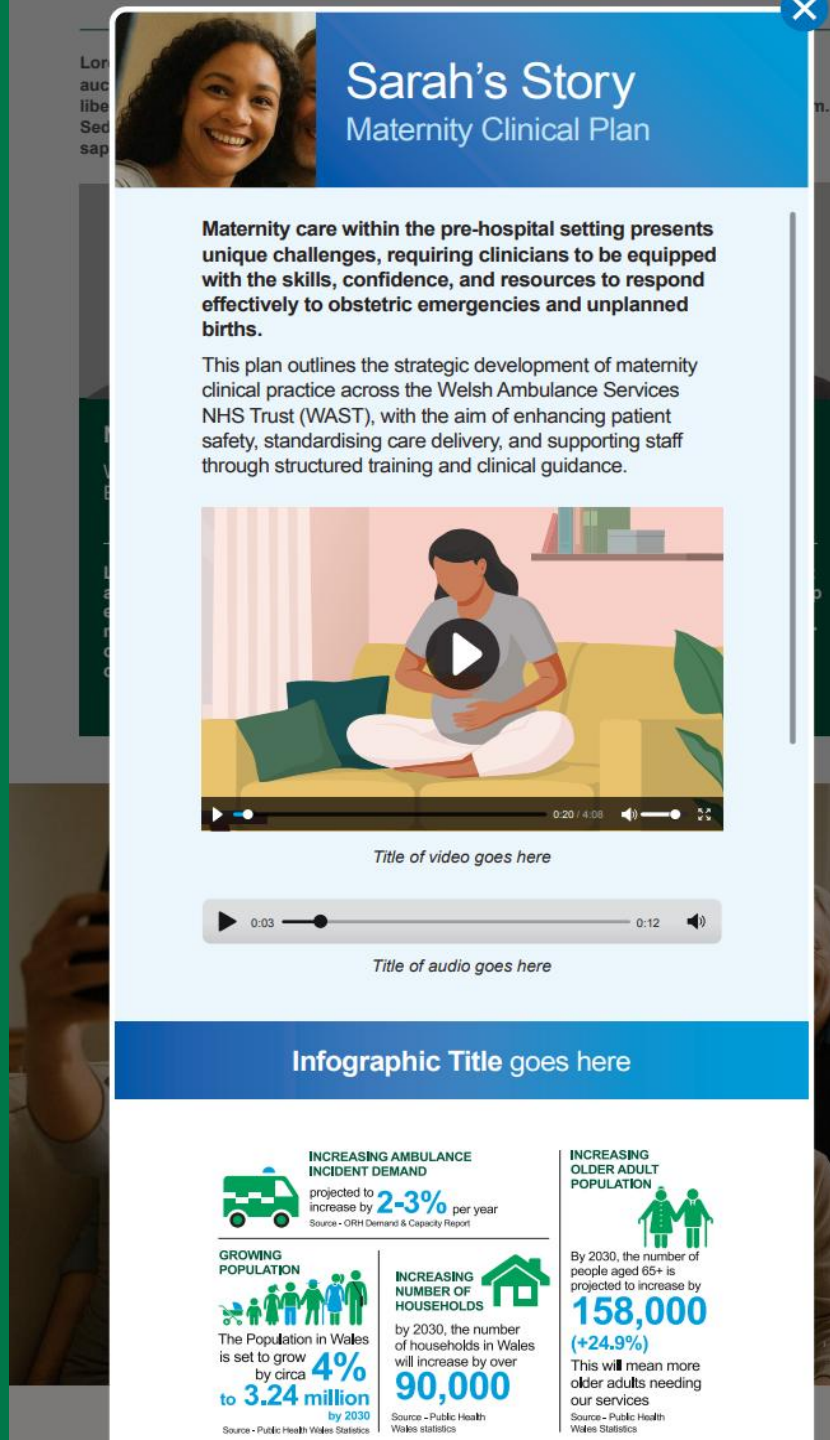
- Maisie (4): RSV & diabetes
- Ellis (14): Mental health & asthma
- Sarah: Early labour
- Dylan: Trauma & chest pain
- Bryn: Cardiac arrest, COPD
- Gwen: Stroke-like symptoms
- Delyth: Fall at home





The Jones Family- Storytelling

- Intuitive navigation
- Multimedia content: animations, films, podcasts, infographics, text.
- Accessible and engaging for all users



Our Enablers

Our Enablers

- Clinical Leadership & Supervision
- Digital
- Measures & Performance
- Research

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Measures & Performance

Subheading goes here

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Title of audio goes here

Thank you for listening

Any Questions?

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AGENDA ITEM No	**15**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**4**

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

MEETING	Quality, Patient Experience & Safety Committee
DATE	08 August 2025
EXECUTIVE	Trish Mills, Director of Corporate Governance / Board Secretary
AUTHOR	Julie Boalch, Assistant Director of Corporate Governance & Risk
CONTACT	Julie.Boalch@wales.nhs.uk

EXECUTIVE SUMMARY

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 for oversight.

2. 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.

3. The score is not based on the volume of cases of catastrophic harm; it is based on any one individual that experiences avoidable harm. The quality dimension of each of these risks will always be a challenging one to reduce whilst patients and the Trust are experiencing delays in the way in which they currently are.

4. Work has continued, since the last meeting, on the design and development of a different approach to presenting these risks which separates controls, assurances and gaps into internal and external themes and categories.

5. This approach describes those things 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.

6. 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 in the same way that this is done for other risk such as the Manchester Arena Inquiry and Cyber Security Risk.

7. 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.

8. Working drafts of Risks 223 and 224 are included at Annex 4 for discussion purposes and to highlight the direction of travel. There is still work to be done on both documents.

9. Members can take assurance that both principal risks have been reviewed during this reporting period in line with the agreed schedule detailed at Annex 3.

10. The Executive Leadership Team (ELT) approved the principal risk activity on 09 July 2025 having considered the review of each risk undertaken throughout June 2025 by Risk Owners and the Assistant Director Leadership Team (ADLT). There have been no material changes to the principal risks during this period.

11. Whilst reducing, handover delays continue to present patient safety risks and extended waits in the community with a deteriorating performance impact being outside of what is acceptable to deliver a safe emergency service.

12. The number of lost hours due to handover delays remained significant reported at 19,673 in May and 15,276 in June. That said, the drop in handover lost hours in June and onwards into July, demonstrates some improvement across key hospital sites in reducing handover delays. Whilst this marks positive and welcome progress towards the 45-minute handover ambition, this downwards trajectory must continue to be sustained over a longer period of time prior to any consideration of a reduction in risk score.

13. 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.

14. 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 which 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.

15. 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.

16. It is important to note that there has been close scrutiny of these two risks in dedicated workshops; the outcome of which is presented to Members today for discussion.

RECOMMENDATION:

17. **Members are asked to consider the contents of the report.**

KEY ISSUES/IMPLICATIONS
18. The key issues are set out in the Executive Summary above.
REPORT APPROVAL ROUTE
19. The BAF was considered by: • Executive Leadership Team (09 July 2025)

REPORT ANNEXES
• Annex 1 - Summary table describing the Trust's Corporate Risks. • Annex 2 – Scoring Matrix • Annex 3 – Frequency of Risk review • Annex 4 - Board Assurance Framework

REPORT CHECKLIST			
Confirm that the issues below have been considered and addressed		**Confirm that the issues below have been considered and addressed**	
EQIA (Inc. Welsh language)	NA	Financial Implications	NA
Environmental/Sustainability	NA	Legal Implications	NA
Estate	NA	Patient Safety/Safeguarding	NA
Ethical Matters	NA	Risks (Inc. Reputational)	NA
Health Improvement	NA	Socio Economic Duty	NA
Health and Safety	NA	TU Partner Consultation	NA

Annex 1 – Corporate Risk Register Summary

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
223 QuEST	The Trust's inability to reach patients in the community causing patient harm and death	**IF** significant internal and external system pressures continue **THEN** there is a risk of an inability and/or a delay in ambulances reaching patients in the community **RESULTING IN** patient harm and death	Director of Operations	**25 (5x5)** →
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	**IF** patients are significantly delayed in ambulances outside A&E departments **THEN** there is a risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised **RESULTING IN** patients potentially coming to harm and a poor patient experience	Director of Quality & Nursing	**25 (5x5)** →

Annex 2 - Risk Scoring Matrix

Consequence:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Safety & Well-being - Patients/ Staff/Public	Minimal injury requiring no/minimal intervention or treatment. No time off work. Physical injury to self/others that requires no treatment or first aid. Minimum psychological impact requiring no support. Low vulnerability to abuse or exploitation - needs no intervention. Category 1 pressure ulcer.	Minor injury or illness, requiring minor intervention. Requires time off work for >3 days Increased hospital stay 1-3 days. Slight physical injury to self/others that may require first aid. Emotional distress requiring minimal intervention. Increased vulnerability to abuse or exploitation, low level intervention. Category 2 pressure ulcer.	oderate 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.
Quality/ Complaints/ Assurance/ Patient Outcomes	Peripheral element of treatment or service suboptimal. Informal complaint/inquiry.	Overall treatment/service suboptimal. Formal complaint (Stage 1). Local resolution. Single failure of internal standards. Minor implications for patient safety. Reduced performance.	Treatment/service has significantly reduced effectiveness. Formal complaint (Stage 2). Escalation. Local resolution (poss. independent review). Repeated failure of internal standards. Major patient safety implications.	Non-compliance with national standards with significant risk to patients. Multiple complaints/independent review. Low achievement of performance/delivery requirements. Critical report.	Totally unacceptable level or quality of treatment/service. Gross failure of patient safety. Inquest/ombudsman/inquiry. Gross failure to meet national standards/requirements.
Workforce/ Organisational Development/ Staffing/ Competence	Short-term low staffing level that temporarily reduces service quality (< 1 day).	Low staffing level that reduces the service quality.	Late delivery of key objective/service due to lack of staff. Unsafe staffing level (>1 day)/competence. Low staff morale. Poor staff attendance for mandatory/key professional training.	Uncertain delivery of key objective/ service due to lack/loss of staff. Unsafe staffing level (>5 days)/competence. Very low staff morale. Significant numbers of staff not attending mandatory/key professional training.	Non-delivery of key objective/service due to loss of several key staff. Ongoing unsafe staffing levels or competence/skill mix. No staff attending mandatory/professional training.
Statutory Duty, Regulation, Mandatory Requirements	No or minimal impact or breach of guidance/statutory duty.	Breach of statutory legislation. Reduced performance levels if unresolved.	Single breach in statutory duty. Challenging external recommendations/improvement notice.	Enforcement action. Multiple breaches in statutory duty. Improvement notices. Low achievement of performance/ delivery requirements. Critical report.	Multiple breaches in statutory duty. Zero performance rating. Prosecution. Severely critical report. Total system change needed.
Adverse Publicity or Reputation	Rumours. Low level negative social media. Potential for public concern.	cal media coverage - short-term reduction in public confidence/trust. ort-term negative social media. blic expectations not met.	Local media coverage - long-term reduction in public confidence & trust. Prolonged negative social media. Reported in local media.	National media coverage <3 days, service well below reasonable public expectation. Prolonged negative social media, reported in national media, long-term reduction in public confidence & trust. Increased scrutiny: inspectorates, regulatory bodies and WG.	National/social media coverage >3 days, service well below reasonable public expectation. Extensive, prolonged social media. MP/MS questions in House/Senedd. Total loss of public confidence/trust. Escalation of scrutiny status by WG.
Business Objectives or Projects	Insignificant cost increase/ schedule slippage.	<5 per cent over project budget. Schedule slippage.	5–10 per cent over project budget. Schedule slippage.	Non-compliance with national targets.10-25 per cent over project budget. Schedule slippage. Key objectives not met.	>25 per cent over project budget. Schedule slippage. Key objectives not met.
Financial Stability & Impact of Litigation	Small loss. Risk of claim remote.	Loss of 0.1–0.25% of budget Claim less than £10,000.	Loss of 0.25–0.5% of budget. Claim(s) between £10,000 and £100,000.	Uncertain delivery of key objective. Loss of 0.5-1.0% of budget. Claim(s) between £100,000 and £1 million. Purchasers failing to pay on time.	Non-delivery of key objective. Loss of >1 per cent of budget. Failure to meet specification. Claim(s) >£1 million. Loss of contract/payment by results.
Service/ Business Interruption	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours. Some disruption manageable by 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.
Environment/Estate/ Infrastructure	Minimal or no impact on environment/service/property.	Minor impact on environment/ service/property.	Moderate impact on environment/ service/property.	Major impact on environment/ service/property.	Catastrophic impact on environment/service/property.
Health Inequalities/ Equity	Minimal or no impact on attempts to reduce health inequalities/improve health equity.	Minor impact on attempts to reduce health inequalities or lack of clarity on the impact on health equity.	Lack of sufficient information to demonstrate reducing equity gap, no positive impact on health improvement or health equity.	Validated data suggests no improvement in the health of the most disadvantaged, whilst supporting the least disadvantaged, no impact on health improvement and/or equity.	Validated data demonstrates a disproportionate widening of health inequalities, or negative impact on health improvement and/or equity.

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

Annex 4 – Board Assurance Framework

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death		Date of Review:	08/07/2025	TREND	OVERALL 25 (5x5)
			Date of Next Review:	08/08/2025	➡	

IF	THEN	RESULTING IN
significant internal and external system pressures continue	there is a risk of an inability and/or a delay in ambulances reaching patients in the community	patient harm and death

	External (LxC)			Internal (LxC)		
Inherent						
Current						
Target						

Strategic objective 1: Providing the right care or advice, in the right place, every time

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.

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.

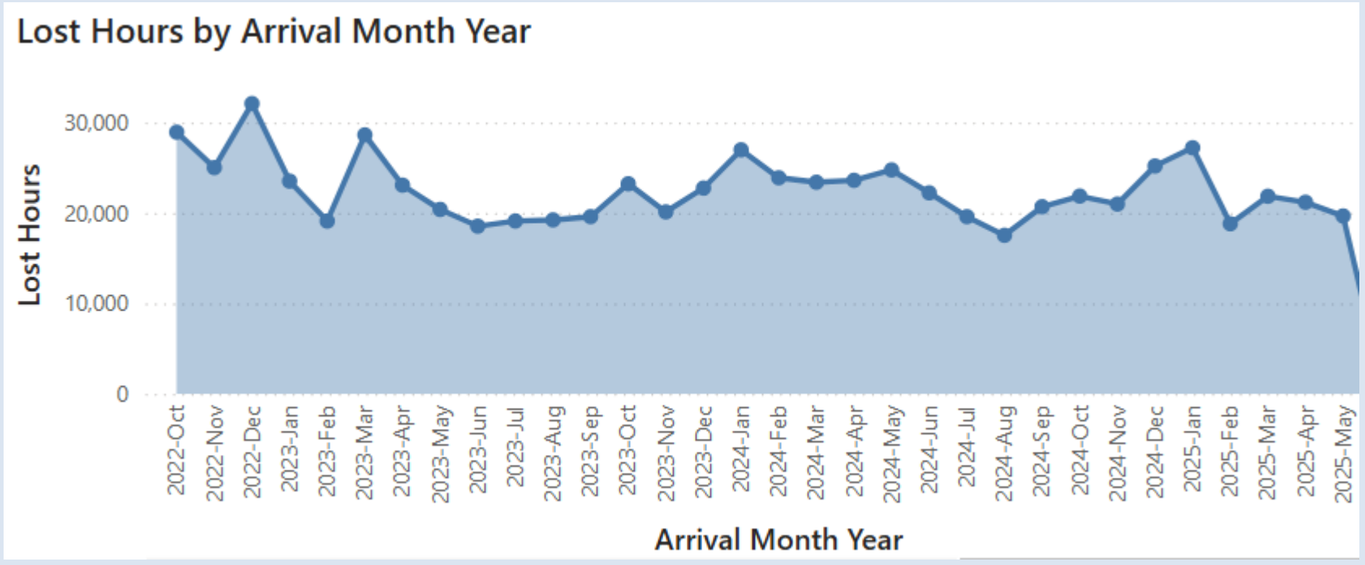
The next steps will include testing separate risk scores for internal and external mitigations, to support the demonstration of the impact of actions taken. This will not affect the overall score of 25 (5x5) which reflects the severity of patient harm and death.

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.

EXECUTIVE OWNER	Executive Director of Operations	ASSURANCE COMMITTEE	Quality, Safety and Patient Experience Committee

Risk Commentary



CONTROLS	ASSURANCES
MONITOR - External	External ***Monitor outcomes and provide regular reports to stakeholders. This ensures while external factors may impact the risk it is monitored and managed effectively.***
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.

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	08/07/2025	TREND	OVERALL 25 (5x5)
		Date of Next Review:	08/08/2025	➡	

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. Local Delivery Units – Hywell Dda and BCU	3. 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
4. Ministerial Advisory Group (MAG)	4. 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.
5. 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 ***How do we know the controls are effective. How will these impact the target risk score?***	Internal ***over the three lines of assurance. How do we know the assurances are effective*** ***Provide assurance on managing controls to ensure the Trust is doing everything in its capacity to reduce the impact of the risk***		
Control 1 – Policies/SOPs 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).	**First Line of Assurance** Daily conference calls (National Huddle) to agree RE levels in conjunction with health boards, weekly Performance, Demand and Capacity meetings to review REAP levels.	**Second Line of Assurance** ODU dashboards, Performance Demand and Capacity performance metrics data and DATIX and compliance reporting to the COO's.	**Third Line of Assurance** Ministerial Advisory Group and Audit Wales investigation of Urgent and Emergency Care System (awaiting report from Audit Wales)
Control 2 – Performance/Tactics ETA Scripting, CCC Emergency Rule, Red call performance, Transfer of Care, ARA (Swansea and YGC), EMS Demand and Capacity Review.	**First Line of Assurance** 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.	**Second Line of Assurance** 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).	**Third Line of Assurance** Ministerial Advisory Group, Audit Wales investigation of Urgent and Emergency Care System (awaiting report from Audit Wales)
Control 3 – Operational Activities National Risk Huddles, Performance, Demand and Capacity meetings, WAST Serious Clinical Incident Forum (SCIF), Operational Handover Group	**First Line of Assurance** Daily Risk Huddles, Weekly Performance Demand and Capacity Meetings, Local business meetings.	**Second Line of Assurance** 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).	**Third Line of Assurance** Ministerial Advisory Group, NHS Exec Handover Group, Audit Wales investigation of Urgent and Emergency Care System (awaiting report from Audit Wales)
Control 4 – Resources 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.	**First Line of Assurance** CSP review and escalation, On Call team start and end of shift, Performance, Demand and Capacity Meetings, Senior Leadership Team meetings.	**Second Line of Assurance** Shift reports, CSP review, On Call rota review, APP Dashboard, Volunteer performance highlight reporting.	**Third Line of Assurance** Ministerial Advisory Group, Audit Wales investigation of Urgent and Emergency Care System (awaiting report from Audit Wales)
Control 5 – Clinical Model Transformation (CMT) Consult and Close (including Mental Health Practitioners), Clinical review of code sets, Remote Clinical Support, Rapid Clinical Screening, expansion of See and Treat resources.	**First Line of Assurance** CPAS, DCR and CQGG Meetings, Clinical Model Transformation Project Board. Senior Leadership Team Meetings. Performance, Demand and Capacity Meetings.	**Second Line of Assurance** Performance, Demand and Capacity metric reporting, CPAS/DCR reporting, Volunteer highlight reporting, clinical model transformation highlight report.	**Third Line of Assurance** Audit Wales investigation of Urgent and Emergency Care System (awaiting report from Audit Wales)

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	08/07/2025	TREND	OVERALL 25 (5x5)
		Date of Next Review:	08/08/2025	➡	

GAPS IN CONTROLS	GAPS IN ASSURANCE
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.
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.
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.
2.	2.
3.	3.

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		**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.**
2. Royal Glamorgan working to 45 minute handover	Sonia Thompson, Assistant Director of Operations		**Jun 25 – Handovers with average of 30 mins. Current ongoing discussion to rollout trial in other areas.**
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		
4. Cross reference the IMTP 2025-27 plan/deliverables with Corporate Risk 223	Judith Bryce, Assistant Director of Operations, National Ops and Support		**Jun 25 – this is planned for the IMTP assurance meeting on 14th July.**
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		**Jun 25 – Awaiting report from Audit Wales** May 25 – Awaiting report from Audit Wales which will come through Audit Committee.

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:	16 July 2025	TREND	OVERALL 25 (5x5)
		Date of Next Review:	16 August 2025	➡	

IF patients continue to be significantly delayed in ambulances outside Accident and Emergency Departments	**THEN** 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	**RESULTING IN** patients coming to significant harm and a poor patient experience

	External (LxC)			Internal LxC)		
Inherent						
Current						
Target						

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.

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.

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.

EXECUTIVE OWNER	Executive Director of Quality and Nursing	**ASSURANCE COMMITTEE**	Quality, Patient Experience and Safety Committee

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 pending 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 agreed standards into routine delivery at every level of the system.

CONTROLS	**ASSURANCES**
MONITOR - External	External ***Monitor outcomes and provide regular reports to stakeholders. This ensures while external factors may impact the risk it is monitored and managed effectively.***
1. **Welsh Health Circular WHC/2024/041: NHS Wales Hospital Handover Guidance (15-minute standard)**	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.

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:	16 July 2025	TREND	OVERALL 25 (5x5)
		Date of Next Review:	16 August 2025		

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.	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. **Six Goals for Urgent and Emergency Care Programme** Goal 4 *Rapid response in physical or mental health crisis.* 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. **NHS Wales Performance Framework 2024-25** 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. **NHS Wales Quality and Safety Framework and Duties of Quality and Candour** 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. **Nationally led operational escalation responses** Risk Huddles, hospital escalation levels and daily national operational call	

MITIGATE - Internal ***How do we know the controls are effective. How will these impact the target risk score?***	Internal ***over the three lines of defence. How do we know the assurances are effective Provide assurance on managing controls to ensure the Trust is doing everything in its capacity to reduce the impact of the risk***		
Control 1: Policies/SOPs/Resources 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). 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. 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.	**First Line of Assurance (Operational)** ODU shift reports, CSP real-time updates, REAP actions logged and enacted in real time; daily huddle notes and agreed actions monitored by Operational Delivery Unit	**Second Line of Assurance (Internal Monitoring)** Senior Leadership Team (SLT) weekly review of Resource Escalation Action Plan (REAP), Integrated Quality and. Performance Report (IQPR)	**Third Line of Assurance** JCC and IQPD reporting. Ministerial Advisory Group and Audit Wales investigation of Urgent and Emergency Care System *(awaiting report from Audit Wales)*
Control 2: Clinical Guidance for staff 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	**First Line of Assurance (Operational)** Datix incident reporting of any cases where clinical concerns are escalated. Incident management	**Second Line of Assurance (Internal Monitoring)** Oversight of incident management and learning through Ambulance Practice	**Third Line of Assurance** National reporting of high severity incidents.

over to the hospital. The guidance ensures safe and appropriate clinical management within appropriate scopes of clinical practice. The Clinical Notice 07/2021 *Escalating a clinical concern with a deteriorating patient outside the Emergency Department* 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 ≥5 for patients is reinforced via national clinical notices.	processes are followed in accordance with the Trust's Adverse Incident Policy. Compliance with mandatory training and competency standards	Steering Group (APSG), Clinical Quality Governance Group and QuESt.	Ministerial Advisory Group and Audit Wales investigation of Urgent and Emergency Care System *(awaiting report from Audit Wales)*
Control 3: Clinical Governance mechanisms 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. 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 *Section 4 Joint investigation* process of the *National Policy on Patient Safety Incident Reporting (May 2023)*. Learning from these incidents should be shared with the Trust once the Health Board has completed their investigation.	**First Line of Assurance (Operational)** Incident reports (Datix); regular meetings to capture learning medical examiner referrals; SCIF meeting records; immediate actions taken and documented in safety briefings	**Second Line of Assurance (Internal Monitoring)** Reporting to Clinical Quality Governance Group (CQGG); assurance papers to QuEST and other Board Committees	**Third Line of Assurance** NHS Wales Internal Audit, external reporting of severe harm incidents (Nationally Reportable Incidents). Ministerial Advisory Group and Audit Wales investigation of Urgent and Emergency Care System *(awaiting report from Audit Wales)*
Control 4: Implementation of Duty of Quality, Candour & Quality Standards 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.	**First Line of Assurance (Operational)** Compliance with statutory reporting duties – training and awareness uptake	**Second Line of Assurance (Internal Monitoring)** Monthly updates through Quality Management Group (QMG)? Monitoring via CQGG Quality dashboard under development	**Third Line of Assurance** 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 *(awaiting report from Audit Wales)*
Control 5: Clinical Model Transformation (CMT) Consult and Close (including Mental Health Practitioners), Clinical review of code sets, Remote Clinical Support, Rapid Clinical Screening, expansion of See and Treat resources.	**First Line of Assurance (Operational)** CPAS, DCR and CQGG Meetings, Clinical Model Transformation Project Board. Senior Leadership Team Meetings. Performance, Demand and Capacity Meetings.	**Second Line of Assurance (Internal Monitoring)** Performance, Demand and Capacity metric reporting, CPAS/DCR reporting, Volunteer highlight reporting, clinical model transformation highlight report.	**Third Line of Assurance** Ministerial Advisory Group and Audit Wales investigation of Urgent and Emergency Care System *(awaiting report from Audit Wales)*
GAPS IN CONTROLS	**GAPS IN ASSURANCE**		
External	External		
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.	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.		
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.	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.		
Internal	Internal		

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:	16 July 2025	TREND	OVERALL 25 (5x5)
		Date of Next Review:	16 August 2025		

1.	1. Routine clinical audit of patient management or deterioration during delayed handovers of care
2.	2. Improved reporting on outcomes of joint investigations

Actions to reduce risk score or address gaps in controls and assurances	Action Owner (Internal only)	Completion / Milestone date	Progress Update
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
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 1st July - phase one, code changes.
3. Cross reference the IMTP 2025-27 plan/deliverables with Corporate Risk 224	Deputy Director of Nursing, QSPE	Q2 2025	
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.

AGENDA ITEM No	**16**
OPEN or CLOSED	**OPEN**
No of ANNEXES	**1**

AUDIT TRACKER – June 2025 (2025/26 Q1)

MEETING	Quality, Experience and Patient Safety Committee (QuEST)
DATE	25 July 2025
EXECUTIVE	Trish Mills, Director of Corporate Governance/Board Secretary
AUTHOR	Lisa Trounce, Head of Compliance & Assurance
CONTACT	trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. This paper provides the Committee with the 2025/26 Q1 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.

3. The Audit Tracker has been updated in Quarter 1 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. At the beginning of 2025/26 Quarter 1, there were 28 open internal audit recommendations relevant to the Committee. Of the 28 open audit recommendations, 16 were due for closure in quarter, and 11 not due.

5. By the end of the quarter, 10 of the 16 (63%) audit recommendations due for closure were confirmed as completed. Of those, three were reported as completed

before the audit was concluded, four met their original deadlines, while the remaining three were completed after one deadline revision.

6. New revised deadlines have been proposed for five recommendations: four from 2023/24 (all on their second revision), and one from 2024/25 (on its first revision). These new revised deadlines relate to the 2023/24 Electronic Patient Clinical Records (ePCR) internal audit, and 2024/25 Roll-out of Penthrox internal audit.

7. Particular attention is drawn to the four open 2023/24 recommendations (681, 683, 684 and 686) relating to the Electronic Patient Clinical Records (ePCR) internal audit. These were originally assigned to the Clinical Directorate but transferred to the Digital Directorate in March 2025, due to their digital nature. Of these, three were already on their final revised deadlines which have all now lapsed.

8. To ensure progress on the ePCR audit recommendations, on 16 June 2026 a meeting was held between the Digital Directorate and Internal Audit to review the outstanding recommendations and agree realistic revised deadlines. Internal Audit were content with the updates provided and proposed next steps. As an outcome of this meeting three of these recommendations have had amended third revised dates of April 2026 applied, with the other outstanding recommendation (Ref: 686) remaining on its existing second revision of September 2025.

External Audit

9. A Concerns Assessment undertaken by the Welsh Risk Pool (WRP) Safety and Learning Team was completed in February 2025, and reviewed in March by the Quality and Nursing Directorate – this resulted in 32 new audit recommendations being added to the tracker in 2025/26 Quarter 1.

10. At the beginning of 2025/26 Quarter 1, there were 44 open external audit recommendations relevant to the Committee: 12 relating to the 2023-24 Quality Governance Follow Up Review, and 32 resulting from the aforementioned WRP Concerns Assessment 2024.

11. Of the 44 open external audit recommendations, 20 were due for closure in quarter, and 24 not yet due.

12. By the end of the quarter, 6 of the 20 (30%) audit recommendations due for closure were confirmed as completed. Of these, two were completed before the report was internal audit was finalised, one met its original deadline, and three due in December 2025 were completed ahead of time.

13. New revised deadlines have been proposed for 17 (53%) of the 32 WRP Concerns Assessment 2024 open recommendations. The shift in dates is required as the backlog of investigations and concerns has been growing. A paper highlighting

the risk in responding to families, patients, coroners, medical examiners and NHS partners, was discussed by the Executive Leadership Team at the end of July 2025 and will later be presented to this committee. The Quality, Safety and Patient Experience Directorate is working on development of a new risk for presentation through the governance processes, and audit improvement will feature as a component to this risk.

14. Particular attention is drawn to three of the WRP Concerns Assessment 2024 audit recommendations (EA/2425-027, EA/2425-031, and EA/2425-35) which all relate to Power BI reporting and are dependent upon automated extraction work.

15. The current version of the tracker is now open for Directorate review for actions due in July, August and September 2025. These updates will then be reported to the Committee at its meeting in November 2025.

RECOMMENDATION

16. 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 revised dates applied to a high number of audit action related to the Welsh Risk Pool Concerns Assessment 2024.

KEY ISSUES/IMPLICATIONS
As set out above.

REPORT APPROVAL ROUTE
2025/26 Q1 Audit Tracker updates presented to the Assistant Directors Leadership Team (shared via email on 100725).

REPORT APPENDICIES
Tracker 2.0 25-26 Q1 (April - June 2025) – QuEST 050825 [in reading room]
• Annex 1 – Audit Tracker 2.0 – 25-26 Q1 Internal Audit Actions (Up to 2023/24)
• Annex 2 – Audit Tracker 2.0 – 25-26 Q1 Internal Audit Actions (2024/25)
• Annex 3 – Audit Tracker 2.0 – 25-26 Q1 External Audit Actions (2023/24)
• Annex 4 – Audit Tracker 2.0 – 25-26 Q1 External Audit Actions (2024/25)

REPORT CHECKLIST			
Confirm that the issues below have been considered and addressed		**Confirm that the issues below have been considered and addressed**	
EQIA (Inc. Welsh language)	NA	Financial Implications	NA
Environmental/Sustainability	NA	Legal Implications	NA
Estate	NA	Patient Safety/Safeguarding	NA
Ethical Matters	NA	Risks (Inc. Reputational)	NA
Health Improvement	NA	Socio Economic Duty	NA
Health and Safety	NA	TU Partner Consultation	NA

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

AGENDA ITEM No	**16.1**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**1**

INTERNAL AUDIT: START OF SHIFT PROCEDURE – COMMENTS FROM ARAC

MEETING	Quality, Patient Experience and Safety Committee
DATE	5 August 2025
EXECUTIVE	Trish Mills, Director of Corporate Governance/Board Secretary
AUTHOR	Sarah Harland, Corporate Governance Officer
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. The Audit, Risk and Assurance Committee (the ARAC) received and discussed the **Start of Shift Procedure audit report** at its meeting on 24 June 2025. This report summarises the discussion from this meeting in reference to this report.

2. **Start of Shift Procedure – Limited Assurance**. The purpose was to assess compliance with the Start of Shift procedure, including the preparation of vehicles and to ensure that key equipment and medicines are available.

3. The Trust's 'Shift Start and Finish' Standard Operating Procedure (SOP), which was last reviewed in March 2024, sets out an agreed process for staff during the commencement and completion of operational shifts, which includes coverage to comply with the requirements of the Road Traffic Act 1998. These arrangements apply to all operational staff within Emergency Medical Services (EMS) and Ambulance Care, and exist to ensure increased efficiencies at the commencement of each shift.

4. Two objectives in the audit were rated reasonable assurance, three limited and one substantial. Three medium priority and two high priority recommendations were raised. The Quality Patient Experience and Safety Committee has oversight of the audit actions and will receive this report at its August meeting.

5. To address the findings, the existing Vehicle Accident Management Task and Finish Group will expand its scope to develop a more efficient system for recording checks and update the SOP accordingly. Judith Bryce and Rhiannon Beaumont-Wood supported the changes, highlighting the need for improved evidence and accessibility. Damon Turner linked the

challenges to wider system pressures, including hospital delays. The Committee welcomed the assurance that progress will be monitored through the Senior Operations Team and reported to the Senior Leadership Team.

RECOMMENDATION: With the onward receipt of the Start of Shift Procedure Internal Audit Report, the committee is asked to take assurance from the outcome of the audit and to note the discussion at the meeting of the ARAC on 24 June 2025.

KEY ISSUES/IMPLICATIONS
Not applicable.

REPORT APPROVAL ROUTE
Not applicable.

REPORT APPENDICES
Appendix 1 Start of Shift Procedure audit report

REPORT CHECKLIST			
Confirm that the issues below have been considered and addressed		**Confirm that the issues below have been considered and addressed**	
EQIA (Inc. Welsh language)	NA	Financial Implications	NA
Environmental/Sustainability	Y	Legal Implications	Y
Estate	NA	Patient Safety/Safeguarding	NA
Ethical Matters	Y	Risks (Inc. Reputational)	NA
Health Improvement	Y	Socio Economic Duty	NA
Health and Safety	Y	TU Partner Consultation	NA

Start of Shift Procedure

Final Internal Audit Report

2024/25

Welsh Ambulance Services University NHS Trust

Limited Assurance

Contents

Review Reference	WAS-2425-11
Fieldwork	April – May 2025
Executive Sign Off	12 June 2025
Audit Committee	24 June 2025
Executive Lead	Lee Brooks, Executive Director of Operations
Audit Team	Osian Lloyd, Head of Internal Audit; Felicity Quance, Deputy Head of Internal Audit

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

To assess compliance with the Start of Shift procedure, including the preparation of vehicles and to ensure that key equipment and medicines are available.

Overview

The Trust's 'Shift Start and Finish' Standard Operating Procedure (SOP), which was last reviewed in March 2024, sets out an agreed process for staff during the commencement and completion of operational shifts, which includes coverage to comply with the requirements of the Road Traffic Act 1998. These arrangements apply to all operational staff within Emergency Medical Services (EMS) and Ambulance Care, and exist to ensure increased efficiencies at the commencement of each shift.

Section 5 of the document clearly sets out the requirements that should be followed by staff when they start their shift, and such has formed the basis of the individual objectives at this review.

Whilst we recognise, anecdotally, that such checks are completed by staff, there is limited evidence available to support and minimal reporting to confirm overall compliance with expectation. Accordingly, we have concluded **limited assurance** on this area. The matters requiring management attention include:

- Review the content of the SOP to align with current practices, including the distinction between expectations for Ambulance Care and EMS as well as training to be undertaken to increase the awareness of the document and the expectations within;
- To address non-compliance with the SOP, consideration of an electronic solution to record, and approve, the completion of the checks required before the start of a shift; the output of which will be saved in a central repository;
- Scheduled reviews of consumables held on the Trust vehicles to rationalise and therefore prevent wastage and excessive ordering; and
- Routine reporting to be undertaken in relation to the compliance with the SOP, which the data collated from an electronic solution could support.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

Scope & Assurance Summary

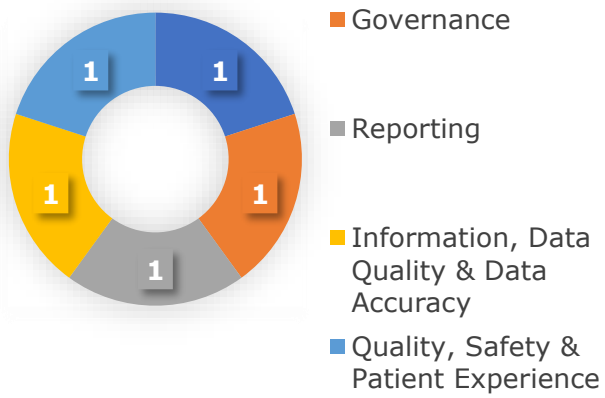
Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	The 'Shift Start and Finish' SOP clearly sets out the requirements to be followed and is communicated and made available to all staff.	1, 2	**Reasonable**
2	Staff book onto the MDT immediately at the commencement of shift which aligns with their working pattern.	-	**Substantial**
3	The checks required before mobilising to any call, as defined with the SOP, are completed and evidenced appropriately.	2, 3	**Limited**
4	For instances where mobilisation checks are not possible (i.e. red incident allocation) this is effectively communicated as per the SOP and evidenced as complete at the earliest opportunity.	3, 5	**Limited**
5	Clinical and equipment checks including morphine are completed at the first available opportunity within the shift, with escalation of any missing or deficient equipment or medication.	4	**Reasonable**
6	Periodic reports on the compliance with SOP are produced and submitted to appropriate management and Trust committees for oversight and escalation.	1, 3, 5	**Limited**

Management Actions

2
High Priority

3
Medium Priority

Themes



Risk Types

Quality or Safety Issues

Legal & Regulatory Non-Compliance

Public Perception & Reputational Risk

Findings & Agreed Action Plan

Objective 1: Procedures	Reasonable

The 'Shift Start and Finish Standing Operating Procedure' (the SOP) is clear and concise in terms of setting out the requirements of staff for both the start and finish of a shift, with Section 5.1 specifically focused on the start of shift arrangements. The SOP is saved on the Trust's Siren page and therefore accessible to all, however, the outcome of an Ambulance Care Quality & Support Day (February 2025) noted that approximately 25% of staff were not aware of the SOP (see **Key Finding 1**).

Coverage of the SOP includes completion of the legal Vehicle Daily Inspection (VDI) checks to comply with the Road Traffic Act, Personal Protective Equipment (PPE) checks; and clinical and equipment checks (see *objective 5*). Detail is also provided in respect of expected time completion of the checks, with 15 minutes determined for a 'cold vehicle' (as per the SOP: *where the vehicle has not been taken over from another crew*); and 10 minutes for others. Appendix 1 to the SOP provides the checklist to be completed by staff as part of these arrangements. Discussions held with staff noted that it is not deemed achievable to undertake all the required checks within the time dedicated - regardless of whether they are allocated to a call at the start of a shift. We also acknowledge that for those stationed at a Make Ready Depot (MRD), there is an assumption such would permit more 'ready' vehicles available; however, noting the current system pressures with handover delays this is not always achievable.

As per the VDI form, there are 26 checks expected to be completed (14 of which have been highlighted as high importance). We also note that on each vehicle is the MDVS (Mobile Data Vehicle System) which includes checks to replicate those included in the VDI – to be signed off as pass/fail. There are a total of 11 checks included on the MDVS. Review of the detail across both has determined that the MDVS covers the same checks listed, however, the VDI is more specific in the expected coverage. For example:

Action as per VDI form	Action as per MDVS
Carry out a general bodywork check looking for damage or anything that could cause a hazard, report any new damage in the defect book.	*Body work and number plates*
Walk round all automatic emergency lighting check.	*All lights, reflectors and indicators.*
Check all light, reflectors, side, head rear, stop and indicators, fog and hazard warning lights are working correctly	

There is no reference within the SOP as to the expectation for the pass/fail acceptance of the MDVS, and the timeframe within which such should be completed following commencement of the shift; and whether such is a supplement or replacement to the VDI checks as currently referenced (see **Key Finding 2** and *objective 3* for further details in relation to completion of the checks).

Key Findings		Risk & Impact	Agreed Management Action
1	**Awareness of the SOP** In February 2025, as part of the Quality & Support days, Ambulance Care focused on enhancing the operational efficiency and safety of ambulance services, particularly through the lens of Shift Start and Vehicle Security during shifts. Weaknesses were noted in relation to awareness of the SOP; as well as completion of expected forms (see Key Finding 3) and the time taken to be taken to complete the checks. As has been reported within the Operations Quarterly Sub-Report (Q4) such has highlighted a training need. Whilst it is appreciated these results are specific to Ambulance Care, consideration should also be given to understanding the current practices applied within EMS to confirm awareness of the SOP.	Non-compliance with legal requirement for vehicle checks.	**Agreed Action:** Communications will be circulated to reinforce the SOP and its contents. The timing of this will coincide with the release of an updated SOP (as reflected in Key Finding 2). **Expected Evidence of Implementation:** Copy of the communications.
		Medium Priority	**Officer:** Sonia Thompson (Assistant Director of Operations, EMS) and Mark Harris (Assistant Director of Operations, Ambulance Care) **Target Implementation Date:** October 2025
	Theme: Policies & Procedures	Control Design	
2	**Update to SOP to reflect current practices** As detailed within the SOP for Start of Shift arrangements: '*staff must complete their legal VDI checks (Appendix 1) to comply with the Road Traffic Act, prior to mobilising any call.*' As reported from a recent Quality & Support day, only 50% of those in Ambulance Care are completing the forms alongside the acknowledgments included in the MDVS; with the rest only using the MDVS. However, there is no reference to MDVS within the SOP which could raise confusion as to whether such is a supplement to, or replacement for, the VDI checks. Further, whilst the headings as per the MDVS correlate with the primary checks as included in the VDI form, the latter provides more detail/guidance for the driver completing. It is also noted that, as a result of the recent Quality & Support Day, (see objective 5) there is a need to update the SOP to align with the needs of the NEPTS/Ambulance Care teams to '*ensure that all staff regardless of their specific roles are on the same page regarding shift commencement procedures.*'	The legal requirements for vehicle checks are not completed appropriately.	**Agreed Action:** The Vehicle Accident Management Task & Finish Group are currently reviewing VDI processes within the Trust in line with the Vehicle Accident Management Internal Audit actions. Given the correlation with this audit, the scope of this group will be expanded to include Start of Shift SOP arrangements. On agreement of the new process from the Task & Finish Group, the SOP will be updated to reflect current practice. Senior Operations Team (SOT) will maintain oversight and responsibility of this audit action. **Expected Evidence of Implementation:** Triple As from the Task & Finish Group to confirm agree process; copy of updated SOP to reflect practice and copy of SOT Triple A to approve amended SOP.
		Medium Priority	**Officer:** Ben Collins (Head of Service, EMS South Central) **Target Implementation Date:** October 2025
	Theme: Governance	Control Design	

Objective 2: Booking onto system at commencement of shift	Substantial

The SOP states that: '*staff must book onto the MDT immediately at the start of shift*.'

There is no monitoring of the time staff book onto the system versus the time their shift commences. However, the mapping of shift patterns for the day is known by the Resource Coordinators at EMSC (Emergency Medical Services Coordination). Should there be no activation /availability of the expected crew members then contact will be made with the assigned Locality Manager / Duty Officer Manager to rectify the situation. Sample testing was unable to be undertaken in this area as there is no formal expectation of reporting between the two systems; issues regarding attendance will be picked up separately through observation and/or concerns logged by fellow members of staff.

During the course of audit fieldwork, a site visit was undertaken at the Cardiff MRD. During the time on site, there were three shift allocations – 06:30hrs, 06:45hrs and 07:00hrs. From observation, it was clear that the staff were logged on and available at the earliest opportunity post arrival; noting that all crews had been dispatched to calls by 07:15hrs.

The same was applicable during the site visit undertaken at the Cardiff East Ambulance Station. Again, through observation and discussion, noting the planned nature of the work undertaken by the Ambulance Care staff at this site, the shifts are timed accordingly to allow the vehicle checks to be completed prior to departure for the allocated journeys of the day.

Objective 3: Completion of checks prior to mobilising to a call	Limited

The SOP states that: '*while undertaking these daily checks you may be auto-allocated to a Red incident. If you have not completed the required vehicle or PPE checks and a call is allocated, then inform EMSC. You will be expected to mobilise at the earliest opportunity and back up can be requested if required.'*

Recognising the service pressures at this present time, it has become the norm to expect to be allocated a red / amber call soon after commencement of a shift. This doesn't permit sufficient time to complete all of the checks as detailed on the VDI form and within the content of the SOP. We were advised that anecdotally, experience has led to reflect on what are the 'core' checks to complete at the start of the shift to allow the vehicle to enter the road safely and respond to a call. Such has been identified as tyre checks, lights, Ad-Blue levels, sufficiency of drugs, and equipment. The site visit to Cardiff MRD witnessed these checks being completed as a minimum before being dispatched to a call (noting all crews on shift during the visit had been dispatched within 10-15 minutes of their start time). It was confirmed that the rest of the checks required would be done at the earliest opportunity, some of which could be whilst waiting to handover a patient at the hospital. There was, however, no reference to reporting back to EMSC that not all checks as per the SOP had been completed prior to dispatch.

With regard to the checks completed by Ambulance Care, noting the planned nature of the work, there should be no issue with the completion of the required checks prior to commencing the journeys allocated. The requirements of the VDI form are the same across services; but there will be differences in terms of clinical and equipment checks due to the nature of provision. However, as per **Key Finding 2**, such is not defined within the SOP.

There was no evidence of a central repository for completed forms; although this is not to say that such are being completed and retained at individual stations. However, at the two site visits undertaken, there was no evidence of documentation retained to support the completion of the checks nor physical sight of forms being used as the checks were being undertaken. As per the site visits, the completion of the screen on the MDVS is deemed the completion of the checks (although it is noted that 'pass' can be selected to be able to log off at the end of the shift without actually having completed the relevant checks).

As noted at the Quality & Support days, there is some confusion as to whether the MDVS is a replacement or supplement to the VDI form (see **Key Finding 2** and *objective 6*).

Without the evidence of the completed and signed checks (as the VDI form suggests), there is the risk of non-compliance with the Road Traffic Act should an incident arise whilst attending a call. A similar issue regarding form completion was raised at our recent Vehicle Accident Management review (issued February 2025: Limited Assurance). Noting that completion of a paper form could be deemed cumbersome, within the time period permitted at the commencement of a shift, consideration should be given to developing an electronic form, via the iPads used by crew members, to be submitted to a central repository (see **Key Finding 3**).

	Key Findings	Risk & Impact	Agreed Management Action
3	**Lack of evidence to demonstrate compliance of checks** As has been identified through the recent Ambulance Care Quality & Support day, 50% of the staff involved (circa 162) completed the paper-based forms as per the SOP. It is not clear as to the completion rate for EMS as such was not the focus for their Quality & Support day; however, the site visits undertaken during the course of audit fieldwork noted that no forms were completed and retained post completion of the checks. Recognising the legal requirement for the completion of these checks, and wider compliance with the SOP, consideration should be given to the development of an electronic version of	Non-compliance with legal requirements.	**Agreed Action:** The Vehicle Accident Management T&F Group are currently reviewing VDI processes within the Trust in line with the Vehicle Accident Management Internal Audit actions, this includes the process to demonstrate compliance and reporting of checks. Given the correlation with this audit, the scope of this group will be expanded to include Start of Shift SOP arrangements. SOT will maintain oversight and responsibility of this audit action.

Key Findings	Risk & Impact	Agreed Management Action
the VDI form, to be made available via the iPads. The receipt into a central mailbox / repository would allow for a date/time stamp to be actioned therefore providing an opportunity to understand the timeframe for completion amongst crews – the output of which can be reported and escalated as appropriate.		**Expected Evidence of Implementation:** Triple A repots from the Task & Finish Group to confirm discussions on the VDI process and reporting mechanisms; and an updated version of the SOP.
Consideration could also be given to the inclusion of sign off for clinical and equipment checks noting there is no specified requirement, as per the SOP, for such to be documented (see *objective 5*).	**High Priority**	**Officer:** Ben Collins (Head of Service, EMS South Central) **Target Implementation Date:** October 2025
Theme: Information, Data Quality & Data Accuracy	Control Operation	

Objective 4: Communication of mobilisation checks	Limited

The SOP states that: *'it is expected that crews will be able to respond to all incidents at the conclusion of these roadworthy vehicle and PPE checks, and all other checks will be completed during the shift, or as soon as possible. Any instance where this is not possible must be discussed with EMS-C at the earliest opportunity and logged accurately.'*

As a consequence of the lack of evidence to demonstrate that checks are being undertaken, and noting we have been informed that they are not all undertaken in the majority of cases before the crew is despatched (see *objective 3*), it limits the ability to provide assurance in respect of this objective.

Discussions were held with an EMS-C administrator, and an Operational Team Leader for Ambulance Care, to confirm the process for the communication of mobilisation checks. Should issues be identified they will be logged with the Resource Coordinator so that adjustments can be made to the shift allocations accordingly. In terms of reporting, there is functionality with the C-3 booking system (EMS) but such has not been requested (in terms of the time that the update is provided versus the start time of the shift). This correlates with the wider point regarding lack of reporting for compliance with the SOP (see **Key Findings 3 and 5**).

Objective 5: Clinical and equipment checks	Reasonable

Overview / Summary of Observations

The SOP states that: '*clinical and equipment checks including morphine should be completed at the first available opportunity within the shift but not necessarily prior to the mobilisation to a call* and *any missing or deficient equipment or medication should be appropriately escalated via the EMS-C to rectify as soon as is practicable.'*

With regards equipment and consumables, there is a standard list for inclusion, as a minimum, on an EMS vehicle. However, there isn't sufficient time at the commencement of the shift to work to tick off each of the items. During the course of the site visit to Cardiff MRD, a walkthrough of the consumables held within a vehicle saloon was completed. It was clear that there was a multitude of items which could have been condensed to match the listing, recognising that expiration dates apply (see **Key Finding 4**). It is recognised that this is a wastage issue rather than a patient safety issue.

Where items of equipment are missing or deficient, initial consideration will be given to other vehicles that are at the respective station. Some may be awaiting collection from fleet and therefore, subject to whether there is an issue with the equipment on board, such can be obtained for fulfil the requirements. Any changes will be communicated to the Locality Manager / DOM with details recorded on the white boards that are maintained at the stations for the allocated vehicles. Where located at a MRD, as was observed with the site visit to Cardiff MRD, enquiries will be made of the stock maintained to address any missing and deficient instances.

In terms of the clinical requirements, there are core items that will be reviewed, including the oxygen tanks, the 'grab bag', saline, and core drugs. It is noted that not all drugs will be held at the relevant stations, although where an Omincell cabinet is located this will be accessed to replenish what is required. Discussions held with a Senior Paramedic during the site visit confirmed that previous crews will replenish what has been used during the response, to the minimum level, as access can be made of the Omincell cabinets at the hospital sites.

Key Findings		Risk & Impact	Agreed Management Action
4	**Review of Consumables** There is a minimum list of expected consumables and equipment to be retained on EMS and Ambulance Care vehicles. Noting the lesser amount on the latter it is easier to maintain a regular stock check of the items. However, with EMS, there is the risk that crew members will pick up what they think is needed within the time period available to complete the check rather than there being a routine stock count completed, which will also pick up expiry dates for items. We appreciate that consumables review will be undertaken on behalf of the paramedics at MRDs; however consideration should be given to a regular scheduled review of consumables at the stations or through the MRD as part of the wider cleaning schedule to rationalise the consumables held and prevent wastage / excessive ordering.	Overstocking of consumables on vehicles can lead to increased wastage costs for the Trust.	**Agreed Action:** The Trust accepts this finding and recognises that whilst there is a list of minimal consumables in MRD this currently is not applied at ambulance stations. The Operations Directorate will share comms to staff on the minimal list of consumables required for Vehicles to reinforce the amount that needs to be held. The list will also be placed on all relevant vehicles. Consideration will also be given to incorporate a regular scheduled review of consumables. **Expected Evidence of Implementation:** A copy of list of consumables that will be added to vehicles, a copy of the comms to reinforce the consumable amounts and Triple A from EMG (EMS Management Group) and Ambulance Care Service Management Meeting to confirm discussions on scheduled review consideration.
		Medium Priority	**Officer:** Sonia Thompson (Assistant Director of Operations, EMS) and Mark Harris (Assistant Director of Operations, Ambulance Care)

	Theme: Quality, Safety & Patient Experience	Control Operation	**Target Implementation Date:** October 2025

Objective 6: Reporting	Limited

During the course of audit fieldwork, a number of discussions have been held with officers (Locality Manager and Duty Operations Manager for EMS; and Service Manager and Operational Team Leader for Ambulance Care) to understand the reporting that can be extracted from systems to determine staff compliance with the SOP.

In all instances, there was no awareness of regular analysis or reporting being completed which could be used as a performance tool to confirm compliance (see **Key Finding 5**). Noting that the vehicles are out on the road and available for response / patient journeys, there is the assumed understanding that the requirements of the SOP have been addressed as those not deemed fit for purpose will be reported through the EMS-C (see *objective 4*) and alternative vehicles, if available, will be allocated for the relevant crews.

As noted in objective 1, the Quality & Support Day undertaken in February 2025 had a specific focus on Start of Shift arrangements for those in Ambulance Care. The outcome of this day has been included in the Operations Quarterly Sub-Report (Q4) which was recently presented to the Quality, Patient Experience and Safety (QuEST), People & Culture and Finance & Performance Committees at their respective May 2025 meetings. There is no evidence of such having been assessed for those within EMS and reported accordingly (see **Key Finding 1**).

The 3 main areas included within the sub-report are detailed as follows, the actions from which correlate with the findings included at this report:

- *Approximately 25% of staff were not aware of the Start of Shift Standing Operating Procedure – this highlights a significant gap in communication and training, suggesting that more efforts are need to ensure all staff are familiar with these crucial guidelines;*
- *Vehicle Daily Inspection processes showed variability with 50% of staff completing paper-based forms alongside MDVS acknowledgement while the other 50% relied solely on MDVS acknowledgements – this inconsistency points to the need for a standardised approach to VDI completion to ensure thorough and uniform checks (*see **Key Finding 3***)*
- *There was confusion among staff regarding the correct procedure for completing a VDI for a cold vehicle – responses varied from 5 to 30 minutes whereas the correct procedure stipulates 15 minutes – this indicates a need for clearer instructions and training to ensure staff are aware of the proper protocols.*

Key Findings		Risk & Impact	Agreed Management Action
5	**Reporting** There is no evidence of routine reporting being undertaken to measure compliance with the SOP, timeliness and accuracy of completion to permit escalation of concerns, should they be identified. Whilst the output of the Quality & Support day has been reported at Committee level, this related to an exercise completed in quarter 4 and was only in relation to Ambulance Care. The use of a central repository for completed forms (see Key Finding 3) would help facilitate reporting.	Management are not aware of any issues associated with the completion of start of shift arrangements.	**Agreed Action:** EMG (EMS Management Group) will review the main key points of the SOP and potential compliance measurements and will complete a dip sample exercise based on the key components to review compliance and discuss next steps to include regular routine reporting. SOT will maintain oversight and responsibility of this audit action. **Expected Evidence of Implementation:** Triple A from EMG into SOT to determine the discussions on the SOP and the results of the dip sample, next steps discussion.
		High Priority	**Officer:** Ben Collins (Head of Service, EMS South Central) **Target Implementation Date:** December 2025
	Theme: Reporting	Control Operation	

Appendix A: Assurance Opinion & Prioritisation of Findings

Assurance Opinion

 **Substantial**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
 **Reasonable**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
 **Limited**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
 **Unsatisfactory**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
 **Advisory**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

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

AGENDA ITEM No	**16.2**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**1**

INTERNAL AUDIT: EMERGENCY NURSE COMMUNICATIONS SYSTEM IMPLEMENTATION (ECNS) – COMMENTS FROM ARAC & FPC

MEETING	Quality, Patient Experience and Safety Committee
DATE	5 August 2025
EXECUTIVE	Trish Mills, Director of Corporate Governance/Board Secretary
AUTHOR	Sarah Harland, Corporate Governance Officer
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. The **Audit, Risk and Assurance Committee** (ARAC) on 24 June 2025 and **Finance and Performance Committee** (FPC) on 21 July 2025 received and discussed the **Emergency Nurse Communications System Implementation (ECNS) audit report.** This report summarises the discussions from both meetings in reference to this report.

2. A significant backlog of audits was noted, with over 400 audits pending completion. An uplift of six auditors is expected in Q2 to address this backlog. There were discrepancies in monitoring tools and a lack of routine audits for clinicians, with 44% not receiving monthly audits as expected. No post-implementation review had been conducted, resulting in the absence of an evaluation of benefits realised and identification of lessons learned. There was no evidence of escalation of ECNS non-compliance, which could impact the Trust's accreditation status. Reporting arrangements have been refreshed but need time to mature. Management acknowledged the findings and noted that the uplift in auditors and improved processes will address many of the key findings. Members were assured that the benefits of ECNS were realised upon implementation and that the project plan pathway framework and templates will help ensure consistent benefits realisation and monitoring across projects.

3. The need for formal evaluation and post-implementation reviews has been a common theme in previous audits, highlighting the importance of pausing to assess the effectiveness and benefits of projects. Oversight of these audit actions are with the Finance and Performance Committee, who were requested by ARAC to discuss further the role that committee has in monitoring the process of such evaluations in the Trust.

4. Three objectives were rated reasonable assurance, with two being limited. There are seven medium priority and two high priority management actions. The Quality Patient Experience and Safety Committee has oversight of the audit actions and will receive this report at its August meeting.

5. Both ARAC and FPC noted that Management had acknowledged the issues and confirmed that the onboarding of six new auditors in Q2, along with improved processes, will help address them.

RECOMMENDATION: With the onward receipt of the Emergency Nurse Communication System Internal Audit Report, the committee is asked to take assurance from the outcome of the audit and to note the discussions at both the ARAC on 24 June 2025 and the Finance and Performance Committee on 21 July 2025.

KEY ISSUES/IMPLICATIONS
Not applicable.

REPORT APPROVAL ROUTE
Not applicable.

REPORT APPENDICES
Emergency Nurse Communications System Implementation (ECNS) audit report

REPORT CHECKLIST			
Confirm that the issues below have been considered and addressed		**Confirm that the issues below have been considered and addressed**	
EQIA (Inc. Welsh language)	NA	Financial Implications	NA
Environmental/Sustainability	Y	Legal Implications	Y
Estate	NA	Patient Safety/Safeguarding	NA
Ethical Matters	Y	Risks (Inc. Reputational)	NA
Health Improvement	Y	Socio Economic Duty	NA
Health and Safety	Y	TU Partner Consultation	NA

Emergency Communication Nurse System Implementation

Final Internal Audit Report

2024/25

Welsh Ambulance Service University NHS Trust

Reasonable Assurance

Contents

Review Reference	WAST-2425-12
Fieldwork	February - April 2025
Executive Sign Off	29th May 2025
Audit Committee	June 2025
Executive Lead	Lee Brooks, Executive Director of Operations
Audit Team	Osian Lloyd, Head of Internal Audit; Felicity Quance, Deputy Head of Internal Audit

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Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

To provide assurance that benefits realised reflect those identified at the outset of the Emergency Communication Nurse System (ECNS) implementation.

Overview

The implementation of the ECNS system within the Trust's Clinical Support Desk (CSD) provided a key tool to support secondary triage of patients calling 999, aligning with the strategic ambition to enhance its remote clinical care provision. The adoption of ECNS built upon the lessons learnt from prior Clinical Contact Centre reviews and reflection from the operational response to the Covid-19 pandemic. It provides a more robust, evidence-based, digitally integrated system in comparison to the previous paper/pdf-based triage tool, offering consistency of questioning, advice and efficiencies of process through areas of automated functionality. The Trust has subsequently received accreditation as a Centre of Excellence in September 2023.

This review is not an assessment of the system implementation itself and is cognisant of the significant system challenges faced by the wider Urgent and Emergency Care system which would continue to impact the Trust and in turn the realisation of some related ECNS benefits. Further, this review did not include the recent integration of the ECNS within the wider 111 service; the safe and effective operation of 111 has been assessed within the 111 Digital Operations review (issued December 2024: substantial assurance).

We have concluded **reasonable** assurance on this area.

The matters requiring management attention include:

- The proposal for investment relating to ECNS included a high-level outline of benefits or outcomes related to system implementation, however this was not accompanied by further refinement of targets, criteria or timescales.
- No post implementation review has been undertaken, resulting in the absence of an evaluation of benefits realised, and identification of lessons learnt.
- Current audit arrangements vary in the degree of coverage resulting in 48% of clinicians not receiving a review in August 2024 and November 2024.
- Capacity issues have resulted in a three-month backlog of ECNS audits (quality assurance reviews of triage calls against the International Academies of Emergency Dispatch (IAED) performance standards), with corresponding effect on timeliness and impact of feedback. In November 2024 the Trust's non-compliance rate was 28%, against the IAED target of 7%.
- Performance Delivery Plans to address periods of underperformance, as outlined within the Quality Assurance Framework, are not in place. Existing gaps in audit coverage across CSD would also impact the ability to identify outliers and prompt plan usage.
- There could be greater standardisation of feedback format and terminology, to provide a clearer link to the ECNS Performance Standards and the categorisation of deviations identified.
- A business case for the transfer of the responsibility for undertaking ECNS audits has been developed, however timescales for completion of the move are yet to be confirmed.
- Reporting arrangements for ECNS have recently been refreshed and will require time to develop and mature. Reporting includes actions to address non-compliance, however these lack the formality of an action plan to monitor progress.
- There was no evidence of escalation of ECNS non-compliance, noting such may impact the Trust's accreditation as a Centre of Excellence, within wider Trust reporting or at committee level.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	Programme benefits were appropriately identified and clearly defined at the outset.	1	**Reasonable**
2	The achievement of benefits were monitored and reported regularly during the implementation period, and mechanisms to ensure the quality of service remain in place.	2, 3, 4, 5, 6	**Limited**
3	Benefits not realised at the close of the programme continue to be subsequently monitored to completion.	6	**Limited**
4	Lessons learnt have been identified from the programme, including feedback gained through patient and staff experience, to inform immediate and future service changes.	1, 6	**Reasonable**
5	Appropriate governance and reporting arrangements have been established post-implementation and operate as intended.	2, 7, 8, 9	**Reasonable**

Management Actions

2 High Priority

7 Medium Priority

Themes

Risk Types

Public Perception & Reputational Risk

Legal & Regulatory Non-Compliance

Choose an item.

Choose an item.

Findings & Agreed Action Plan

Objective 1: Programme benefits were appropriately identified and clearly defined at the outset.	**Reasonable**

The case for the adoption of ECNS, a clinical decision support software, was outlined in 2021 within the '*999 Remote Clinical Triage Support systems, Quality and Safety. A Proposal for Investment*' ('the investment case'). This referenced both the Trust's ambition to further develop its remote clinical triage capacity, to build upon a clinical review of Clinical Contact Centre ('the CCC clinical review') undertaken in 2019; and lessons learnt from operational changes made as part of the organisation's response to the Covid-19 pandemic.

The adoption of ECNS was to replace the Manchester Triage System (MTS); a set of 53 paper/pdf process flow charts primarily designed for face-to-face use. In comparison ECNS offers over 250 distinct algorithms: providing age and gender specific clinical triage protocols, with the ability - through assessment and critical thinking - to arrive at an appropriate recommended care outcome, alongside consistent self-care instructions.

The investment case also compared the limitations of MTS: noting a lack of integration with other Trust electronic systems resulting in limited opportunities to generate data for the quality assurance and quality improvement of calls, which ECNS functionality addressed. ECNS also included an integrated audit tool ('Ascent Quality Assurance' or 'AQUA') which, through its alignment to the International Academies of Emergency Dispatch (IAED) performance standards, would provide a system to ensure the consistency and quality of calls. This in turn would lead to both improved patient experience and outcomes. System implementation would include the establishment of a new Professional Practice Education (PPE) team to provide training, coaching and audit capacity, with the investment case specifying the need for an educator to clinician ratio of 1:10 (c.6WTE).

The investment case also noted that through the system's data capture and call structure, there would be opportunities to reduce the average call time from 19 minutes to between 11-15 minutes; with associated productivity and financial savings forecast. Opportunities to increase the 'hear and treat' (now known as 'consult and close') rates were also noted. The benefits which could be seen within the wider health system were also referenced, which included increased numbers of patients triaged, reduced number of ambulance conveyances, reduced number of patients attending Emergency Departments, and associated impact on handover delays.

Whilst the investment case contained the identification and description of benefits and outcomes; targets, criteria or timescales to achieve these were not set out (**See Key Finding 1**).

The implementation period coincided with a number of other service changes, notably the expansion of the Clinical Support Desk (CSD) through the integration of an additional 36 paramedics, and establishment of a dedicated Mental Health clinician team. The Senior Responsible Owner and project manager have both since left the organisation, but other key contacts noted the pace and impact of these changes as contributing factors to the lack of supporting documentation.

In 2024, the Trust introduced a formal Project Plan Pathway toolkit which provides guidance, templates and defines roles and responsibilities between senior responsible owners, change managers, and project support; and the implementation of this should help address the issues above within future projects.

Key Findings		Risk & Impact	Agreed Management Action
1	**Benefit realisation gap analysis** While the investment case outlines high-level benefits or outcomes, noting some would be immediately evident in comparison to the previous triage system, these were not accompanied by definitions of baseline measures, target criteria, or timescales and leads. The mapping of the above would have allowed assessment and measurement of the extent to which the benefits have been realised.	Gaps within the approach to the identification and definition, to the failure to realise benefits.	**Agreed Action:** The Trust accepts this finding and agrees with the need for broader learning and clarity at the outset of developments such as this. As set out, the publication of the Project Plan Pathway published in 2024 is anticipated to address this finding going forward and therefore the Trust is satisfied that this action is addressed.
			Expected Evidence of Implementation: Closed
		Medium Priority	**Officer:** N/a **Target Implementation Date:** N/a
	Theme: Planning, Delivery & Deadline Management	Control Design	

Objective 2: The achievement of benefits were monitored and reported regularly during the implementation period, and mechanisms to ensure the quality of service remain in place.	**Limited**

Benefit achievement: An ECNS Project Plan was developed to direct implementation commencing in November 2021 and system launch on 17 May 2022. This contained key actions and timescales for the rollout of underlying infrastructure, user acceptance training, and deadlines for the submission of evidence to support accreditation as a centre of excellence (ACE). As per *objective one*, ECNS implementation was initially a deliverable within the CCC Clinical Review project, and in December 2022 ECNS was included within the transfer of the remaining CCC project actions to the Trust's Gateway to Care (G2C) Programme. Review of programme highlight reports provided RAG rated updates in progressing these structural and workforce changes. We note this did not include specific review of ECNS benefits, and no post implementation report could be provided to demonstrate any detailed assessment of these. (See **Key Finding 6**).

CSD performance dashboards capture ECNS related indicators, which include call times, protocol use, outcomes, and call conversion to consult and close on both a CSD service wide and individual clinician basis. Review of the reports indicate reductions in call times have not materialised in line with the expectation of the investment case, remaining consistent with pre implementation averages; but consult and close levels have seen an increase (March 2021 – 6%, September 2024 – 9.6% - *Trust Monthly integrated Quality & Performance Report*).

The Trust has been successful in gaining ACE for its use of ECNS, receiving approval from the IAED in September 2023; in doing so gaining dual accreditation having previously achieved ACE for its Medical Prioritisation Dispatch System (MPDS). It is also notable that the Trust has achieved this through utilising a paramedic and nurse staffing mix (*see objective 4*).

Quality mechanisms: To retain accreditation status, there is a requirement that the Trust audits 132 calls per month[1] and meets a target of 93% call compliance. Compliance is determined through the assessment of a random selection of calls against IAED Performance Standards ('the performance standards'). Key elements of the performance standards have been combined with local guidance and procedural information within a Trust developed ECNS Quality Assurance Framework (QAF).

Concerns regarding the audit process were raised in September 2024 (including the categorisation of non-compliant audits into thematic reporting which were therefore excluded from the compliance total; and increasing audit sample numbers to lower the overall compliance rate). Such practices were immediately stopped (see objective 5); however, in the period following this non-compliance increased from 18% in August 2024, to 28% in November 2024, against the ACE target of 7%.

The performance standards also include timescales for feedback to be provided, however capacity constraints within the PPE team (currently 2.8WTE) has resulted in delays in completion, noting December 2024 audits were still to be completed as at April 2025. Whilst the need to review the operational capacity of the PPE team and to appoint dedicated ECNS auditors within an Operations Quality team has been recognised, a timescale was not known at the time of audit fieldwork (See **Key Finding 2**).

Additionally, walkthrough and testing of the audit process identified:

- Enhancement of audit feedback could be enhanced through standardisation of format and terminology (see **Key Finding 3**).
- The schedule which captures clinician performance does not reconcile with the AQUA performance reports (see **Key Finding 4**).
- Audit coverage of clinicians varies across months (See **Key Finding 4**).
- The performance development plan structure as outlined within the QAF is not in operation (see **Key Finding 5**)

[1] The monthly audit requirement is determined by an IAED formula based upon the CSD annual call intake.

Key Findings		Risk & Impact	Agreed Management Action
2	**ECNS Audit arrangements** Capacity constraints within the PPE team (currently 2.8WTE) has resulted in delays in completion, with December 2024 audits still to be completed as at April 2025, resulting in a backlog in excess of 400 audits. The need to review the operational capacity of the PPE team has been recognised by Integrated Care management, and a business case to secure dedicated ECNS auditors within an Operations Quality team (within the Emergency Medical Service Co-ordination structure) has been approved, although a timescale of implementation was not available at time of audit fieldwork.	Continued lack of capacity to deliver audits could result in loss of accreditation.	**Agreed Action:** The Trust will have the uplifted number of 6 ECNS auditors in place in Q2 of 25/26 financial year. This uplift will be commensurate with the levels agreed in the business case. **Expected Evidence of Implementation:** The uplifted levels will be evidenced through establishment reports.
		High Priority	**Officer:** Jonathan Edwards, Assistant Director of Operations **Target Implementation Date:** 30th September 25
	Theme: Resourcing	Control Design	
3	**ECNS Audit report format** Review of audit reports confirmed that they provided a mix of recognition of good practice alongside areas where corrective feedback was required. IAED performance standards notes that when providing feedback there should be focus on the exact performance that did not meet the standard. Our review of 30 audit reports noted that 13 did not reference the performance standard where an issue had been identified; and 17 did not indicate the categorisation of deviation. Currently audit reports are circulated via email to the clinician and line manager, however, there is no requirement for receipt or acknowledgement of content.	Unclear and delayed feedback impact on the value and ability to influence practice of audits.	**Agreed Action:** Quality Audit realigned to Operations Quality and bespoke job description being created to appoint into permanent Quality Audit (Clinical) posts. Operations Quality to have management and leadership oversight. Levelling to be undertaken to set out expectations for inclusion of all required information such as performance standards and deviation categories and a request to support levelling will be made to the International Academies of Emergency Dispatch (IAED). Consideration will be given more widely on how to ensure monitoring of receipt of feedback and respective managers/local management teams updated.
			Expected Evidence of Implementation: Quality assurance processes will be developed and refined internally, and the IAED Accredited Centre of Excellence (for which the Trust has for ECNS) sets out required standards which will be monitored closely in monthly compliance reports, submitted to the IAED and internally monitored by the Integrated Care Quality Meeting which reports onward into the Senior Operations Team (SOT).
		Medium Priority	**Officer:** Andrew Garner, Service Manager, Operations Quality

Key Findings		Risk & Impact	Agreed Management Action
	Theme: Performance Monitoring	Control Operation	**Target Implementation Date:** 31st December 2025 (this is when the full establishment should be realised following OCP).
4	**ECNS Monitoring arrangements** The QAF and IAED performance standards include the need for ongoing monitoring of individual clinician performance on a routine basis. A locally held spreadsheet has been developed to support this due to constraints within the AQUA reporting tool and need for cleansing of prior user data. Inconsistencies were noted when comparing this spreadsheet to AQUA generated reports regarding the clinicians included (10 identified as receiving audits but not detailed within the spreadsheet) and the number of audits recorded (only one out of six months totalling the required 132 audits). Additionally, we identified: • six clinicians yet to receive audits, and • on average, 44% of CSD clinicians did not receive an audit each month within our sample period June 2024 – November 2024.	Lack of consistent oversight may result in noncompliance being missed.	**Agreed Action:** A review will be conducted to move to a single monitoring mechanism with appropriate data cleansing processes. The reporting mechanism will be embedded into Integrated Care Quality Meeting (ICQG) and through the Senior Ops Governance Structure along with CQGG. Those not in receipt of an audit are being prioritised. **Expected Evidence of Implementation:** AQUA Reporting will be the primary methodology used to report compliance.
		High Priority	**Officer:** Peter Brown, Assistant Director of Operations **Target Implementation Date:** 30th September 2025
	Theme: Performance Monitoring	Control Operation	
5	**ECNS Performance Development Plans** Where a clinician is identified as 'below a performance threshold' the QAF outlines a performance development plan (PDP) structure to be applied to offer action plans which include additional support, enhanced audits and further escalation where improvement is not achieved. At present, due to the lack of capacity within the PPE team to undertake additional audits, the PDP process is not actively practiced. However, we were advised that local management will engage with ECNS users on wider performance issues. The limitations in coverage and number of clinicians receiving regular audits (see key finding 4) also impacts the effectiveness of the PDP process in identifying those who require additional support.	Lack of mechanisms to address continued noncompliance.	**Agreed Action:** As per the agreed action for Key Finding 2 the Trust will have the uplifted number of ECNS auditors in place in Q2 of 25/26 financial year. This uplift will be commensurate with the levels agreed in the business case. This will enable the required levels of audits. **Expected Evidence of Implementation:** The uplifted levels will be evidenced through establishment reports.
		Medium Priority	**Officer:** Jonathan Edwards, Assistant Director of Operations **Target Implementation Date:** 30th September 2025

Key Findings		Risk & Impact	Agreed Management Action
	Theme: Performance Monitoring	Control Operation	

Objective 3: Benefits not realised at the close of the programme continue to be subsequently monitored to completion.	**Limited**

As per *objective two*, in December 2022 the implementation of ECNS was included within the transfer of the outstanding actions from the CCC Clinical Review project to the G2C Programme. G2C highlight reports reviewed listed remaining areas of focus as the use of ECNS functionalities such as video consultations, directory of services and email/text function.

Review of CSD performance dashboards confirms that the use of video consultation within triages has increased in the time since implementation, with the number of such calls rising from under 100 per month at the end of 2022, to between 400-500 video consultations per month between October 2024 – March 2025.

Discussion with key contacts noted that there is continuing progress in utilising other parts of the system, although alternative functionality will be used to communicate call summaries to patients. End of consultation summaries are produced and transferred to the Welsh Clinical Portal for access by wider health services, such as GP Practices or health board urgent care services. We note that fuller integration of ECNS with the clinical portal is a deliverable within the Remote Integrated Care Project; as is continuing to make improvements to the directory of services.

As per *objective one*, the ECNS investment case included forecasts for productivity and financial gains resulting from reductions in call times, however CSD performance reports indicate that these forecast reductions have not materialised. The achievement of such will have been directly impacted by continuing unscheduled care pressures.

We could not identify any subsequent periodic review or reporting on system benefits since the project closed. As such, this, combined with the lack of defined benefits, would mean the Trust is not fully sighted in relation to initial or subsequent achievement. (See **Key Finding 6**)

	Key Findings	Risk & Impact	Agreed Management Action
6	**Periodic Benefit Assessment** We could not identify any post implementation review, or subsequent assessment of the system benefits since the closure of the project. As such the Trust will not be sighted on the system impacts, outcomes and progress towards benefit realisation.	The effectiveness and confidence could be impacted where benefits are not periodically assessed.	**Agreed Action:** The Trust accepts this finding and agrees with the necessity for clearer benefits assessment milestones at the beginning of such programmes. The majority of benefits were, however, fully realised upon implementation. Consequently, ongoing periodic benefits assessments were not planned. The later rapid addition of 28 full-time clinicians, while helpful, shifted focus and changed baseline operational benefits of other metrics, due to new and rotating CSD staff and demand-capacity adjustments. Operational measures are now monitored through existing mechanisms. The Trust will develop a clear table of evidence outlining which benefits have been achieved on implementation (how and why) and which outstanding benefits require more work or are now being monitored through existing mechanisms or link to existing agreed actions within this audit.

			Expected Evidence of Implementation: Development of a table of ECNS benefits with outline of evidence or monitoring.
		Medium Priority	**Officer:** Mike Brady, Assistant Clinical Director for Remote Care
	Theme: Performance Monitoring	Control Operation	**Target Implementation Date:** 30th September 2025

Objective 4: Lessons learnt have been identified from the programme, including feedback gained through patient and staff experience, to inform immediate and future service changes.	**Reasonable**

Prior to implementation, representatives of the Trust had published within the *Annals of Emergency Dispatch & Response* journal (an official international peer-reviewed journal published by the IAED) the justification for its use of a paramedic and nurse staffing mix: '*Proposed use of the emergency communication nurse system in Welsh ambulance service 999 secondary triage with paramedic and nurse users'* (2021). This noted that paramedics experience in dealing with a wide range of patient presentation, increasing scope of practice and the Trust's evolving approach to telephone triage which supported this.

The paper included the intention to undertake further research in the period following implementation to explore themes, trends, outcomes and efficiencies; and two further publications have followed – '*Emergency Communication Nurse System Outcomes of Advanced Medical Priority Dispatch Codes in a UK ambulance service*' (2024) and '*999 triage. A comparison of UK ambulance nurse and paramedic case mix, outcomes and audit compliance'* (2024). Both papers were based upon the review of patient data and audits of calls across the period May 2022 – November 2022. The former noted the '*positive range of outcomes reached through secondary consultation'*, whilst the latter noted that having assessed patients with the same 'symptomology' there '*was little difference in the clinical outcomes nurses and paramedics reached for their patients and little difference in the overall compliance of their call audits, which were overwhelmingly safe.'*.

As per *objective 3*, no post implementation review has been undertaken following programme closure, the need to ensure adequate capacity for reflection following significant changes was noted in discussion with key contacts. (See **Key Findings 1 & 6**)

At present we note there is no mechanism to allow for patient feedback to be directly collected for ECNS calls, outside of established Trust feedback routes generally available. We are informed the Trust is investigating how it can develop capturing user feedback within the wider Integrated Care service, and feedback received features within monthly Quality Management Group meetings. Staff feedback is captured within the established Integrated Care Quality and Support days, this recently included gathering responses on staff wellbeing, workload and pressures.

Objective 5: Appropriate governance and reporting arrangements have been established post-implementation and operate as intended.	**Reasonable**

Following the implementation of ECNS, a Quality Group was established to identify and review themes and trends, however we could only source documentation for one meeting held in August 2022. We note that, the existing 111 Quality Group was expanded (November 2024) to include CSD under a revised Integrated Care Quality Group (ICQG) remit, with refreshed terms of reference in place to reflect this change, and. discussions with management highlighted awareness that the operation and reporting from the group will need time to mature. The case for investment (see objective one) listed a number of ways in which ECNS data may inform planning and assist in analysis of outcomes, but we were not able to identify that level of analysis within the current reporting arrangements. (See **Key Finding 7).** The CSD ECNS Audit and Quality report provided to the ICQG included an outline of actions to address areas of non-compliance, such as development of supporting guidance to be shared with clinicians, and links to be established with Duty Operations Managers to ensure audit feedback is addressed. However, these actions are not formalised into a plan to address non-compliance rates (See **Key Finding 8**).

The ICQG produces a highlight report following each meeting which is shared with the Operations Directorate Senior Operations Team. There is also a monthly presentation to the Trust Quality Management Group (QMG). Whilst we did not identify either document highlighting the recent issues in completing audits and the increasing non-compliance rate, we were informed that both groups had awareness of the identified issues.

The Operations Senior Leadership Team (SLT) received a report in January 2025 referencing concerns that the prior approach to ECNS audits had obscured the Trust's compliance rate, and this was included within the SLT highlight report to the Trust's Executive Leadership Team. The same SLT meeting endorsed the transfer of audit responsibility to the Operations Quality team within the EMS Co-Ordination, however, further discussion at the March 2025 meeting noted this was still in train (see **Key Finding 2**).

Board-level committees (Finance and Performance, Quality Safety and Patient Experience, and People and Culture committees) regularly receive the Operations Directorate Quarterly Reports (ODQR) which highlight key issues and service developments. Review of the Q2 and Q3 reports (Q4 not reported at completion of fieldwork) did not identify any reference to ECNS non-compliance levels or the possible impact to the Trust's ACE accreditation (see **Key Finding 9**). The Q2 ODQR included that the recent completion of an action plan to address non-compliance within the MPDS has led to the Trust no longer being in remediation status for its accreditation under that discipline.

Within the Trust, the Clinical Prioritisation Assessment Software Group (CPAS) provides oversight for the development of 'clinical guidance and pathways' for both 999 and integrated care. CPAS terms of reference were amended in 2023 to include ECNS and reflect the retirement of the Trust Medical Director who had provided direct oversight during system implementation. Review of CPAS agenda papers noted discussion of ECNS including system issues and updates where applicable.

Key Findings		Risk & Impact	Agreed Management Action
7	**ECNS Quality Reporting** Whilst we could identify inclusion of activity, compliance rates, and themes included within service quality reports, discussion with officers indicated that these were limited by the relatively small number of audits undertaken per month. Further, we did not identify reporting in line with areas referenced within the investment case which included analysis of: • patient presentation through analysis of previous health interactions • sensitivity of referrals • efficacy of supporting algorithms.	Full functionality and benefits from the system may not be realised within current reports.	**Agreed Action:** Scheduled to be routinely shared with QMG with the SBAR going to CQGG in May 2025. **Expected Evidence of Implementation:** SLT minutes, IC Audit and ELT to ELT triple A Report, CQGG SBAR
		Medium Priority	**Officer:** N/a **Target Implementation Date:** Closed post fieldwork
	Theme: Information, Data Quality & Data Accuracy	Control Design	
8	**Actions to address non-compliance rates** The ICQG receives a regular Audit and Quality report in relation to ECNS use within CSD. Noting the reported increase in number of non-compliant calls, the report includes a summary of actions in place to address these. However, whilst status updates were provided for some listed actions, these are not captured formally with associated timescales and leads.	Lack of clarity of action ownership and deadlines may result in improvements not being realised.	**Agreed Action:** A revised action plan with agreed action owners and timelines will be presented to the June Integrated Care Quality Group with monthly monitoring through that mechanism and reporting through Senior Operations Governance Structure through the AAA mechanism. **Expected Evidence of Implementation:** ICQG Papers will demonstrate the required detail.
		Medium Priority	**Officer:** Peter Brown, Assistant Director of Operations **Target Implementation Date:** 30th June 2025
	Theme: Planning, Delivery & Deadline Management	Control Operation	

Key Findings		Risk & Impact	Agreed Management Action
9	**Reporting to Committee** Trust Committees receive regular reporting from the Operations Directorate on key issues and service changes. We note committee reporting has not included the issues currently faced in addressing ACE accreditation compliance rates in respect of ECNS, and the potential risk that this accreditation may be lost.	Lack of escalation may leave the Trust unsighted on a reputational risk.	**Agreed Action:** Committee reporting for Q4 2024/25 includes the issues currently faced in addressing ACE accreditation compliance rates in respect of ECNS. **Expected Evidence of Implementation:** Operations Quarterly Report (Q4 provided to QUEST 9th May 2025)
		Medium Priority	**Officer:** N/a
	Theme: Reporting	Control Operation	**Target Implementation Date:** Closed post fieldwork.

Appendix A Assurance Opinion & Prioritisation of Findings

Assurance Opinion

	**Substantial**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**Unsatisfactory**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Advisory**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

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Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership]

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Shared Services Partnership
Audit and Assurance Services

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Audit Wales

Urgent and Emergency Care – Arrangements for Managing Demand Welsh Ambulance Services University NHS Trust

Date issued: April 2025

Document reference: 4820A2025

This document has been prepared for the internal use of the Welsh Ambulance Services University NHS Trust as part of work performed in accordance with statutory functions.

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Contents

Summary report

About this report

1 This report sets out the findings from the Auditor General's 2024 review of the arrangements for managing demand for urgent and emergency care at the Welsh Ambulance Services University NHS Trust (the Trust). The work is the second phase of a programme of work focused on several elements of the urgent and emergency care system in Wales. The first phase, which examined discharge planning and the impact of patient flow on urgent and emergency care, has been reported separately in regional reports covering the health board and local authorities for each of the seven health and social care regions[1].

2 Our approach recognises that the urgent and emergency care system is complex, with many different organisations needing to work together to provide urgent and emergency care and to ensure the wider system works effectively and efficiently. The Welsh Government's Six Goals for Urgent and Emergency Care Programme (Six Goals Programme) launched in 2021, provides the context for our work. At the time of our review, the urgent and emergency care system in Wales continues to be under significant pressure.

3 Our work has examined how the Trust is managing demand for urgent and emergency care services. Specifically, we looked at how it is working to reduce conveyance to Emergency Departments and how it supports the treatment of patients in the right place, first time for their needs, where better alternatives to attendance at Emergency Departments exist. The work has been undertaken to help discharge the Auditor General's statutory duties under Section 61 of the Public Audit (Wales) Act 2004 to be satisfied that the Trust has proper arrangements in place to ensure the efficient, effective, and economic use of its resources.

4 We undertook our work between May 2024 and January 2025. The audit methods and criteria we used to deliver our work are summarised in **Appendix 1 and 2**.

[1] The seven health and social care regions align with the seven regional partnership boards.

Key facts and figures

Calls to 111 and 999	
2,427	Average number of calls to the 111 service every day in February 2024[2] (101 calls an hour).
14%	Calls to 999 that were ended following a WAST telephone assessment (providing advice or signposting to alternative services) in February 2024[3], compared to 8.2% in February 2019
178%	Increase in Category A (red) ambulance calls between February 2019 and February 2025.
15%	999 callers who cancelled their ambulance or were told that the Trust could not send an ambulance to them during February 2025, compared to 24% in November 2024.

Ambulance response	
51%	Category A (red) ambulance calls responded to within eight minutes in February 2025, compared to 72% in February 2019. The national target is 65%.[4]
02:03hrs	Average response time to amber calls in February 2025, an increase of 1 hour 37 minutes compared to the average in February 2019.
63%	Patients conveyed to hospital following a 999 call in February 2025, compared to 68% in February 2019.

[2] Due to the Trust implementing a new 111 system for call handling and clinical assessment there has been disruption to the reporting of this data since February 2024.

[3] This verified data is currently only available up to April 2024, however February 2024 data used for comparative purposes.

[4] As described in paragraph 55 the level of demand and the number of patients the Trust is reaching within eight minutes is growing.

Handover delays	
16%	Patients handed over from ambulance crews to an emergency department within 15 minutes of arrival in February 2025, compared to 53% in February 2019 and against a national target of 100%.
1,601	Number of patient handovers which took longer than 4 hours in February 2025.
18,812	Lost hours due to handover delays in February 2025, compared to 5,610 lost hours in February 2019. This is an increase of 235%.
463	Patients estimated to be coming to severe harm because of long handover delays in February 2025[5]. This equates to 3.5% of total handovers.

Funding	
£0	Direct allocation of Six Goals Programme funding.

[5] Based on modelling developed by the Association of Ambulance Chief Executives, 2021

Key messages

Overall conclusion

5 Overall, we found that **changes to service delivery are leading to improvements in managing urgent and emergency care demand, supported by clear and regularly monitored plans. However, their impact is hindered by limitations in joined up data and access to alternative pathways in health boards as well as by continually high levels of handover delays at Emergency Departments.**

Key findings

Planning arrangements

6 The Trust has robust and clear plans for managing urgent and emergency care demand, with changes aimed to better manage demand by treating patients in the community rather than taking them to hospital, where possible.

7 Plans are informed by data and seek to address the risks associated with urgent and emergency care with actions that are aligned to the Six Goals Programme. The Trust does not have direct access to national six goals funding in the same way as health boards. As a result, the Trust is largely reliant on identifying sources of, and bidding for, national allocations to enact service changes it believes could improve patient safety and experience, which has caused plans to be deferred or delayed in recent years. However, the Trust has prioritised the uplift in allocation to progress plans to transform its clinical model in an attempt to mitigate avoidable harm within its control.

Accessing services

8 The Trust employs a range of methods to provide members of the public with information on its urgent and emergency care services. Although there is no communication plan, the Trust has recently updated its engagement plan to support its Clinical Model Transformation Programme. The Trust uses methods including social media posts and public engagement events to engage with and inform the public about using urgent and emergency care services. However, there are no mechanisms in place to assess and monitor the public's understanding of its services and when these should be accessed.

9 The Trust is aware of ongoing issues with the 111 Wales website, including the symptom checker. While small improvements are being progressed to address immediate functionality concerns, a draft business case has been developed to support more substantial improvements. The symptom checker tool is currently signposting users to out-of-date information which the Trust recognises as a priority issue. The Trust has agreed to use discretionary capital funding to begin

work on updating the symptom checkers, with further funding to support comprehensive improvements included in the drafted business case currently under discussion with commissioners.

10 Over recent years, the Trust has expanded the range of services it offers, including expanding its clinical desk, developing additional specialist practitioners and increasing its use of advanced paramedic practitioners. These are having a positive impact on managing urgent and emergency care demand. Rates of providing remote advice to patients have risen since pre-pandemic levels, with early data indicating that there are further improvements since the Trust changed its clinical model in November 2024. As a result, more patients are being treated over the phone and less are being conveyed to hospital.

11 However, the Trust's ability to redirect patients is also reliant on the availability of alternative services in health boards. While referrals to the GP out of hours services are increasing, referrals to alternative services remain low. The Trust holds a directory of services for each health board area, but these are not always accurate and up to date. Issues accessing alternative pathways by Trust staff, including Urgent Primary Care Centres and Same Day Emergency Centres also means that conveyance to an Emergency Department often remains the default destination when remote or face-to-face clinical assessment have identified an ongoing healthcare need for the patient.

12 The benefits of the service changes made by the Trust also continue to be outweighed by the continuing problems with long handover delays across Wales. Only 16% of patients were handed over from ambulance crews to an Emergency Department within 15 minutes of arrival over the last twelve months, compared to a national target of 100%. Response times for both red and amber calls continue to be challenged, with risks that both delays in response times and handover delays are resulting in patients coming to harm. Lack of available ambulances is likely also leading to higher attendance rates at emergency departments across Wales, as patients make their own way to hospital. Some of these patients may not have needed to go to the emergency department, but opportunities for paramedics to treat patients remotely (See and Treat) earlier in their patient journey are being missed due to handover delays.

Scrutiny and monitoring arrangements

13 The Board and operational groups regularly monitor and scrutinise the progress of plans and their impact on mitigating avoidable patient harm and operational risks.

14 There is a range of data to monitor and scrutinise how the Trust’s service changes are working. However, this data is not joined up with health board data, which limits the Trust’s understanding of how its services impact on the entire patient journey, though the Trust is currently working to find solutions to this issue. The Trust is capturing staff and patient feedback, which it feeds into its future strategic plans, but response rates are low.

Recommendations

15 **Exhibit 1** details the recommendations arising from our work. The Trust's management response to our recommendations is summarised in **Appendix 3**.

Exhibit 1: recommendations

Recommendations
Accuracy of 111 Wales website R1 To ensure information used to signpost patients to urgent and emergency services are accurate, the Trust should work with partners to review and replace any out-of-date or misleading information on the 111 Wales website, for example, the NHS Direct Wales phone number **(Paragraph 27)**.
Directories of Service R2 To ensure the Trust has access to accurate and up-to-date information on health board services it should work with health boards to identify leads for maintaining the directories **(Paragraph 45)**.

Detailed report

Planning arrangements

16 This section considers whether the Trust has robust plans in place to manage the demand on urgent and emergency care services. We were specifically looking for evidence of plans:

- being informed by relevant and up to date information;
- identifying and seeking to address key risks associated with urgent and emergency care services;
- aligning with requirements of the Six Goals Programme, and clearly setting out how alternative clinical pathways will work; and
- identifying the current and required levels of resource and staffing to achieve the intended ambitions.

17 We reviewed the Trust's Integrated Medium-Term Plan (IMTP) along with its longer-term strategic framework, its plans relating to its Clinical Model Transformation Programme[6] developed during 2024, and its winter plan for 2024-25.

18 We found that **plans for managing urgent and emergency demand are robust and clear and clearly align to the national Six Goals Programme.**

19 The findings from our review of the plans are summarised in **Exhibit 2**.

Exhibit 2: approach to planning urgent and emergency care services

Audit question	Yes/ No/ Partially	Findings
Plans are informed by relevant and up to date information?	**Yes**	The Trust's plans contain relevant and up-to-date information, including operational performance, demographic predictions and demand and capacity data. They also include modelled scenarios for the Trust's performance, based on actual and potentially improved levels of handover

[6] The Clinical Model Transformation Programme is a programme of work the Trust is leading, with the support of commissioners and partners. The programme seeks to increase clinical input within the patient call cycle and to provide a greater range of response options for patients who need a face-to-face assessment. These changes should enable more patients to access treatment appropriate to their needs without the need for a hospital conveyance.

Audit question	Yes/ No/ Partially	Findings
		delays experienced within the broader health system.
Plans identify and seek to address key risks associated with urgent and emergency care services?	**Yes**	The Trust's plans clearly identify key risks and mitigating actions. Risks align with those identified through the Trust's corporate risk register. These risks focus on the impact of operational pressures on the Trust's ability to provide a safe service for patients. These risks have been at the highest score of 25 since December 2019 due to ongoing and increasing pressures. The Trust is currently engaged in a programme of work which includes a review of these risks to delineate between what can be managed and mitigated by the Trust and what external factors the Trust can monitor and seek to influence. Risks in relation to specific service changes and projects are also identified and regularly overseen by operational groups, with concerns escalated to the Trust's Strategic Transformation Board.
Plans align with requirements of the Six Goals for Urgent and Emergency Care Programme, and clearly setting out how the alternative clinical pathways will work?	**Yes**	The IMTP is explicit about its alignment to the Six Goals Programme and demonstrates how the Trust can make a meaningful contribution across each individual goal. Appendix 1 of the IMTP clearly articulates each goal, the relevant quality statement, the actions the Trust intends to take to achieve each goal and what it anticipates being the measurable benefits of its actions. Relevant sections throughout the body of the IMTP detail how alternative pathways or service improvements will work. The IMTP, along with the documents on the clinical model transformation programme outline changes aimed to better manage demand by treating patients in the community rather than taking them to hospital, where possible. These include introducing rapid

Audit question	Yes/ No/ Partially	Findings
		clinical screening for 999 calls to identify potential opportunities to signpost them to alternative services, expansion of Advanced Paramedic Practitioner roles and enhancing falls services.
Plans identify the current and required levels of staffing and resource to achieve the intended ambitions?	**Partially**	The IMTP has clear implications for increasing the workforce in specific service areas. Plans to support these implications are further detailed within the Trust's strategic workforce plan. The IMTP does not clearly identify the costs required to pursue additional schemes, and whether they require additional funding. However, this detailed information is available within the Trust's more detailed financial plans. The Trust does not receive a direct allocation of Six Goals funding in the same way as health boards, though it can access funding via the health boards to contribute to specific health-board schemes. The limited availability of additional funding has led to the Trust needing to slow the pace or defer planned changes to some of its services in recent years. However, in line with other NHS bodies, the Trust received an uplift in its core allocation during 2024-25, which enabled it to progress its clinical model transformation programme.

Source: Audit Wales

Accessing services

20 This section considers whether the Trust has appropriate arrangements in place to encourage and enable people to access urgent and emergency care services that best meet their needs, and whether these arrangements are working. We were specifically looking for evidence of:

- effective signposting of patients to the most appropriate urgent and emergency care services;
- staff having access to good information on the range of services available to patients, and the extent to which there is good engagement between Trust and health board staff involved in urgent and emergency care;
- a range of services that help manage urgency and emergency demand; and
- whether the above arrangements are helping to positively manage demand for urgent and emergency care services.

21 We found that **the Trust's approach to managing demand is improving, but handover delays limit the operational efficiencies gained from improvements, and information on the entire patient journey is not joined up.**

Signposting of services to the public

22 We found that **activity to signpost information to the public is not evaluated to ensure it is effective, and there are ongoing issues with the 111 Wales website.**

Communication plans

23 The Trust does not have a communication plan which sets out how it engages with the public to improve and support their understanding of how to access urgent and emergency care services. However, the Trust has recently updated its Engagement Plan, originally developed in 2023, to support its Clinical Model Transformation Programme which includes information on public messaging. However, the engagement plan is very high-level and does not outline the details of its approach to public engagement.

24 The Trust employs a range of methods to provide members of the public with information on its urgent and emergency care services. These methods include social media posts, news coverage in times of significant pressure, and information contained on the Trust and 111 Wales websites. Through its Public Engagement and Community Involvement Team, the Trust also holds events to engage with the public. According to an internal audit report in February 2025, this team held 147 events between January 2023 and October 2024 where it met with a variety of community groups. As part of these events the Trust will inform patients which services they should access and when.

111 Wales website

25 The 111 Wales website describes itself as 'the home of health advice and information for people living in Wales' and is a key tool to signpost the public to healthcare options. It includes symptom checkers, information on what to do out of hours, a directory of nearby services and advice on planned care and living well. The number of website hits on the 111 Wales website increased significantly during 2023. Currently an average of 400,000 – 550,000 people access the 111 website each month across Wales.

26 Available data does not show the main reasons people visit the 111 Wales website, but there is data on the main reasons for people calling the 111 phoneline. The top five reasons for calls are set out in **Exhibit 3**.

Exhibit 3: top five reasons for calling 111 (February 2024)

All-Wales position	% of all calls
Dental problems	4.1
Abdominal pain	2.4
Chest pain	1.6
Cough	1.4
Rash	1.0

Source: Ambulance Services Indicators

27 We reviewed the 111 Wales website symptom checker to understand what advice is available to patients searching for help on the most common conditions. We found that the website can be unreliable, with the symptom checker sometimes failing and displaying an error message. Our tests of the symptom checker showed that it can also refer the user to out-of-date information, including the old NHS Direct Wales number (**Recommendation 1**). Furthermore, our review found that the skin rashes tool has limited functionality, consisting of a slideshow of images. The Trust routinely seeks feedback from the public via an online survey to understand their experiences of the 111 Wales website. Past feedback from the public has raised similar issues with the functionality of the symptom checker and the website more generally.

28 The Trust is aware of ongoing issues with the symptom checker and recognises the need for increased investment in the website. While small changes are being made to improve its functionality and user experience, the Trust has also invested in the development of virtual assistant technology during 2024-25, which was ongoing at the time of our fieldwork. To address wider challenges, the Trust has drafted a business case to support more substantial changes to the website,

including updated symptom checker functionality and enhanced governance of the digital front door. The business case will be submitted to commissioners and the national Six Goals Programme Board following discussions with Welsh Government regarding financial envelopes and commissioner expectations. The business case will also cover 111 communications activity, and as this work progresses, the Trust should ensure it includes mechanisms to evaluate the effectiveness of its public engagement and adapt its approach where needed.

Staff awareness and ability to refer

29 We found that **referral pathways and processes between the Trust and health boards do not work seamlessly which is impacting access to alternative services.**

Assessment and treatment

30 During the last ten years, the Trust has introduced many initiatives and service changes to enhance its clinical offering with the aim of increasing the treatment of patients within the community and reducing conveyances to hospital. This has included expanding its clinical desk to provide advice to patients over the phone to 999 callers as well as introducing a referral process for patients seeking mental health support to have fast and direct access to relevant health board services (referred to as '111 press 2'). The Trust has also invested in its ability to treat patients face-to-face within the community, enabling them to stay at home, including increased its advanced paramedic practitioner workforce.

31 The ability of the Trust to treat, provide advice or signpost information to patients to avoid conveyance to hospital is referred to as 'consult and close'[7] and 'see and treat.' **Exhibit 4** sets out the extent to which the ambulance call centre can manage patients after assessment (consult and close), and ambulance crews can manage patients at the scene (see and treat).

[7] Previously referred to as 'hear and treat'.

Exhibit 4: percentage of ambulance calls and responses ended after telephone assessment (May 2023 – April 2024) or at scene (May 2023– April 2024) [8]

Indicator	All-Wales position	Trend
% of ambulance 999 calls ended after telephone assessment (consult and close)	13.9	
% of ambulance responses treated at scene (see and treat)	12.1	

Source: Ambulance Service Indicators

32 The rate of consult and close has increased substantially in recent years, from 8.2% in February 2019 to 14% in February 2024. This increase is mainly due to an increasing investment in recruiting clinicians to operate its Clinical Support Desk, particularly as part of plans to mitigate annual winter pressures.

33 Recent unverified data shows that the number of patients treated or referred to alternative services over the phone is further increasing after the Trust introduced rapid clinical assessments. In 2023 WAST commissioned a clinical model design of the Trust's EMS service by ORH.[9] The work ecommended that 999 calls should be reviewed and either referred for a fuller remote clinical assessment or returned to the queue to receive an ambulance dispatch. After receiving an increased core allocation to its base budget in 2024-25 due to inflation, the Trust decided to progress this recommendation and recruited 28 clinical navigators to launch the first phase of its Clinical Model Transformation Programme in November 2024. Unverified data for December 2024 showed the rate increasing from under 15% to over 20%.

34 When a call is ended through consult and close, a patient may have received a range of advice which can include self-care, contacting their GP within normal working hours, or signposting to other available services, (as set out in **Exhibit 5**). Within the Trust, there has been an increase in the range of available services to directly refer to. These include the mental health '111 press 2' service which directs patients to mental health support, as well as the urgent dental service to book urgent appointments. The urgent dental service is available via 111 for five of the seven health boards (excluding Aneurin Bevan and Cardiff and Vale who have their own services).

35 In 2023, the Trust also developed its capability to remotely monitor and manage patients within the community through the Connected Support Cymru service. This

[8] Data not available beyond April 2024.

[9] ORH, also known as Operational Research in Health Ltd, is a company which conducts research and analysis of emergency services aimed at optimising resource use and response.

service uses the support of volunteer responders, clinical support desk clinicians and remote monitoring technology to manage patients remotely and keep them at home, where appropriate. This service is currently in its early stages, with plans for it to be scaled up over the next few years as outlined within the Trust's IMTP 2024-27. However, this service currently utilises short-term funding from NHS charities together which is due to conclude in March 2025. The future of this service depends on the level of additional investment available.

36 Whilst the rate of patients treated at scene increased during the 12 months between March 2024 and February 2025, the rate has decreased slightly over a longer period. Between March 2019 and February 2020, the rate stood at an average of 2,770 patients treated at scene per month, compared to an average of 2,321 between March 2024 and February 2025.

37 The Trust has been expanding its advanced paramedic practitioner service to avoid hospital conveyance and improve patient outcomes. Advanced paramedic practitioners provide enhanced treatments to patients within their homes or communities. Since the introduction of the advanced paramedic practitioner role in 2017, the number of these roles within the Trust has increased to 119 as of February 2025, with recruitment of a further 11 currently underway. The Trust's IMTP sets out plans to further increase this workforce by 40 per year up to 2027, dependent on availability of funding. Case studies, local evaluations and interviews show that the advanced paramedic practitioner role is making a significant impact in treating patients closer to home. However, this is not currently being demonstrated clearly within 'see and treat' data that is available. The Trust is undertaking work to understand the reasons for this.

38 In addition to advanced paramedic practitioners, the Trust has developed a Cymru High Acuity Response Unit (CHARU) which provides advanced care to the most critically ill patients, including those experiencing cardiac arrest or major trauma. Data presented to the Trust's Finance and Performance Committee in September 2024 shows the service supporting better outcomes for 'red' calls such as cardiac arrests.

39 For urgent needs that are not immediately life-threatening, the Trust is also seeking to develop its own services, including falls responders. The Trust provides two levels of falls response services, with level one focused on lifting patients from the floor. Level two works with health boards to provide greater support to patients following a fall that are experiencing worsening frailty, by undertaking a full medical and social assessment at the point of need.

Referral to other services

40 As well as the availability of its own alternative services, the Trust's ability to refer patients to alternative services depends on the availability of those services within the health board regions. We found each health board has a range of services in place to manage and treat urgent and emergency care needs.

41 **Exhibit 5** sets out the extent to which 111 has been able to refer patients to other urgent and emergency services.

Exhibit 5: referral to other services (March 2023 - February 2024)

Indicator	All-Wales position	Trend
% of 111 calls referred to GP out of hours	41.5	
% of 111 calls advised to attend Emergency Department / Minor Injuries Unit	10.6	
% of 111 calls referred to urgent dental service	9.7	
% of 111 calls referred to 999	6.7	
% of 111 calls advised to contact their GP (in-hours)	4.6	
% of 111 calls referred to another health professional	2.0	

Source: DHCW Urgent and Emergency Care Dashboard, GP Out of Hours Data, Ambulance Services Indicators

42 The data shows that the most common service 111 callers are referred to is the GP out of hours service, with this rate increasing between March 2023 and February 2024. This rate aligns to public messaging which signposts patients with urgent out of hours needs to contact 111 to access GP out of hours services and suggests that public messaging is generally working effectively in this regard. The rate with which 111 call handlers refer patients to contact their own GP in hours (4.6%), indicates that patients could be better informed about which service to access, however it is also likely to reflect how the public are increasingly struggling to gain appropriate access to in-hours GP appointments due to capacity issues within primary care. The low rate of referrals to other health professionals (2%) also suggests that there are limited alternative services in place for 111 call staff to refer patients with specific conditions to access.

43 Between February 2022 and February 2024, 5.2% of 999 calls were transferred to the 111 service, on the basis that the calls were deemed non-urgent and therefore could be dealt with through alternative services. However, 27.7% of these calls were transferred back to 999 with an outcome of ‘ambulance required’ This comparatively high rate suggests that while these cases are not sufficiently urgent to warrant a 999 response, options for alternative services were either not in place or not accessible.

44 To facilitate effective referral between the Trust and health boards, there needs to be a sufficient range of appropriate pathways that the Trust staff are aware of and can access. One of the key ambitions of the Clinical Model Transformation Programme is to increase collaboration between the Trust and health boards to

identify potential pathways for patients, and to ensure that Trust clinicians have appropriate access to those pathways, either by streaming patients to health board clinical hubs, or directly to a care pathway via the directory of service.

45 The Trust holds a directory of service for each health board area. Directories of service have been set up to hold accurate and up-to-date information on available alternative pathways that patients can be signposted to by remote clinicians and paramedics. However, our fieldwork found that arrangements for maintaining the directories of service need to be strengthened between the Trust and health boards to ensure they are accurate and up to date, including containing the right opening hours for services (**Recommendation 2**).

46 Where pathways are established, our fieldwork also found that there are issues with ensuring Trust staff can access them. This can be because:

- referral criteria is unclear or too limited;
- pathways do not allow for referrals from Trust staff; or
- the extent of variation in the way in which services operate make them more challenging for Trust staff to access consistently or efficiently.

47 Interviews with a range of staff groups suggested that the inconsistencies in the availability of, and access to, alternative services serve to reinforce Emergency Departments as the default destination for ambulance conveyances.

48 In line with the ambitions of the Six Goals Programme, some health boards have established Urgent Primary Care Centres (UPCCs). The principle of UPCCs is to provide diagnosis and treatment to patients with urgent but non-life-threatening injuries or illnesses. However, the UPCC models developed in response to the Six Goals Programme vary within and between health boards. The Trust has been piloting booking patients directly into UPCCs from the 111 service, but this is limited to a small number of appointments and for very specific conditions. This stops Trust staff from using UPCCs to their full potential to manage urgent demand in the way they are intended.

49 Another key ambition of the Six Goals Programme was for health boards to establish Same Day Emergency Centre(s) (SDECs) to provide same day assessments and treatment without the patient needing to be admitted into hospital overnight. We have found that the SDEC models developed in response to the Six Goals Programme also vary across health boards. This variation results in a lack of clarity for Trust staff as to the referral criteria in place and the pathways they should use to access SDECs.

50 In response to this issue, Welsh Government issued an all-Wales policy on direct paramedic referral to same day emergency care in April 2022. The policy clarifies the different expectations of Trust and health board staff to support effective referrals into SDECs. However, despite the policy stating that it is ‘essential for the Welsh urgent and emergency care system that direct paramedic referral into SDEC/Ambulatory services is implemented’, Trust data shows that, between May

2023 and February 2025, on average only 0.13% of patients conveyed were taken to a health board SDEC each month.

51 We heard varying reasons for this low rate of referral during our fieldwork. This included technical issues but more prominently because SDEC units tend to become full within minutes of opening due to broader pressures on Emergency Departments. They then remain full until it becomes too late to accept any new referrals before the units close.

Impact of services to help manage demand

52 We found that **recent work to reduce conveyance to Emergency Departments is outweighed by unacceptably long handover delays across Wales**

Ambulance response times

53 Data shows that demand on the Trust's services, particularly in relation to red calls, has increased, placing additional strain on its ability to provide a timely service. Red calls across Wales increased by 178% between February 2019 and February 2025, with an average of 5,367 red calls per month between March 2024 and February 2025 (an average of 179 calls per day). This is in part due to the need to increase the number of conditions within the red categorisation to ensure they receive a timelier response. Whilst the number of amber calls has declined slightly since the pandemic, they continue to account for most of the 999 calls, with an average of 24,412 calls per month between March 2024 and February 2025 (an average of 814 calls per day).

54 The average percentage of red calls responded to within eight minutes between March 2024 and February 2025 was 48.6% and significantly below the target of 65%. However, during those 12 months, performance has improved with the Trust reaching a greater number of patients within eight minutes. For example, in December 2024 and January 2025 the Trust reached 33% and 22% more patients than its average two-year rate. Following the recent announcement by the Cabinet Secretary for Health and Social Care there will be changes to monitoring performance, with the creation of two separate metrics: one for cardiac and respiratory arrest; and another for other red emergency calls. These changes will take effect from 1 July 2025[10].

55 In contrast to red calls, responses to amber calls have become significantly poorer in recent years. On average, the response time to amber calls between March 2024 and February 2025 was 1 hour 50 minutes, rising to 9 hours 58 minutes for the patients who waited the longest (95th percentile). This performance fluctuated during those 12 months, with significant deterioration during December 2024 and

[10] On 11 March 2025 the Cabinet Secretary for Health and Social Care announced changes to the performance framework for ambulance services effective from 1 July 2025.

January 2025 due to winter pressures. Average response times for those months were 3 hours, 1 minute and 2 hours, 29 minutes respectively.

56 Call handlers provide patients with their estimated response time during their call. As a result, since 2022 a significant proportion of 999 callers have called back to cancel their place in the queue for an ambulance response ('cancelled calls'). There have also been circumstances where call handlers have been required to inform patients that they were unable to dispatch an ambulance response to them due to operational pressures at that time ('no send/can't send'). Concerningly, there is no method to capture what happens to these patients to find out if they decided to make their own way to the Emergency Department, found alternative services for their needs or simply decided not to receive treatment.

57 The Trust routinely captures and reports data on the number of cancelled calls or calls that received a 'no send/can't send' response. In September 2024, this cohort accounted for 9,440 calls or 21% of patients who dialled 999 that month. Further work by the Trust has established that up to 20% of all cancellations come from patients presenting with chest pain or falls, conditions that can result in significant patient harm. The Trust Board has heard directly about the impact this can have on patients, including a patient story during 2023 where a patient suffered a cardiac arrest within the hospital car park after being driven to hospital by a family member due to lack of ambulance availability.

58 As part of the Clinical Model Transformation Programme, the Trust took the decision in November 2024 to stop providing a 'no send/can't send' response, relying on the impact of its new changes such as rapid clinical screening to better manage demand. This means that the Trust takes greater responsibility for the patient and patient risk. This appears to be starting to have a positive impact, as data from February 2025 shows that the numbers of cancelled ambulances had reduced to 5,815, accounting for 15% of the total calls for that month.

Conveyance to hospital

59 After the ambulance has been dispatched and it is decided that the patient needs hospital assessment and treatment, they will be conveyed. Whilst the conveyance rate to hospital by the ambulance service was substantially impacted during the pandemic, data since 2023 shows a steadily decreasing conveyance rate when compared with pre-pandemic levels, with rates dropping from 68% (19,022 patients) in February 2019 to 63% (11,705 patients) in February 2025.

60 Data that shows where patients are conveyed to indicates further opportunities to increase conveyance to destinations other than the Emergency Department. **Exhibit 6** sets out the destination for all conveyances.

Exhibit 6: conveyance destination as a proportion of total conveyance (March 2024 – February 2025)

Indicator	All-Wales position	Trend
% of patients conveyed to major emergency departments	88.7	
% of patients conveyed to minor injuries units	6.4	
% of patients conveyed to major acute medical admissions unit	3.1	
% of patients conveyed to other unit e.g. mental health or maternity unit	1.8	

Source: Ambulance Services Indicators

61 The overwhelming majority of conveyance continues to be to Emergency Departments. This is likely to be the most appropriate destination for many calls, which, are by their nature, urgent and/or life-threatening. However, our interviews with ambulance and health board staff suggest that barriers exist which inhibit ambulance crews from conveying patients to settings which may be more appropriate for their needs.

62 For example, conveyance rates to minor injuries units are consistently low. Part of the reason for this is that there is significant variation in opening hours and criteria for accepting referrals to the minor injuries units operating within and between health boards. As a result, those we interviewed stated that paramedics will tend to rely on Emergency Department conveyance. This reduces the risk that the patient will not be accepted by the minor injuries unit, which results in poor patient experience and inefficiencies in having to undertake additional transportation to the Emergency Department.

63 We also heard that some alternatives to the Emergency Department, such as direct referral to units within specialties can be reluctant to accept referrals from paramedics. This is due to the types of observations and tests paramedics can complete. These services would prefer for patients to be routed through the Emergency Department first.

64 However, data on conveyance to hospital following 999 calls from a care home is showing some signs of improvement. This rate decreased from a high of 64.8% in November 2023 to a low of 58.7% in September 2024. This suggests that some of the work the Trust is doing to support care homes, including by supplying lifting equipment or providing enhanced falls response services, is resulting in lower rates of conveyance to hospital.

Ambulance handovers

65 Data shows that ambulance handover delays continue to be at unacceptable levels. Only 16% of patients were handed over from ambulance crews to an Emergency Department within 15 minutes of arrival between March 2024 and February 2025, against a national target of 100%. This compares to 56% between March 2018 and February 2019. Under half (43.9%) of the patients conveyed to an Emergency Department were handed over within an hour during February 2025. The average time for patient handover in December 2024 was 2 hours, 12 minutes. In England, the average handover delay for December 2024 was 39 minutes.

66 These high levels of handover delay result in extremely high numbers of 'lost hours' where a paramedic crew is unable to respond to other calls within the community, with lost hours routinely over 20,000 a month during 2024. This roughly equates to between one quarter or one third of the available capacity of the ambulance service each month. Comparing lost hours for February 2025 with those in February 2019 shows a 235% increase. The lost hours in February 2025 equate to 1,597 12-hour paramedic shifts.

67 Research commissioned by the Association of Ambulance Chief Executives (AACE) states that patients experiencing delays of over one hour are much more likely to experience avoidable harm because of the delay they face. Using the modelling developed as part of that research, the Trust has estimated that 463 patients (3.5% of conveyed patients) came to severe harm because of long handover delays in February 2025.

68 Despite the Trust's increasing activity to avoid hospital conveyance by remote treatment, either over the phone or in person, data shows that there remains a significant amount of work to do to improve handover performance. Lack of available ambulances will also lead to higher attendance rates at emergency departments across Wales, as patients make their own way to hospital. Some of these patients may not have needed to go to the emergency department, but opportunities for paramedics to treat patients remotely (See and Treat) earlier in their patient journey are being missed due to handover delays.

69 Problems associated with handover delays are widely recognised. In March 2025, the Cabinet Secretary for Health and Social Services announced the establishment of a patient handover improvement delivery group. This group is intended to identify and oversee action aimed at improving ambulance patient handover performance, learning from UK-wide and international best practice. An update on the progress of this group's work is anticipated in July 2025.

Scrutiny and monitoring arrangements

70 This section considers whether the Trust is doing enough to monitor the performance of its urgent and emergency care services, and applying lessons learnt to improve services further. We were specifically looking for evidence of:

- arrangements for monitoring the impact of alternative clinical pathways; and
- effective oversight and scrutiny of the delivery of plans for urgent and emergency care.

71 We found that **there is good oversight of performance and plan progress relating to urgent and emergency care demand which is informed by staff and patient feedback but is limited by lack of joined up data**

Monitoring impact

72 We found that **monitoring of plans is informed by regular staff and patient feedback, but without joined up data the Trust cannot monitor the effectiveness of referral pathways with certainty.**

73 The findings that have led us to this conclusion are summarised in **Exhibit 7**.

Exhibit 7: approach to monitoring the impact of alternative pathways on urgent and emergency care services

Audit question	Yes/ No/ Partially	Findings
Is the Trust tracking and reporting data to show whether patients are accessing urgent and emergency care services appropriately?	**Partially**	The Trust routinely tracks relevant data on demand, rates of signposting and referral to alternative services (consult and close) and rates of conveyance to hospital units, including Emergency Departments. However, Trust and health board information systems are not currently linked up to enable the tracking of an entire patient journey i.e. to confirm whether patients followed advice they have received.
Is regular patient feedback is being	**Yes**	The Trust captures patient feedback through regular CIVICA experience surveys[11]. There are

[11] Civica Experience is a software which helps healthcare professionals collect and analyse data to turn patient feedback comments into insights.

Audit question	Yes/ No/ Partially	Findings
sought and used to inform and improve plans?		surveys in place for 999, 111 and the Trust's falls service. These surveys capture patient responses to questions including their overall rating of the experience for the service they received, as well as more specific questions, such as whether patients intend to follow the advice they found on the 111 Wales website. The Trust recognises that response rates to these surveys are low, with 371 responses across each of those listed above between April and September 2024, and it continues to explore options to increase participation. Supporting appendices of the Trust's IMTP summarise patient feedback and concerns relating to services, including 111 and 999 services and links them to specific actions within the plan which aim to address those concerns and improve patient experience.
Is there regular staff feedback on the impact of changes to services and pilots to identify and apply lessons?	**Yes**	The Trust shows a commitment to hearing from staff, including via monthly WAST Live virtual staff meetings, surveys and bi-annual Chief Executive Officer roadshows held in ambulance stations and offices across Wales. Furthermore, the Trust involves trade union representatives in key working groups and each board committee, as well as through the Welsh Ambulance Service Partnership Team. These mechanisms provide a staff perspective during decision making. In January 2025, the Trust surveyed staff involved in delivering the Clinical Model Transformation Programme and the associated new initiatives. The survey asked staff for their views on the way in which changes have been implemented. The response rate was low at 17% (30 responses) and whilst overall scores were mostly positive, comments included concerns about the pressure caused by the pace and scale of the programme, as well as a need for more regular and meaningful staff engagement. The Trust is currently developing actions to respond to these concerns.

Audit question	Yes/ No/ Partially	Findings
		Staff feedback and related actions to address areas of concern are also included within an appendix of the Trust's IMTP.

Source: Audit Wales

Oversight and scrutiny

74 We found that **there is regular operational and strategic oversight and scrutiny of the performance and the delivery of plans**

75 The findings that have led us to this conclusion are summarised in **Exhibit 8**.

Exhibit 8: approach to oversight and scrutiny of urgent and emergency care services

Audit question	Yes/ No/ Partially	Findings
Is there effective oversight of urgent and emergency care performance operationally, including scrutiny and assurance on the effectiveness of plans and actions being taken to better meet demand?	**Yes**	The Trust provides operational oversight and scrutiny of its actions to improve demand management through its Clinical Transformation Board, and supporting workstreams, as well as its Integrated Strategic Planning and Development Group. These groups are supported by strong arrangements, including appropriate membership and regular frequency. The Trust continues to oversee and manage performance in line with its Quality and Performance Management Framework 2022-25. Operational performance is scrutinised at detailed levels by various operational, quality and planning subgroups before being collated and submitted for oversight and challenge by the Executive Leadership Team.
Is there effective oversight of urgent	**Yes**	Performance information on the Trust's urgent and emergency care services is regularly

Audit question	Yes/ No/ Partially	Findings
and emergency care performance at the committee and board level, including scrutiny and assurance on the effectiveness of plans and actions being taken to better meet demand?		reported to the Performance and Finance Committee; the Quality, Experience and Patient Safety Committee; and the Board. In 2024, the Trust developed a patient harm mitigation scorecard. This provides a collective set of metrics to indicate the levels of harm that may be occurring as a result of system pressures. However, again this information is limited due to the absence of joined up information between the Trust and its commissioning health boards. As a result, the scorecard only indicates estimated levels of harm based on the AACE model. The Finance and Performance Committee and the Board are also responsible for overseeing the progress of the Trust's Integrated Medium-Term Plan.

Source: Audit Wales

Appendix 1

Audit methods

Exhibit 9 sets out the audit methods we used to deliver this work. Our evidence is limited to the information drawn from the methods below.

Exhibit 9: audit methods

Element of audit approach	Description
Documents	We reviewed a range of documents, including: • Integrated Medium Term Plan and appendices; • Corporate Risk Register and Board Assurance Framework; • Internal Audits; • Winter Plan; and • Clinical Model Transformation Stakeholder briefing document, September 2024.
Interviews	We interviewed the following: • Executive Director of Operations; • Executive Director of Paramedicine; • Executive Director of Strategic Planning and Performance; • Director of Partnerships and Engagement; and • Assistant Director, Commissioning and Performance.
Group discussions	We held group discussions with the following: • Advanced Paramedic Practitioners.
Observations	We observed the following meeting(s): • Finance and Performance Committee; and • Board.
Data analysis	We analysed data relating to urgent and emergency care services, using the following sources: • Ambulance Services Indicators; • Data provided from the Trust, including rates of consult and close and SDEC referrals;

Element of audit approach	Description
	• DHCW Urgent and Emergency Care Dashboard; • StatsWales; and • Data provided by Welsh Government in relation to GP out of hours services.
Website and practice reviews	We reviewed the Trust's website and social media accounts relating to the provision of information to the public on accessing urgent and emergency care services.

All audit work has been delivered in accordance with the International Organisation of Supreme Audit Institutions (INTOSAI) audit standards.

Appendix 2

Audit criteria

Exhibit 10 sets out the audit criteria that we used to deliver this work.

Exhibit 10: audit criteria

Audit questions	Audit criteria
Does the Trust have robust plans in place to manage the demand for urgent and emergency care services?	
Do plans seek to improve the management of demand through changes to service delivery in line with the six goals for Urgent and Emergency care?	• Strategies and/or plans relating to urgent and emergency care: – are based and grounded in rich and up-to-date information, informed by urgent and emergency care demand data (past and future), including peaks in activity at certain times/days and months, demographics, and conditions of patients. – identify and seek to address key risks associated with demand for urgent and emergency care services. – align with the plans of partner Health Boards. – align with the requirements of the Welsh Government Six goals for Urgent and Emergency Care for better managing demand. – include documented information on alternative clinical pathways, including how and when they should be accessed.
Do plans identify the current and required	• Strategies and/or plans detail the:

Audit questions	Audit criteria
levels of resource and staffing to achieve the ambitions?	– resource requirements and identified funding to support any changes to service delivery included within the strategy/plan. – workforce and skills required to meet demand, including for changes in models of delivery such as winter peaks. The plan is clear about the required resources of clinical and non-clinical skills/staff.
Are arrangements in place to encourage and enable people to access the right care, in the right place, at the first time, and are these working?	
Is the Trust effectively signposting urgent and emergency care services to the public, so they know how to access services appropriately?	• The Trust provides clear information on available services and alternatives to emergency departments to the public through various avenues – websites, call handlers, posters/leaflets, advertisements, social media, videos etc. • Strategies and/or plans on public communication align to requirements of goals 2 and 3 of the WG Six goals for Urgent and Emergency Care (Right care, right place, first time) • There is evidence to suggest patients have a good understanding of how to access urgent and emergency care services that are appropriate to their needs
Do staff have good knowledge of, and access to, information regarding the range of other services available to their patients and at what times they are available?	• There is engagement between the Trust and health boards about alternative pathways in place and the future of urgent and emergency care services. Information on these pathways and services are accessible for staff. • Staff can refer directly / divert patients to more appropriate settings for their needs, including Minor Injury Departments, Urgent Primary Care Centres (UPCC) and Same Day Emergency Centres (SDEC).
Is there evidence that changes to service delivery are resulting in	• Referrals into new service models are in line with the ambitions of the six goals for urgent and emergency care policy handbook. • WAST can refer at least 4% of cases to SDEC.

Audit questions	Audit criteria
better demand management?	• Data indicates that there are increasing rates of See and Treat and Hear and Treat. • Calls to 111 are answered quickly and abandonment rates are low. • Emergency ambulance response times, ambulance handover delays and waits within Emergency Departments and Minor Injury Units are improving. • Data indicates that there are fewer amber calls requiring an upgrade to red due to lengthy response times. • Data shows decreasing volumes of patients with low acuity / minor complaints presenting at Emergency Departments. • Data indicates that calls diverted between 999 and 111/NHS Direct Wales are appropriate with low levels of calls diverted back and low numbers of re-contact rates.
Is the Trust doing enough to monitor the performance of its urgent and emergency care services and apply lessons learnt to improve the services further?	
Is the Trust monitoring the effectiveness of alternative clinical pathways, including by seeking feedback from staff and service users?	• The Trust tracks and reports data to show whether patients are accessing urgent and emergency care services appropriately. • The Trust can evidence that it seeks patient feedback regularly and uses it to inform and improve plans. • Regular feedback is sought from various staff on the impact of changes to services and pilots to identify and apply lessons
Is there effective scrutiny and assurance in relation to delivering plans for urgent and emergency care and alternative clinical pathways?	• There is effective oversight of urgent and emergency care performance operationally and at the committee and board level. This includes scrutiny and assurance on the effectiveness of the plans and actions being taken to better meet demand. Oversight and scrutiny are informed by comparative benchmarking and learning from other bodies where appropriate. • There are arrangements in place for monitoring and oversight of economy, efficiency, and effectiveness of project investment from Welsh Government. This includes establishing value for money and what difference the project has made.

Appendix 3

Management response to audit recommendations

Exhibit 11 sets out the Trust's management response to the recommendations made because of this audit.

Exhibit 11: management response

Recommendation	Management response	Completion date	Responsible officer
Accuracy of 111 Wales website R1 To ensure information used to signpost patients to urgent and emergency services are accurate, the Trust should work with partners to review and replace any out-of-date or misleading information on the 111 Wales website, for example, the NHS Direct Wales phone number **(Paragraph 28)**.	The Trust accepts this recommendation. While WAST is not directly commissioned to manage the 111 Wales website, we fully support the need for accurate content to signpost patients safely. We routinely raise concerns, such as outdated references to NHS Direct Wales and will strengthen this by formally escalating issues through an agreed assurance route with Digital Health and Care Wales. A business case has been drafted to propose a new governance model with dedicated resources for oversight and content management to improve accuracy and ownership. Discussions with Welsh Government are ongoing regarding financial envelopes and commissioner expectations, which are prerequisites to formal submission.	May 2026	Director of Digital Services

Recommendation	Management response	Completion date	Responsible officer
	Website content accuracy will be a standing item at the monthly 111 Wales digital governance group. Over the next 12 months, issues will be actively monitored, and formal escalations logged to demonstrate progress and provide evidence of action taken.		
Directories of Service R2 To ensure the Trust has access to accurate and up-to-date information on health board services it should work with health boards to identify leads for maintaining the directories **(Paragraph 46)**.	The Trust accepts this recommendation. We agree on the need for accurate and up-to-date service information. While WAST does not control the content provided by health boards, we maintain mechanisms to receive and manage this data. The recommendation is therefore best addressed through strengthened collaboration with health boards, who remain responsible for the accuracy of their service information. A business case has been drafted to improve Directory of Services (DoS) governance and support. Discussions with Welsh Government are ongoing regarding financial envelopes and commissioner expectations, which are prerequisites to formal submission. WAST will continue to update any content we own/publish into to the DOS and will escalate outdated information to relevant health boards. This will be monitored over 12 months, with escalations logged as evidence of action.	May 2026	Director of Digital Services

Source: Audit Wales

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We welcome correspondence and telephone calls in Welsh and English. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

AGENDA ITEM No	**18**
OPEN or CLOSED	**Open**
No of ANNEXES	**2**

COMMITTEE PRIORITIES AND CYCLE OF BUSINESS MONITORING REPORT

MEETING	Quality, Patient Experience and Safety Committee
DATE	05 August 2025
EXECUTIVE	Trish Mills, Director of Corporate Governance/Board Secretary
AUTHOR	Trish Mills, Director of Corporate Governance/Board Secretary Sarah Harland, Corporate Governance Officer
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. This report updates the Committee on progress against the agreed Cycle of Business for the Committee. Progress is steady across all priorities and there is nothing to escalate from the Cycle of Business.

RECOMMENDATION: The Committee is asked to note the update.

KEY ISSUES/IMPLICATIONS

No issues to raise.

REPORT APPROVAL ROUTE

Not applicable.

REPORT APPENDICES

Annex 1 – QuEST Committee Cycle of Business Monitoring Report 2025/2026

Annex 2 – QuEST Committee Cycle of Business Notes

REPORT CHECKLIST			
Confirm that the issues below have been considered and addressed		**Confirm that the issues below have been considered and addressed**	
EQIA (Inc. Welsh language)	Yes	Financial Implications	N/A
Environmental/Sustainability	N/A	Legal Implications	N/A
Estate	N/A	Patient Safety/Safeguarding	N/A
Ethical Matters	N/A	Risks (Inc. Reputational)	N/A
Health Improvement	N/A	Socio Economic Duty	N/A
Health and Safety	N/A	TU Partner Consultation	N/A

COMMITTEE PRIORITIES AND COMMITTEE CYCLE MONITORING REPORT FOR 2025/26

SITUATION

2. This report updates the Committee on progress against the agreed Cycle of Business and the priorities that it set for 2025/26. Progress is steady across all priorities and there is nothing to escalate from the Cycle of Business.

BACKGROUND

3. During the effectiveness reviews, it was agreed that it is good practice for Committees to set priorities for the forthcoming year. The Committee's priorities, which are set out below, were agreed by the Trust Board in May 2025 and will be tracked quarterly.

4. The Committee's Cycle of Business was approved by the Committee in April 2025. The agenda is set with reference to that cycle, together with the Forward Planner, Action Log and highest rated principal risks.

5. The Monitoring Report is at Annex 1. The 'pre-agenda setting' key indicates that items in green show where they are cycled for a particular meeting. Items in beige indicate they are a prompt at agenda setting as they may be *ad hoc* items such as business cases or external reports.

6. The 'post-agenda setting' key indicates that items in blue were either on the agenda as scheduled or is 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.

ASSESSMENT

7. The **Committee priorities**, and progress against them is as follows:

Priority	Progress
• Continued monitoring and reporting on performance against the Duty of Quality and Duty of Candour	**2025/26 PROGRESS** • 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.

	<u>2024/25 PROGRESS (included as this priority was carried over into 2025/26)</u> • 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.
• Prioritising the implementation of the new Strategic Quality Plan to ensure tangible outcomes	**2025/26 PROGRESS** • The Committee received the Strategic Quality Plan 2025-2028 at its meeting on 9 May 2025, and it was subsequently endorsed for approval by the Board. The Board approved the plan on 29 May 2025.
• Focus on the Clinical Model Transformation, ensuring robust quality assurance and patient experience improvements	**2025/26 PROGRESS** • Verbal updates on the Ministerial Advisory Group Wait 45 Taskforce and Revised Performance Framework will be provided at the August 2025 meeting.

8. **RECOMMENDATION: The Committee is asked to note the update.**

PAPER	PRE C'EE FORUM	FREQUENCY	Q1	Q2	Q3	Q4	LEAD	PURPOSE	COMMENT/COMPLIANCE
QUEST COMMITTEE - CYCLE OF BUSINESS 2025/26									
TERMS OF REFERENCE NOTED IN RED TEXT									
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)
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 devises by exception) & exception report - see Note 10
External reports	CQGG	Ad Hoc					EDQN/DP	Assurance	
Dementia Standards Report	CQGG	Annually					EDQN	Assurance	See Notes
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
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
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) Q2 Included within the PTR Report**
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	
SUB-GROUPS									
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
GOVERNANCE									
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	
PROMPTS									
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
- Ah hoc / item considered - not programmed
- Item deferred
- Reporting developing

1	**Putting Things Right Report**	Note in February 2024 Quest PTR report that future reports will move to aggregated thematic reviews to determine patters and trends corporately and at Health Board levels. Audit Wales Quality Governance Review 2022 made recommendations related to quality information. The 2024 Qualty Governance Follow Up Review (October 2024) re-opened previously closed recommendations as follows: - 8.1 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 - 8.2 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. - 8.3 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 - 8.4 Develop patient outcome measures to support its existing quality measures. This has been re-opened. 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. 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. 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.
2	**Duty of Quality and Duty of Care**	The 2024 Qualty Governance Follow Up Review recommendations as follow: 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
3	**Annual Quality Report**	H&C (Q&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 The 2024 Qualty Governance Follow Up Review recommendations as follow: 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
4	**Annual Duty of Candour Report**	H&C(Q&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. 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. The 2024 Qualty Governance Follow Up Review recommendations as follow: 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
5	**Dementia Standards**	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. Reporting on compliance against the 20 dementia care pathway standards being developed in 23/24 (see Nov 22 QUEST paper for link to standards).
6	**QIA**	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. QUEST paper 110523 - CQGG will: (a) Be assured that there is an appropriate QIA process undertaken for all new and existing Trust wide service redesign/transformation, projects and cost improvements; (b) Receive oversight reports on new and existing Trust wide schemes/projects that have undergone a full QIA to ensure risk planning is robust and the impact on quality and performance is being thoroughly assessed and negative impact mitigated (c) Have oversight of the framework and central repository for all QIA's; initial screening and full QIA. (d) have oversight of onward report to the Executive Management Team; Quality, Patient Experience and Safety (QuEST) Committee and; Trust Board, as appropriate. Reports to QuEST will identify QIAs completed and explicitly identify those that have required EMT review and authorisation.
7	**Clinical Audit**	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. QUEST to assure Audit Committee that clinical audit plan in place via AAA from Chair of QUEST. Clinical Audit Internal Audit done in 2023/24 - see recommendations Audit Wales Quality Governance Review Update 2024 made recommendations related to clinical audit: R3 - There are opportunities to further enhance reports on the Trust's Clinical Audit function, by: - 3.1 More clearly highlighting any changes made to the approved Clinical Audit Plan; and - 3.2 Capturing key findings, outcomes and learning from completed audits 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
8	**Meds Management and Medical Devices**	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. Any exception reporting on meds management or medical devices to Quest by exception. MM audit compliance in Q1 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
9	**Mortality reviews**	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. 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. Audit Wales Quality Governance Review 2022 made recommendations related to mortality reviews. The 2024 Qualty Governance Follow Up Review (October 2024) re-opened previously closed recommendations as follows: 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: - 3.1 The number of reviews undertaken, and the numbers of reviews required but not yet complete. **This has been re-opened.** - 3.2 Any significant concerns, lessons learned and what changes have been made as a result. **This has been re-opened.** - 3.3 Updates on actions to address the mortality review backlog. **This has been re-opened.** - 3.4 Updates on progress implementing the all-Wales Learning from Mortality Reviews Framework. **This can remain closed.** 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. **This has been re-opened.** Report writers shoudl 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. See Learning From Deaths report to QUEST 13 August 2024 for background detail.
10	**Mental Health**	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. Mental health KPIs to be developed in 2025/26
11	**Quality Plan**	Audit Wales Quality Governance Review Follow Up 2024 recommendations: Quality Strategy 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. Quality Strategy monitoring R2 - There is scope to strengthen quality strategy implementation plan delivery reporting. To enhance clarity, the Trust should, in its progress reports: - 2.1 Provide timescales for the expected delivery of each action; - 2.2 Differentiate between the progress of individual actions and strategic outputs; and - 2.3 Ensure that progress reports are reported regularly and are included in the QuESt cycle of business [note the report indicates quarterly from August 2024]