Bundle Quality, Patient Experience and Safety Committee 6 August 2026

Agenda attachments

00 Agenda

09:30 - OPENING ITEMS

1 Chair's Welcome, Apologies and Quorum

2 Declarations of Interest

Item 02 Board Member Register of Interests 23 June 2026

3 Minutes of the Open Meeting 7 May 2026 (Confirmation of recording/transcript deletion of previous meeting)

Item 03 2026-05-07 unconfirmed QUEST Public Minutes

4.1 Action Log & Matters Arising

Item 04.1 Action Log

4.2 Committee AAA Highlight Report 7 May 2026

Item 04.2 Quest Committee Highlight Report 7 May 2026

4.3 FOR APPROVAL, ASSURANCE AND DISCUSSION

5 09:35 - Patient Experience: Anna Jenkins

Anna's neighbour, Mario (Jolazza) had a stroke, in early December (2025) first call to 999 was advised of a two-hour wait for an emergency ambulance. Anna and another neighbour, attended after Mario's spouse contacted them as she was away at the time. They considered conveying Mario themselves and called ahead to Bronglais Hospital to verify it would be the appropriate hospital to bring him into. The hospital recommended bringing Mario in directly; however, this was not feasible, due to concerns about safety moving him, Mario weighted 16 stone and would need to have been lifted down a flight of stairs.

A subsequent update from the ambulance service indicated an extended wait of up to six hours. As a result, the fire service was contacted to assist with moving Mario into a vehicle. They responded promptly, enabling Mario to be transported to the hospital by his neighbours. Upon arrival, Mario was diagnosed with a stroke and required transfer to Bristol for neurosurgical treatment.

Anne later reflected on the contrast between services, describing the ambulance response as inflexible and highly scripted, which limited effective communication, while the fire service acted quickly and decisively. She submitted a formal complaint and has since acknowledged the lasting personal impact of the incident.

Item 05 Experience Story Tracker - Anna Jenkins

5.1 10:00 - Staff Experience Update: Mr Mike Senior

Item 05.1 Staff Experience Tracker Update Mike Senior

6 10:05 - Operations Directorate Quarterly Report Q1 2026/27

Item 06 Operations Quarterly Report Q1 2026-2027

7 10:25 - Strategic Quality Plan 2025/28 Mid-Point Review

Item 07 Strategic Quality Plan 2025-2028 Mid-Point Review

Item 07 Annex 1 Strategic Quality Plan 2025-2028 Mid-Point Review

8 10:40 - Monthly Integrated Quality Performance Report [MIQPR] June 2026

Item 08 MIQPR

Item 08 Annex 1 Monthly Integrated Quality and Performance Dashboard

9.1 10:50 - Concerns, Patient Safety and Legal Services Report April - May 2026

Item 09.1 Concerns, Patient Safety and Legal Services Quarterly Report April-May 2026

Item 09.1 Annex 1 Concerns, Patient Safety and Legal Services April-May 2026

9.2 Concerns Management Improvement Programme Progress Report

Item 09.2 Concerns Management Improvement Programme Progress Report

9.3 11:30 - COMFORT BREAK

10 11:45 - Clinical Audit Plan Update Q1 2026-27
Item 10 Clinical Audit Plan Q1 2026-27 Update to QuEST
Item 10 Annex 1 Clinical Audit Plan 2026-27 Q1 Update
Item 10 Annex 2 Clinical Audit Plan Q4 2025-26 Update to CIAT

11 11:55 - Infection Prevention and Control (IPC)
Item 11 Infection Prevention & Control Work Plan Update

12 12:10 - New NHS Wales Engagement Process
Item 12 Healthcare Inspectorate Wales - New NHS Wales Engagement Process Implementation and Assurance Update
Item 12 Annex 1 Healthcare Inspectorate Wales - New NHS Wales Engagement Process

13 12:20 - Risk Management and Board Assurance Framework
Item 13 Risk Management Report

14.1 12:30 - Audit Tracker 2026-27 Q1 (April - June 2026) Exception Reporting
Item 14.1 Audit Tracker 2026-27 Q1 (April - June 2026) Exception Reporting

14.2 Internal Audit Report - Clinical Prioritisation and Assessment Software (CPAS) Group: Governance and Change Management (Reasonable Assurance) (AS/JC)
Item 14.2 Feedback Report from ARAC to QuEST CPAS Group
Item 14.2 Annex 1 CPAS Group Governance Workflow Final Internal Audit Report

15 12:40 - Committee Cycle of Business Monitoring Report and 2026/27
Item 15 Cycle Monitoring Report August 2026
Item 15 Annex 1 Tab 1
Item 15 Annex 1 Tab 2

15.1 CONSENT ITEMS [None]

15.2 12:45 - CLOSING ITEMS

16 Reflections

17 Any Other Business

18 Date & Time of the Next Meeting: 5 November 2026 at 09:30

Length of Meeting:	03:20		[PUBLIC] QUEST COMMITTEE - 6 August 2026					Deadline for Papers: 28 July 2026			Last good practice Exec Review: 22 July 2026	
Time	**Mins allotted**	**Agendum**	**Title**	**Format**	**Item for**	**Item requested by**	**Paper prepared by**	**Item presented by**	**Colleagues to cc**	**Scheduled at ELT**	**Further approval route (if app.)**	**Notes**
			OPENING ITEMS									
		1	Chair's Welcome, Apologies and Quorum	Verbal	Information	Standing	n/a	Chair	n/a			
		2	Declarations of Interest	Verbal	To State Conflicts	Standing	n/a	Chair	n/a			
09:30	00:05	3	Minutes of the Open Meeting 7 May 2026 **(Confirmation of recording/transcript deletion of previous meeting)**	Paper	Approval	Standing	n/a	Chair	n/a			
		4	4.1 Action Log & Matters Arising 4.2 Committee AAA Highlight Report 7 May 2026	Paper	Discussion	Standing	n/a	Chair	n/a			
			FOR APPROVAL, ASSURANCE AND DISCUSSION									
09:35	00:30	5	Patient Experience: Anna Jenkins	Video	Discussion	CoB	Quality	Penny Durrant	Leanne Hawker, Alison Kelly			
		5.1	Staff Experience Update : Mike Senior	Verbal	Assurance	CoB	Quality	Penny Durrant	Leanne Hawker, Alison Kelly			
10:05	00:20	6	Operations Directorate Quarterly Report Q1 2026/27	Paper	Assurance	CoB	Operations	Lee Brooks	Judith Bryce Toni-Marie Norman			
10:25	00:15	7	Strategic Quality Plan 2025/28 Mid-Point Review	Paper	Assurance	CoB	Quality	Penny Durrant	Kate Blackmore			
10:40	00:10	8	Monthly Integrated Quality Performance Report [MIQPR] June 2026	Paper	Assurance	CoB	SPP	Rachel Marsh	Hugh Bennett, Mark Thomas Mel O'Connor			
10:50	00:40	9	9.1 Concerns, Patient Safety and Legal Services Report April - May 2026 9.2 Concerns Management Improvement Programme Progress Report	Paper	Assurance	CoB	Quality	Penny Durrant	Claire Appleton, Alison Kelly			
11:30	00:15		COMFORT BREAK									
11:45	00:10	10	Clinical Audit Plan Update Q1 2026-27	Paper	Assurance	CoB	Clinical	Andy Swinburn	Jonathan Chippendale			
11:55	00:15	11	Infection Prevention and Control (IPC) Work Plan Update	Paper	Assurance	Forward Planner	Quality	Penny Durrant	Sarah Morgan, Alison Kelly			
12:10	00:10	12	New NHS Wales Engagement Process	Paper	Assurance	Forward Planner	Quality	Penny Durrant	Alison Kelly			
12:20	00:10	13	Risk Management and Board Assurance Framework * Risk 223 The Trust's inability to reach patients in the community causing patient harm and death * 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 * Risk [tbc) Putting Things Right * Risk 700 Listening to People	Paper	Assurance	CoB	Gov	Julie Boalch	n/a			
12:30	00:10	14	14.1 Audit Tracker Q1 2026/27 14.2 Internal Audit Report - Clinical Prioritisation and Assessment Software (CPAS) Group: Governance and Change Management *(Reasonable Assurance)* (AS/JC)	Paper	Assurance	CoB	Gov	Trish Mills	Lisa Trounce			
12:40	00:05	15	Committee Cycle of Business Monitoring Report and 2026/27	Paper	Assurance	CoB	Gov	Julie Boalch	Sarah Harland			
			CONSENT ITEMS The items that follow are for information only. Should a member wish to discuss any of these items they are requested to notify the Chair so that time may be allocated to do so.									
			CLOSING ITEMS									
		16	Reflections	Verbal	Discussion	Standing	n/a	Chair	n/a			
12:45	00:05	17	Any Other Business	Verbal	Discussion	Standing	n/a	Chair	n/a			
		18	Date & Time of the Next Meeting: 5 November 2026 at 09:30	Verbal	Information	Standing	n/a	Chair	n/a			
12:50	**03:20**		**CLOSE**									

LEAD PRESENTERS

Name	Position
Julie Boalch	Assistant Director of Corporate Governance and Risk
Lee Brooks	Executive Director of Operations
Jonathan Chippendale	Assistant Director of Clinical Development
Penny Durrant	Interim Director of Nursing
Bethan Evans	Chair and Non-Executive Director
Rachel Marsh	Executive Director Planning and Performance
Trish Mills	Director of Corporate Governance/Board Secretary

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended
AHMAD, Umar Afthab DR	**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	GP Partner at Plains View Surgery, Nottingham	Financial Interest	2014	
		Primary Care Network Clinical Director for Arrow Health, Nottingham	Financial Interest	2019	
		Non-executive Director (appointed company director) for Primary Integrated Community Services Ltd, Nottingham and small shareholder [Company number 08763136]	Financial Interest	2023 and 2016	
		Owner and company director of Travel Jab Guru Ltd – online medical travel advice [Company number 14685908]	Financial Interest	2023	
		Local Medical Committee Member	Financial Interest	2019	
		Nottingham Integrated Care Board Cardiovascular Disease and Stroke Prevention Clinical Design Authority Lead	Financial Interest	2025	
		Associate Non-executive Director Nottinghamshire University Hospital Trust (non-voting member of the board)	Financial Interest	2024	
BEESLEE, Jayne	**Non-Executive Director** * Chair of Finance and Performance Committee * Member of the Remuneration Committee * Member of the Remuneration Committee	Employment fro interim assignments via Public Sector Resourcing (an agency) regarding the rev iew of major UK Government programmes (remunerated nex of tax via an umberella company - Danbro Employment Umbrella Ltd)	Financial Interest	01 October 2023	
		Governor on the Finance and General Purposes Committee of Cardiff and Cale Further Education College	Non-Financial Personal	01 February 2024	
		Fellow Chartered Institute of Persennel and 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	
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	
		Trustee of Action for Children Pension Board	Position in Charity or Voluntary Organisation	22 May 2023	
		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	
		Chair - Taff Housing Association	Any Other Interest	17 July 2025	
		Member of Governing Body / Independent Member – Kaplan International Colleges UK Ltd [05268303	Non-Financial Professional	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	Group Chair of South Central Ambulance Service NHS Foundation Trust and South East Coast Ambulance Service NHS Foundation Trust	Directorships	27 March 2026	
		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	
DURRANT, Penny	**Deputy Director of Nursing, Quality and Governance**	Nil Declaration		30 May 2026	
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	
		Companty 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
EVANS, Bethan	**Non-Executive Director**	Company Director - Hawthorn Court Property Limited	Directorships	27 April 2022	
[continued]	* Chair of Quality, Patient Experience & Safety Committee	[Previously called My Choice Healthcare (Three) Limited, Company name changed 12.08.2022 - #13371375]	Directorships	27 April 2022	
	* Member of Finance & Performance Committee	Company Director - Ocean Living Property Limited	Directorships	22 July 2022	
	* Member of People & Culture Committee	Company Director - Hawthorn Court Care Limited	Directorships	22 July 2022	
	* Member of Remuneration Committee	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	
		Longhope Property Ltd	Directorships	12 February 2026	
		My Choice Healthcare England Ltd	Directorships	26 August 2025	
		My Choice Healthcare Ltd	Directorships	26 August 2025	
		Glyncornel Care Ltd	Directorships	16 August 2022	
HITCHON, Estelle	**Director of Partnerships and Engagement**	Member of Academi Wales Expert Panel	Position in Charity or Voluntary Organisation	15 July 2024	
		Independent Governor (Non-Executive Director), Coleg Sir Gar/Coleg Ceredigion	Non-Financial Personal	01 January 2025	
HUTCHINGS, Hayley	**Non-Executive Director**	Emeritus Professor, Swansea University	Non-Financial Professional	31 May 2025	
	* Member of the Remuneration Committee				
	* Member of the Academic Partnership Committee	Consultant Advisor to the FASAR Trial, Nottingham Trent University	Financial Interest	25 March 2026	
	* Member of the People and Culture Committee				
JACKSON, Ceri	**Non-Executive Director & Vice Chair of the Trust Board**	Management Consultant primarily working in third sector	Interest in Companies and Securities	01 May 2019	
	* Chair of the People and Culture Committee	Associate Director of SamKat Consulting Ltd in my capacity as self-employed management consultant	Directorships	01 June 2021	
	* Member of the Charity Committee				
	* Member of Audit Committee				
	* Member of Quality, Patient Experience & Safety Committee				
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**	Chartered Fellow of the CIPD		2005	
MARSH, Rachel	**Deputy Chief Executive/Executive Director of Strategy,**	Nil Declaration			
MILLS, Patricia (Trish)	**Director of Corporate Governance/ Board Secretary**	Nil Declaration			
PARRY, Hugh	**Trade Union Partner**	Nil Declaration			
ROBERTS, Edward	**Interim Finance Director (from 09 September 2025)**	Nil Declaration			
ROWAN, Hannah	**Non-Executive Director**	Director, St Martin's Associates (Business consulting and coaching)	Directorships	04 April 2022	
	* Chair of Academic Partnership Committee	Non -Executive Director Qualifications Wales (regulator for all non degree qualifications in Wales)	Any Other Interest	01 April 2021	
	* Member of Charity Committee				
	* Member of People & Culture Committee	Elected member, The governing body of the church in Wales (Parliament of church in Wales - voting member)	Any Other Interest	01 April 2021	
	* Member of Remuneration Committee				
SAMMUT, Jonathan (Jonny)	**Director of Digital Services [appointed 26.09.2023]**	Fellow of the British Computer Society – FBCS	Any Other Interest	04 March 2024	
		Federation of Informatics Professionals - Leading Practitioner	Any Other Interest	25 April 2024	
		Chair of BCS Hub Wales	Any Other Interest	20 June 2025	
		Co-opted into the BCS Community Board	Any Other Interest	12 August 2025	11 August 2026
		CHIME (College of Healthcare Information Management Executives) Digital Health Fellowship - UK Cohort 2026	Non-Financial Professional	07 May 2026	
		Working With AI, Not Against It book published commercially and generates royalty income from sales.	Financial Interest	24 February 2026	
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**	Nil Declaration			

TURNER, Damon	**Trade Union Partner**	Nil Declaration			

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended
Executive Director of Quality and Nursing [from 01 August 2022]	**Executive Director of Quality and Nursing [from 01 August 2022]**	Chair/Director - Thornbury Carnival Community Interest Company Voluntary	Position in Charity or Voluntary Organisation	01 August 2019	
		Member Royal College Nursing	Any Other Interest	01 August 2022	
		Committee member - Royal College Nursing, Nurses in Management and Leadership Forum Steering Committee	Position in Charity or Voluntary Organisation	01 August 2022	
		Vice Chair - Royal College of Nursing, Nurses in Management and Leadership Forum Steering Committee	Position in Charity or Voluntary Organisation	03 February 2025	
WOOD, Emma	**Chief Executive (from 01 October 2025)**	Chartered Fellow of CIPD (Chartered Institute of Personnel and Development)	Non-Financial Professional	2000	
		Member of Yoga Professional Alliance	Non-Financial Personal	July 2025	
		Part-time Yoga Teacher at Burnham Swim and Sports Academy Leisure Centre	Financial Interest	July 2025	
		Sub/Relief Yoga Teacher at Omni Studio, Worle, North Somerset	Financial Interest	04 April 2026	

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

WELSH AMBULANCE SERVICES NHS UNIVERSITY TRUST
UNCONFIRMED MINUTES OF THE PUBLIC SESSION OF THE MEETING OF THE QUALITY, PATIENT EXPERIENCE AND SAFETY (QuEST) COMMITTEE HELD ON 7 MAY 2026 VIA TEAMS

Meeting started at 09:30

PRESENT:

Bethan Evans	Non-Executive Director and Chair
Ceri Jackson	Non-Executive Director and Vice Chair of the Board
Dr Umar Ahmad	Non-Executive Director
Lee Brooks	Executive Director of Operations
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Mark Marsden	Trade Union Partner
Trish Mills	Director of Corporate Governance/Board Secretary
Jonny Sammut	Director of Digital Services
Andy Swinburn	Executive Director of Paramedicine

IN ATTENDANCE:

Claire Appleton	Head of Putting Things Right *(left after Item 8)*
Kate Blackmore	Assistant Director of Quality Governance
Jonathan Chippendale	Assistant Director of Clinical Development
Penny Durrant	Deputy Director of Nursing, Quality and Governance
Sarah Harland	Corporate Governance Officer
Leanne Hawker	Head of Patient Experience & Community Involvement
Huw Jackson	Head of Medicines Management *(Item 16)*
Alison Kelly	Business and Quality manager
Wendy Herbert	Assistant Director of Quality and Nursing
Osian Lloyd	Head of Internal Audit, NWSSP
Alex Payne	Corporate Governance Manager

APOLOGIES:

Henry Garrard	Trade Union Partner
Hugh Parry	Trade Union Partner
Liam Williams	Executive Director of Quality and Nursing

OBSERVING:

AnnaMaria Williams	Corporate Governance Officer

OPENING ITEMS

1. CHAIR'S WELCOME, APOLOGIES AND QUORUM

1.1 The Chair extended a warm welcome to Dr Umar Ahmad, newly appointed non-executive director. Apologies were received as set out above. Quorum was confirmed.

2. DECLARATIONS OF INTEREST

2.1 Dr Umar Ahmad advised that his declarations of interest had been submitted too late for inclusion within the papers, and confirmed they will be updated and reflected in the papers for the next meeting.

3. MINUTES OF PREVIOUS MEETING 3 FEBRUARY 2026

3.1 The minutes of the public meeting held on 3 February 2026 were approved.

4. ACTION LOG AND MATTERS ARISING

4.1 The action log was reviewed and discussed, with updates added to the log.

ITEMS FOR ASSURANCE, DISCUSSION OR APPROVAL

5. STAFF EXPERIENCE: MR MIKE SENIOR – COMMUNITY FIRST RESPONDER

5.1 Leanne Hawker presented the staff experience item, which focussed on Mr Mike Senior, a Community First Responder (CFR), who described the use of video consultation technology to support the remote clinical assessment of a young child. Members noted that the use of video enabled the Clinical Support Desk clinician to visually assess the patient, provided reassurance to the patient's family and enhanced the responder's confidence in the care being delivered.

5.2 Members welcomed this example as a positive demonstration of innovation, compassionate care and effective use of digital technology. Members recognised the potential value of video consultation in improving patient and family reassurance, supporting responders and clinicians, and enhancing patient experience, particularly for certain presentations and patient groups.

5.3 Members reviewed the broader adoption of video consultations, expressing concerns about possible effects on call duration and efficiency if implemented widely. Members emphasised the need to balance clinical benefits with accessibility, digital inclusion, patient dignity and data security. Current use is low, likely due to cultural factors rather than technical ones. Video consultations may be especially useful in areas such as paediatrics, stroke assessment and mental health.

5.4 Members agreed that while the discussion was valuable, the strategic consideration of a "video-first" approach and the wider operational implications, should be taken forward as an action for the Executive Leadership Team (ELT) to discuss, rather than being progressed through QuEST.

The committee noted Mr Senior's experience.

5.1 PATIENT EXPERIENCE UPDATES – MR ROY DAVIES

5.1 The committee received an update on progress arising from the previous patient experience relating to Mr Roy Davies. Members noted that actions identified following the original discussion, had been progressed and that improvement activity was underway. Members were assured that learning from the patient experience had translated into meaningful action.

The committee noted the update from the previous patient experience, Mr Roy Davies.

6. OPERATIONS DIRECTORATE QUARTERLY REPORT Q4 2025/26

The papers for this item are in the committee pack in IBabs and on the Trust's website, therefore detail of the content is not repeated here.

6.1 Lee Brooks presented an overview the Operations Directorate Q4 report, outlining key operational developments, ongoing performance pressures and improvement activity. Lee reported a Directorate restructure from five to four Assistant Director portfolios, and noted interim capacity pressures pending the appointment of the Deputy Director in July, after which the report structure would be reviewed.

6.2 Progress against the Putting Things Right (PTR) recovery plan was highlighted, including a reduction in overdue matters and improved operational oversight, alongside confirmation that the Medical Priority Dispatch System (MPDS) accreditation had been maintained and re-accreditation work had commenced.

6.3 Updates included video consultations, the Falls Desk trial (with ongoing Welsh Government support), new Remote Integrated Care Services, and improved SMS patient communications. Challenges remain, such as hospital access issues, delays for Section 136 patients and Datix investigation backlogs.

6.4 Members welcomed the report's positive developments, including reduced Datix backlogs and successful outcomes from the Falls Desk. Members raised concerns about growing financial pressures and uncertainty in short-term funding, asking if QuEST could help address delays. Lee assured that efforts are ongoing to improve benefit evidence and national engagement, but noted future funding remains outside the Trust's direct control.

6.5 Rachel Marsh stressed the need to demonstrate the benefits of Clinical Model Transformation (CMT) and noted ongoing efforts to improve evidence for Welsh Government. Rachel reported active collaboration with national programmes and commissioners, highlighting successful evaluations such as the Falls Desk. Members agreed the Falls Desk consistently delivers patient benefit, and recognised that strong evidence and evaluation remain essential for future funding and sustainability.

The committee received the Operations Directorate Q4 Report 2025/26 and welcomed the progress and improvements described.

7.1 PUTTING THINGS RIGHT REPORT (PTR) Q4 2025/26

The papers for this item are in the committee pack in IBabs and on the Trust's website, therefore detail of the content is not repeated here.

7.1.1 Wendy Herbert presented the PTR report Q4 2025/26, highlighting better statutory compliance despite ongoing pressures. Recovery actions have improved assurance and sustainability. The Trust responded appropriately to a Public Services Ombudsman report and promptly addressed Prevention of Future Deaths reports. A Welsh Government assessment is in progress, with results to be shared later.

7.1.2 Wendy reported major improvements in concerns management, with all concerns acknowledged, fewer overdue no-regret incidents and lower complaint volumes. Wendy also observed an increase in complaints versus previous years, adding capacity pressures.

7.1.3 Wendy also reported improvements in near-miss and low-harm reporting, confirming that assurance in this area was included within the report and supported onward assurance to ARAC. Wendy drew attention to ongoing challenges in closing Datix incidents, though noted improving performance, and highlighted emerging themes around delayed access to premises, particularly affecting patients experiencing mental health crises.

7.1.4 Wendy advised that Listening to People regulations national guidance and training materials were issued very late, however the Trust had been as prepared as possible, with staff training underway. Wendy confirmed that national KPIs were still awaited, with the exception of the requirement that 40% of eligible concerns be resolved through early resolution.

7.1.5 Jonny Sammut noted that the PTR report issues are mainly regarding demand, capacity and prioritisation within digital services, and not digital maturity. Jonny advised that a Digital Oversight Group (DOG) will launch in June to improve coordination, as many projects now compete for resources. Jonny also clarified that Datix is managed through Shared Services rather than by the Trust's digital teams, limiting their influence over system changes.

The committee received the report as assurance on activity within the Putting Things Right and Legal Services portfolio; and received assurance regarding current compliance and recovery progress, noting areas requiring continued committee oversight to support sustainable improvement and statutory assurance.

7.2 CONCERNS MANAGMENT PROGRAMME PROGRESS REPORT APRIL 2026

The papers for this item are in the committee pack in IBabs and on the Trust's website, therefore detail of the content is not repeated here.

7.2.1 Wendy Herbert provided an update on the Concerns Management Programme, outlining progress across the recovery, implementation and sustainability phases. Wendy advised that significant improvements had been delivered during the recovery phase, including reductions in backlogs relating to concerns, incidents and coroner statements, supported by additional temporary capacity.

7.2.2 Wendy confirmed that, while improvements had been achieved by the end of March, recovery could not yet be closed as further actions were required and were now being progressed through the implementation phase. Wendy reported that governance arrangements had been strengthened, with oversight provided through the programme board and Strategic Transformation Board (STB).

7.2.3 Key risks highlighted included sustainability and capacity, particularly following the withdrawal of additional temporary resources, and digital readiness, with further work planned to assess system capability and data requirements.

7.2.4 Lee Brooks raised serious concerns about delays in accessing premises, especially when police or fire services declined attendance, leading to patient access issues and even cases where patients were found deceased. Lee noted this presents a significant safety risk beyond mental health. An interim joint operating model began on 1 April 2026, assigning forced entry to Fire and Rescue Services, with the issue now escalated and monitored by the Joint Emergency Services Committee (JESC). The Chair stressed the importance of ongoing updates to QuEST about the interim operating model and its progress during the pilot period. Members recommended raising this as a formal alert through the AAA, emphasising it was a significant risk that required prompt Board attention.

7.2.5 Members highlighted improvements from the Concerns Management Programme, but questioned lasting impact due to temporary staffing, increasing clinical negligence claims and overdue coronial statements. Wendy reported progress, but noted sustainability is uncertain given new regulations, delayed guidance and unpredictable demand, especially regarding early resolution meetings. Operating models, capacity reviews and digital readiness efforts continue, resulting in fewer overdue coronial statements. Claire Appleton attributed changes in clinical negligence figures to administrative delays and legal case transfers, with external pressures growing due to reduced coronial timescales.

7.2.6 Members asked about the rise in complaint volumes and the difference between patient complaints and non-patient enquiries. Wendy explained that more low-harm complaints in Ambulance Care Services were due to stricter eligibility criteria and delayed ambulance responses, drawing increased public and political attention. Claire Appleton added that non-patient enquiries include various contacts such as lost property and general questions, since there is no central contact point, and efforts are underway with Communications to redirect these where possible.

7.2.7 Rachel Marsh advised that benefit realisation and evaluation evidence are being strengthened, with progress reported via MIQPR and at Board level. Rachel noted the Concerns Management Programme has robust governance overseen by the STB, and her team is assisting with transformation, process-mapping and sustainability to embed improvements and ensure ongoing assurance.

7.2.8 Members acknowledged the significant organisational effort involved, with improvement achieved against a backdrop of sustained operational pressure and staffing constraints. Strengthened governance arrangements were welcomed, including programme oversight, with regular executive leadership scrutiny.

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

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

The committee noted the current position of the PTR / Concerns Management programme; received assurance regarding progress made during the recovery period; noted that further evidence is required to demonstrate sustained delivery, particularly in relation to digital maturity, sustainability and trajectory planning; and supported continued executive oversight of the programme until improvements are demonstrated as embedded and sustained.

8. MONTHLY INTEGRATED QUALITY PERFORMANCE REPORT (MIQPR)

The papers for this item are in the committee pack in IBabs and on the Trust's website, therefore detail of the content is not repeated here.

8.1 Rachel Marsh presented the final MIQPR under the current framework, noting a new set of measures will begin in April. The report now focuses on QuEST indicators and highlights ongoing issues with resource allocation for high-acuity calls, emergency response times and hospital handover delays. While some year-on-year improvements were seen, performance is still below expectations. These challenges are being addressed in the CMT Programme, with emphasis on demand management and benefit realisation. Complaint response rates have improved due to recovery actions, and clearer future performance trajectories will be reported through the MIQPR.

8.2 Members questioned whether performance could improve given ongoing handover delays and system pressures, seeking a clearer roadmap for assurance. Rachel advised that progress depends on handover improvements outside the Trust's control, but their CMT Programme is addressing internal factors such as demand management and benefit realisation. Handover delays remain the main challenge, and national focus on the 45-minute standard has been renewed.

8.3 Lee Brooks added that performance measures cannot improve without addressing hospital handover delays. Lee emphasised that the Ambulance Performance Framework alone will not solve these issues, and real progress depends on reducing delays across the system. Without such changes, the Trust's performance remains limited.

8.4 Members asked if ongoing efforts were being made to reduce sickness absence, noting recent slight improvement but a two-year average still above target. Rachel advised that rates have stayed fairly static and further action is planned via the IMTP, with Executive leads assessing progress.

8.5 The Chair noted ongoing challenges, including hospital handover delays beyond the Trust's control, but recognised progress. The Chair stressed the need for a balanced approach, welcomed clearer plans and confirmed continued monitoring via future MIQPR reports.

The committee received the March 2026 Monthly Integrated Quality and Performance.

9. SPOTLIGHT ON CLINICAL INDICATORS: OUT OF HOSPITAL CARDIAC ARREST (OOHCA) – RETURN OF SPONTANOUS CIRCULATION FROM CARDIAC ARREST (ROSC)

The papers for this item are in the committee pack in IBabs and on the Trust's website, therefore detail of the content is not repeated here.

9.1 Andy Swinburn reviewed OOHCA clinical indicators, emphasising survival to discharge over ROSC. Andy noted survival rates improve slowly, citing international examples such as King County, Seattle, where progress is incremental. Local data shows a gradual upward trend comparable to global benchmarks. Andy stressed that lasting improvement in cardiac arrest outcomes depends on ongoing, system-wide efforts.

9.2 Members asked if the review of deprivation's impact on OOHCA outcomes would include lessons from across the UK, highlighting the value of broader comparison. Andy confirmed that wider learning is being used, such as Scotland's Public Access Defibrillator (PAD) mapping method, which compares cardiac arrest rates with defibrillator locations. Andy noted that defibrillators are more often found in affluent areas and that future efforts will focus on improving equitable access and outcomes.

9.3 The Chair asked Andy to define what constitutes "good" OOHCA outcomes in Wales and how they should be measured, emphasising collaboration beyond WAST and accurate baseline data. Andy responded that defining "good" is challenging due to limited historic survival data, but highlighted

ROSC rates now consistently at 20–25%. Andy noted international improvements stem from long-term cultural changes such as CPR education and PAD, with expected annual gains of 1–2%. Baseline evaluation began when survival became a main indicator. Andy emphasised that success depends on whole-system efforts, including public education and partner collaboration.

9.4 Members observed that survival-to-discharge outcomes reflect whole-system performance, not solely the Ambulance Service, and are influenced by factors such as hospital and critical care capability. Members noted that while ROSC/resource rates are a key indicator within WAST's control, survival-to-discharge is subject to wider system variation, and asked how this should be interpreted. Andy agreed, confirming that survival-to-discharge is heavily dependent on hospital and intensive care quality, and that poor downstream care would adversely affect outcomes regardless of pre-hospital performance.

9.5 The Chair thanked Andy for the presentation and discussion, noting the importance of focusing on clinical outcomes rather than speed alone. The Chair acknowledged that improvements in OOHCA outcomes would be incremental and dependent on whole-system factors, and welcomed the continued emphasis on partnership working and long-term cultural change.

The committee received the presentation and gained assurance from the actions underway to improve outcomes for cardiac arrest patients.

10. INTERNAL AUDIT REPORT: CYMRU HIGH ACUITY RESPONSE UNIT (CHARU)

The papers for this item are in the committee pack in IBabs and on the Trust's website, therefore detail of the content is not repeated here.

10.1 The committee reviewed the Internal Audit report for Cymru High Acuity Response Unit (CHARU), which offered **reasonable assurance**. Andy Swinburn confirmed the anticipated findings, noting no new significant issues and ongoing progress on known actions. Osian Lloyd summarised the audit, citing areas of good practice and three medium-priority actions (training, benefits realisation, and steering group representation), all agreed with management and underway. The Chair welcomed the assurance, and noted the Audit Risk and Assurance Committee's prior consideration, and requested confirmation on timely delivery, Andy confirmed confidence in delivering all actions as scheduled.

The committee received and took assurance from the Cymru High Acuity Response Unity (CHARU) Internal Audit Report and noted the discussion at the meeting of the Audit, Risk and Assurance Committee on 2 March 2026.

11. DUTY OF QUALITY ANNUAL REPORT 2025/26

The papers for this item are in the committee pack in IBabs and on the Trust's website, therefore detail of the content is not repeated here.

11.1 Kate Blackmore presented the Duty of Quality Annual Report, noting improvements in its format and accessibility. Kate advised that the Safeguarding and Infection Prevention and Control (IPC) annual report contents had been integrated to streamline reporting and reduce duplication. The Sway platform was used for better accessibility and analytics, with content now organised into sections for easier navigation. Kate confirmed alignment with other key publications and timely delivery.

11.2 Members praised the report's quality and usefulness, suggesting highlighting patient safety more clearly and detailing Board and Committee oversight, including QuEST and lived experience, to improve context on governance. Kate reported that statutory guidance shaped the structure and aimed to avoid duplication, but agreed to strengthen contextual narrative and clarify governance before Board review.

11.3 Penny Durrant supported members observations and agreed that it may be beneficial for the report to lead more clearly with patient safety to set the context before covering other areas. Penny noted this would help external readers better understand the Trust's priorities and approach to quality. The Chair commended the report, highlighting its integration of Safeguarding and IPC content and effective use of narrative and visuals. The Chair recommended patient safety be more prominent for external clarity and suggested adding brief explanations where needed, such as Welsh language skill levels.

11.4 Jonny Sammut commented that, given recent Board discussions on digital maturity, it may be helpful for the report to more explicitly reference digital and analytical capability, including areas such as dashboards, automation, the Digital Champions Network and the adoption lead role, to provide additional assurance on how digital enablers are supporting quality improvement. Kate acknowledged the suggestion, and advised that engagement with Digital colleagues had taken place.

11.5 The Chair confirmed Members endorsement of the 2025/26 Duty of Quality Annual Report for Trust Board review, pending refinement as discussed, and for the revised version to be shared with the Chair before submission.

The committee endorsed the Duty of Quality Annual Report for 2025/26 for onward approval by Trust Board, subject to refinements as discussed; and received assurance regarding the Trust's progress in meeting the requirements of the Duty of Quality, the Duty of Candour and the Health & Care Quality Standards for Wales, recognising areas requiring continued improvement and oversight.

12. STRATEGIC QUALITY PLAN 2025/28 IMPLEMENTATION PLAN PROGRESS UPDATE

The papers for this item are in the committee pack in IBabs and on the Trust's website, therefore detail of the content is not repeated here.

12.1 Kate Blackmore provided a progress update on delivery of the Strategic Quality Plan 2025–28, advising that work is underway across the implementation plan, but acknowledging concerns about the capacity and feasibility of delivering the full scope as originally set out. Kate confirmed that, in response to previous committee feedback, a new IMTP deliverable has been agreed to formally review the Strategic Quality Plan, with Executive engagement planned for June to clarify strategic direction and priorities.

12.2 Kate advised that the review process would take place during Q2, enabling the plan to be refined and aligned with organisational capacity and wider strategic priorities. Kate also highlighted progress in embedding quality governance, confirming that the annual review of actions to improve services had been completed through the Quality Management Group and would be reported to Clinical Quality Governance Group (CQGG), alongside an effectiveness review of the Group's role in supporting the Duty of Quality and quality management systems.

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

12.4 Jonny Sammut advised that there had been recent positive progress in relation to long-standing system-wide data-sharing constraints. Jonny reported that a new national group, led by Digital Health & Care Wales (DHCW) and the Deputy CMO, had commenced work to explore policy and legislative solutions, and confirmed that the Trust now has representation within this work, providing an opportunity to influence future direction. Jonny noted this as a positive early step, albeit recognising that legislative change will take time.

12.5 Members requested clearer timelines for resolving system-wide data-sharing issues, suggesting that if progress is slow, the Trust should consider mitigation measures rather than just noting the risk. Jonny Sammut advised that, since similar legislation exists in England, advancement within a year is feasible unless national policies delay it. Jonny noted past over-complication and current engagement as chances to guide the process. Ceri added that QuEST should monitor this closely and receive regular updates, due to its broader impact on quality, assurance and delivery.

12.6 Members asked if clearer progress could be expected by August, given current capacity issues, and requested clarification on the challenges related to the parent governance group. Kate advised that a more definitive update would follow Executive engagement in June and the Q2 review, which should help refine priorities and deliverability. Kate added that governance arrangements were being developed with the Corporate Governance team to ensure proper forum placement, and confirmed ongoing improvement work for supporting systems such as Datix Cymru and Shared Services.

12.7 Following committee discussion, it was agreed that officers would provide a further update to QuEST following Executive engagement and the Q2 review, setting out revised priorities, governance arrangements and deliverability of the Strategic Quality Plan 2025–28, including clarity on mitigation where system constraints persist.

12.8 Trish Mills queried the appropriateness of a "homeless" or undefined governance group for oversight of the Datix work, noting this did not represent good governance. Trish suggested that the emerging Digital Oversight Group (DOG) may be the most appropriate parent forum for this work, and advised that this could be explored and resolved offline.

The committee noted that delivery of the Strategic Quality Plan remains off track against original implementation timelines; received assurance regarding progress against priority actions and mitigating controls in place; endorsed the revised delivery approach and timeline extensions where required; and supported continued cross-organisational work to address key system dependencies, including Insight & Data Services capacity and Commissioner alignment, where these remain critical to delivery.

13. RESPIRATORY PROTECTIVE EQUIPMENT (RPE) REPORT (OVERVIEW AND UDPATE)

The papers for this item are in the committee pack in IBabs and on the Trust's website, therefore detail of the content is not repeated here.

13.1 Sarah Morgan delivered an update on Respiratory Protective Equipment (RPE), highlighting the Trust's shift from Filtering Face Piece (FFP3) masks to Powered Air-Purifying Respirators (PAPRs), due to unsustainable fit-testing and frequent failures. PAPRs offer consistent protection, are now part of the emergency fleet, and have high compliance with robust training supported by RPE champions. The main challenge is central assurance, since PAPR training isn't required on ESR, limiting Trust-wide reporting, steps are being taken to improve this.

13.2 Penny Durrant emphasised that the transition to PAPRs represented a significant organisational change, achieved despite considerable people and operational challenges. Penny highlighted the strong collaboration between IPC, Control and Operations teams, particularly the shift in mindset and improved relationships that enabled delivery.

13.3 Penny formally recognised the sustained effort of Sarah Morgan and colleagues. The Chair welcomed Penny's comments, acknowledged the scale and importance of the work undertaken, and commended the cross-directorate collaboration in delivering a clinically sound and robust approach to staff safety. The report provided moderate assurance on these arrangements, with a clinically robust and embedded model in place and no evidence of systemic safety risk.

The committee

1. **Noted that the Trust has successfully transitioned to a PAPR-based Respiratory Protective Equipment (RPE) Model and that there is no evidence of systemic equipment failure or immediate staff safety concerns;**
2. **Noted that further work is underway to strengthen organisational reporting, maintenance consistency and local stock management arrangements to support improved corporate assurance and regulatory compliance;**
3. **Took assurance that mandating PAPR training within ESR and alignment to the mandatory training matrix will be completed by May 2026, enabling consistent organisation-wide compliance reporting; and**
4. **Requested that any material deterioration in compliance, training assurance or equipment governance is escalated through the Clinical and Quality Governance Group and the Quality, Patent Experience & Safety Committee through routine IP&C assurance reporting.**

14. PATIENT EXPERIENCE AND COMMUNITY INVOLVEMENT (PECI) BI-ANNUAL REPORT (OCTOBER 2025 – MARCH 2026)

The papers for this item are in the committee pack in IBabs and on the Trust's website, therefore detail of the content is not repeated here.

14.1 Leanne Hawker presented the biannual Patient Experience and Community Involvement (PECI) report, which combines patient insights with performance and quality data to assure care quality, safety and person-centredness. Leanne noted consistently positive staff compassion and professionalism, with patients distinguishing staff care from broader system pressures affecting access. Patient experience is regularly reviewed by the Quality Management Group and linked to quality improvement activities. While system risks such as access delays still impact patient experience and equity, the reporting clearly connects insight to action.

14.2 Leanne advised that community engagement is now more focused and aligned with service improvement, with better governance oversight. Leanne noted that organisational changes briefly decreased direct engagement, but next steps include improving feedback collection (including SMS), aligning with Listening to People regulations, and integrating patient experience into quality governance for measurable improvements.

14.3 The Chair commended the improved clarity and relevance of the PECI report, highlighting that the report now clearly articulates the 'so what', providing assurance on the quality of care delivered while reinforcing the impact of wider system pressures on patient experience that continue to require system-level action. The Chair noted recurring themes, such as delays caused by system pressures, and praised consistent staff compassion and professionalism. The Chair thanked Leanne and the team, expressed support for their progress, and acknowledged the report.

14.4 Members raised concerns about patient dissatisfaction with aspects of the NHS 111 service, questioning if call-back expectations and response times are being effectively managed, and stressing the need for actionable learning under the Trust's control. Lee Brooks advised that survey responses are currently too low to draw firm conclusions, but expects patient insight to become more valuable as feedback increases, particularly via planned SMS surveys supporting targeted improvements.

14.5 Jonny Sammut discussed work with the PECI team to improve NHS 111 online and webchat, including engagement with patient and disability groups. Early user feedback is guiding more human-centred digital access and shaping the future NHS "front door" in Wales. The Chair emphasised connecting patient insight to service design, and valued its influence on future digital projects.

14.6 Members questioned the rise in complaints and asked for clarification on the difference between patient complaints and non-patient enquiries. Leanne explained that most complaints were low-harm cases, especially in Ambulance Care Services, due to stricter eligibility for patient transport and broader system pressures. Leanne advised that complaint themes are regularly reviewed and efforts continue to manage demand and redirect non-patient enquiries effectively.

14.7 Rachel Marsh noted that patient experience feedback, including NHS 111 data, is already reflected within the MIQPR and is routinely considered as part of IMTP development and priority-setting. Rachel highlighted that the feedback reinforces known pressures, particularly around call-backs and waiting times, and emphasised the importance of using patient experience insight to inform improvement of NHS 111 as a key front door to the system, especially as its role continues to expand.

The committee received the report and took assurance that appropriate mechanisms are in place to capture, record, engage and act on people's experiences, whilst recognising ongoing risks relating to access, system delays and the reach of engagement activity; and noted the activities undertaken during this reporting period and acknowledge that PECI reports will be shared publicly through the Trusts People & Community Network.

15. MORTALITY INTELLIGENCE REPORT

The papers for this item are in the committee pack in IBabs and on the Trust's website, therefore detail of the content is not repeated here.

15.1 Wendy Herbert presented the Learning from Deaths (Mortality Intelligence) report, covering the period October 2025 to March 2026. Seasonal increases in Medical Examiner referrals were noted, alongside continued operation of the two-tier triage process for review of deaths. Members discussed the backlog of Level 2 multidisciplinary reviews, acknowledging this reflects capacity pressures during PTR recovery and incident management activity, but were assured that learning continues to be identified and that plans are in place to reduce the position.

15.2 Recurring themes remain consistent and system-driven, including prolonged waits for ambulance response, patient deconditioning, limitations in community and end-of-life care, and outcomes in time-critical conditions such as stroke and sepsis. Two Regulation 28 Prevention of Future Death reports were received and responded to within required timescales, with themes aligning to known organisational risks.

15.3 Members welcomed recent digital safety improvements to the ePCR system, strengthening NEWS2 controls, but emphasised the need for continued focus on timeliness and sustainability, with clearer indicative timeframes requested in future reporting.

The committee received the Mortality Intelligence report for discussion, and requested that future reports include clearer indicative timescales for planned actions and next steps, to support ongoing assurance and oversight.

16. MEDICINES MANAGEMENT ASSURANCE REPORT 2025/26

The papers for this item are in the committee pack in IBabs and on the Trust's website, therefore detail of the content is not repeated here.

16.1 Huw Jackson presented the 2025/26 Medicines Management Assurance report, confirming safe and effective medicines management across the Trust, with continued improvement and strong compliance. Vehicle audits and Omnicell cycle counts showed near full compliance, with process changes and automation. Controlled drug oversight improved, with no unresolved discrepancies in the quarter. National paramedic Patient Group Direction (PGD)) compliance hit 99%, ensuring robust legal and clinical assurance. Use of access category antibiotics exceeded national targets, and antimicrobial prescribing decreased among advanced practitioners, supported by enhanced guidance and formulary controls.

16.2 Jonathan Chippendale highlighted improvements since QuEST addressed earlier PGD issues, praising restored governance, stewardship, and digital formulary development. Jonny Sammut confirmed capital funding for Omnicell licence renewals, ensuring system sustainability.

16.3 Members expressed concerns about financial risks related to the internal medicines hub if the business case stalls. Huw noted progress with Service Level Agreements but risks persist due to external supply reliance, recommending in-house supply for better control. Jonathan added that an internal hub could improve stock rotation and expiry management, potentially increasing efficiency and reducing costs, though exact benefits remain unquantified.

16.4 The Chair thanked Huw for his report, noting significant improvement, stronger compliance and controls, and welcomed collaborative efforts.

The committee received the annual Medicines Management Assurance report 2025/26 and discussed the report, with no additional assurance requirements.

17. RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK

The papers for this item are in the committee pack in IBabs and on the Trust's website, therefore detail of the content is not repeated here.

17.1 Trish Mills introduced the Risk Management and Board Assurance Framework report, explaining that the agenda sequencing reflected the Trust's highest rated strategic risks, which had been discussed throughout the meeting. Trish advised that the two principal risks have remained on the risk register at a high level for a number of years and have been reviewed monthly. Trish noted that the risks have been refined to distinguish between those within the Trust's influence, and those outside direct control, to support clearer assurance and monitoring.

17.2 In relation to *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,* Trish invited Lee Brooks to provide an update. Lee advised that the risk had been re-escalated to a score of 5x5, following three consecutive months of deterioration, and that this escalation would now proceed through formal governance processes.

17.3 Members stressed the importance of recognising system-wide risks, especially given the absence of a Cabinet Secretary and ongoing financial challenges. Members called for continued focus at the national and civil service level. Lee advised that escalation and engagement persisted despite these issues, with recent guidance from Welsh Government through NHS Wales Performance and Improvement. Lee highlighted that handover delays remain a major risk, demanding ongoing attention and coordinated action.

17.4 Wendy Herbert advised that recent discussions with Healthcare Inspectorate Wales (HIW) had highlighted the need to balance risk across the system, noting that while corridor care is a focus of inspection, the greatest patient safety risk may lie in patients waiting in the community without assessment or treatment. Wendy emphasised the importance of recognising this broader risk context when considering system pressures and assurance.

The committee considered the contents of the report including, the controls in place against the risks and the actions described to further mitigate the risks.

18. AUDIT TRACKER Q4 2026/26

The papers for this item are in the committee pack in IBabs and on the Trust's website, therefore detail of the content is not repeated here

18.1 Trish Mills introduced the revised Audit Tracker approach, explaining that reporting now focuses on actions at their final agreed deadlines, particularly those arising from high-priority findings or limited assurance audits, to strengthen risk-based oversight and assurance. Trish advised that this provides clearer visibility of residual risk and delivery confidence.

18.2 The Chair welcomed the revised format, noting that it provided clearer and more meaningful assurance for the committee. Ceri Jackson supported the new approach and confirmed that the Audit Tracker had also been reviewed positively at the Audit Risk and Assurance Committee.

The committee reviewed and scrutinised the current position regarding high priority internal audit actions and external audit actions on their final revised date, to ensure that there is sufficient assurance in terms of mitigation of associated risks.

CONSENT ITEMS

19. COMMITTEE CYCLE OF BUSINESS MONITORING REPORT

The papers for this item are in the committee pack in IBabs and on the Trust's website, therefore detail of the content is not repeated here.

The committee noted the Cycle of Business Monitoring report.

CLOSING ITEMS

20. REFLECTIONS

20.1 Reflections included a sense of strong assurance across a wide range of areas. Members noted the positive impact of cross-directorate working, which is helping to embed quality across the organisation. Overall, the committee reflected a positive trajectory, with clear progress evident alongside an ongoing commitment to maintaining focus on key risks and areas for improvement.

21. ANY OTHER BUSINESS

21.1 Kate Blackmore advised that communications had been issued regarding the forthcoming WAST Quality Event (WASTQ), themed *"Quality Without Barriers"*, and encouraged members to consider attending and to promote the event within their teams, noting limited capacity and the value of engagement. The Chair thanked Kate for the update, welcomed the focus on quality and inclusion, and supported the promotion of the event across the organisation.

22. DATE AND TIME OF THE NEXT MEETING

22.1 6 August 2026 at 9:30.

MEETING CLOSE: 13:36

ACTION LOG - UPDATE
QUEST COMMITTEE

Minute Ref	Date	Agenda Item	Action Note	Responsible	Due Date	Progress/Comment	Status
06-02/26	3 February 2026	**Ministerial Advisory Group WAIT 45 Taskforce**	**Update on Ministerial Advisory Group Wait 45 Taskforce** The committee noted that performance developments and national expectations relating to the Wait 45 Taskforce have changed since the paper was written. The Committee therefore requests that the Executive Lead provide regular updates on progress of the Ministerial Advisory Group's work, Health Board recovery trajectories, and any implications for WAST's operational delivery. Updates should include emerging risks, system-wide engagement and changes to national direction.	**Lee Brooks**	6 August 2026	**Update 20 July 2026** Lee Brooks advised that the task force is no longer in operation and will provide a short verbal update at the meeting on 6 August. **Update at meeting 7 May 2026** Lee Brooks provided an updated verbal briefing advising that the operational risk (*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*) had now been reviewed by the Operations Senior Leadership Team and, following three consecutive months of comparative deterioration, the risk score had been increased from 20 to 25. Lee noted that this escalation would now progress through the usual governance route and was expected to be reflected at Trust Board, subject to formal approvals. Lee further advised that Welsh Government has instructed NHS Wales Performance and Improvement (P&I) to support the rapid implementation of the 45-minute hospital handover protocol across Wales. P&I will take an active facilitation and assurance role during May, engaging directly with health boards to assess operational readiness, reset implementation timelines where necessary, and agree standard operating procedures. Initial engagement will prioritise the most challenged health boards. While members welcomed this as a positive development, Lee expressed caution, noting that similar approaches had been attempted previously and that the effectiveness of this renewed intervention would need to be demonstrated. The committee noted the escalation of the risk, welcomed the renewed national support for implementation of the 45-minute protocol, and agreed to continue to receive updates through established governance processes as the position develops. **Update 23 April 2026** Memorandum received from Lee Brooks provided to deal with this action. **Update 3 March 2026** Following the Agenda Setting Meeting on 26 February, it was agreed that Lee Brooks will draw out an update on the Wait 45 roll-out, release to respond, within the Operations Report at the May meeting [to include staff impact for PCC and the impact across the organisation where it aligns to performance, quality/patient safety/experience and our people]. Email sent to LB on 3 March 2026 requested this. Once received, committee to decide the outcome of the action going forward.	Complete
10-02/26	3 February 2026	**Infection Prevention and Control**	**IPC Progress update** The committee noted ongoing work to strengthen IPC governance, including the development of a formal audit cycle, updated training requirements, and improved fleet cleanliness arrangements. The committee requests that the Head of Infection Prevention and Control provide an update at the next meeting, setting out (1) progress against the 2026/27 IPC work plan, (2) implementation of national All-Wales Cleaning Standards, and (3) any identified resource or operational risks requiring escalation.	**Penny Durrant**	6 August 2026	**Update 21/05/2026** Alison and Penny confirmed Sarah Morgan will provide update at 6 August 2026 meeting. **Update following the Agenda Setting Meeting on 26 February 2026 for May meeting** Deferred: Update following ASM for May Meeting: Await update re the PHW BAF re IPC, so not appropriate to bring forward re the 26/27 point yet. LW can't bring to the May mtg. Defer this point re the improvement plan. On the first point, progress re 26/27 workplan, example of need to give assurance of robust governance process. Note for the forward planner re this item.	Complete
15-02/26	3 February 2026	**Healthcare Inspectorate Wales (HIW) New NHS Wales Engagement Process**	**New NHS Wales Engagement Process** The Committee noted the introduction of the new HIW NHS Wales Engagement Process and its implications for organisational quality governance. Members requested that the Executive Lead for Quality & Patient Safety provide an update outlining (1) how the organisation will implement the new engagement requirements, (2) any anticipated changes to reporting or assurance processes, and (3) any associated risks requiring escalation to the Trust Board.	**Penny Durrant**	6 August 2026	**Update from Penny Durrant 16/07/2026** Healthcare Inspectorate Wales - New NHS Wales Engagement Process Implementation and Assurance Update to be presented to the Clinical & Quality Governance Group on 17 July 2026 ahead of updating Executive Leadership Team on 22 July 2026 via the Clinical & Quality Governance Group AAA, and Quality, Patient Experience & Safety Committee on 6 August 2026. **Update from Penny Durrant 18/06/2026** Healthcare Inspectorate Wales - New NHS Wales Engagement Process Implementation and Assurance Update to be presented to the Clinical & Quality Governance Group on 17 July 2026 ahead of Executive Leadership Team on 22 July 2026, and Quality, Patient Experience & Safety Committee on 6 August 2026. **Update following the Agenda Setting Meeting on 26 February 2026** Deferred to the August meeting as we won't know what the requirements will be and so they'll be nothing to say. Note: This will need to go to ELT first.	Complete
12-05/26	5 May 2026	**Strategic Quality Plan 2025/28 Implementation Plan - Progress Update**	Following committee discussion, it was agreed that Kate Blackmore would provide a further update to QuEST following Executive engagement and the Quarter 2 review, setting out revised priorities, governance arrangements and deliverability of the Strategic Quality Plan 2025–28, including clarity on mitigation where system constraints persist.	**Penny Durrant (Kate Blackmore)**	6 August 2026	**Update 21/05/2026** Alison and Penny confirmed Kate Blackmore will have a direction, if not a completely revised plan, and will continue to send through quarterly updates which will align with the timescales.	Complete
18-02/26	3 February 2026	**Committee Annual Report 2025/26 and Cycle of business 2026/27**	**Clinical Model Transformation Evaluation** As part of reviewing the Committee Annual Report 2025/26 and agreeing priorities for 2026/27, the committee requested that a formal evaluation framework for the Clinical Model Transformation (CMT) Programme be developed and reported to QuEST. This evaluation should provide clarity on expected benefits, measurable outcomes, delivery risks, and the approach for monitoring impact across the year. The committee agreed that oversight of CMT benefits realisation must be embedded within the 2026/27 Cycle of Business.	**Rachel Marsh**	5 November 2026	**Update following the Agenda Setting Meeting on 26 February 2026** Deferred from May 2026 Q1. Trish requested this to be removed as won't be ready and advised that they are currently in discussions but it will take some time to filter through. Removed from August agenda at Trish's request.	Not due
9.2-28/05	28 May 2026	**Monthly Integrated Performance Report (MIQPR)**	**ACTION REQUEST FROM TRUST BOARD TO QUEST** **Deep Dive on patient waiting times** An action was taken for the board to use the refreshed MIQPR to identify issues requiring deeper scrutiny and to request deep dives on these from committees, with each committee potentially having responsibility for a certain set of indicators; it was specifically agreed for this to include a deep-dive on longer wait times for patients to come to QuEST committee.	**Rachel Marsh**	5 November 2026	**Update from Rachel Marsh 07/07/2026** I spoke to Hugh about this and he in turn has asked Penny and Andy what their thoughts are. The three of them are also working through new QUEST metrics, so I wonder whether it might be best to push this deep dive to the next QuEST, as the teams are concentrating on the metrics work. (In response to this, Secretariat wrote to Chair to advise of the situation). **QuEST Secretariat update 10 June 2026** Action request received from Trust Board Secretariat. To be included in the August agenda.	Not due

QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE
HIGHLIGHT REPORT TO BOARD

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

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

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

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

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

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

ADVISE

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

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

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

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

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

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

ASSURE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

RISKS

Risks Discussed:

The committee reviewed the most recent risk report on **risk 223 (**the Trust's inability to reach patients in the community causing patient harm and death) and **risk 224** (significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service).

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

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

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

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

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

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

	Attended
	Deputy attended
	Apologies received
	No longer member

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

QuEST Committee briefing
6 August 2026

Patient Story: Anna Jenkins
Learning from Lived Experience and Incident Impact

peci.team@Wales.nhs.uk

Summary of Experience Story - Anna Jenkins

https://youtu.be/u4sXAmgM0Dk?si=vONRd5048opWoXlY

Anna's neighbour, Mario, experienced symptoms consistent with a stroke and was initially advised of a two-hour wait for an emergency ambulance. Anna and her neighbour, Annie, attended after being contacted by Mario's spouse, who was away at the time. Due to the delay, they sought advice from Bronglais Hospital, which recommended bringing him in directly; however, this was not feasible because of concerns about safely moving him downstairs. Mario weighed 16 stone, was vomiting continuously and flailing his arms in distress.

A subsequent update from the ambulance service indicated an extended wait of up to six hours. As a result, the fire service was contacted to assist with moving Mario into a vehicle. They responded promptly, enabling Anna, her spouse, and Annie to transport him to the hospital. Upon arrival, Mario was diagnosed with a stroke and required transfer to Bristol for neurosurgical treatment.

Anne later reflected on the contrast between services, describing the ambulance response as inflexible and highly scripted, which limited effective communication, while the fire service acted quickly and decisively. She submitted a formal complaint and has since acknowledged the lasting personal impact of the incident."

Initial Key Risks and Issues Identified

- **Delayed Emergency Response**
  - Initial advice of a two-hour response increased to an estimated six hours as the incident progressed.
  - Significant clinical risk due to time-critical nature of stroke treatment
- **Patient Safety Risk**
  - Potential for worsened neurological outcomes due to delayed access to definitive stroke care.
  - Increased risk of long-term disability
  - Neighbours managing a deteriorating medical emergency without clinical support.
- **Emotional and Psychological Impact**
  - Significant distress experienced by those involved
  - Ongoing psychological impact and need for recovery support
- **Public Confidence and Trust**
  - Negative experience leading to formal complaint
  - The differing experience of emergency services had the potential to reduce public confidence.

Further Experiential Context

- 5 calls were made to 999 between 22:12 and 01:40
- Across these calls, ETAs ranging from 1 to 6 hours were advised.
- Before contacting the Fire Service, Anna drove to the nearby Llanidloes War Memorial Hospital to try and access a carry chair to convey the patient downstairs.
- Following the incident, the community purchased a manual stair chair which is now available locally should it ever be required.

Timeline

21:15	Onset of Symptoms. Patient sends SMS to his wife in Australia describing symptoms.
21:45	Patient's wife video-calls him and observes unilateral facial droop, suspecting stroke. Contacts neighbour, Annie, in Llanidloes.
22:12	Annie makes 999 call reporting signs of stroke – advised 2-hour ETA for ambulance.
23:40	Call to WAST advising deteriorating condition. Advised 1 hour ETA.
01:15	Further call as no sign of ambulance – advised 6-hour ETA
01:30 (approx)	Anna calls Fire Service via 999
01:40 (approx)	Anna calls WAST via 999 to request falls team.
02:00 (approx)	Fire service assists with evacuates of patient to Anna's car.
03:00 (approx)	Patient arrives at Bronglais Hospital – treatment commences.

Negative Impact Observed

- Delayed access to stroke care created a risk of poorer neurological outcome because stroke treatment is time critical.
- Potential risk associated with moving the patient without clinical supervision
- Distress and anxiety experienced by neighbours managing the emergency
- Perception of ambulance service as inflexible and difficult to engage
- Evidence of system pressure affecting timely emergency response
- Call handling processes were perceived as limiting flexibility during a complex situation.

Themes Identified for Assurance

- Ability to respond within clinically appropriate timeframes
- Monitoring delays affecting time-critical conditions such as stroke.
- Consideration of support for patients, families and bystanders following traumatic incidents.
- Support mechanisms for patients, families, and bystander's post-incident
- Incorporation of lived experience into learning

Actions Taken / In Progress

- A formal complaint has been made and the case presented to the Trust's Complex Case Panel (CCP). The patient, Mario has provided consent for the CCP to access his medical records; this process remains ongoing.

- Work is underway through the Trust's Call to Door programme to better understand delays affecting patients with suspected stroke and STEMI, including analysis of performance data and opportunities to improve response.

- This includes, exploring data and building better understanding of the challenge.

Required Areas of Continued Focus

- Experience story shared with the Call to Door Task and Finish Group to inform further review of call flow, prioritisation and response to time critical conditions.
- Recognise and manage psychological harm as a quality outcome
- Continue to narrow the gap between protocol led call handling and the expectations and experience of patients and callers.
- Continue to address the impact of system pressures on patient experience, timely care and public confidence.

Intended Improved Outcomes for patients/callers

- Improved response times to patients in the community
- Improved experience and outcomes for patients with suspected stroke.
- Lived experience continues to inform learning and service improvement.

Stroke Incidents in Wales

- An estimated 7,400 people in Wales experience a stroke or transient ischaemic attack each year
- Around 70,000 stroke survivors are living with long-term disability in Wales
- Stroke and transient ischaemic attacks (TIA) are becoming more prevalent in the Welsh population due to combination of ageing demographics, rising rates of risk factors, and lifestyle changes.
- This reinforces the importance of considering emotional and psychological impact alongside clinical outcomes when reviewing patient safety incidents.

Welsh Ambulance Service – response to stroke calls

- Overhauled 999-response system - replaced "amber" category with a dedicated **"Orange Now"** classification specifically for time-sensitive emergencies like suspected strokes and heart attacks.

Implemented:

- **Rapid Clinical Screening:** Specially trained clinicians in clinical contact centres to triage calls faster to identify stroke symptoms earlier.
- **Orange Priority:** As strokes are time-critical, Orange category ensures prioritised face-to-face clinical assessment, pre-hospital interventions, and rapid transport to specialist care.
- **Outcome Focus:** shifts the focus from simple clock targets to overall patient recovery and survival.

- These developments were introduced following this incident and demonstrate the Trust's continuing focus on improving outcomes for patients with time critical conditions.

Wider Organisational Learning and Strategic Assurance

What this story demonstrates

- Harm extended beyond the patients' clinical outcomes. This incident caused distress, anxiety, and ongoing psychological impact for those involved. A quality service needs to include emotional and psychological safety, not just physical outcomes.
- The neighbours' actions ensured the patient reached hospital when an ambulance response was significantly delayed.
- This experience highlights a difference between the Trust's clinical prioritisation processes and the expectations and experience of those seeking help.

Response contribution to Trust Priorities

Trust Priority	Evidence from this story
Listening to People	Lived experience informs improvement.
Duty of Quality	Feedback translated into learning.
Patient Safety	Communication supports safer assessment.
Health Equity	Orange time sensitive call category
Person-centred Care	Rapid clinical screening introduced

Organisational Learning

•Shared through governance routes.
•Story contributes to continuous improvement.

Assurance Summary

This experience demonstrates how patient stories are used alongside incidents, concerns, legal claims and mortality reviews to strengthen organisational learning, identify improvement opportunities and support delivery of safe, equitable and person-centred care.

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

QuEST Committee Update briefing
6 August 2026

Staff Story: Mike Senior, CFR

Updated: 27 May 2026

peci.team@Wales.nhs.uk

Mike Senior

Summary of Patient Experience Story

Mike's story (recorded March 2026) – https://youtu.be/sLFuIQGnPJk?si=1gDumywLUIpC4Uhb

On 15 November 2025, CFR Mike Senior (Fairbourne Team) attended an incident in Tywyn, Gwynedd, involving a 17-month-old patient. During consultation with the Clinical Support Desk (CSD), a paramedic initiated a live video link to Mike's mobile phone to visually assess the patient.

Mike reported that the use of video enabled the Clinical Support Desk clinician to visually assess the patient, provide reassurance to the patient's family and enhanced the responder's confidence in the care being delivered.

He was previously unaware that this capability was available within the Trust and described it as a sensible and effective approach, particularly in paediatric cases.

Following the incident, Mike submitted a formal compliment praising the professionalism and support provided by the CSD paramedic.

Key Risks and Issues Identified

- Potential value of video consultation in improving patient and family reassurance, supporting responders and clinicians, and enhancing patient experience, particularly for certain presentations and patient groups.
- Consideration of the impact of broader adoption of video consultations, on call duration and operational efficiency.
- Need to balance clinical benefits with accessibility, digital inclusion, patient dignity and data security.
- Current utilisation remains low and the reasons for this require further evaluation.
- Video consultations may be especially useful in areas such as paediatrics, stroke assessment and mental health.

Mike Senior

Impact

- Positive impact of live video technology in supporting clinical decision-making and reassurance for patients, families, and responders.
- Increased staff confidence and strengthened remote clinical oversight.

Themes for Assurance

- Positive innovation, compassionate care and effective use of digital technology.
- Enhanced patient/family experience through visible clinician input, providing reassurance and confidence in the care being delivered.
- The Trust is delivering safe, compassionate, and innovative care through digital tools that enhance clinical decision making and patient experience.

Actions Taken / In Progress

- Strategic consideration of a “video first” approach and wider operational implications, to be taken forward as an action for the Executive Leadership Team (ELT) to discuss.

Required Areas of Continued Focus

- This case demonstrates the potential clinical and experiential benefits of video consultation, balanced by the need for structured implementation, governance and evaluation before wider adoption.

- To support the effective use of video consultation to enhance clinical decision-making, patient experience and workforce confidence, underpinned by robust governance and evaluation.

Intended Outcomes

- Stronger Clinical Support for Frontline Staff/Responders feeling better supported in decision-making
- Confidence in managing complex cases
- Potential to reduce unnecessary escalation or conveyance where clinically appropriate.
- Increased Adoption of Digital Innovation with sustained increase in appropriate use of video consultation
- Cultural shift towards “digital-first where clinically appropriate”
- Clear operational guidance embedded in practice

OPERATIONS DIRECTORATE
QUARTERLY REPORT FOR COMMITTEES
2026-27 Q1 (April – June 2026)

REAP 4, Critical Incident and Major Incident

During the week commencing 22 June 2026, the Trust experienced a period of significant operational pressure, resulting in escalation to REAP 4. This escalation was driven by sustained increases in demand driven by the impact of extreme hot weather. In response to this continued pressure, the Welsh Ambulance Service declared a Critical Incident on Friday 26 June 2026, reflecting the level of disruption and the need for enhanced organisational coordination to maintain critical services and manage patient and staff safety. The critical incident was stood down on Monday 29 June. This occurred in the same week as the Major Incident in Kidwelly on 23 June 2026, following a road traffic incident involving a bus, where emergency services responded alongside partner agencies. Thirteen casualties were assessed and discharged at scene, and a further six people were taken to hospital for further medical attention, with no injuries believed to be life-threatening.

National Operations & Support

Challenges

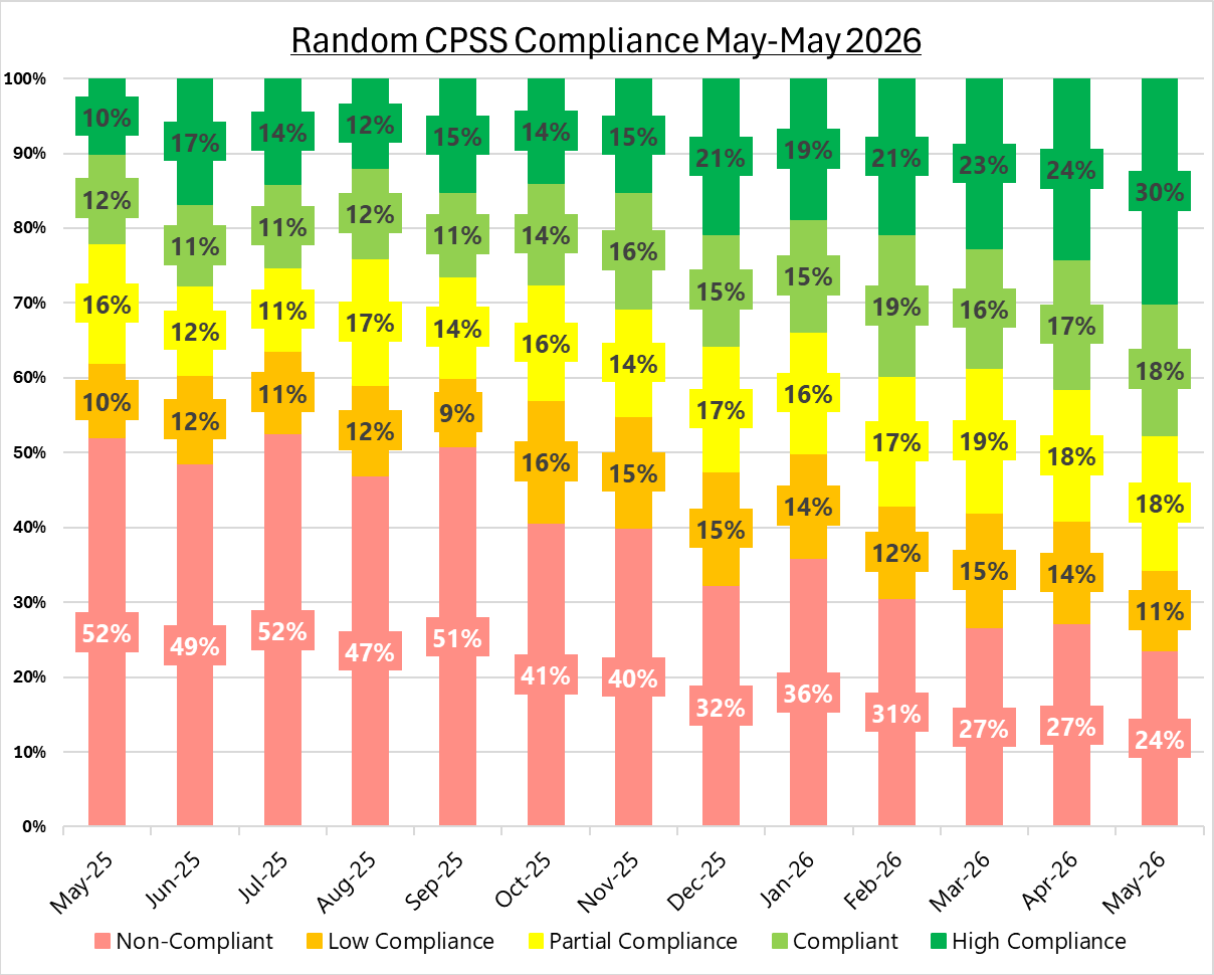
General Update

ECNS and CPSS Compliance

There continues to be steady improvements in CPSS and ECNS random audit compliance, with a reduction of non-compliance and an improvement in compliance and high compliance. The Operations Quality department will be meeting with the International Academies of Emergency Dispatch (IAED) to discuss plans to work towards Accredited Centre of Excellence (ACE) status for CPSS and (renewed) ECNS. Update papers will be prepared when further scoping and information has been obtained on required activities into Senior Operations Team (SOT).

The below shows the compliance levels for CPSS and ECNS. The 5 compliance levels set by the IAED for call audit are high-compliance, compliant, partial-compliance, low-compliance and non-compliance.

CPSS compliance (last 12 months):



ECNS for May 2026:

	Percentage	Number of Cases
High Compliance	51%	110
Compliance	18%	38
Partial Compliance	17%	36
Low Compliance	2%	4
Non-Compliant	13%	29

(There is only one month data for ECNS due to the implementation of the Integrated Care Clinical Queue)

IMTP

Volunteers in Major Incidents

The Volunteer Service, working in partnership with colleagues from Emergency Preparedness, Resilience and Response (EPRR), is developing a new Enhanced Community First Responder (ECFR) role to support the Trust's response to major incidents across Wales. ECFRs will operate as part of the wider multi-agency response, providing clinical support within the safe zone during large-scale

or complex incidents. The first cohort of volunteers are being trained in July in support of a pilot in the Cardiff area with further pilot areas across the remainder of Wales going live over the next twelve months.

GRS Cloud

The Trust successfully migrated from GRS on-premise to the Cloud environment on 12-13th May, with minimal disruption to service users. This means that our GRS systems are now cloud based rather than being hosted on local physical server equipment. A two-week post-migration hyper care period followed, and identified issues were resolved promptly. A small number of minor, non-business-impacting issues remain and are being managed through business-as-usual escalation routes with the vendor, Total Mobile. The GRS Android mobile application remains unavailable, with the issue logged and being actively progressed with Total Mobile and Digital Health Care Wales.

Positive user feedback has been received to date, particularly in relation to single sign-on functionality. The GRS SharePoint support resources and communications have been well utilised, helping to reduce demand on Resourcing and Digital Service Desk support. The Project Closure Report is scheduled for submission to Board on 16 July.

Volunteer Closure Report

The Trust's inaugural volunteer strategy Visible, Valuable Volunteering was completed with a closure report submitted in April 26. The report provided an update on the five-year journey of volunteering across WAST, showing how the service has moved from strengthening core foundations such as visibility, recognition, communication, training and governance, towards a more structured, digitally enabled and sustainable model. Key achievements include improved volunteer governance, additional skills and drugs, implementation of the Volunteer Management System and ePCR access, strengthened training and PPE compliance, growth in Volunteer Car Service and Community Welfare Responder activity, development of tiered responder pathways, governance audit assurance, enhanced partnership models and secured workforce capacity. Those uncompleted actions will be incorporated into a subsequent plan with clear ownership, milestones and reporting to maintain safe delivery, a positive volunteer experience and continued benefit for patients and communities.

National Operations Coordination Centre (NOCC)

The Trust has prioritised funding to establish a National Operations Coordination Centre (NOCC), incorporating a dedicated Incident Response Desk (IRD), to strengthen command, control and coordination for major and complex incidents while protecting business as usual delivery. This directly responds to recommendations from the Manchester Arena Inquiry and aligns with civil contingencies expectations for early, integrated incident management and timely decision-making. Following approval of the capital business case in May, the programme has moved rapidly from design into delivery, with designs finalised and procurement on track (tender July, return August, approval September), alongside continued alignment of estates, ICT and operational requirements. IRD workforce planning has progressed with the appointment of the IRD Operations Manager and next steps will focus on advancing the IRD defined scope, performance measures and operating model, and phased recruitment of staff to maintain service resilience. Engagement has progressed from targeted to wider organisational reach, supported by leadership briefings, operational sessions following a structured communications approach. As dedicated space on SIREN can be found here.

The financial position remains within expected parameters and delivery continues to be aligned to end-of-year implementation.

Coordination & Integrated Care

Challenges

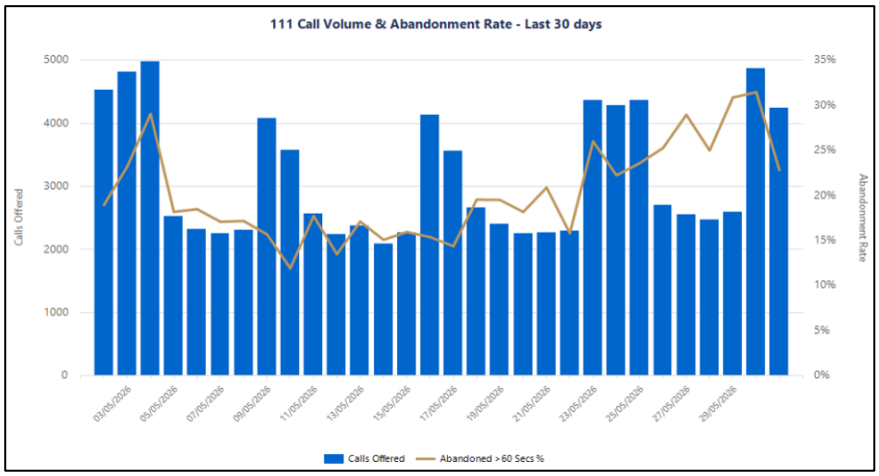
Integrated Care System Business Continuity Arrangements
Focus remains on strengthening the business continuity arrangements used when the Interoperability Toolkit (ITK) electronic link is unavailable. During these periods, alternative processes are required to transfer Integrated Care Clinical Queue (ICCQ) information between organisations, which can lead to variation in interpretation and operational delays. Work continues with Health Boards and system suppliers to improve consistency, strengthen guidance, and enhance support during periods of increased demand.

Interim secure data transfer arrangements are currently being developed to support information sharing should the ITK electronic link fail, with appropriate governance, audit and access controls being established. In parallel, longer-term CAD/MIS enhancements are planned end of July/early August to provide a more standardised and resilient approach to ICCQ information transfer, improving consistency across organisations and supporting effective patient flow when business continuity arrangements are required.

Operational Delays due to Clinical Information Visibility
Following the introduction of the Integrated Care Clinical Queue on 21 April, Health Boards have reported challenges in reviewing and interpreting clinical information due to the increased volume of notes being transferred into Adastra. This has created inefficiencies in identifying key clinical information and has the potential to contribute to operational delays.

WAST is working with system suppliers to improve how information is presented and to explore options for reducing unnecessary content. As an interim measure, Health Boards are being advised to use the Default message format and Encounter History view, which provides a clearer and more structured presentation of the relevant data.

Exceptional NHS 111 Wales May Demand
May 2026 saw exceptional NHS 111 Wales demand more commonly associated with winter pressures, with 97,123 calls offered, making it the second-highest monthly volume in the last 12 months and only 7% below the December 2025 peak of 104,542 calls. Demand increased by 5% compared to April and placed significant pressure on service capacity, despite occurring outside the traditional winter period.



The sustained increase in activity impacted operational performance, with the answer rate reducing to 65.0% and the proportion of callers abandoning after 60 seconds rising to 20.7%, levels comparable to those experienced during peak winter demand. This increase in volume also drove high levels of onward activity across urgent care pathways, including 20,971 urgent primary care dispositions, highlighting the system-wide impact of the elevated demand experienced throughout May.

The exceptional demand experienced during May is likely to have been influenced by two Bank Holidays, five weekends (four in April and June), and the associated impact of reduced access to GP and other healthcare services. In addition, the service is investigating the impact of Voice over Internet Protocol (VoIP) calls, which are currently reported as 'border calls' due to limitations in accurately identifying caller location from IP-based calls (generally mobile users utilising Wi-Fi calling), which may have contributed to the increased call volumes observed.

Integrated Care and EMS Coordination Abstractions

Sickness-related abstractions continue to be a focus across Integrated Care and EMS Coordination. Within Integrated Care, support is centred on early intervention and wellbeing-focused management to reduce sickness absence, support timely returns to work and prevent progression to long-term absence. While long-term sickness has reduced, a slight seasonal increase in short-term absence is being monitored. Inbound performance has improved, with sickness reducing to 8.83%, although weekend absence remains an area of focus. Continued partnership working with People Services and Occupational Health is supporting ongoing improvements.

Within EMS Coordination, sickness-related abstractions continue to present operational challenges. An action plan has been developed and is awaiting formal review, with ongoing collaboration between Service Managers and People Services to support implementation. EMSC coordination arrangements and mitigation measures remain in place to maintain safe and effective service delivery, alongside a programme of work led by Locality Managers to deliver a consistent and sustainable approach across all sites.

IMTP

Integrated Care Clinical Queue (ICCQ)
Overall, all workstreams were delivered in line with the planned Go-Live date of 21st of April. All Standard Operating Procedures (SOPs) and associated processes have now been fully developed, approved, and the queue successfully went live on 21st of April as planned. This includes detailed arrangements to maintain business continuity in the event of any service interruptions. Teams were provided with support during the early weeks of implementation, to ensure confidence and competence.

111 Roster Review
Roster briefing sessions were successfully delivered to managers in April, establishing a strong foundation for consistent communication and understanding. The programme has continued to progress, with 1:1 meetings undertaken in May to support individual roster discussions and decision-making. The Call Handler element has continued to develop positively and is on track to be delivered by the end of Quarter 2, maintaining strong momentum across implementation activity. For clinicians, a detailed analysis of outcomes is underway. This is being supported through ongoing collaborative work with Optima Shift to refine rostering models and align these with clinician preferences, supporting a well-informed and sustainable implementation approach.

Welsh Language Clinical Consultations Plan 2026–2031
The Delivering Clinical Consultations in Welsh Plan 2026–2031 has been developed to meet Welsh Language Standards requirements and sets out how the Trust will strengthen its ability to provide clinical consultations in Welsh through the principle of the Active Offer. Building on the previous plan, the new strategy maintains a focus on NHS 111 Wales whilst expanding its scope to include RICS clinicians and the NHS 111 digital offer. Key areas include workforce development, recruitment, digital innovation, service improvement, engagement and performance monitoring.

The plan and supporting documentation, including the Quality Impact Assessment and Equality Impact Assessment, were endorsed by Senior Operations Team on 30 June. The plan has already been endorsed by Clinical Quality Governance Group and will continue through the remaining governance process, including consideration by Clinical Advisory Group. Following final approval, detailed implementation plans and projects will be developed, with a formal review planned at Year 3 to assess progress and consider further expansion across Integrated Care services.

General Update

Falls Desk
The Falls Desk continues to deliver significant system benefit, managing over 5,200 incidents since launch and supporting more than 2% of all 999 demand with a small clinical workforce. Continued positive outcomes secured Welsh Government funding for 2026/27.

Clinical impact remains strong, with 74% of patients receiving advice within two hours and 75% of patients requiring assistance from the floor supported within two hours, reducing risks associated

with prolonged lies. A total of 908 patients were remotely assisted from the floor, with 28% subsequently managed through a Consult and Close outcome, avoiding ambulance dispatch where clinically appropriate.

The model has improved utilisation of specialist falls resources, contributing to 431 additional incidents attended (+7.2%) compared with the previous year, while maintaining vehicle utilisation at approximately 60%. Management of eligible falls incidents increased to 22% in April and May.

Performance has remained resilient despite a reduction in staffing from April 2026 to one clinician and one response coordinator, with further temporary capacity planned from November 2026 to February 2027 to support demand.

Introduction of the new 1st Line Management Structure:
On the 1st of June, Integrated Care went live with the new line management structure. This introduces roles of; Duty Operations Manager, Senior Clinical and the Workflow Coordination Manager. This is in crucial step forward that provides a unified leadership team across the Remote Integrated Clinical Services functions.

EMSC Locality Manager Programme of Work
The Locality Manager (LM) programme has established a more consistent and collaborative approach across the three sites, with a clear framework defining roles, responsibilities, and expectations. This has strengthened operational leadership, improved team visibility, and aligned key processes including performance, sickness, flexible working, and workforce planning. Regular weekly and monthly LM forums are now embedded, supporting shared decision-making, peer support, and improved coordination both internally and with external partners.

Health Care Professional Test of change HCP
The tests of change focused on alternative approaches to how community Healthcare Professional (HCP) calls are managed with the aim of improving clinical prioritisation, reducing unnecessary emergency dispatch, and increasing use of alternative care pathways.
Two tests of change have been undertaken throughout April to support early clinical involvement and robust information capture at the point of call through the use of the Medical Priority Dispatch System (MPDS) Medical Transfer Protocol Suite (MTPS)initial findings indicate clear opportunities to better align response levels with patient need, reduce avoidable ambulance dispatch, and strengthen use of alternative pathways, informing the development of a more efficient and clinically robust future model.

Improving Response Times for High-Risk Stroke Patients
A review identified that a specific group of high-risk stroke patients (showing obvious stroke symptoms) were routinely being filtered through an additional assessment stage, despite most ultimately requiring an emergency ambulance response. This step has later been deemed to be unnecessary. A change was implemented and went live on 10 June, allowing these high-risk stroke patients to be sent straight to an ambulance response and prioritised within the existing urgent queue. This removes an average wait of around 14 minutes per patient, with greater time savings during periods of high demand.

The change offers potential to improve response and arrival times for some stroke patients with minimal impact on overall demand, as most of these patients were already receiving an ambulance. Performance and patient safety will continue to be closely monitored to ensure the intended benefits are realised.

Immediate Release and Rapid Handover at English Hospital
Following recent engagement between leads and management teams at Shrewsbury and Telford Hospital NHS Trust (SaTH), agreement has been reached to implement Immediate Release and Rapid Handover processes across both hospital sites, effective from 1 June. This development aligns SaTH with existing practices already established within Welsh NHS health boards and is intended to improve patient flow, reduce ambulance turnaround times, and support system resilience.

Multiagency Incident Transfer Update – Dyfed-Powys Police Go-Live
Dyfed-Powys Police successfully went live with Multiagency Incident Transfer (MAIT) system on 18 May. This marks a key step forward in strengthening multi-agency collaboration, enabling more efficient and timely sharing of incident information between services. The implementation is expected to support improved situational awareness, streamlined communication, and enhanced joint working across agencies. We now have three of the four police forces across Wales on the MAIT platform.

Emergency Operations

Challenges

Handover 45
In line with NHS P&I handover 45 target requirements work has progressed with ABUHB, SBUHB and BCUHB. Structured meetings have taken place collaboratively with WAST and Health Boards colleagues. The three Health Boards have now produced plans detailing how the required target will be achieved which have been presented to NHS P&I.

Phase two involving HDUHB, CVUHB and CTMUHB is commencing imminently with initial meetings to share data packs and proposals for the prompt development of an action plan the demonstrates delivery against the handover 45 targets.

IMTP

APP Roster Review
All 7 Health Board areas have completed their consultation/discussion processes with the advanced practice workforce. Each locality has provided roster leads who are representing their colleagues to build new rotas that contain the required rotational elements for that specific area. Once draft rotas have been agreed by the locality APPs, they will be processed through the resource and finance teams. Currently each Health Board is at slightly different stages of the process, but this is progressing well.

Fleet Review T&F Group
Work continues to progress well with a recent SBARN – SLS/Tail Lift Costs Benefits Analysis presented to SLT. This paper looks comparing the use of a Power Load self-loading stretcher system and power chair as opposed to the current vehicle lift system. The paper includes a cost benefits analysis to allow for discussion at a senior level to establish if these new self-loading systems could replace the tail lift systems and whether the benefits would support the Net Zero Strategy (2030) from Government.

Multi Casualty Triage Bags (MCTB)
Following learning from the Manchester Arena Inquiry (MAI) and internal Major Incident exercises, in May 2026 the Trust issued Multi Casualty Triage Bags (MCTBs) to frontline response vehicles (EA/UCS and SRVs). Rollout completed at the end June 2026. The MCTB and existing PAX carry sheet can be used for any multi-casualty incident, where the numbers of patients outweigh resources available. This allows those first attending a multi-casualty incident to deploy Life Saving Interventions (LSIs) faster and more consistently. The aim of this is to reduce the 'Care Gap' - the time from an injury sustained to treatment beginning. There is no new equipment in the MCTBs and therefore no requirement for additional staff training on the contents, but familiarisation modules on both LM365 and Sway have been implemented and E&D have been provided with bags for awareness on staff induction and MIST sessions. The MCTBs have already been used successfully at the recent Cardiff multi-agency training incident. A spot check audit of the MCTBs will be completed in Autumn 2026 for compliance and feedback has been invited from colleagues as to usage.

Business Continuity
The implementation of the Trust's Business Continuity software is approaching full rollout. Work is underway to formalise reporting mechanisms, which will support consistent oversight of compliance and risk across directorates. A draft reporting framework will be presented to SOT and SLT in the coming weeks.

HART Uplift Business Case
The HART uplift business case has been endorsed by P&I and is ready for imminent submission to WG. Following engagement with WG colleagues, the scope of the submission has been expanded to include a request for SORT clinical decontamination capability funding. Prior Trust Board approval from the Trust's MAI work is used for case submission, and if successful appropriate governance for spending approvals will be undertaken.

Wales Risk Register
A detailed gap analysis against the Wales Risk Register is currently underway, with scoring methodology adapted to reflect WAST-specific risk exposure rather than Local Resilience Forum (LRF), providing a more accurate organisational risk profile. The analysis is considering key domains including training and exercising, workforce capacity, specialist capability, and the robustness of existing plans. The outputs will inform actions to address identified gaps and strengthen compliance with national resilience expectations.

Euros & Tour De France
Euros 2028 and Tour De France are significant events coming to Wales. Advance planning work therefore continues, with recruitment to key roles successfully completed and all three post holders in place by June 2026. Strategic objectives have now been approved by SLT, providing a clear

framework for delivery, and work is underway to translate these into defined operational outputs and deliverables.

A training needs analysis has been completed, identifying key command roles and informing the development of a structured two-year training and exercising programme to build capability and assurance. Engagement with multi-agency partners across Wales and the wider UK is ongoing.

As yet however no dedicated funding has been made available to WAST for planning or implementing arrangements for these events. A point which has been made in forums. WAST has set out at high level costs for Euros 2028 and provided this to NHS P&I.

General Update

TOIL Pilot
The TOIL pilot agreed in partnership has concluded with success demonstrating an increase in the approval of TOIL applications. However, momentum is vital to ensure that the hard work undertaken throughout the pilot does not drop off. Therefore, a TOIL oversight group has been established in partnership to monitor progress going forward.

Ambulance Care

Challenges

Demand and CMP challenges
During Q1, Ambulance Care has experienced an increase in demand for patient transport requests, at times exceeding available operational capacity. This has resulted in periods where demand has outstripped resource availability, requiring the activation of Capacity Management Plan (CMP) actions to maintain service delivery and patient safety. These pressures have been particularly evident during same-day activity and peak demand periods, where resource gaps have necessitated prioritisation of patient cohorts and the use of alternative solutions.

While a range of actions continue to mitigate these pressures, the gap between demand and capacity remains a key operational challenge. Ongoing work is focused, through the NEPTS improvement programme, on improving forward planning, maximising utilisation of available resources, and aligning workforce to activity, to support a more resilient and sustainable service model.

IMTP

NEPTS Improvement Programme
The programme has made good progress during the initiation phase and is currently reporting a Green RAG status. Key governance documentation, including the PID and Terms of Reference, has been developed and is scheduled for approval at the inaugural Programme Board. Programme structures are now in place, with stakeholder mapping and objectives aligned to the JCC NEPTS vision completed, and the business cycle defined to align with reporting requirements.

Workstreams have been mobilised, with leads appointed, regular reporting established, and supporting documentation, including RAIDs and plans, being developed.

NEPTS Roster Review progress
The NEPTS Roster Review continues to progress in line with the agreed approach. All areas have developed compliant rota options and are moving through the voting process. Most areas voting has now finished, with the remaining areas completing through July. One rota has gone live on the 6th July.

The next step is now to implement the remainder of rota's and redesign our entire plurality model around the new rota's, which is a significant piece of work.

Completion of this exercise will represent an important step in aligning workforce capacity to operational demand, with transitional impacts on service stability and performance being actively monitored.

General Update

NEPTS Annual Report
The service has released its first ever annual report which can be found here. The report has been developed using a mix of performance information and patient feedback and represents a balanced view of the service in an easy read format. The document will be shared with commissioners and Health Boards and be replicated bi-annually moving forward.

Patient Feedback
Patient experience feedback remains broadly positive in relation to staff professionalism and communication. However, recurring themes relating to booking processes, wait times, and accessibility highlight areas for targeted improvement. Work is ongoing to strengthen inclusive access and address identified gap

SMS - Digital Enhancements to Patient Communication
In June 2026, Ambulance Care added additional SMS text messaging functionality to patients to improve communication, patient preparedness, and overall service flow. This includes pre-journey SMS notifications, enabling patients to confirm whether transport is still required. Early indications suggest this is supporting a reduction in unnecessary journeys and improving overall capacity utilisation across the service.

In addition, vehicle mobile SMS updates provide real-time notifications to patients when crews are en-route, improving patient awareness, readiness for collection, and reducing delays on arrival.

The final step in this process will be focused on integration with the new NEPTS app, which allows patients to see where their vehicle is, review bookings, contact the service and cancel online. Implementation of the app is imminent pending completion of the relevant information governance processes.

These digital enhancements represent a key step towards modernising patient interaction and improving operational efficiency, with further evaluation planned to assess their impact on aborted journeys, waiting times, and overall patient experience

Pan Directorate Updates

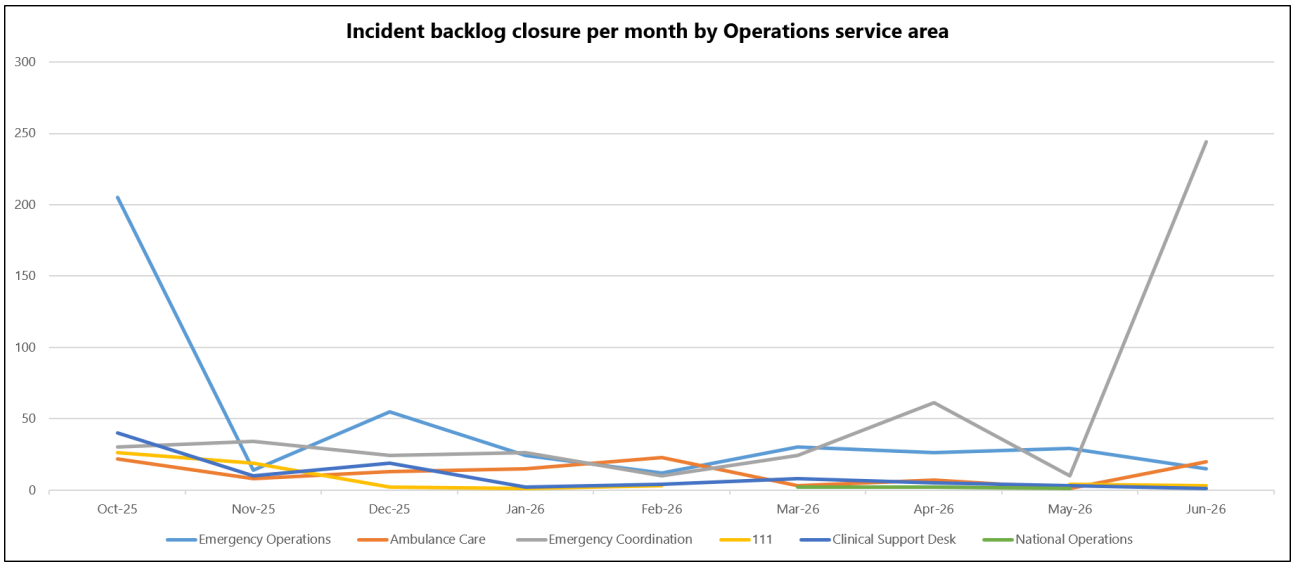
Financial Savings

At the end of Month 2, the Operations Directorate is reporting a broadly positive financial position, with a marginal in-month underachievement of £2k and a year-to-date variance of £2k below plan, following a break-even position in Month 1. The current forecast indicates a potential £26k shortfall against the overall savings plan, driven primarily by ongoing pressures within fleet fuel costs across EMS Operations and Ambulance Care. Despite this, performance across other areas remains strong, with National Operations, Coordination, and Integrated Care achieving planned savings, and EMS overall overachieving in part due to non-pay savings. Forecast trajectories suggest that some early shortfalls, particularly within fuel and falls schemes, are expected to recover later in the financial year, with improving fuel prices also presenting a potential mitigating factor. Overall, excluding fuel-related pressures, the savings programme is progressing well and remains broadly on track.

CC Level 3	CC Level 4	Scheme	Annual Plan	CM Plan	CM Actual	CM Variance	YTD Plan	YTD Actual	YTD Variance	Forecast Plan	Forecast Actual	Forecast Variance
DX01-Operations Directorate	DX02-ADO-NOS	Non Pay MWF	215,000	18,000	18,000	0	35,000	35,000	0	215,000	215,000	0
DX01-Operations Directorate	DX02-ADO-NOS	Non Pay Travel & Subs, Conferences	14,000	0	0	0	0	0	0	14,000	14,000	0
DX01-Operations Directorate	DX02-ADO-NOS	Non Pay Volunteers	25,000	0	0	0	25,000	25,000	0	25,000	25,000	0
DX01-Operations Directorate	DX02-ADO-NOS	Pay Vacancy Operations - IRD	266,843	55,505	55,505	0	111,010	111,010	0	266,843	266,843	0
DX01-Operations Directorate	DX02-ADO-NOS	Pay Vacancy Operations - Non Frontline	61,000	12,000	12,000	0	49,000	49,000	0	61,000	61,000	0
DX01-Operations Directorate	DX02-ADO-NOS	Pay Vacancy Operations - ODU	18,157	6,052	6,052	0	12,104	12,104	0	18,157	18,157	0
DX01-Operations Directorate	DX02-ADO-NOS Total		600,000	91,557	91,557	0	232,114	232,114	0	600,000	600,000	0
DX01-Operations Directorate	DX03-ADO - Coordination & IC	Non Pay Taxi	180,000	0	0	0	0	0	0	180,000	180,000	0
DX01-Operations Directorate	DX03-ADO - Coordination & IC	Non Pay Travel & Subs, Conferences	20,000	0	0	0	0	0	0	20,000	20,000	0
DX01-Operations Directorate	DX03-ADO - Coordination & IC	Pay Management Operations - IC Desk	289,000	35,000	35,000	0	70,000	70,000	0	289,000	289,000	0
DX01-Operations Directorate	DX03-ADO - Coordination & IC	Pay Management Operations - IC Manager	38,000	3,000	3,000	0	6,000	6,000	0	38,000	38,000	0
DX01-Operations Directorate	DX03-ADO - Coordination & IC	Pay Vacancy Operations - Non Frontline	64,000	6,000	6,000	0	6,000	6,000	0	64,000	64,000	0
DX01-Operations Directorate	DX03-ADO - Coordination & IC Total		591,000	44,000	44,000	0	82,000	82,000	0	591,000	591,000	0
DX01-Operations Directorate	DX04-ADO - Emergency Medical Services	Non Pay Fuel	100,000	9,000	0	-9,000	18,000	0	-18,000	100,000	48,000	-52,000
DX01-Operations Directorate	DX04-ADO - Emergency Medical Services	Non Pay Help Point	40,000	0	0	0	40,000	40,000	0	40,000	40,000	0
DX01-Operations Directorate	DX04-ADO - Emergency Medical Services	Non Pay Hospital Concessions	100,000	10,000	10,000	0	20,000	20,000	0	100,000	100,000	0
DX01-Operations Directorate	DX04-ADO - Emergency Medical Services	Non Pay M&SE Stock Control	100,000	9,000	20,000	11,000	18,000	41,000	23,000	100,000	123,000	23,000
DX01-Operations Directorate	DX04-ADO - Emergency Medical Services	Non Pay Travel & Subs, Conferences	40,000	0	0	0	0	0	0	40,000	40,000	0
DX01-Operations Directorate	DX04-ADO - Emergency Medical Services	Non Pay Uniforms	12,000	1,000	7,000	6,000	2,000	16,000	14,000	12,000	26,000	14,000
DX01-Operations Directorate	DX04-ADO - Emergency Medical Services	Non Pay Winter Vehicles	50,000	0	0	0	0	0	0	50,000	50,000	0
DX01-Operations Directorate	DX04-ADO - Emergency Medical Services	Non Pay Wrexham ATC	10,000	0	0	0	10,000	10,000	0	10,000	10,000	0
DX01-Operations Directorate	DX04-ADO - Emergency Medical Services	Pay Management Operations - Paramedics (APP)	145,000	12,000	12,000	0	24,000	24,000	0	145,000	145,000	0
DX01-Operations Directorate	DX04-ADO - Emergency Medical Services	Pay Management Operations - Skill Mix	500,000	42,000	42,000	0	84,000	84,000	0	500,000	500,000	0
DX01-Operations Directorate	DX04-ADO - Emergency Medical Services	Pay Variable Operations - End of Shift	96,000	8,000	13,000	5,000	16,000	25,000	9,000	96,000	105,000	9,000
DX01-Operations Directorate	DX04-ADO - Emergency Medical Services	Pay Variable Operations - Overtime	850,000	71,000	71,000	0	142,000	142,000	0	850,000	850,000	0
DX01-Operations Directorate	DX04-ADO - Emergency Medical Services Total		2,043,000	162,000	175,000	13,000	374,000	402,000	28,000	2,043,000	2,037,000	-6,000
DX01-Operations Directorate	NX10-ADO - Ambulance Care	Non Pay FALLS	150,000	12,000	0	-12,000	24,000	0	-24,000	150,000	150,000	0
DX01-Operations Directorate	NX10-ADO - Ambulance Care	Non Pay Fuel	40,000	3,000	0	-3,000	6,000	0	-6,000	40,000	20,000	-20,000
DX01-Operations Directorate	NX10-ADO - Ambulance Care	Non Pay Taxi	208,000	14,000	14,000	0	26,000	26,000	0	208,000	208,000	0
DX01-Operations Directorate	NX10-ADO - Ambulance Care	Non Pay Travel & Subs, Conferences	26,000	0	0	0	0	0	0	26,000	26,000	0
DX01-Operations Directorate	NX10-ADO - Ambulance Care	Pay Management Operations - UCS	415,000	35,000	35,000	0	65,000	65,000	0	415,000	415,000	0
DX01-Operations Directorate	NX10-ADO - Ambulance Care	Pay Variable Operations - End of Shift	14,000	2,000	2,000	0	4,000	4,000	0	14,000	14,000	0
DX01-Operations Directorate	NX10-ADO - Ambulance Care	Pay Variable Operations - Overtime	250,000	0	0	0	0	0	0	250,000	250,000	0
DX01-Operations Directorate	NX10-ADO - Ambulance Care Total		1,103,000	66,000	51,000	-15,000	125,000	95,000	-30,000	1,103,000	1,083,000	-20,000
DX01-Operations Directorate Total			4,337,000	363,557	361,557	-2,000	813,114	811,114	-2,000	4,337,000	4,311,000	-26,000
Grand Total			4,337,000	363,557	361,557	-2,000	813,114	811,114	-2,000	4,337,000	4,311,000	-26,000

Datix Backlog

Since backlog recovery work commenced in September 2025, a total of 2,285 historic incidents have been closed, representing a 71% reduction from the original 3,205 cases, some of which dated back to 2021/22.



From September 2025, services have reported 3,869 new incidents and closed 2,425 of them, achieving a 63% closure rate. This represents a 5% increase in review and closure rates on last quarter, indicating encouraging improvements in compliance and timeliness.

Further improvement activities are being scoped to maintain and continue to improve compliance with DATIX processes, including consideration of updates to the reporting hierarchy to strengthen oversight and accountability. There will also be a continued focus on ensuring consistent application of reporting requirements, appropriate access to the system, and improved awareness through communication and targeted training, supporting ongoing improvement across services.

Listening to People (LTP)

During this quarter, the Operations Directorate has continued to focus on the management of concerns as a key component of patient experience, quality improvement and organisational learning. Whilst the previous Putting Things Right (PTR) backlog recovery plan successfully reduced the historic backlog and improved visibility of concerns activity, the Directorate continues to face significant challenges in sustaining this position.

Performance has remained under considerable pressure throughout the quarter, with further increases in overdue concerns reflecting ongoing operational pressures, capacity constraints and rising demand. This demonstrates that, despite earlier recovery work, the Directorate has not yet reached a stable business-as-usual position and remains at risk of further deterioration without continued intervention and oversight.

In response, strengthened governance arrangements have been introduced, including enhanced reporting through the Senior Operations Team (SOT). These arrangements provide greater visibility of performance, support earlier identification of emerging risks and delays, and enable more timely escalation where concerns are not progressing as expected. However, these measures are intended to stabilise performance rather than indicate that the underlying challenges have been resolved.

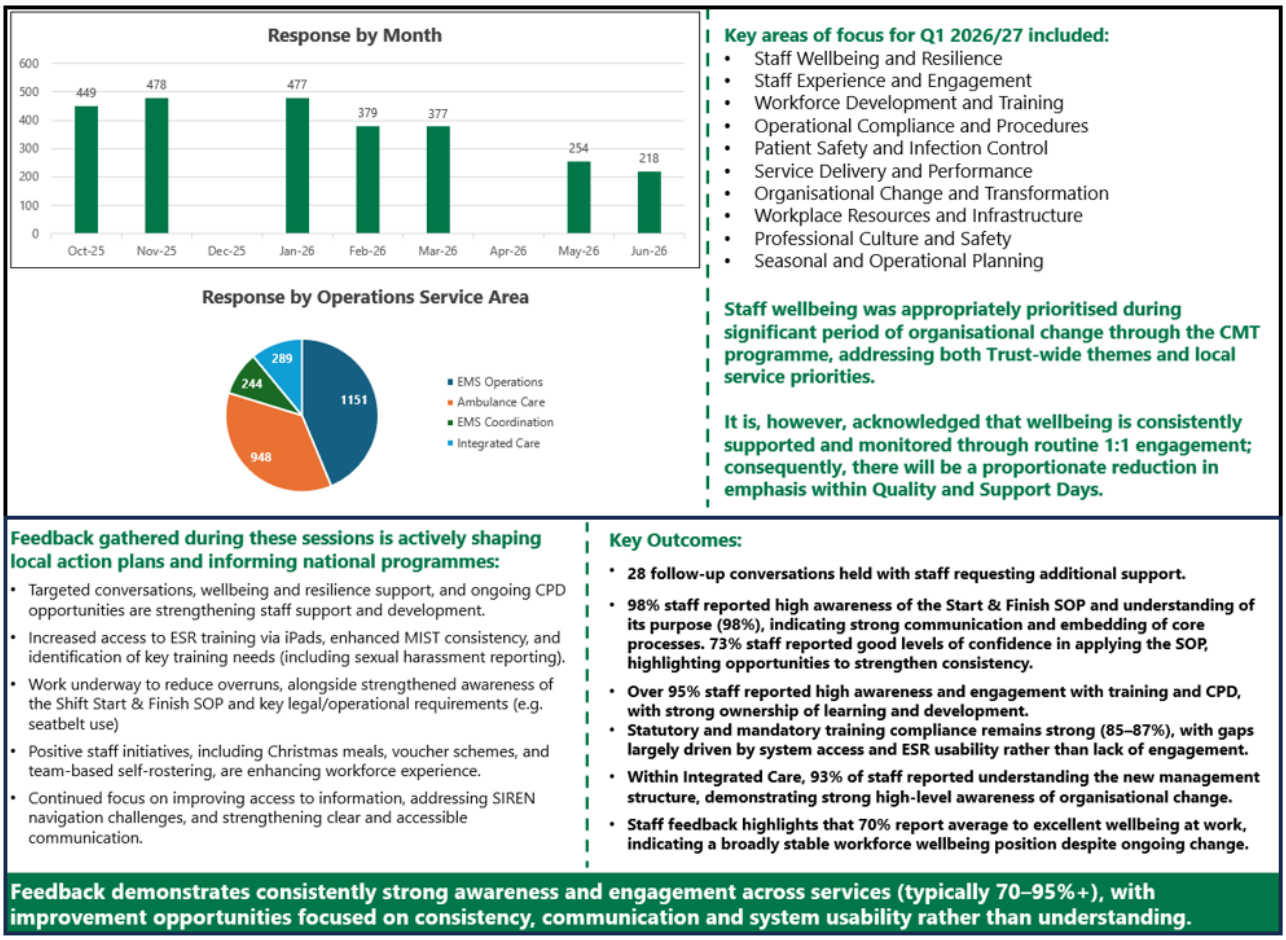
The Directorate continues to work towards embedding more sustainable processes and consistent management of concerns across service areas. A key focus remains improving both the timeliness and quality of responses while reducing the number of overdue cases. Further work is required before confidence can be gained that improvements are fully embedded. A directorate SOP is under development which will set out key roles and responsibilities across the directorate, including the process for resolution of lower grade concerns.

This work also supports the transition from the PTR process to the Listening to People framework, which places greater emphasis on timely, proportionate and person-centred handling of concerns. Whilst progress has been made in preparing for this transition, further work is required to ensure that processes, reporting arrangements and governance are fully aligned with the new framework.

Overall, the Directorate continues to face a challenging position, with performance remaining fragile and requiring sustained management attention. The strengthened oversight arrangements provide a clearer understanding of current performance, but the priority for the next quarter will be to regain control of the overdue position, improve compliance with response times, embed effective SOT oversight, finalise the SOP and continue the transition to the Listening to People framework.

Quality and Support Days

The monthly Quality and Support Days continue to be delivered with a themed focus on specific priority areas. This approach enhances opportunities for meaningful engagement, enabling local managers to maintain visible leadership presence while facilitating one-to-one discussions with staff. Through these sessions, managers can guide staff through the subject matter in a structured way, providing targeted support, increasing understanding, and reinforcing key messages.



Of the 56 Operations Quality and Support Day follow-up actions identified, 46 have been completed. This reflects strong progress and demonstrates a continued commitment to learning, improvement, and timely action.

Essential Conversations

Engagement has improved following the introduction of an 8-week notice period for sessions. During the reporting period, 45 colleagues completed the programme at the Leadership Symposium, contributing to a total of 127 completions between March and June. While 293 colleagues are yet to complete the programme, uptake remains strong, with 110 colleagues already booked onto sessions scheduled for September. To support continued demand, additional sessions have been arranged for October, with dates to be released shortly.

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

Agenda Item No. 07

REPORT TITLE

Strategic Quality Plan 2025-2028 Mid-Point Review

MEETING

Name of meeting	Quality, Patient Experience & Safety Committee
Date of meeting	6 August 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Andy Swinburn, Executive Director of Paramedicine Penny Durrant, Interim Director of Nursing
Author(s) of report	Kate Blackmore, Assistant Director of Quality Governance

PURPOSE OF REPORT

☐ Approval	☒ Endorsement
☐ Assurance	☐ Discussion
☐ Information (goes in consent items)	☐ Noting

REPORT SUMMARY

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

1. A midpoint review of the Strategic Quality Plan 2025-2028 implementation arrangements has been completed to assess delivery progress, organisational capacity and alignment with evolving national and organisational priorities. The review concludes that whilst significant progress has been achieved, revisions are required to ensure delivery remains proportionate, achievable and focused on measurable quality outcomes.
2. The review identified opportunities to simplify implementation arrangements, remove duplication with existing organisational programmes and strengthen accountability for delivery. A revised Implementation Plan has therefore been developed, retaining the strategic ambitions of the Plan whilst improving deliverability and alignment with the Duty of Quality, Health and Care Quality Standards and NHS Wales accountability requirements.
3. Key strengths identified include progress in establishing quality governance infrastructure, quality management system development, quality intelligence capabilities, patient experience measurement and quality improvement methodologies. These provide a strong foundation for the remaining period of the Strategy.
4. The principal challenges identified relate to population health capacity, analytical capability and the impact of competing organisational priorities. These issues have informed the revised implementation approach and remain subject to ongoing governance oversight.
5. Overall, the review provides moderate to substantial assurance that the Strategic Quality Plan remains deliverable within the remaining timeframe, subject to implementation of the revised arrangements and continued monitoring through established governance mechanisms.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

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

1. Receive assurance from the findings of the Strategic Quality Plan 2025-2028 midpoint review;
2. Approve the revised Implementation Plan and associated changes to delivery arrangements;
3. Receive assurance that the revised implementation approach strengthens alignment with the Duty of Quality, Quality Management System maturity and NHS Wales accountability requirements; and
4. Note the residual risks identified and the arrangements for their ongoing monitoring through established governance structures.

ADDITIONAL PAPER(S)

Set out here any annexes. See writing and presentation guidance here regarding materiality and use of the Reading Room

The Quality, Patient Experience & Safety Committee is requested to receive the following:
Annex 1 Revised Strategic Quality Plan Implementation

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [link to objectives and what good looks like]	
☐ SO1: Providing the right care or advice, in the right place, every time	☐ SO2: Enabling our people to be the best they can be
☐ SO3: Being at the forefront of innovation and technology	☐ SO4: Developing services in collaboration
☒ SO5: Being quality driven and clinically led	☐ SO6: Delivering exceptional value

RISK(S) THIS REPORT MITIGATES

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

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

Quality Domains (select all that apply) [link to standards]		
☐ Safe	☐ Timely	☒ Effective
☒ Efficient	☐ Equitable	☐ Person Centred
Quality Enablers (select all that apply) [link to standards]		
☒ Leadership	☐ Workforce	☒ Culture
☐ Information	☒ Learning Improvement and Research	☐ Whole Systems Approach

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [link to goals]		
☐ A socially responsible and inclusive employer	☐ An innovative and sustainable organisation	☐ A pro-active, accessible and equitable care provider
☒ n/a	☒ n/a	☒ n/a

IMPACT ASSESSMENTS FOR CONSIDERATION

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

Does this paper require an impact assessment	☒ No ☐ Yes
If yes, what impact assessment is attached	

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
17 July 2026	Clinical & Quality Governance Group

SITUATION

1. Following completion of the Strategic Quality Plan midpoint review and engagement with strategic leads, the Implementation Plan has been refreshed to ensure delivery activity remains achievable, appropriately prioritised and aligned with organisational and national expectations. The revised Implementation Plan is presented to provide assurance on the changes made, the rationale for those changes and the arrangements for ongoing governance and delivery.

2. The refresh has been undertaken within the context of the NHS Wales Operating and Accountability Framework, which identifies Quality as Pillar 1 of organisational accountability, and the statutory Duty of Quality, which requires NHS bodies to exercise all functions with a view to securing continuous improvement in the quality of health services.

BACKGROUND

3. The Strategic Quality Plan 2025-2028 was approved with an accompanying Implementation Plan intended to coordinate delivery across multiple programmes and workstreams. Since approval of the plan, the Quality, Experience and Safety Committee (QuEST) has maintained regular oversight of implementation progress through its established cycle of business. During this period, the Committee has considered a range of quality governance matters, these discussions have reinforced the importance of ensuring that strategic quality activity remains deliverable, measurable and capable of providing meaningful assurance regarding improvements in quality, safety, experience and outcomes.

4. QuESt members have sought assurance that Delivery Plans are achievable within available resources, supported by appropriate governance structures and capable of evidencing progress against strategic ambitions. This reflects recommendations from the Audit Wales Quality Governance Follow-Up Review that Quality Plans should be realistic, clearly linked to available capacity and supported by robust implementation and monitoring arrangements.

5. The Implementation Plan refresh has therefore been informed not only by the Strategic Quality Plan midpoint review, but also by continued dialogue with QuESt regarding deliverability, quality governance, benefits realisation, outcome measurement and organisational learning. In particular, Committee discussions over the last twelve months have highlighted the need to reduce duplication with existing programmes, strengthen reporting of strategic outcomes, improve alignment with the Duty of Quality and Health and Care Quality Standards, and ensure that implementation activity remains proportionate to the resources

available. The revised Implementation Plan seeks to respond directly to these themes by simplifying delivery arrangements, clarifying accountability and strengthening focus on measurable improvements in quality, safety, experience and population outcomes.

6. Subsequent implementation planning, through the midpoint review, reflected on the duplication between some planned activities and existing organisational programmes including the Integrated Medium-Term Plan (IMTP), Directorate Plans, Quality Management System development, Digital Programmes and Clinical Model Transformation activities. During the midpoint review, agreement was reached to simplify implementation arrangements, focus on key outcomes rather than large numbers of individual actions and ensure that the Implementation Plan supports delivery of the Duty of Quality, Quality Management System maturity and organisational accountability requirements.

7. The review recognised that future assurance should increasingly focus on the organisation's ability to demonstrate improvements in quality, safety, experience and outcomes, consistent with both the Quality Standards 2023 and the accountability expectations described in Pillar 1 of the NHS Wales Operating and Accountability Framework.

ASSESSMENT

What Has Been Achieved

8. Whilst the Implementation Plan has been refreshed to improve deliverability and focus resources on a smaller number of strategic priorities, considerable progress has been made during the first phase of implementation. Delivery to date has established many of the organisational foundations required to support the Strategic Quality Plan over the remainder of its lifespan. Key deliverables already completed or substantially progressed include:
   - Introduction of benefits realisation and evaluation methodologies to support improvement activity and demonstrate organisational impact.
   - Completion of organisational improvement methodology development based on recognised quality improvement principles.
   - Significant progress in the development of quality statements, quality assurance self-assessments and organisational maturity assessments across operational and corporate services.
   - Enhancement of accessible patient information and communication resources, including easy-read materials, British Sign Language resources, multilingual accessibility functionality and bereavement information.
   - Development of compassionate communication learning resources and educational packages available through organisational learning platforms.

- Establishment of Datix governance arrangements, delivery of training resources and continued progress in strengthening incident, feedback and learning intelligence capabilities.
- Progression of patient experience measurement through implementation and expansion of patient-reported experience measures and associated feedback mechanisms.
- Advancement of quality intelligence and dashboard development to improve access to information and support evidence-based decision making.

Key Changes Made

9. The revised Implementation Plan removes activities that are already monitored through other established governance structures and Strategic Programmes. This reduces duplication and strengthens accountability. This activity will continue to be delivered through programmes such as the People & Culture Plan, Digital Plan, Strategic Equality Plan and through Clinical Model Transformation, all helping to build a culture of quality throughout the organisation.

10. Several population health activities relating to dedicated public health capacity, Training Programmes and specialist public health support have been discontinued or consolidated because delivery was dependent upon resources and expertise that are not currently available.

11. The Population Health Programme has been streamlined into two primary themes:
    - Organisational Awareness.
    - Data Insights, Evidence and Evaluation.

    These themes focus on raising awareness of health inequalities and prevention, improving population health intelligence and strengthening the use of evidence to support quality improvement and service development.

12. Value Based Health Care has been repositioned as a cross-cutting principle rather than a standalone programme. This reflects the Duty of Quality expectation that organisations use value-based approaches to improve the outcomes that matter most to people, reduce unwarranted variation and make effective use of available resources. Value-based principles will therefore inform workstreams rather than being delivered separately.

13. The commitment to deliver Corporate Parenting has been discontinued, whilst we understand the value in the Corporate Parenting Charter, current data links across the broader health system as well as capacity within our safeguarding teams prevents us from completing the activity within the timescale initially identified.

14. The Implementation Plan has been updated to reflect the transition from a singular focus on Quality Impact Assessment processes towards a broader impact assessment approach that incorporates emerging Health Impact Assessment requirements and supports compliance with statutory implementation expectations by April 2027. This will enable the organisation to further embed quality-driven, evidence-based and prevention-focused decision-making across both clinical and non-clinical functions.

15. The revised plan reflects changes arising from the organisational Service Review impacting the Patient Experience and Community Involvement (PECI) Team, which resulted in a strategic shift away from coordinating and governing local engagement activity. As a consequence, several actions previously framed around engagement have been removed from the Implementation Plan. This does not represent a reduction in local engagement activity, which continues to take place across services and directorates. Rather, the role of the PECI function has evolved to focus on the systematic collection, analysis and triangulation of experiential insight and intelligence to support quality improvement, service development and organisational decision-making. A new internal commissioning model has been introduced to prioritise PECI resource against agreed organisational priorities, ensuring that engagement and insight activity is aligned to IMTP deliverables, strategic objectives and areas of greatest organisational impact. This change strengthens the organisation's ability to utilise patient, public and staff experience as part of the wider intelligence framework supporting the Duty of Quality, Quality Management System development and Pillar 1 (Quality) of the NHS Wales Operating and Accountability Framework.

Alignment with National Accountability and Statutory Responsibilities

16. The revised Implementation Plan takes into consideration the expectations of Pillar 1 (Quality) of the NHS Wales Operating and Accountability Framework. This includes the requirement to demonstrate compliance with Quality Standards, evidence of learning translating into improved outcomes, reduction of harm and the use of triangulated intelligence and assurance to support decision making and improvement.

17. The Implementation Plan has been aligned to support the statutory Duty of Quality by strengthening activities that support quality planning, quality assurance, quality improvement, organisational learning and quality management system maturity.

18. The revised Implementation Plan is intended to provide assurance that the Strategic Quality Plan remains deliverable within the remaining timeframe of the Strategy. The Plan remains aligned with national accountability requirements, and statutory responsibilities under the Duty of Quality through Quality Management System development, whilst reducing duplication.

Risks

19. Notwithstanding the improvements made, residual risks remain in relation to:

    - Availability of specialist population health expertise.
    - Dependence on analytical and data-linkage developments.
    - Competing organisational priorities.

20. These risks are recognised within the revised approach and will continue to be monitored through the existing Governance Framework and escalation processes where required.

RECOMMENDATION

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

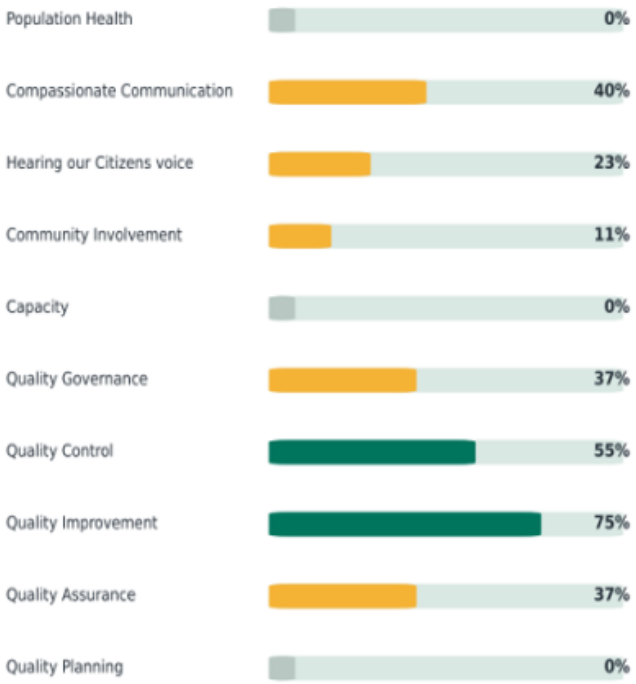
Appendix 1 - Overview

Strategic Quality Plan 2025-2028

Implementation activities: progress, assurance and delivery focus

Revised Plan
27% complete

Delivery workstreams



Assurance Links

Pillar 1 : Quality
Compliance, learning, outcomes and reduced harm

Duty of Quality
Quality-driven decisions across all functions

Quality Standards 2023
Embedding assessment across domains and enablers

Value Based Health Care
Embedded across workstreams, not a separate programme

Experiential Intelligence
Experiential insights targeted to strategic priorities

Impact Assessment
QIA/EQIA/HIA integrated and proportionate

Achievements

- ✔ Accessible outward facing resources enhanced.
- ✔ Annual review of action from user voice completed
- ✔ Datix governance forum and recovery plan established
- ✔ Quality Statements completed/substantially progressed
- ✔ Compassionate communication learning resources developed
- ✔ QI&A governance documentation and policy framework completed
- ✔ Improvement methodology and benefits realisation approach developed.
- ✔ Impact assessment approach broadened to include HIA requirements

Welsh Ambulance Services University NHS Trust

Project name	REVISED - Strategic Quality Plan Implementation
Plan owner	Kate Blackmore
Project start date	3/25/2025
Project finish date	9/18/2028
Duration	905 days
% complete	27%
Exported on	7/2/2026

Task number	Outline number	Labels	Name	Bucket	Start	Finish	Duration	% complete	Priority	Depends on	Delivery Confidence	Assigned to	Dependents (after)
1	**1**		**Population Health**		**4/1/2025**	**3/31/2028**	**784 days**	**0%**	**Medium**				
2	**1.1**		**Organisational Awareness**		**9/1/2026**	**3/31/2028**	**414 days**	**0%**	**Medium**				
3	1.1.1		Develop and implement a Health Inequalities and Prevention Awareness Programme for staff and volunteers.	Population Health	9/1/2026	3/31/2028	414 days	0%	Medium			Leanne Hawker, Fiona Maclean	
4	**1.2**		**Strategic Leadership & Accountability**		**4/1/2025**	**3/31/2028**	**784 days**	**0%**	**Medium**				
5	1.2.1		Explore introduction of Population Health Champions across all levels	Population Health	4/1/2025	3/31/2028	784 days	0%	Medium			Fiona Maclean, Leanne Hawker	
6	1.2.2		Population Health Self Assessment & Continuous Improvement	Population Health	9/1/2026	12/31/2026	88 days	0%	Medium			James Houston, Kate Blackmore	
7	1.2.3		System Partnerships	Population Health	9/1/2026	9/1/2026	1 day	0%	Medium			Hugh Bennett, James Houston, Kate Blackmore	
8	1.2.4		Develop a population health intelligence capability through strengthened system partnerships, linked NHS Wales data, and evidence-based evaluation to identify health inequalities and inform service development and improve outcomes for the people of Wales	Population Health	9/2/2026	3/31/2028	413 days	0%	Medium			Kate Blackmore	
9	**2**		**Compassionate Communication**		**4/1/2025**	**9/18/2028**	**905 days**	**40%**	**Medium**				
10	2.1		Formalise & Strengthen the offer of listening discussions in line with LtP Regulations	Person Centred Care	4/1/2026	9/18/2028	644 days	0%	Important			Claire Appleton	
11	2.2		Enhance outward facing resources to emphasise service user needs and communication preferences	Person Centred Care	7/18/2025	3/31/2026	183 days	100%	Urgent			Leanne Hawker	
12	2.3		Collaborate with teams to promote compassionate, open & transparent communication	Person Centred Care	6/2/2025	3/31/2028	740 days	10%	Medium			Kate Blackmore	
13	**2.4**		**Develop educational resources focussed on the impacts of compassionate communication**		**4/1/2025**	**3/31/2026**	**261 days**	**100%**	**Medium**				
14	2.4.1	People & Culture Plan	Increase content of communication training packages with essential skills team	Person Centred Care	4/1/2025	3/31/2026	261 days	100%	Important			Jo Kelso	
15	2.5		Explore the development of a compact with the public to outlines how we will engage and communicate with service users	Person Centred Care	4/1/2025	9/30/2026	392 days	95%	Important			Leanne Hawker	
16	**3**		**Hearing our Citizens voice**		**4/1/2025**	**3/31/2028**	**784 days**	**23%**	**Medium**				
17	3.1		Develop and enhance PROMs/PREMs to balance against clinical outcomes.	Value Based Health Care	4/1/2025	3/31/2028	784 days	50%	Important			Leanne Hawker	
18	3.2	Timeline extended	Expand and embed annual review of actions taken to improve services based on user voices	Person Centred Care	1/5/2026	4/30/2026	84 days	100%	Medium			Kate Blackmore	
19	3.3	CMT	Through CMT workstreams Develop Data linkage and new metrics to better understand our service user experiences	Person Centred Care	4/1/2025	9/30/2026	392 days	0%	Urgent			Leanne Smith	
20	3.4		Provide insights from People & Community Networks to improve the personal value of our population	Value Based Health Care	4/1/2025	3/31/2028	784 days	0%	Medium			Fiona Maclean, Leanne Hawker	
21	**4**		**Community Involvement**		**4/1/2025**	**3/31/2028**	**784 days**	**11%**	**Medium**				
22	4.1		Continue to review and develop opportunities to provide employment and volunteer opportunities to the people of Wales	Value Based Health Care	4/1/2025	3/31/2028	784 days	0%	Medium			Sara Mills	
23	**4.2**		**Community Network Growth**		**6/2/2025**	**3/31/2027**	**478 days**	**30%**	**Medium**				
24	4.2.1		Expand network to ensure it is representative of diverse communities	Person Centred Care	6/2/2025	3/31/2027	478 days	30%	Medium			Leanne Hawker, Kathryn Cobley	
25	**5**		**Capacity**		**4/1/2025**	**3/31/2028**	**784 days**	**0%**	**Medium**				
26	5.1	People & Culture Plan	Build effective partnerships to coproduce and collaborate on key initiatives	Leadership & Governance	4/1/2025	3/31/2028	784 days	0%	Medium			Sara Mills, Kate Blackmore	
27	**6**		**Quality Governance**		**4/1/2025**	**3/31/2028**	**784 days**	**37%**	**Medium**				
28	6.1		Grow partnership relationships with quality leaders to create an environment of continuous improvement	Leadership & Governance	4/1/2025	3/31/2028	784 days	0%	Medium			Kate Blackmore, Christopher Evans, Penny Durrant	
29	**6.2**		**Embed Health & Care Quality Standards into monitoring & evaluation processes**		**4/1/2025**	**1/28/2027**	**478 days**	**19%**	**Medium**				
30	6.2.1		Review Quality dashboards and assessments to align with Health & Care Quality Standards	Leadership & Governance	4/1/2025	1/28/2027	478 days	0%	Medium	31FF		William Clarke	
31	6.2.2		Develop Monitoring and Governance arrangements	Leadership & Governance	9/2/2025	9/30/2026	282 days	0%	Medium			Kate Blackmore	30FF
32	6.2.3		Develop evaluation matrix through Simply Do portal	Leadership & Governance	6/30/2025	2/27/2026	175 days	100%	Important	56SF		Christopher Evans	
33	6.3		Integrate Impact Assessments into proportionate, user-centred and digitally enabled framework	Leadership & Governance	4/1/2026	3/31/2027	261 days	0%	Medium			Kate Blackmore, William Clarke, Kathryn Cobley	
34	**6.4**		**Embed assessments at every level of improvement and transformation**		**8/1/2025**	**3/31/2026**	**173 days**	**100%**	**Medium**				
35	6.4.1		Align QA and QI as part of quality hub	Leadership & Governance	10/1/2025	3/31/2026	130 days	100%	Important	55SF		Christopher Evans	
36	6.4.2		Design processes for de-implementation	Leadership & Governance	8/1/2025	10/31/2025	66 days	100%	Low			Christopher Evans	
37	6.4.3		Create Governance Documentation for Improvement	Leadership & Governance	11/3/2025	2/27/2026	85 days	100%	Medium	56FS		Christopher Evans	
38	**6.5**		**Datix Recovery & Improvement Plan**		**4/1/2025**	**3/31/2027**	**522 days**	**62%**	**Medium**				
39	**6.5.1**		**Enhance the governance and configuration of Datix Cymru**		**4/1/2025**	**8/31/2026**	**370 days**	**57%**	**Medium**				
40	6.5.1.1		Develop Governance Forums	Leadership & Governance	4/1/2025	3/31/2026	261 days	100%	Important			Kate Blackmore	
41	6.5.1.2		Review and update Datix Recovery and Improvement Plan in collaboration	Leadership & Governance	9/1/2025	12/31/2025	88 days	100%	Medium			Tracey Thomas	
42	6.5.1.3		Develop change logs and configuration definitions	Leadership & Governance	9/1/2025	8/31/2026	261 days	0%	Medium			Tracey Thomas	
43	6.5.2		Provide accessible training materials and guides to support our teams	Leadership & Governance	4/1/2025	9/30/2026	392 days	80%	Important			Tracey Thomas, Jo Kelso	
44	**6.5.3**		**Turn data to knowledge through accessible dashboards providing thematic intelligence to support continuous improvement**		**7/1/2025**	**3/31/2027**	**457 days**	**53%**	**Medium**				
45	6.5.3.1		Create Capacity to support development of datix dashboards	Leadership & Governance	7/1/2025	3/31/2026	196 days	100%	Important			Kate Blackmore	
46	6.5.3.2		Explore digital innovation to support thematic intelligence	Leadership & Governance	1/1/2026	3/31/2027	325 days	25%	Low			William Clarke, Tracey Thomas	
47	**7**		**Quality Control**		**4/1/2025**	**3/31/2028**	**784 days**	**55%**	**Medium**				
48	7.1	QPM Steering Group	Through QPM Steering Group we will support all teams to assess their quality management systems	Quality Management Systems	4/1/2025	5/29/2026	304 days	64%	Medium			Hugh Bennett	
49	7.2		Develop processes to support 'double loop' learning to support innovation and transformation	Quality Management Systems	4/1/2026	3/31/2028	523 days	50%	Important			Christopher Evans, Hugh Bennett	
50	**8**		**Quality Improvement**		**4/1/2025**	**4/1/2026**	**262 days**	**75%**	**Medium**				
51	8.1		Develop Organisational Improvement Methodology around IHI principles	Quality Management Systems	4/1/2025	5/1/2025	23 days	100%	Medium			Christopher Evans	
52	8.2	Timeline extended;JMTP Link	Build Capacity & Conditions for our people to balance change management principles with QI methodology	Quality Management Systems	7/1/2025	3/31/2026	196 days	27%	Medium			Christopher Evans	
53	8.3	Timeline extended	Provide and support Quality Improvement Training including data analysis for our people	Quality Management Systems	4/1/2025	3/31/2026	261 days	68%	Medium			Christopher Evans	
54	8.4		Develop Skills for our people at all levels to become Empowered to drive change and improvement	Quality Management Systems	1/1/2026	4/1/2026	65 days	90%	Medium			Christopher Evans	
55	8.5		Develop Systemic View of Quality Improvement Methodology to support co-production	Quality Management Systems	4/1/2025	3/31/2026	261 days	100%	Important			Christopher Evans	35SF
56	8.6		Develop systems to demonstrate the impact of improvements	Quality Management Systems	6/2/2025	10/31/2025	110 days	100%	Important			Christopher Evans	37FS, 32SF
57	**9**		**Quality Assurance**		**4/1/2025**	**3/31/2028**	**784 days**	**37%**	**Medium**				
58	9.1		Support teams to develop clear Quality Statements that describe what quality means for each of our functions	Quality Management Systems	5/14/2025	5/29/2026	273 days	100%	Medium			William Clarke	
59	9.2		Support teams to undertake Quality Assurance Self Assessment to support the development of robust quality management systems	Quality Management Systems	5/14/2025	9/30/2026	361 days	60%	Medium			William Clarke	
60	9.3		Support and guide the development of information & intelligence data to monitor our services in line with H&C Quality Standards 2023	Quality Management Systems	6/16/2025	3/31/2027	468 days	43%	Important			Kate Blackmore	
61	9.4		Measure outcomes that matter to people using data and intelligence to drive innovation	Value Based Health Care	4/1/2025	3/31/2028	784 days	0%	Medium			Kate Blackmore, Hugh Bennett	
62	**10**		**Quality Planning**		**4/1/2025**	**3/31/2028**	**784 days**	**0%**	**Medium**				
63	10.1		Embed co-production and lived experience methodologies within our planning design principles	Value Based Health Care	4/1/2025	3/31/2028	784 days	0%	Medium			James Houston	
64	10.2		Support the review of the long term strategy through a quality lens	Quality Management Systems	1/1/2027	3/31/2028	326 days	0%	Important			Kate Blackmore, James Houston	
65	10.3		Support the development of Directorate Plans to include QPMF improvement workplans and use of H&C Quality Standards	Quality Management Systems	10/1/2026	3/31/2027	130 days	0%	Medium			James Houston	
66	10.4		Foster a collaborative relationship with the JCC's Quality & Safety committee	Commissioning & Monitoring	11/3/2025	3/31/2028	630 days	0%	Important			Kate Blackmore, Hugh Bennett, Claire Appleton	

Effort	Effort completed	Effort remaining	Milestone	Notes	Completed
				Whilst the implementation team recognise the need to embed population health principles in all organisational decision making, with a particular focus on ensuring these principles are part of any changes, new plans or impact assessments, a lack of capacity and dedicated public health expertise is a significant	
32792 hours	**0 hours**	**32792 hours**	**No**	**barrier.**	
12544 hours	**0 hours**	**12544 hours**	**No**	**Increase organisational awareness, understanding and application of health inequalities and prevention principles across all directorates to support equitable care, improved population health outcomes, and fulfilment of the Duty of Quality.**	
12544 hours	0 hours	12544 hours	No	Theme of WASTQ expected to focus on the determinants of health, health inequalities and the implications for the whole organisation.	0/7
20248 hours	**0 hours**	**20248 hours**	**No**		
12544 hours	0 hours	12544 hours	No		
				As part of LTS development work has commenced to undertake strategic intelligence gathering including a PESTLE analysis of external factors. This will include a review of long term demographic and population data. Further discussion required regarding the requirement and approach to undertake a population	
1408 hours	0 hours	1408 hours	No	health needs assessment at an organisational level.	
				Maintain and enhance WAST's participation in national population health and health inequalities forums, including the AACE Reducing Health Inequalities Group, to influence policy, share learning and promote the ambulance sector's contribution to improving population health and reducing inequity across the	
24 hours	0 hours	24 hours	No	wider health and care system	0/4
6272 hours	0 hours	6272 hours	No		0/5
17760 hours	**7123.2 hours**	**10636.8 hours**	**No**		
5152 hours	0 hours	5152 hours	No	newregulations require the formal delivery of listening discussions by 1st April,with preparatory work needing to start immediately despite the lack of detailedstatutory guidance with the expectation that the process will mature over time.	
				Refreshed WAST resources and platforms, provision of easy read and pictorial information for those with learning disabilities, Recite Me contract renewed to enable BSL and other languages to be available to convert information on Trust websites. BSL videos also made available and large print. Bespoke children's	
1464 hours	1464 hours	0 hours	No	resources also available. Bereavement materials are complete and about to be printed.	2/2
5920 hours	592 hours	5328 hours	No		1/1
2088 hours	**2088 hours**	**0 hours**	**No**		
				Essential skills team has been increasing content available through Learn 365, focusing on individuals lacking prior educational achievement in communications, such as those without GCSE English or Welsh. The team provides specialist input, particularly targeting ACs and EMTs with identified gaps. The team was fully established as of 1 December, now offering resources and support in both	
2088 hours	2088 hours	0 hours	No	English and Welsh. Digital learning package now live containing 2 items "embedding civility in how we work and communicate" and "short guide to writing effective, civil and compassionate emails". This package will be expanded as part of ongoing educational plans including a multi-generational package which is currently in development for release during Q1 of 2026.	4/4
3136 hours	2979.2 hours	156.8 hours	No	Linked to IMTP deliverable The compact has been drafted. Final progress is pending feedback from Estelle to ensure alignment with related place-based work. A meeting to finalise this is scheduled for April. Delivery remains planned for September, and timelines are not currently at risk.	2/2
22624 hours	**3808 hours**	**18816 hours**	**No**		
				PREM for Ambulance Care in place with continued monitoring. Discussions to progress on other PREMs for other service areas ongoing. 04/03/26 - A combined approach using FFT with additional specific questions is in place. The main gap identified is organisational awareness and promotion of the PREM, rather	
6272 hours	3136 hours	3136 hours	No	than development of the tool itself. Further progress is expected once SMS functionality is live, enabling wider rollout. This deliverable is not due for completion in the current financial year.	1/1
672 hours	672 hours	0 hours	No	Annual review of actions takes please as part of the terms of reference for QMG and will form part of year end activity, with assurance reporting through to CQGG. Annual review scheduled through cycle 34 (April 26) Review completed and reported to CQGG as part of cycle 34 activity.	1/1
				Confidence for delivering system level data linkage by current delivery date is low (Amber to red) with internal progress stronger than external due to lack of two way data sharing and legal mechanisms to facilitate reciprocal data sharing. DHCW is leading the national data sharing initiative, WAST teams have	
3136 hours	0 hours	3136 hours	No	completed requirements but broader system level linkage relies on DHCW progress.	0/2
12544 hours	0 hours	12544 hours	No		
13920 hours	**2294.4 hours**	**11625.6 hours**	**No**		
6272 hours	0 hours	6272 hours	No		
7648 hours	**2294.4 hours**	**5353.6 hours**	**No**		
7648 hours	2294.4 hours	5353.6 hours	No	Review of Network undertaken, promotion paused due to capacity within the team.	
12544 hours	**0 hours**	**12544 hours**	**No**		
				Work to date has included the creation of a leadership community, which emerged from recent symposiums and essential conversations sessions. This community is intended to facilitate sharing of learning, collaboration, and communication among leaders. Partnerships have also been strengthened with trade	
12544 hours	0 hours	12544 hours	No	union partners, the culture champions network, and a range of active staff networks, which have grown significantly over the past year. Senior colleagues are increasingly engaging with these networks to gain insight and feedback, supporting more inclusive and well-rounded decision making. Additionally, collaboration with lived experience advisors and cross-team partnerships has been emphasised to ensure diverse perspectives inform organisational initiatives.	0/1
48964.8 hours	**11816.8 hours**	**37148 hours**	**No**		
18816 hours	0 hours	18816 hours	No		
7480 hours	**1400 hours**	**6080 hours**	**No**		
3824 hours	0 hours	3824 hours	No		
2256 hours	0 hours	2256 hours	No		
				User-estimated benefit statements, describing solution impact according to Health and Care Quality standards, have been designed for initial improvement triage. High tier improvements are subsequently reviewed by a Project Board of senior advisors, and a benefits realisation matrix is used to validate key impact	
1400 hours	1400 hours	0 hours	No	areas, including: strategic alignment; patient impact; feasibility; cost/benefit; staff engagement; and data availability.	1/1
				Develop and implement an integrated impact assessment approach that aligns Quality Impact Assessments, Equality Impact Assessments and Health Impact Assessments into a proportionate, user-centred and digitally enabled framework, supporting consistent decision-making, reducing duplication, and ensuring	
6264 hours	0 hours	6264 hours	No	consideration of quality, equity and population health impacts across the organisation.	0/6
2248 hours	**2248 hours**	**0 hours**	**No**		
1040 hours	1040 hours	0 hours	No	QI&A dual-stream reporting & process evaluation is now framed within a Quality Management System that incorporates portfolios of accountability, key performance metrics, and robust governance routes.	1/1
				Granular systems design, with a QMS lens and Improvement Cymru frame of reference, now streamlines continued evaluation of process maturity, process workflow, identification of key pinch-points, improvement opportunities and system planning cycles; facilitating the identification and de-implementation of	
528 hours	528 hours	0 hours	No	unreliable and unstable processes.	
680 hours	680 hours	0 hours	No	A new QI&A policy framework now supports decision-making and standardises Quality delivery, scrutiny, and reporting.	3/3
14156.8 hours	**8168.8 hours**	**5988 hours**	**No**		
4880 hours	**2792 hours**	**2088 hours**	**No**		
				31/03/26 - CQGG approached for possible parent group having failed to identify an alternative governance route. CQGG effectiveness and sub-groups currently under discussion and corporate governance will now explore parent group options. ToR have been submitted to CQGG and further discussion is now	
				expected in April. Forum is operational with agreed Terms of Reference and meeting monthly. Approval route complexities acknowledged. Task agreed to be closed with ongoing iterative improvement. 04/02/26 - Timeline extended to ensure parent group for Datix Governance Group is resolved prior to	
				confirmation of completion. Datix User Group and Datix Governance Group established with Terms of Reference and regularly scheduled meeting schedule. Parent Group currently creates a risk following the closure of SQT, engagement with Digital directorate for an appropriate linkage point has proved	
2088 hours	2088 hours	0 hours	No	unsuccessful at this time - work ongoing to resolve.	1/1
704 hours	704 hours	0 hours	No	Updated content added to Datix Recovery and improvement plan with monitoring now built in to Datix Governance Group agenda items.	1/2
				Changes logs are being maintained manually by the Datix System lead team to track system changes, especially those not auditable through the system. Work continues to update and clearly define profiles with descriptions outline the permissions provided. A definition document is being created to specify what	
2088 hours	0 hours	2088 hours	No	each profile provides and the associated SQL, ensuring transparency and mitigating risks related to hidden data.	1/2
				04/03/26: Core training materials are in place and have been delivered. However, ongoing Datix recovery work and quarterly system upgrades mean materials require regular updating. The group agreed this should be treated as a point-in-time deliverable, with future changes managed as continuous improvement.	
				Timelines may be reprioritised, but there is still time within the current plan period. 04/02/26: Timeline should be deferred beyond the original completion date. Quarterly system upgrades, capacity of key stakeholders and the implications of the Listening to People regulatory change are impacting on ability to	
				deliver within timeframe. Priority of deliverable should be reviewed as lack of national regulatory guidance for 'Listening to People' system upgrades will now take precedence. Datix System Lead efforts to provide accessible training	
				materials and guides. Processes	
				have been streamlined for accessing bite size training via Learn 365, and that	
				relevant narratives are being included in systems like MIST and datix. Feedback received regarding safeguarding that, despite improvements, narrative	
2508.8 hours	2508.8 hours	0 hours	No	quality remains an issue, possibly due to confusing subject matter. Education content will be monitored for quality improvements following interventions and approach revisited if necessary.	4/4
6768 hours	**2868 hours**	**3900 hours**	**No**		
				Capacity within the Quality Assurance team has been improved through recruitment of vacant posts and through utilising underspend in pay to increase Datix system capacity through bank contract in order to achieve deliverables. Delays in delivering centralised access to Datix intelligence has impacted the	
				delivery of expected dashboards but engagement continues between quality and digital directorate to resolve this. Capacity has been created through recruitment and role redesign. Remaining issues relate to data access (semantic environment), not capacity. Consideration given to closing the task. 07.04.26 - OCP	
				work is approaching conclusion which will develop further capacity within Datix system and intelligence capacity for Quality Governance. Semantic environment for feedback and incidents has been delivered but technical challenges create limitations in the refresh rate. Work to move to databricks data solution is	
1568 hours	1568 hours	0 hours	No	now commencing with the feedback and incidents modules prioritised before additional modules are added.	2/3
5200 hours	1300 hours	3900 hours	No		0/2
8708 hours	**3648.48 hours**	**5059.52 hours**	**No**		
				9/14 self assessments completed and presented to steering group. P&C/F&C drafts have been received and will be presented to steering group in April 26 bring completion to 78%. 3 areas of operation are outstanding. Expect to complete self-assessments, governance maps and scorecards for all of the Trust in	
2432 hours	1556.48 hours	875.52 hours	No	26/27.	1/1
6276 hours	2092 hours	4184 hours	No	Requested initial meeting with Chris to start looking into this.	1/1
7328 hours	**3648.2 hours**	**1864.8 hours**	**No**		
184 hours	184 hours	0 hours	No	QI processes, and accompanying policies, are now framed by the Improvement Cymru model, situated within a Quality Management System.	
				Integration of organisational methodologies Collaboration between the quality improvement team and the change management team is ongoing, with both groups recognizing the importance of integrating change management principles with quality improvement methodology. While the change management	
1568 hours	423.36 hours	1144.64 hours	No	team is fully on board and eager to collaborate, progress has been delayed due to scheduling challenges. The plan is to meet and develop a wraparound approach, with the expectation that once discussions take place, the process will move quickly and be completed by the end of the financial year.	1/2
				Faculty systems and processes are developed with the team undertaken CET development to support the quality of education delivered. Formal training sessions will be delivered after internal readiness is achieved. Coaching and mentoring using improvement principles is already active however formal training	
2088 hours	1419.84 hours	668.16 hours	No	will only be marked as complete once initial training courses have been delivered and evaluated. Formal QI training is expected to take 12-18 months to deliver and the delivery dates have been extended to reflect this timeline.	4/5
				Refresher planning cycles and QI register now designed and populated. Delivery of refresher training delayed due to long-term sickness (x2), with consequent reduction in team capacity. Discussions with the Workforce, Education & Development team are ongoing, with 'fast-track' CET training planned to mitigate	
520 hours	468 hours	52 hours	No	absenteeism impact going forward.	0/1
				QI&A now employs a systems approach, supporting and connecting multiple organisational sub-systems and their respective assurance mechanisms. A purpose statement - including mission, vision, values, pillars, and key metrics - cements the team offer and provides a template for organisational scope and	
2088 hours	2088 hours	0 hours	No	trajectory, processual accountability, and directorate co-production.	2/2
				A new Quality Management Systems approach with - standardised benefits realisation matrices, tiering and accountability of improvement support needs, solution alignment with Health and Care Standards, national data collection and reporting mechanisms - collectively maximise potential spread and impact of	
880 hours	880 hours	0 hours	No	improvement activity.	6/6
20188.56 hours	**5314.4 hours**	**14874.16 hours**	**No**		
1965.6 hours	1965.6 hours	0 hours	No	02/06/26 Operations: All complete Corporate: 24 Complete with final 3 in progress with timescales provided and work underway.	1/1
				02/06/26: Operations: The same 4 EMS ones from last time are 'completely complete', Ambulance Care and EPRR have completed assessments but assessments and reviews not been to QMG yet, 111 & CSD both partially complete and no work been done for a while due to PTR Recovery, Volunteers hadn't started	
				at the last reminder, EMSC not started and were not expecting to due to PTR Recovery Corporate: 12 'completely complete', 3 completed assessments but assessments and reviews not been to QMG yet, 2 in progress with suggestions for additions before beginning reviews, 5 more services are engaging but not	
1934.96 hours	1732.8 hours	202.16 hours	No	complete yet , 3 teams are engaging but no progress reported.	1/2
				02/06/26 - Data bricks data across all modules now landing in data warehouse, error reporting and quality assurance work requried before transition to semantic environment for self serve reporting. Updated QA dashboard has been QA'd by IDS minor tweaks required before publication. Previous update: Quality	
				assurance dashboard updates and enhancements commenced with this increased insight being shared informally through QMG. Delivery of this information and intelligence data is dependent on access to intelligence through semantic environments and linkages to IDS capacity. Datix feedback and incidents	
3744 hours	1616 hours	2128 hours	No	module semantic environment created with caveats.	
12544 hours	0 hours	12544 hours	No	Create a quality outcome framework, bringing together patient impact, experience, clinical outcomes, productivity and workforce measures	0/2
27648 hours	**0 hours**	**27648 hours**	**No**		
6272 hours	0 hours	6272 hours	No		
5216 hours	0 hours	5216 hours	No		
1040 hours	0 hours	1040 hours	No	Work has commenced to review internal planning processes including the refresh of directorate level planning. Work to incorporate wider organisational plans is included in phase 2 due to commence from Q3.	
15120 hours	0 hours	15120 hours	No	Governance inside JCC currently unclear.	

Checklist items	Sprint	Goal
Support managers and quality leads to consider impacts;Establish an annual Health Inequalities and Prevention Awareness campaign;Share local and national data, patient stores and lived experience feedback;Promote understanding of groups experiencing poorer health outcomes;Incorporate health inequalities, pr	Backlog	
	Backlog	
	Backlog	
Use intelligence, evidence and system learning to inform organisational priorities;Strengthen collaboration with NHS Wales Partners, PHW etc to identify opportunity to reduce inequity;Share learning, innovation and evidence from WAST and partner orgs to support pop health practice;Identify and maintain WAST r	Backlog	
Use population intelligence from local and national partners to support our work;Implement a phased approach to expanding data linkage and population health analytical capability;Produce actionable intelligence and evaluation evidence to inform service development.;Embed health inequalities considerations wi	Backlog	
	Backlog	
Bereavement materials expected to be approved by end march and printed in April;All Trust Outward facing resources available in language/format of choice	Backlog	
WASTQ Theme July 2025	Backlog	
Develop general workplace communication resources for deployment via self service on Learn365;Arrange workshop to deliver suggested learning package exploring content from WASTQ;Review Compassionomics and Civility Saves Lives to inform bitesize learning;Develop digital learning package on compassionate	Backlog	
Reviewing draft compact with expectations of LLais;Draft compact developed with input from public network members.	Backlog	
PREM for CMP in use	Backlog	
original timeline 05/01/2026 to 31/03/26	Backlog	
external - system level data linkage is lagging due to vague initial planning and lack of 2way data;internal - connecting 111, 999 and EPCR data to an intelligence set is progressing	Backlog	
	Backlog	
	Backlog	
	Backlog	
Social partnership events with focus on collaboration & compassionate practices	Backlog	
	Backlog	
	Backlog	
	Backlog	
Recruit RI&I Lead	Backlog	
Embed the integrated assessment process within governance, planning and service improvement programe;Explore and implement digital solutions;develop unified impact assessment methodology;Establish a framework for incorporating HIA into organisational decision making;Identify opportunities for alignment,	Backlog	
Define QA metric for QI processes	Backlog	
	Backlog	
Mapping;Team purpose;Portfolio Planning	Backlog	
Timeline extended until end of Qtr 4 to allow governance routes to be resolved.	Backlog	
Datix workshop completed on 7th September 2025 reviewing the existing plan and identifying improveme;Update the plan with new activity	Backlog	
Original timeline 01.09.25 - 31.03.26;completion of profile work expected to extend beyond end of fiscal year	Backlog	
Timeline for delivery deferred to end Qtr 2;Reprioritised from Urgent to Important due to priority of regulation changes;Training videos created by system lead and content leads;Bitesize training sessions scheduled and advertised.	Backlog	
Semantic Environment;Information & Intelligence Manager recruited and utilised;Bank capacity recruited and utilised	Backlog	
Quality Assurance dashboard linked to incidents and feedback modules developed and released;Powerapp to monitor workload and identify experiential feedback	Backlog	
original timeline 01.04.25 - 31.03.26	Backlog	
original timeline due to start on 01/04/25 - deferred to start April 26	Backlog	
	Backlog	
Timeline extended to complete by end of Q4 25 from end of Q3 25;Change management/QI plan	Backlog	
Original timeline expected to complete 31/12/25 extended to include CET requirements;Populate Q hub with training materials (aligned to IC framework;Complete faculty plan;Allocate leads to Improvement Cymru stages;Start WAST L3 & L4 training for QI team	Backlog	
Offer training update to QI support team	Backlog	
Purpose statement (mission, values, pillars etc.);Deep dive QI mapping	Backlog	
MS Forms solution for Volunteer access to SimplyDo;Create risk & lessons learnt register;QI reporting platform (LifeQI & Power BI);Personalised portfolios (accountability);Align core objectives and measures to organisational strategy;Develop benefit realisation matrix (light)	Backlog	
Original timeline expected by 31/12/25 this has been extended to support engagement with teams	Backlog	
Align with H&C standards to provide team level H&C standard assessment;original timeline extended from 31/03/26	Backlog	
	Backlog	
Assess and develop balanced score cards based on impact and feedback;QOF T&F Group	Backlog	
	Backlog	
	Backlog	
	Backlog	
	Backlog	

Agenda Item No.	8

REPORT TITLE

Monthly Integrated Quality Performance Report – June 2026

MEETING

Name of meeting	Quality, Patient Experience and Safety Committee
Date of meeting	6 August 2026
Public or Private	Public
If private - rationale	Choose item from below

REPORT SPONSOR

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

PURPOSE OF REPORT

☐ Approval	☐ Endorsement
☒ Assurance	☒ Discussion
☐ Information (goes in consent items)	☐ Noting

REPORT SUMMARY:

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

1. The purpose of this report is to provide senior decision makers in the Trust with an integrated dashboard (Our Patients, Our People, Value and Partnerships/System Contribution) focused on the "vital few" key metrics. This report is for **June2026.**

2. The integrated dashboard identifies that Arrest performance remains within the expected target range, while Emergency and Orange (Now) performance continue to indicate that the current system is not yet capable of consistently achieving the required standards. For the committee specific metrics, Stroke and STEMI call-to-door times also remain significantly above the required standard, reflecting the wider pressures across ambulance response and hospital handover. There were 31 catastrophic patient safety incidents in June but completed investigations continue to demonstrate that the overwhelming majority result in No Harm or Low Harm outcomes; however, there remains a significant level of coroner activity.

3. The Trust has re-established the Call Categorisation Task & Finish Group, that delivered phases one and two of the Ambulance Performance Framework, with a focus on patient flow optimisation through the new clinical model. Particular areas of focus include: the management of breathing difficulties, potential over triaging into Orange (Now), Clinical Navigator processes and capacity, call to door times, dispatch optimisation and time on scene. The aim is to make changes no later than 30 November, linked to the Trust's winter plan.

4. Hospital handover performance has improved materially compared with the same period last year, with 13,813 hours lost in June 2026 compared with 15,278 in June 2025. This is welcome progress, but performance remains significantly above the level the Trust's operating model is designed to cope with i.e. half this number of lost hours. The application of W45 should see a level of hospital handover lost hours of 6,000 to 7,000 hours, depending on the level of conveyance.

5. The work of the Call Categorisation Task & Finish Group and the application of W45 pan-Wales are the core responses to improving patient safety in the 999/emergency ambulance care pathway, along with enhanced reporting through the Trust Board and committee specific MIQPRs, with further work required to bring reporting of concerns, patient experience and NRIs over 365 days on line for the next iteration of this report.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

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

1. **Consider the June 2026** Integrated Quality and Performance Report and actions being taken and determine whether:
    a. The report provides sufficient assurance.
    b. Whether further information, scrutiny or assurance are required, or
    c. Further remedial actions are to be undertaken through Executives.
    d. Note the additional metrics included and the additional work that will continue with Directors to refine the QUEST committee specific metrics.

ADDITIONAL PAPER(S)

Set out here any annexes. See writing and presentation guidance here regarding materiality and use of the Reading Room

Annex 1 - Monthly Integrated Quality and Performance Dashboard

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [link to objectives and what good looks like]	
☒ SO1: Providing the right care or advice, in the right place, every time	☒ SO2: Enabling our people to be the best they can be
☒ SO3: Being at the forefront of innovation and technology	☒ SO4: Developing services in collaboration
☒ SO5: Being quality driven and clinically led	☒ SO6: Delivering exceptional value

RISK(S) THIS REPORT MITIGATES

Where relevant note the local, directorate, corporate or BAF risk number
223 - The Trust's inability to reach patients in the community causing patient harm and death 224 - Handover of Care Delays Outside Accident and Emergency Departments Impacts on Access to Definitive Care Being Delayed and Affects the Trust's Ability to Provide a Safe & Effective Service for Patients 100 - Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

Quality Domains (select all that apply) [link to standards]		
☒ Safe	☒ Timely	☒ Effective
☒ Efficient	☒ Equitable	☒ Person Centred
Quality Enablers (select all that apply) [link to standards]		
☒ Leadership	☒ Workforce	☒ Culture
☒ Information	☒ Learning Improvement and Research	☒ Whole Systems Approach

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [link to goals]		
☒ A socially responsible employer	☒ An innovative and sustainable organisation	☒ A pro-active, accessible and equitable care provider
☐ n/a	☐ n/a	☐ n/a

IMPACT ASSESSMENTS FOR CONSIDERATION

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

Does this paper require an impact assessment	☒ No ☐ Yes
If yes, what impact assessment is attached	

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
29 Jul-26	Hugh Bennett – Assistant Director Commissioning & Performance

SITUATION

1. The purpose of this report is to provide the QuEST Committee with the Trust's performance scorecard (the same one that goes to Trust Board) to give an overall view on the Trust's performance, and then committee specific metrics. This report is for **June 2026.**

2. This is the first iteration of a QUEST committee specific MIQPR.

BACKGROUND

3. The MIQPR continues to evolve. This iteration, the first QUEST committee specific MIQPR, includes graphs for the Trust Board metrics, where QUEST is the lead committee and additional graphs for metrics that are specific to the committee. Some metrics are still under development, with the expectation that these will be resolved through the next cycle of reporting. Further discussions will continue with Directors to finalise this set of metrics and Committee will be asked to confirm and approve at its next meeting.

4. The report includes trajectories for a number of measures; in the same way Trust Board has received. These should be regarded as an early iteration intended to support oversight and discussion, with further refinement expected as the underlying modelling matures.

5. Trajectories are not yet included for the operational time-based response metrics e.g. call to door times. These measures are more complex to model and require a longer period of stable data from the new clinical model before reliable forecasting can be presented to the Board. The simulation modelling software that supports this is currently being updated.

6. Previous iterations of the MIQPR have included Statistical Process Control (SPC) charts. This version extends their use and introduces a revised presentation to support clearer interpretation by the Committee.

> Statistical Process Control (SPC) charts help distinguish between the normal variation expected within a stable process and signals that performance has changed. The centre line shows average performance, while the upper and lower process limits show the range within which results would usually be expected to fall.

Patterns within the limits indicate common cause variation. Patterns such as a sustained shift above or below the average, a trend, or a single point outside the limits indicate special cause variation and should prompt further consideration.
SPC helps the Board assess not only whether performance is above or below target, but whether the current system is capable of achieving that target consistently. The Board may also wish to consider, through a future development session, whether further time would be helpful to strengthen shared understanding of SPC interpretation.

ASSESSMENT

Our Patients

7. **Clinical outcomes**: stroke and STEMI call-to-door times remained significantly above the required standard in June 2026. This reflects the wider pressures described elsewhere in the report, particularly ambulance response performance and hospital handover delay. Improvement action is being taken through the CMT benefits workstream, in particular, the Call Categorisation Task & Finish Group, to model and improve the component stages of these pathways. The Return to Spontaneous Circulation (ROSC) rate which was 20.3% in June 2026 compared to 22.1% in May 2026, with an underlying upward trend.

8. **Patient Harm:** June 2026 represented a period of increased reporting activity and strong closure performance. Growth in reported incidents was influenced by our critical incident and the heat wave-related operational demand, while focused work through the SOT delivered substantial progress in incident closure rates. Despite an increase in incidents initially assessed as Severe or Catastrophic, completed investigations continue to demonstrate that the overwhelming majority result in No Harm or Low Harm outcomes.

9. **Patient Experience Surveys** metrics are under development. The expansion of experience feedback through SMS surveys across 999 and 111 services is expected to increase response volumes and enhance emotional and thematic analysis. New PREM measures for specific patient cohorts, including CMP patients, are already identifying service improvement opportunities. In addition, the People, Impact and Insight Subgroup is exploring further approaches to

capturing patient experiences to support service transformation and benefits realisation.

10. **Nationally Reportable Incidents / Concerns Response**: During June 2026, the Trust reported two Nationally Reportable Incidents (NRIs). Work continues to develop the Beacon Measure for NRIs open beyond 365 days, with progress dependent upon IDS capacity. The implementation of the revised Concerns Regulations on 1 April 2026 represents a significant change to the statutory reporting framework. The Trust is awaiting the publication and confirmation of final national KPI definitions, which will inform future performance reporting and benchmarking arrangements.

11. **Joint Investigation Framework / Duty of Candour**: in June 2026, 15 serious patient safety incidents were referred to health boards under the Joint Investigation Framework and Duty of Candour was enacted on one occasion.

12. **Coroners:** June 2026 saw sixteen Coroner requests, the lowest monthly figure reported across the past two years. This represents a continued reduction from previous months and contributes to a strong downward trend throughout 2026.

13. **Safeguarding:** In June 2026, combined safeguarding activity totalled 596 reports, representing the highest overall safeguarding reports seen across the past two years. Despite this significant increase, both Child Safeguarding and Adult at Risk reporting-maintained compliance levels above 90%.
The Beacon Measure for Level 1 training compliance is under development.

RECOMMENDATION

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

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

Monthly Integrated Quality & Performance Report

June 2026
Annex 1 – Top Indicator Dashboard

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

Annex 1 – Top Indicator Dashboard
Version 1.0
July 2026

by Commissioning & Performance Team

Delivering on our Strategic objectives

Overall strategic objective profile

STRATEGIC OBJECTIVE	DESCRIPTOR	RED	AMBER	GREEN	TBD	MOA
SO1 – Our Patients	Significant performance challenges	8	2	4	2	0
SO2 – Our People	Mixed performance	2	1	3	0	0
SO3 – Innovation & Digital Transformation	Strong performance	0	0	1	0	1
SO4 – Partnerships & System Contribution	Significant performance challenges	5	0	0	0	1
SO5 – Quality, Safety & Patient Experience	Mixed performance	1	0	1	2	1
SO6 – Finance, Resources & Value	Mixed performance	2	0	2	0	0

The dashboard shows significant performance challenges across Strategic Objectives 1 and 4, with mixed performance across Strategic Objectives 2, 5 and 6, and strong performance in Strategic Objective 3. The most significant challenges currently facing the organisation relate to patient access, operational responsiveness, workforce capacity and wider system flow.

Section 1: Monthly Indicators / Top Indicator Dashboard

Top Monthly Indicators	Ambition 2026/27	Apr-26	May-26	Jun-26	2 Year Average	RAG
Our Patients (SO1&5)						
Return of Spontaneous Circulation (ROSC)	25-30%*	23.9%	22.1%	20.3%	21.6%	R
Stroke Call to Hospital Door Times	01:30	02:35	02:32	02:43	02:28	R
STEMI Call to Hospital Door Times	01:30	02:25	02:46	02:35	02:33	R
NOF Call to Hospital Door Times						
Arrest (Purple) Median	6-8 Minutes*	07:39	07:45	07:42	N/A	G
Arrest (Purple) 90th	<20 Minutes	18:23	18:00	18:20	N/A	G
Emerg. (Red) Median	6-8 Minutes*	09:24	09:12	09:32	N/A	R
Emerg. (Red) 90th	<20 Minutes	22:37	22:39	23:14	N/A	R
Now (Orange) Median	<60 Minutes	01:26	01:22	01:29	N/A	R
Time to Integrated Care RICS 1 90th Percentile	<60 Minutes					
Can't Send & Cancelled by Patient Volumes	<5,770	5,712	6,109	6,288	7,003	A
NHS111 Call Handling Abandonment Rates	<10-15%	18.8%	19.7%	16.1%	12.2%	A
Renal Repeat Cancellation	Zero	0	0	0	N/A	G
Oncology Journeys arriving within 45 mins and up to 15 minutes after appointment time	>70%	73.9%	72.8%	74.5%	76.7%	G
Advanced Discharge & Transfer journeys collected less than 60 minutes after booked time (NEPTS)	>95%	71.6%	72.7%	67.6%	77.8%	R
% of 111 call presented in Welsh, Answered in Welsh	>70%	60.0%	51.3%	58.0%	58.4%	R
National Patient Reported Experience Measure (average overall experience score)	85%					
Concerns Response within 30 Days	>40%					
Enactment of the Duty of Candour Total	100%	67%	100%	100%	N/A	G
National Reportable Incidents reports (NRI)	MOA	2	12	2	5	MOA
Joint Investigation Framework Referrals to HBs	<7	12	10	15	13	R

Top Monthly Indicators	Ambition 2026/27	Apr-26	May-26	Jun-26	2 Year Average	RAG
Our People (SO2)						
% of Under-represented Groups Offered	>7%	55.6%	34.4%	26.70%	N/A	G
EMS Hours Produced (Against Planned)	95%	88%	87%	87%	86.08%	A
Sickness Absence *(all staff)*	<6%*	7.72%	7.62%	7.70%	7.90%	R
Staff Turnover Rate	<10%*	7.87%	8.36%	8.32%	8.10%	G
PADR/Medical Appraisal	>85%	76.52%	74.63%	73.67%	73.96%	R
Statutory & Mandatory Training	>85%	89.40%	89.52%	89.31%	86.78%	G
Finance & Value (SO6)						
Average Jobs per Shift (EA)	>2.3	2.96	3.06	3.02	2.77	G
Average Jobs per Shift (APP)	4.75	2.57	2.59	2.59	2.98	R
NEPTS Activity Cancelled (by CMP, Patients & HBs)	<10%	19.1%	18.3%	19.3%	17.7%	R
Financial balance - annual expenditure YTD as % of budget expenditure YTD	100%	100%	100%	100%	100%	G
Partnerships / System Contribution (SO3&4)						
Number of Patients using Albot	MOA	5,374	5,263	5,286	N/A	MOA
Webchats as a % of Web Site Hits	>1.35%	1.43%	1.51%	1.51%	N/A	G
111 Outcomes (999 & ED)	MOA	16.1%	15.4%	17.0%	19.0%	MOA
Successful Consult & Close Outcome	>22%	19.7%	17.2%	17.1%	17.9%	R
% See & Treat & Alternative pathways (of verified activity)	>20%	10.36%	9.59%	10.03%	10.58%	R
Number of Handover Lost Hours	<6000	13,748	14,057	13,874	17,512	R
Number of Handovers over 45 mins	Zero*	4,534	4,597	4,612	5,562	R
Reduction in Number of Conveyances to ED as % of Verified	30%	33.84%	37.92%	36.90%	35.44%	R

RAG Indicates -

TBD: Status cannot be calculated (To Be Determined)

MOA – Measure of Activity

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)

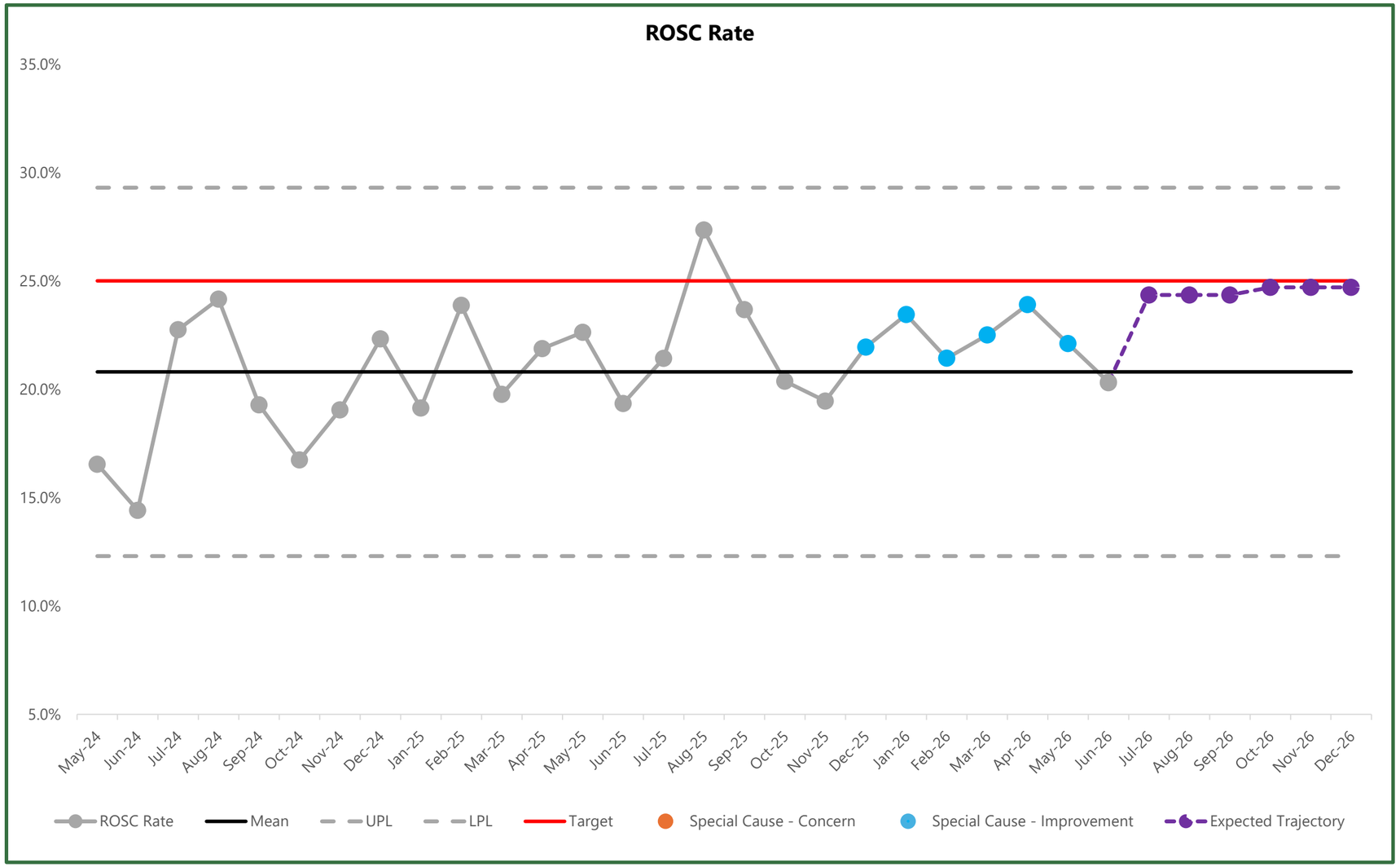
***NHS Wales Performance Framework Measures 26/27 (Feb-26)**

Our Patients

Return of Spontaneous Circulation (ROSC)

Strategic Objective 1

ROSC
R



Analysis

Return of Spontaneous Circulation at hospital (from cardiac arrest) – 20.33% in June 2026.

The ROSC SP chart shows some special cause variation with improvement between December 2025 and May 2026; however, the mean remains below the 25% target, the system and process will not reliably deliver the ambition, and improvement action is required.

Improvement Plans and Actions

The Trust has in place an Improving Out of Hospital Cardiac Arrest Workstream. This includes work on early recognition and call for help, early CPR, early defibrillation, ALS & post resus and data & analytics with all actions rated green(on target) currently, except for data & analytics. This related to data linking between health organisations so that patient outcomes can be understood.

The CMT Benefits Workstream is currently in the process of establishing a Data Linking Task & Finish Group, to help provide increased focus in this area and resolve data linking on the cardiac arrest patient pathway, but also on other key pathways for the Trust. The Director of Commissioning for Ambulance Services & 111 has offered to sit on this T&F to help open doors in the wider health care system. This work of this group is currently paused due to capacity issues, but this is being further considered.

Expected Performance Trajectory

The purple line on the graph shows the predicted trajectory over the next six months, which is expected to rise by 0.25% per quarter and be achieving the target by year end.

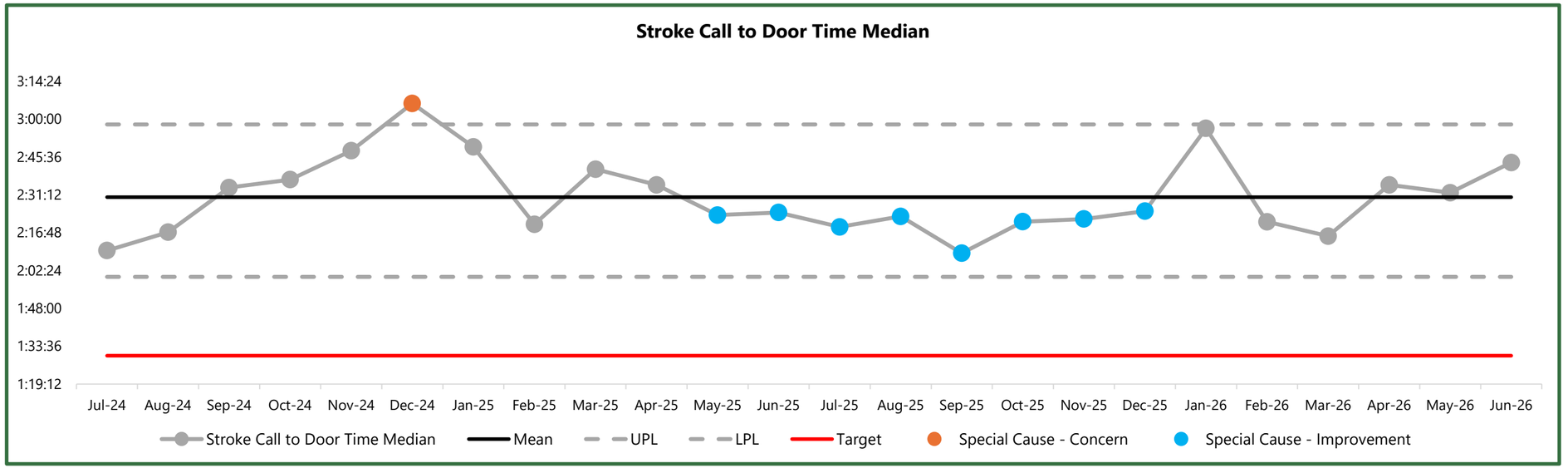
Our Patients

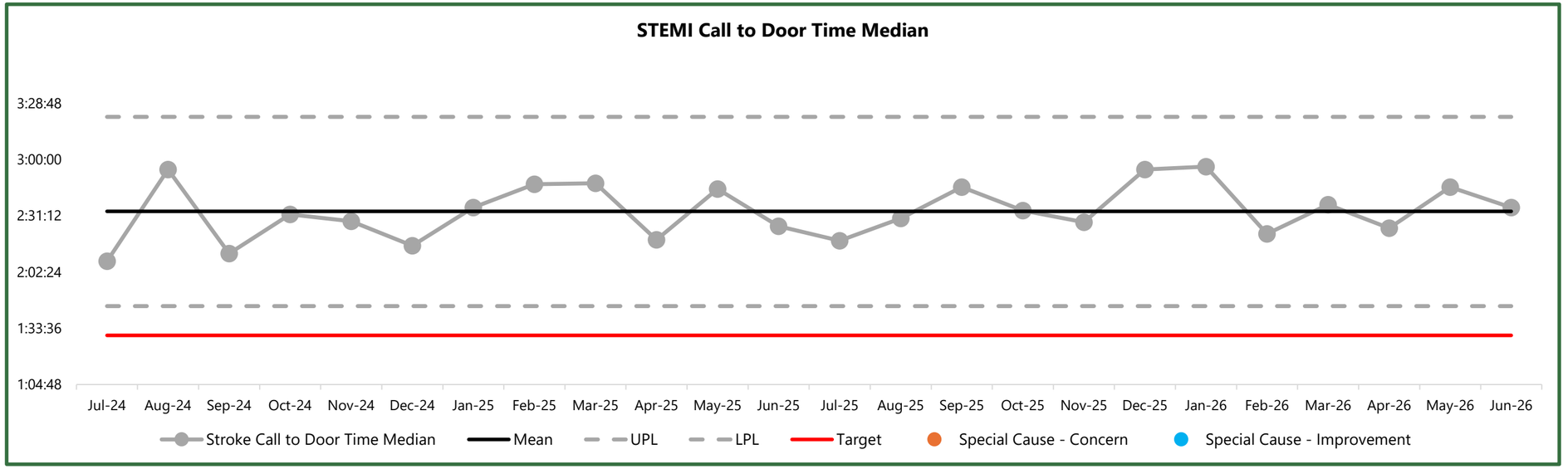
Stroke & ST-elevation myocardial infarction (STEMI) patients

Time-Based metrics

Strategic Objective 1

Stroke Call to Door	STEMI Call to Door
R	R





Analysis:

Stroke call-to-door times show special cause deterioration in late 2024, followed by a sustained shift to improvement during mid–late 2025; however, recent data has returned to common cause variation around the mean of 2 hours 30 mins.

STEMI call-to-door times demonstrate predominantly common cause variation, with performance fluctuating around the mean of 2 hours 33 mins.

For both pathways, the processes remain stable but will not deliver the ambition of 1 hour 30 mins, and process improvement is required.

Remedial Plans and Actions:

The Trust's ambition is to improve the call to door times to 1.5 hours. The CMT Benefits Workstream has set up its structures for the third year of the CMT programme, in particular, the Call Categorisation (3) Patient Flow Task & Finish Group, which includes call to door times.

Expected Performance Trajectory:

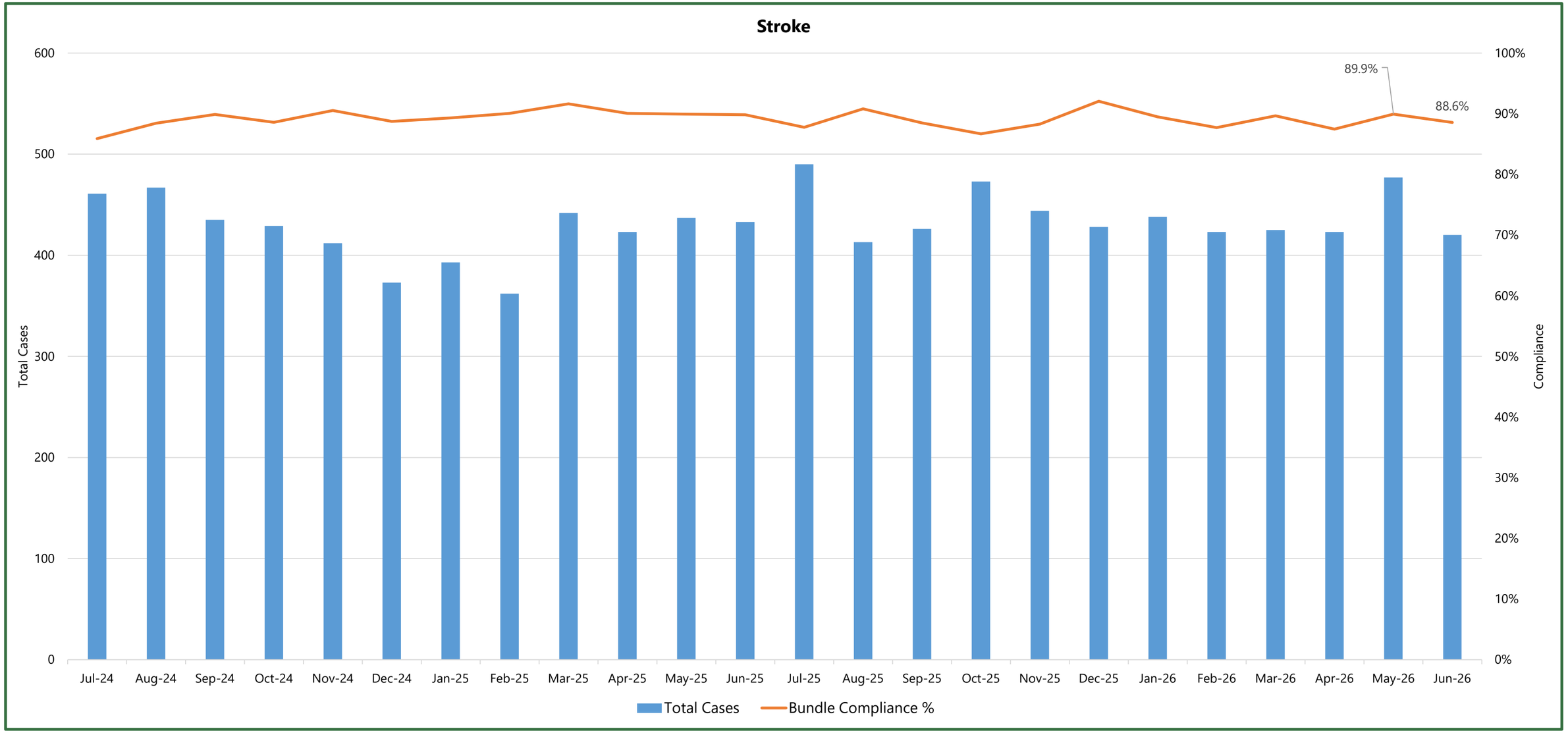
Modelling call to door times is complex so is not yet available for this iteration of the revised MIQPR. The aim is to model all the Call Categorisation (3) improvements, plus W45 compliance, as part of the Trusts' approach o winter planning.

Our Patients

Stroke Bundle Compliance

Strategic Objective 1

MOA

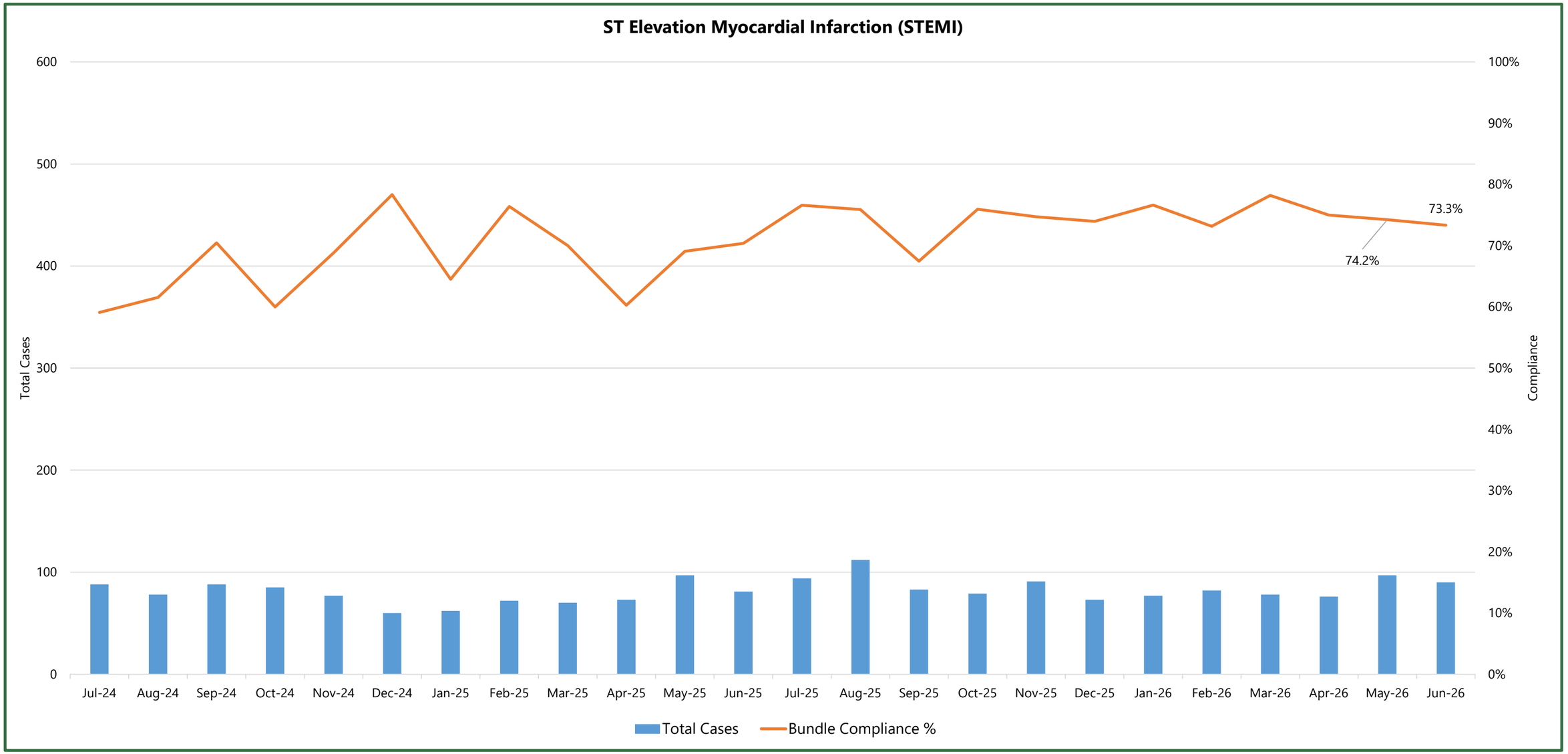


Our Patients

STEMI Bundle Compliance

Strategic Objective 1

MOA

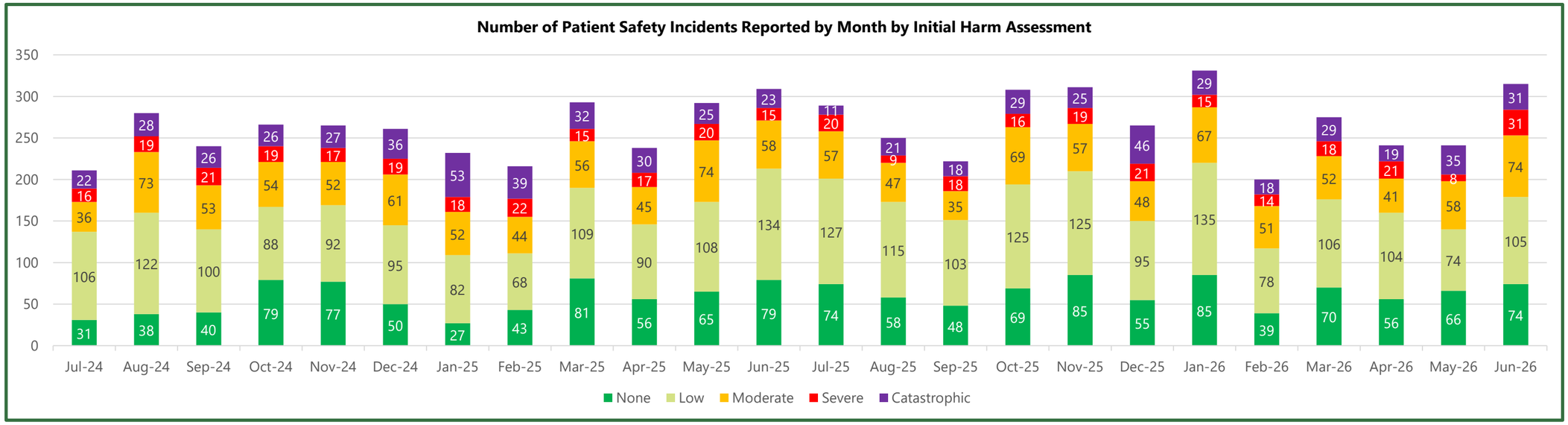


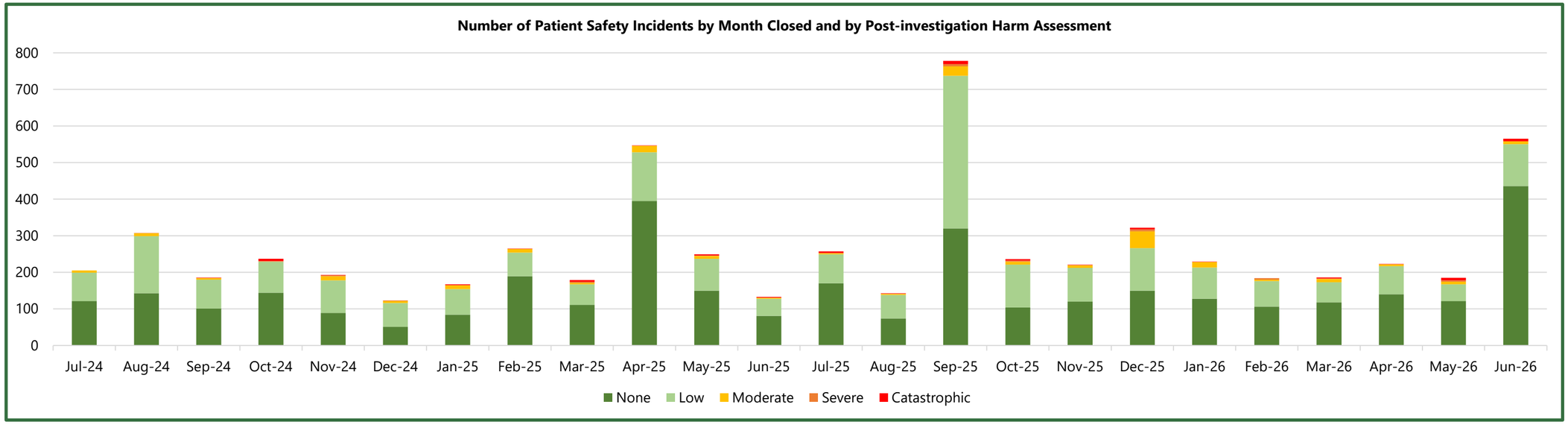
Our Patients

Patient Harm Incident Volumes

Strategic Objective 1

MOA





Our Patients

Patient Experience Surveys
NHS P&I Beacon Measures

Strategic Objective 5

National Patient Reported Experience Measure

June-26		
NEPTS (535 responses)	**Benchmark**	**Score**
How long did you wait for your transport to take you home after your appointment?	85	82
Were you happy with the transport your received?	85	96
999 (14 responses)	**Benchmark**	**Score**
The 999-call taker who answered your call listened carefully and explained what was going to happen next.	85	85
The length of time I waited for an ambulance to arrive was acceptable	85	100
111 (55 responses)	**Benchmark**	**Score**
Do you feel your call to 111 Wales was helpful?	85	34
Did you follow the advice given to you by NHS111 Wales?	85	89
Would you consider using NHS111 Wales again?	85	38
WAST Overall - Friends & Family Test	**Ranked from very poor to very good.**	
How was your overall experience with the service today?		
Ambulance Care	100% Good	
Integrated Care (NHS111 Wales Telephone line)	25% Very Good	50% very Poor
NHS 111 Wales Online	25% Good	8.33% 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

Experiential survey intelligence presents a mixed picture across services. 999 and NEPTS are achieving expected benchmark measures, with Ambulance Care (NEPTS) feedback remaining highly positive. However, NHS 111 Wales remains a significant area of concern with most key measures performing below baseline expectations. Whilst respondents indicate they are following the advice provided 50% of respondents indicate their overall experience as poor, a pattern consistent with previous reporting periods and indicative of persistent dissatisfaction among a proportion of callers.

Remedial Plans & Actions

The planned expansion of experiential reach out through the introduction of SMS survey in 999 and 111 services is expected to increase feedback volumes and enable greater emotional mapping and thematic analysis. Introduction of PREM measures associated with specific cohorts of patients such as CMP, are beginning to identify opportunities for service improvement. The Introduction of the People, Impact and Insight subgroup is also exploring additional methods for capturing experiences to support transformation and benefits realisation.

Expected Performance Trajectory

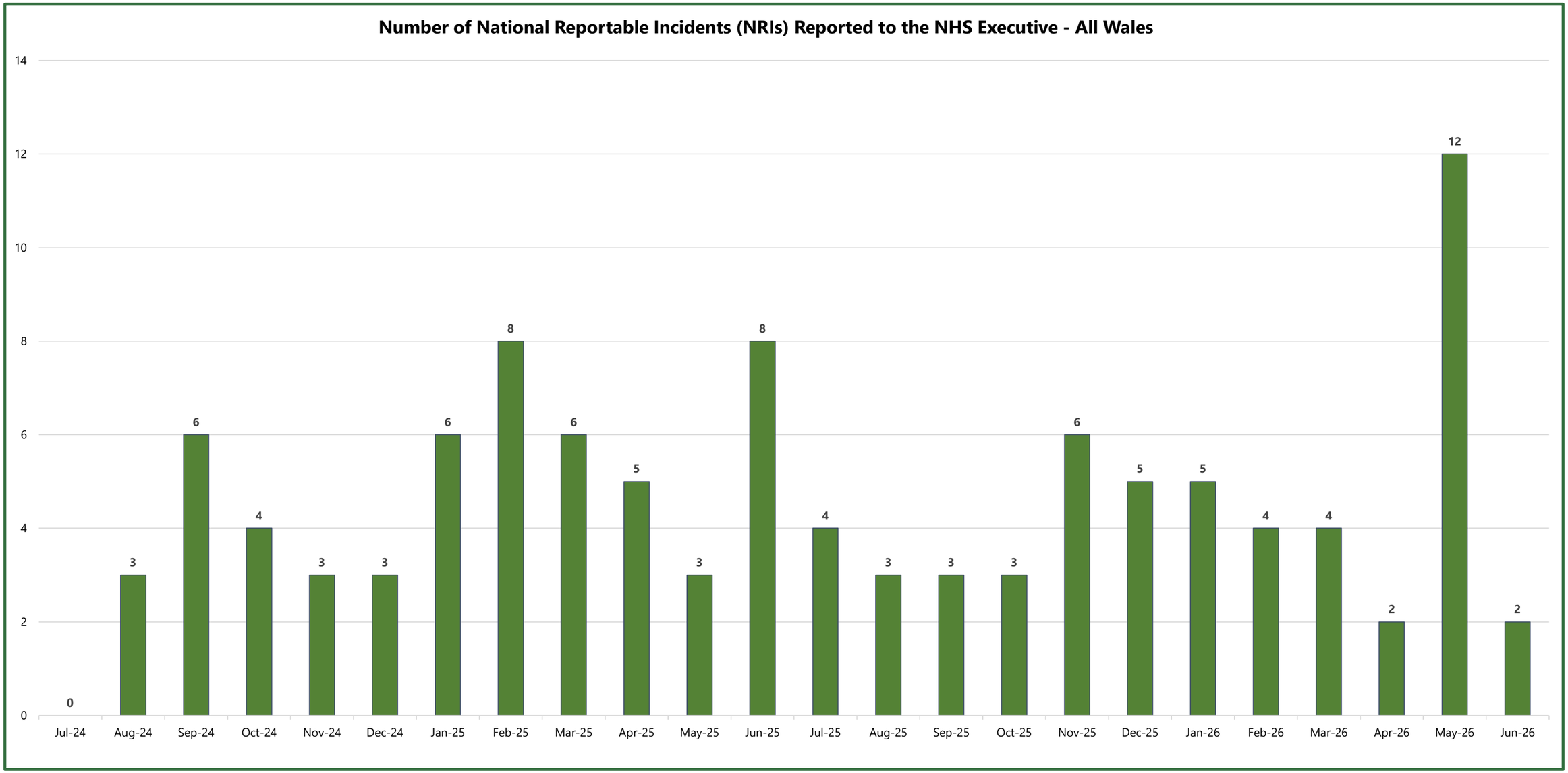
The expansion of survey approaches is expected to provide richer and more experiential intelligence improving the Trust's ability to identify themes and target improvement activity. However, the introduction of revised Patient Needs assessment, may result in a short-term deterioration in some experiential measures as service delivery and public expectations adjust.

Our Patients: Quality, Safety & Patient Experience

Patient National Reportable Incidents

Strategic Objective 5

NRIs
MOA



*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 National Reportable Incidents

NHS P&I Beacon Measures

Strategic Objective 5

NRIs

MOA

Under Development

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

Our Patients: Quality, Safety & Patient Experience

Concerns

NHS P&I Beacon Measures

Strategic Objective 5

Under development

Analysis
Revisions to the Concerns Regulations were implemented from 1 April 2026. The Trust awaits confirmation from Welsh Government on the final definitions for the proposed Key Performance Indicators. In the meantime, implementation of the revised Regulations and associated improvement work continues, with performance reporting against the new indicators commencing once those definitions are confirmed.

The Concerns Management Improvement Programme was refreshed on 22 July to simplify delivery, strengthen accountability and increase operational grip. A weekly Concerns Planning & Delivery Group has replaced the previous delivery forum and is responsible for coordinating the Early Resolution Sprint, monitoring progress against agreed milestones, managing dependencies and escalating barriers to delivery.

The existing Data & Digital Group and Improvement Group will merge into a single fortnightly Improvement Group, providing one coordinated forum to oversee delivery, monitor progress and drive the longer-term improvement programme.

Remedial Plans and Actions
These revised arrangements consolidate activity into a single improvement plan. Strategic Transformation Board has requested tangible progress over the six-week period from 13 July. The key deliverables are:

i. Increased operational grip through a weekly Planning & Delivery Group with clear ownership, trajectory monitoring and escalation of delivery risks.

ii. Completion of the first Delta Share import from Datix into the WAST data warehouse, enabling Power BI reporting and improved visibility of performance against the revised Regulations.

iii. Delivery of the Early Resolution Sprint, supporting consistent application of the revised Concerns Regulations by ensuring concerns are managed at the appropriate level of response and resolved as early as is proportionate and appropriate.

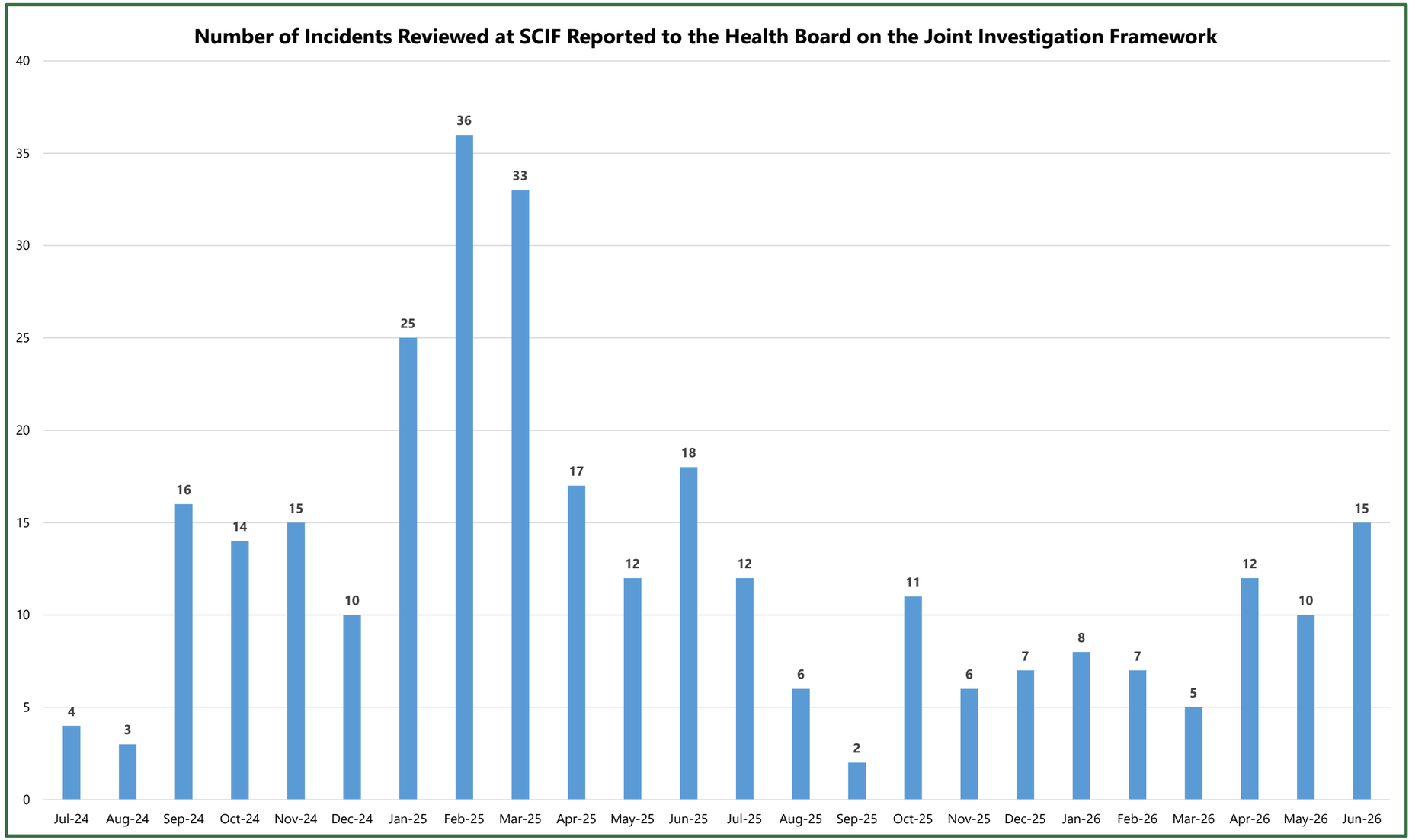
Progress against these actions will be monitored through the fortnightly Improvement Group and reported through MIQPR and Trust Board.

Our Patients

Joint Investigation Framework

Strategic Objective 5

JIF
R



Analysis
The number of investigations needing to be shared with other NHS Wales organisations has increased this month, reflective of deteriorating performance in hospital handover times.

Remedial Plans and Actions
The ambition is to reduce the number of JIF referrals to seven, which is based on what the Trust thinks will be the level, if handover reduction is achieved i.e. W45.

The Trust has engaged with NHS P&I and supported workshops on handover reduction and W45 compliance, with health boards. The Trust is now in receipt of specific W45 compliance trajectories from health boards and will start reporting health board performance against these, in the monthly Operations Performance, Demand & Capacity meeting.

Expected Performance Trajectory
It is difficult for the Trust to set a trajectory for this indicator, as W45 is a health board responsibility each health board has its own trajectory for W45 compliance, so the Trust would anticipate a downward trajectory in SCIFs reported to health boards, with the ambition of seven per month being delivered in Q4 2026/27.

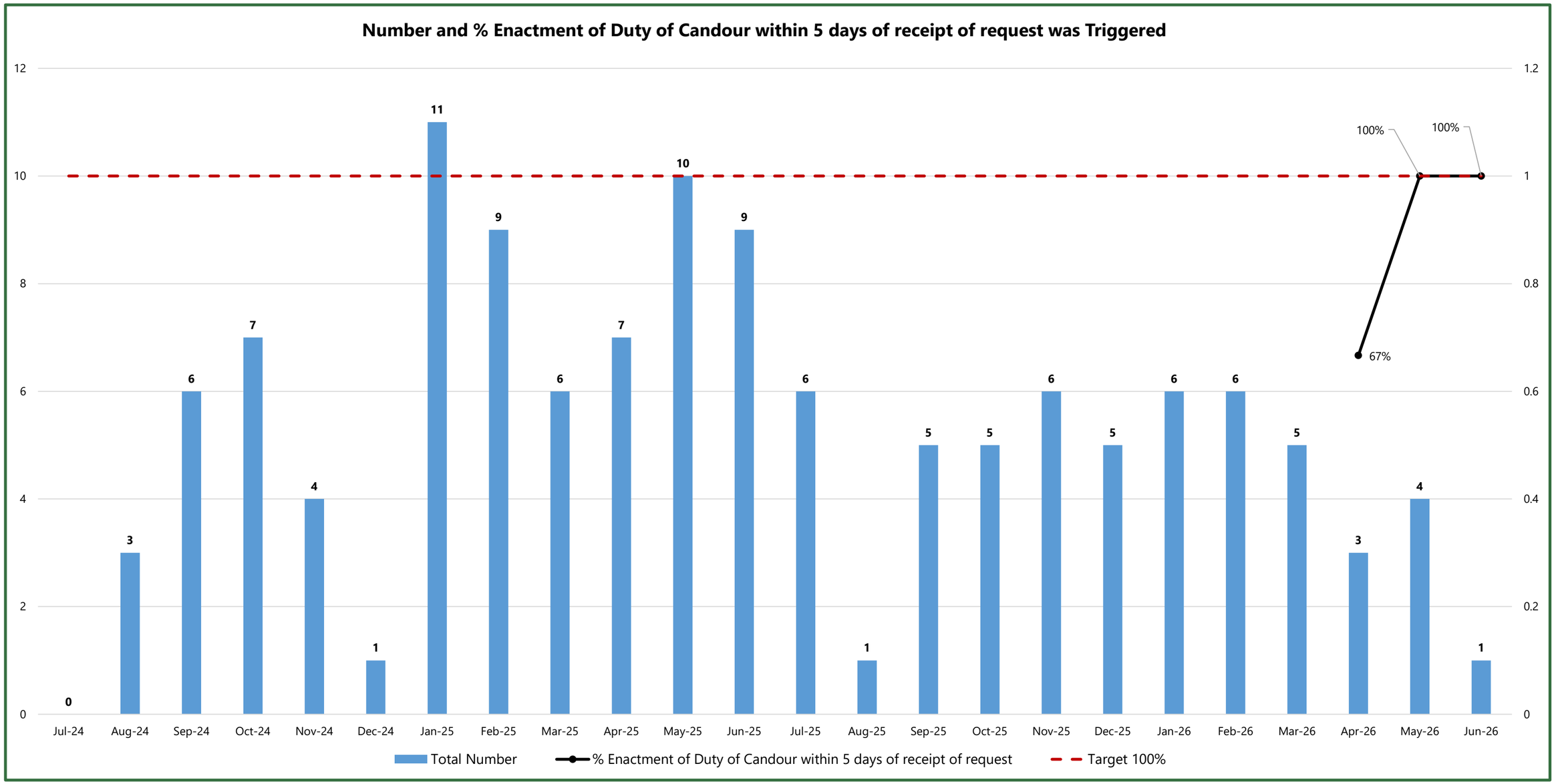
**NB: Data correct on the date and time it was extracted; therefore, these figures are subject to change*

Our Patients

Duty of Candour

Strategic Objective 5

G



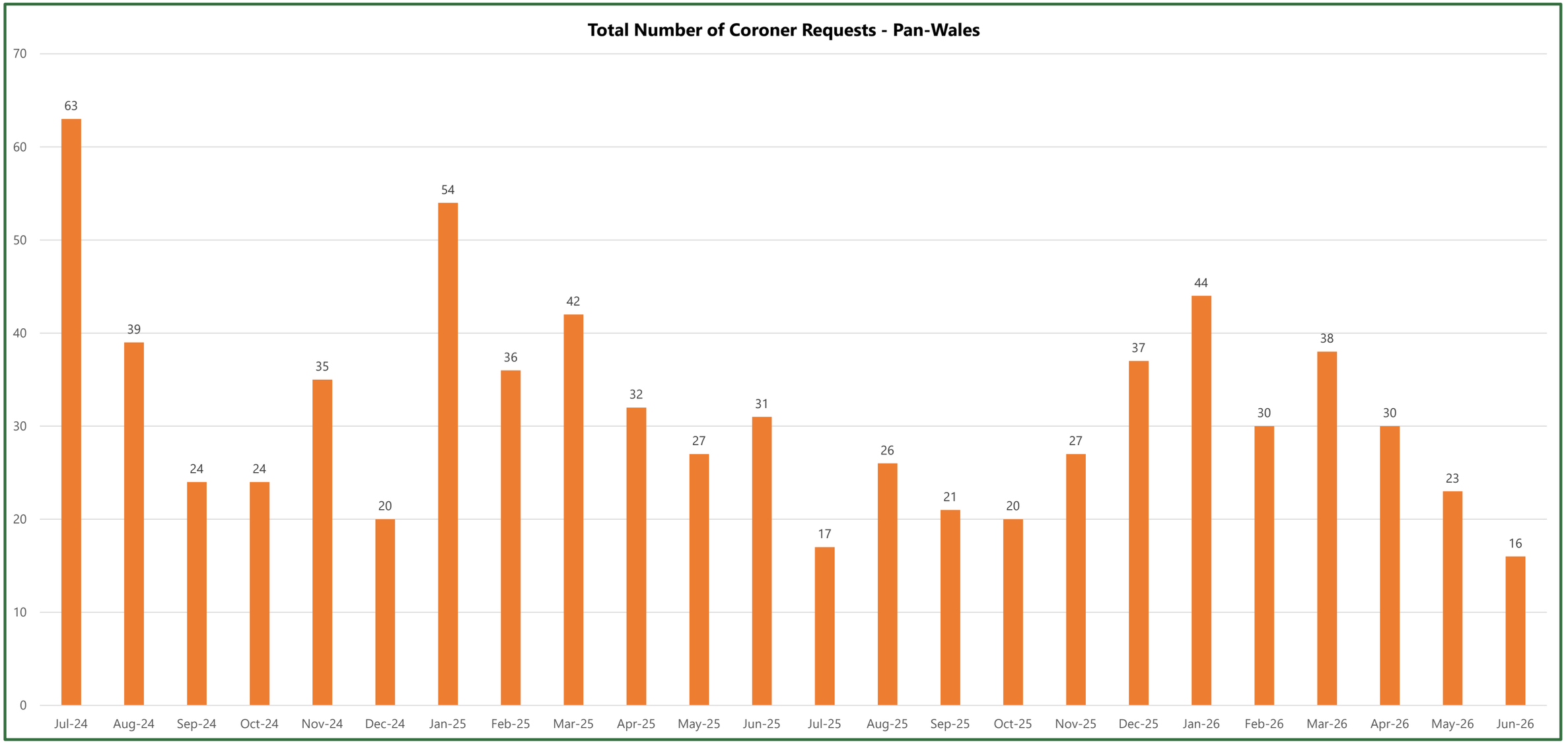
*NB: Data correct on the date and time it was extracted; therefore, these figures are subject to change

Our Patients

Coroners

Strategic Objective 6

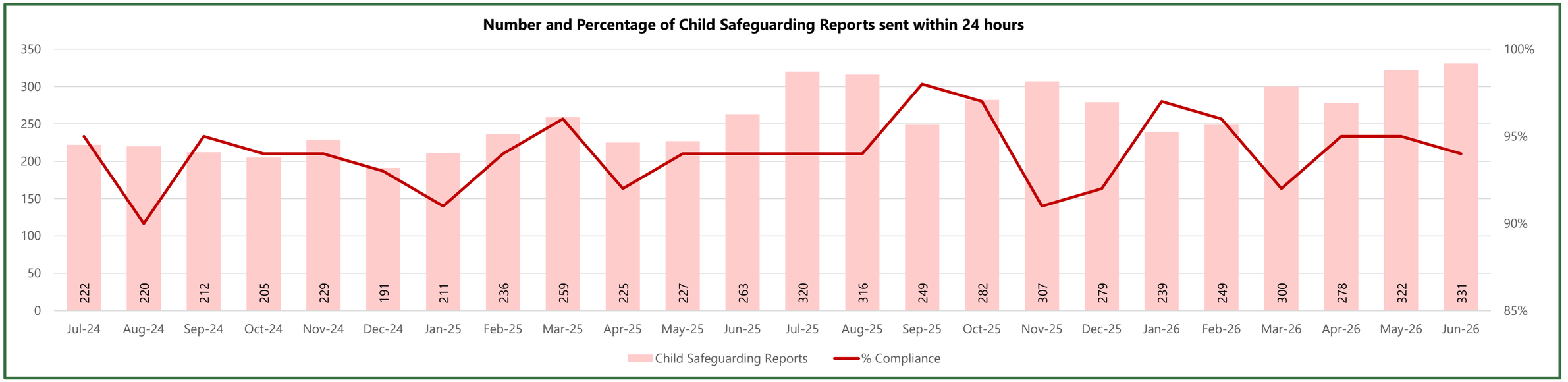
MOA

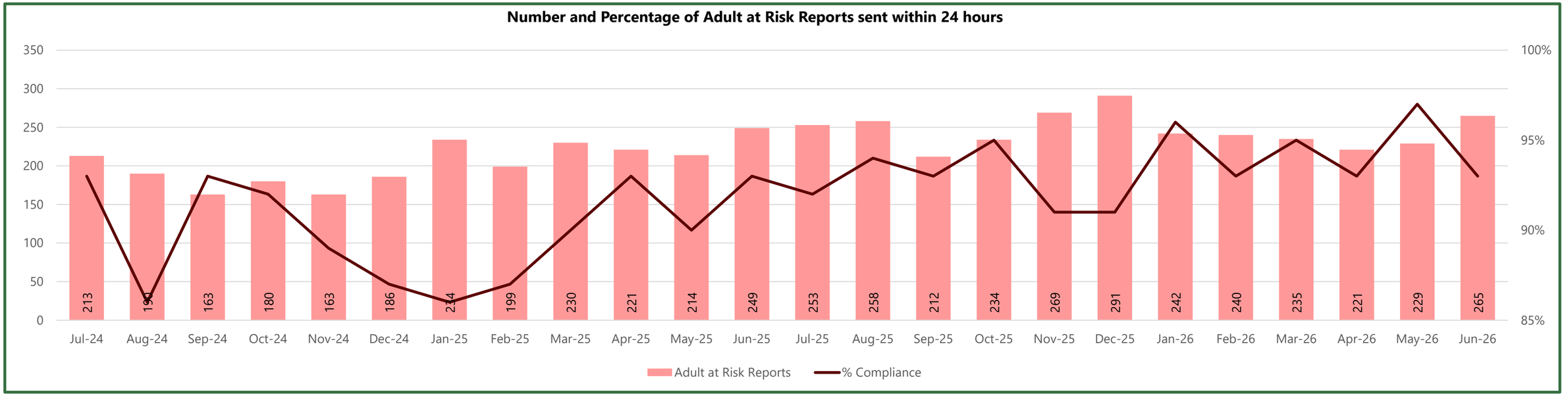


Our Patients
Safeguarding

Strategic Objective 6

MOA





Our Patients

Safeguarding Compliance (Level1)

NHS P&I Beacon Measures

Strategic Objective 6

MOA

Under Development

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		

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

Agenda Item No.	9.1

REPORT TITLE

Concerns, Patient Safety and Legal Services Report: April - May 2026

MEETING

Name of meeting	Quality, Patient Experience & Safety Committee
Date of meeting	6 August 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Andy Swinburn, Executive Director of Paramedicine
Author(s) of report	Claire Appleton, Assistant Director of Putting Things Right

PURPOSE OF REPORT

☐ Approval	☐ Endorsement
☒ Assurance	☒ Discussion
☐ Information (goes in consent items)	☐ Noting

REPORT SUMMARY

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

1. This report provides assurance to the Quality, Patient Experience and Safety Committee (QuESt) on the Trust's performance, compliance and risk position across the Concerns, Patient Safety and Legal Services portfolio for April and May 2026.

2. It demonstrates evidence of improvement in several key compliance measures including Duty of Candour, Learning from Events reporting and reductions in overdue Nationally Reportable Incidents. However, this is balanced by ongoing pressures including data limitations, workforce and analytical capacity constraints and capacity to deliver the learning elements of the mortality governance processes. Of highlighted concern is organisational adaptation to the changed profile of complaints management, with high volumes of cases not being resolved at Stage 1 and progressing to Stage 2 solely to secure the extended timeframe. This is being addressed through the Concerns Management Improvement Programme, although improvement has not yet been fully realised.

3. Overall, the position remains one of partial assurance. While progress is evident and governance arrangements remain in place and continue to provide oversight. Continued focus is required on strengthening data capability, improving early resolution of complaints, managing capacity across investigative and mortality processes, and embedding a more systematic, organisation-wide approach to learning and improvement.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

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

1. Receive the report as assurance on activity within the Concerns, Patient Safety & Legal Services portfolio; and
2. Identify any additional assurance requirements.

ADDITIONAL PAPER(S)

Set out here any annexes. See writing and presentation guidance here regarding materiality and use of the Reading Room

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

Annex 1 Concerns, Patient Safety and Legal Services Quarterly Report: April-May 2026

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [link to objectives and what good looks like]	
☒ SO1: Providing the right care or advice, in the right place, every time	☐ SO2: Enabling our people to be the best they can be
☐ SO3: Being at the forefront of innovation and technology	☐ SO4: Developing services in collaboration
☒ SO5: Being quality driven & clinically led	☒ SO6: Delivering exceptional value

RISK(S) THIS REPORT MITIGATES

Where relevant note the local, directorate, corporate or BAF risk number
Risk ID 700 *Failure to implement and deliver the statutory requirements of the revised Concerns Regulations and accompanying 'Listening to People' Guidance.*

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

Quality Domains (select all that apply) [link to standards]		
☒ Safe	☒ Timely	☒ Effective
☒ Efficient	☒ Equitable	☒ Person Centred
Quality Enablers		
☒ Leadership	☒ Workforce	☒ Culture
☒ Information	☒ Learning Improvement & Research	☒ Whole Systems Approach

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [link to goals]		
☐ A socially responsible and inclusive employer	☐ An innovative and sustainable organisation	☒ A pro-active, accessible and equitable care provider

IMPACT ASSESSMENTS FOR CONSIDERATION

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

Does this paper require an impact assessment	☒ No ☐ Yes

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
17 July 2026	Clinical Quality Governance Group

SITUATION

1. This report covers the Concerns, Patient Safety and Legal Services portfolio for April and May 2026. This includes:

   - 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 Reports (LFER) and Welsh Risk Pool submissions)
   - The Assistant Director for Putting Things Right (PTR), supported by the Head of Concerns and Learning Patient Safety Team PTR and Legal Services Team also lead the Trust's approach to learning from mortality. This is covered in detail within the separate twice-yearly Learning from Mortality Report to this Committee.

BACKGROUND

2. QuESt members are asked to note the revised approach to the reporting cycle for this paper. Whilst the current quarterly reporting cycle provides regular oversight, strict alignment to financial quarters has constrained the time available for robust data validation, analysis and assurance development. As a result, reports have at times been more descriptive than analytical, limiting the depth of assurance provided to Committee members.

3. The approved changes retain a three-monthly reporting frequency but remove the requirement to align reporting periods to financial quarters. A transitional approach is implemented this report, covering a two-month period to provide additional time for data validation, triangulation and confirmation of actions.

4. This revised cycle is intended to strengthen the quality, reliability and interpretive value of reporting by:

   - enabling more comprehensive data validation and resolution of anomalies
   - supporting deeper analysis and clearer identification of themes and risks
   - improving confidence in the accuracy and ownership of actions
   - enhancing the overall assurance narrative provided to QuESt

5. The change reflects a clear prioritisation of assurance quality and informed scrutiny over strict adherence to financial reporting timelines, with the aim of supporting more robust and meaningful Committee oversight going forward.

6. Data metrics are currently being realigned to reflect the revised National Performance Indicators introduced in this year's NHS Wales Performance Framework. Whilst metric definitions for the Listening to People Assurance Framework have now been agreed and published, the associated extraction and calculation methodologies have not yet been defined. As a result, internal development work has not progressed at the required pace, and the Committee is receiving a reduced dataset compared to previous reporting cycles. This will be addressed once national specifications are confirmed. In the interim, assurance is necessarily based on available operational intelligence rather than the full suite of planned performance measures.

7. Committee members are advised that, on a broader scale, and unrelated to reporting periods or national guidance, the accessibility, extraction and availability of data remain constrained. These limitations are driven by capacity pressures and competing priorities across both the quality governance portfolio and Intelligence & Data Services (IDS). This continues to present a risk to the consistency, breadth and depth of reporting, and impacts the level of assurance that can be readily provided.

8. Assurance can be provided in relation to the accessibility of individual case-level information. Staff across Listening to People, Patient Safety and Legal Services retain visibility of individual cases through operational systems and raw data dashboards. The current limitation relates not to access to individual cases, but to the availability of analytical reporting, including Statistical Process Control (SPC) charts and derived metrics, which restricts the organisation's ability to demonstrate trends, variation and performance at a system level.

9. Mitigating actions are being progressed within existing resource parameters. However, sustained improvement will depend on the quality and maturity of reporting will be dependent on increased analytical capacity, clarity of national data specifications, and prioritisation of reporting requirements across the system.

ASSESSMENT

External Assurance

10. The Trust has received one Section 27 Report (non-public interest) from the Public Services Ombudsman for Wales. The Report concluded that the concern was not upheld.

11. The Trust has not received any Regulation 28 Prevention of Future Death Reports in the last quarter.

12. In the last report to QuESt members, information was shared about a focussed Assessment Report completed by NHS Wales Performance and Improvement Quality and Safety Team. The assessment found that while investigations consistently describe what happened, there is less clarity on why system factors contributed, and actions are often focused on individual or procedural responses rather than stronger system-level controls. This aligns with the Trust's own ambitions to strengthen organisational learning through its Quality Management System. Despite material limitations within the report methodology, the Trust recognises these findings as constructive and aligned with established patient safety principles, identifying an opportunity to strengthen the articulation of systems-based learning and the effectiveness of proposed actions.

13. There was no evidence of unsafe investigative practice, and existing governance arrangements remain robust, but further work is required to improve consistency, transparency and clarity in demonstrating systems-based learning and the strength of actions to reduce recurrence.

14. The Trust's response will therefore focus on supporting targeted enhanced systems-based training, improved documentation, strengthened assurance and triangulation of learning data, and continued collaboration with national partners.

Internal Assurance

15. The progress of the Concerns Management Improvement Programme is provided in a separate paper to this Committee.

16. As referenced in paragraph 6, data relating to complaints acknowledgement and response performance is unavailable due to a combination of internal data analyst capacity and external specification still being awaited, limiting current assurance in this area.

17. Performance in Duty of Candour has improved over the reporting period, increasing from 67% compliance in April to 100% in May, providing assurance that statutory communication requirements with families are being met more consistently. The single case that exceeded the 5 working day target did so because of uncertainty surrounding guideline application of the revised Concerns Regulations where incidents occurred prior to the 1 April 2026, but Duty of Candour was triggered post 1 April 2026. National expectations have now been clarified the expected approach, reducing the likelihood of recurrence.

18. The Trust has no overdue Learning from Events Report requiring submission. Three Claims cases have an Amber deferred status, and no Redress cases are deferred. There are also no Red deferred cases at the National Learning Advisory Panel. This provides assurance that learning evidence submitted by the Health and Safety and Patient Safety Teams is being presented in a timely manner and is of an appropriate quality, as demonstrated by the low level of deferrals and the absence of Red deferrals.

19. Overdue coronial statements have shown a marked improvement from earlier peaks, though they remain above the Trust's target of zero, indicating continued pressure within legal processes. Capacity challenges including Service Manager absence, commitments across the Clinical Model Transformation Programme and demand spikes are preventing further improvement. This remains an operational risk requiring continued monitoring.

20. Early indications from the new Listening to People Framework show an increase in Stage 1 complaints progressing to Stage 2, rising from 16 in April to 40 in May. While this is a proxy measure, it is indicative of service area pressures in aligning sufficient capacity and experience to resolving complaints at an early resolution stage.

21. Within mortality governance, there was a significant reduction in open Medical Examiner cases toward the end of 2025, reaching a low of 10 cases, but this position has deteriorated through 2026, rising to 109 cases by May awaiting Level 2 review. This exceeds the internal tolerance level and indicates renewed pressure within mortality review processes. Assurance is provided that Level 1 review arrangements remain consistently timely, securing effective alignment of existing Concerns Management and Clinical Governance Pathways, with high-risk cases being incident-reported for consideration at Rapid Incident Review and Serious Case Incident Forums. This risk is currently contained through existing governance arrangements but remains vulnerable to capacity constraints within the Level 2 review process, particularly the availability of clinical leadership and administrative support required to progress reviews in a timely manner.

22. Across patient safety indicators, the data suggests a relatively stable position in terms of incident reporting volumes, with no evidence within the dataset of sudden or significant variation. The distribution of incidents by harm level and the number of joint investigations with Health Boards indicate ongoing demand on investigation capacity, with activity sustained across the reporting period. Closure data shows continued throughput of investigations, though variation between months suggests inconsistency in processing rates, which aligns with wider programme risks regarding capacity and sustainability.

23. The complaints profile indicates a relatively steady volume of concerns being received each month, with no marked reduction in demand. Taking a longer-term perspective, it is noted that case volumes have seen a 50% uplift over the past two years. The new Listening to People focus on timely Stage 1 early resolution should be viewed as a supportive national intervention that prioritises complainant needs and promotes proportionate responses. Successful implementation will depend upon organisational capacity to resolve concerns earlier within the process.

24. Mortality governance data shows variability in Medical Examiner Referrals and coroner engagement over time, with peaks and troughs across the reporting period. This reflects both fluctuations in seasonal impact and ongoing pressure on governance processes, which is consistent with the rise in open Medical Examiner cases noted above.

25. Overall, the dataset presents a mixed but improving position. There is clear evidence of recovery in some core compliance areas, particularly LFER performance, Duty of Candour and reduction in Nationally Reportable Incidents. However, this is balanced by emerging or ongoing risks, including inconsistent complaint timeliness data, increasing conversion rates to Stage 2, rising Medical Examiner caseloads, and variability in investigative throughput.

26. Taken together, the data supports a position of partial assurance, where progress is evident but not yet stable. Continued focus on sustaining compliance gains, strengthening early resolution in complaints, and addressing capacity constraints within mortality and investigation processes will be critical to maintaining improvement and mitigating residual risk.

Learning and Improvement

27. A structured Learning Framework is being developed to strengthen organisational learning, support continuous improvement and ensure that insights from complaints, patient safety incidents and legal casework are translated into measurable improvements in care. The Framework is built around four key principles:

- timely; aligned to investigation milestones
- proportionate; to harm/complexity
- inclusive; co-produced with those affected
- safely shared; respecting data-protection

28. The Framework supports the continued cultural shift from a culture of reporting to a culture of learning, ensuring that lessons are shared consistently across the organisation and embedded into operational and strategic decision-making. A strengthened quality governance focus, embedding learning from concerns within the Trust's quality management cycle, will provide enhanced oversight of

learning themes, implementation progress and assurance of impact through regular reporting to established quality governance forums.

29. A complaint received from a transgender patient highlighted the importance of consistently delivering inclusive, person-centred care. Learning has focused on promoting respectful communication, improving awareness of gender identity considerations, and reviewing systems and processes to ensure patients are treated with dignity, respect and compassion. This learning will inform ongoing equality, diversity and inclusion initiatives and support improvements in patient experience

30. A complaint received following the first heat-related demand spike (May heatwave, 21-29 May 2026) has assisted in a timely review of mechanisms to proactively support patient safety at scene during periods of extreme weather. The issues raised included about maintaining patient comfort, dignity and safety while awaiting transport or care. Learning has focused on strengthening risk assessment processes, improving escalation arrangements during periods of extreme weather, and reviewing local mitigations to minimise patient exposure. This will support safer care delivery and enhance the patient experience, particularly for vulnerable individuals.

31. NRIs reported during April and May reflect demand-related pressures in Integrated Care and the nature of risk-based decision-making in Rapid Clinical Screening.

RECOMMENDATIONS

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

NEXT STEPS

33. Stabilisation of leadership arrangements whilst continuing implementation of the Concerns Management Improvement Programme, strengthen organisational learning arrangements, improve analytical capability and reporting maturity, and embed the requirements of the Listening to People Framework.

Welsh Ambulance Services University NHS Trust

Concerns, Patient Safety & Legal Services dataset

GIG CYMRU NHS WALES

Ymddiriedolaeth Brifysgol GIG
Gwasanaethau Ambiwlans Cymru

Welsh Ambulance Services
University NHS Trust

April-May 2026

Claire Appleton
Assistant Director of PTR

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

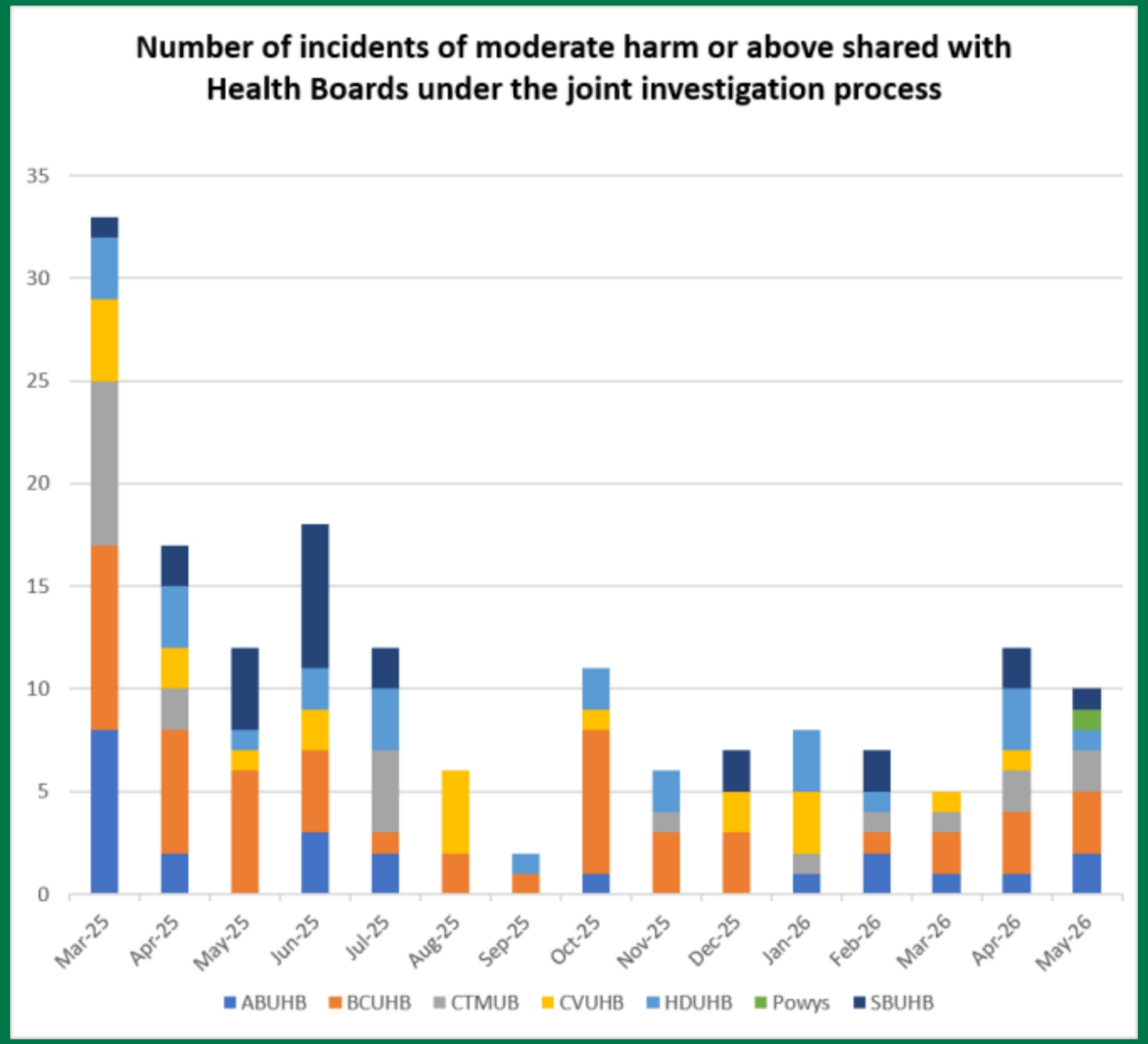
Data contained within this report is accurate at the time of reporting.

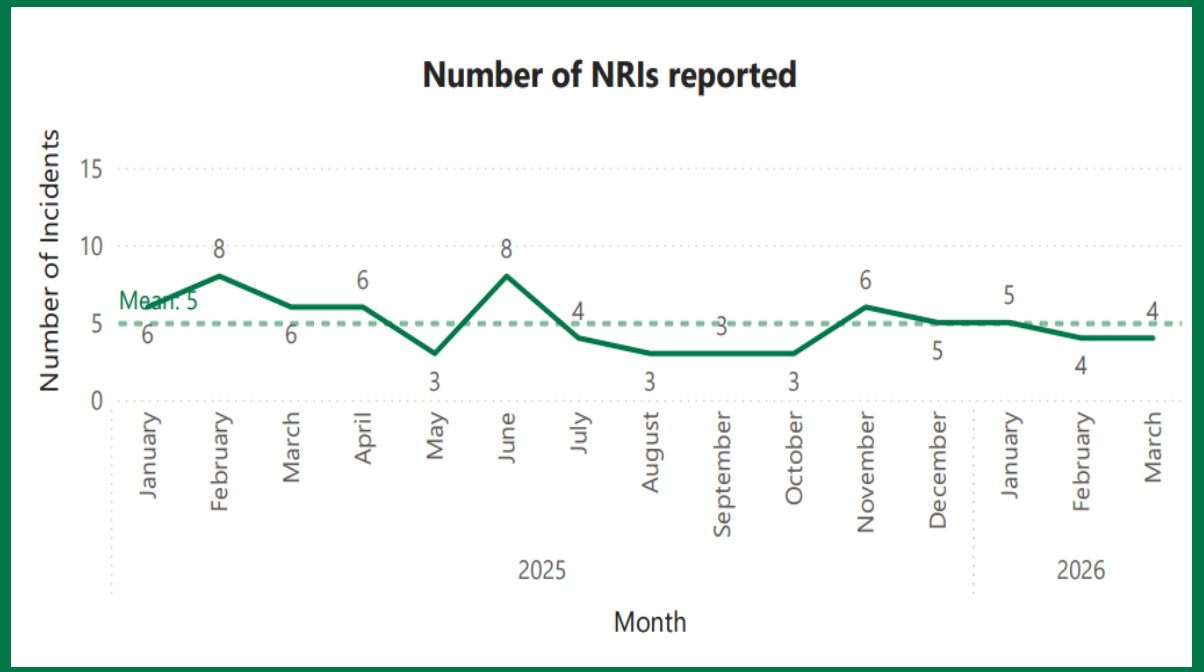
Data may be subject to change following validation, retrospective reviews and audits and ongoing clinical governance processes including regrading of incidents.

Quality and Safety Compliance

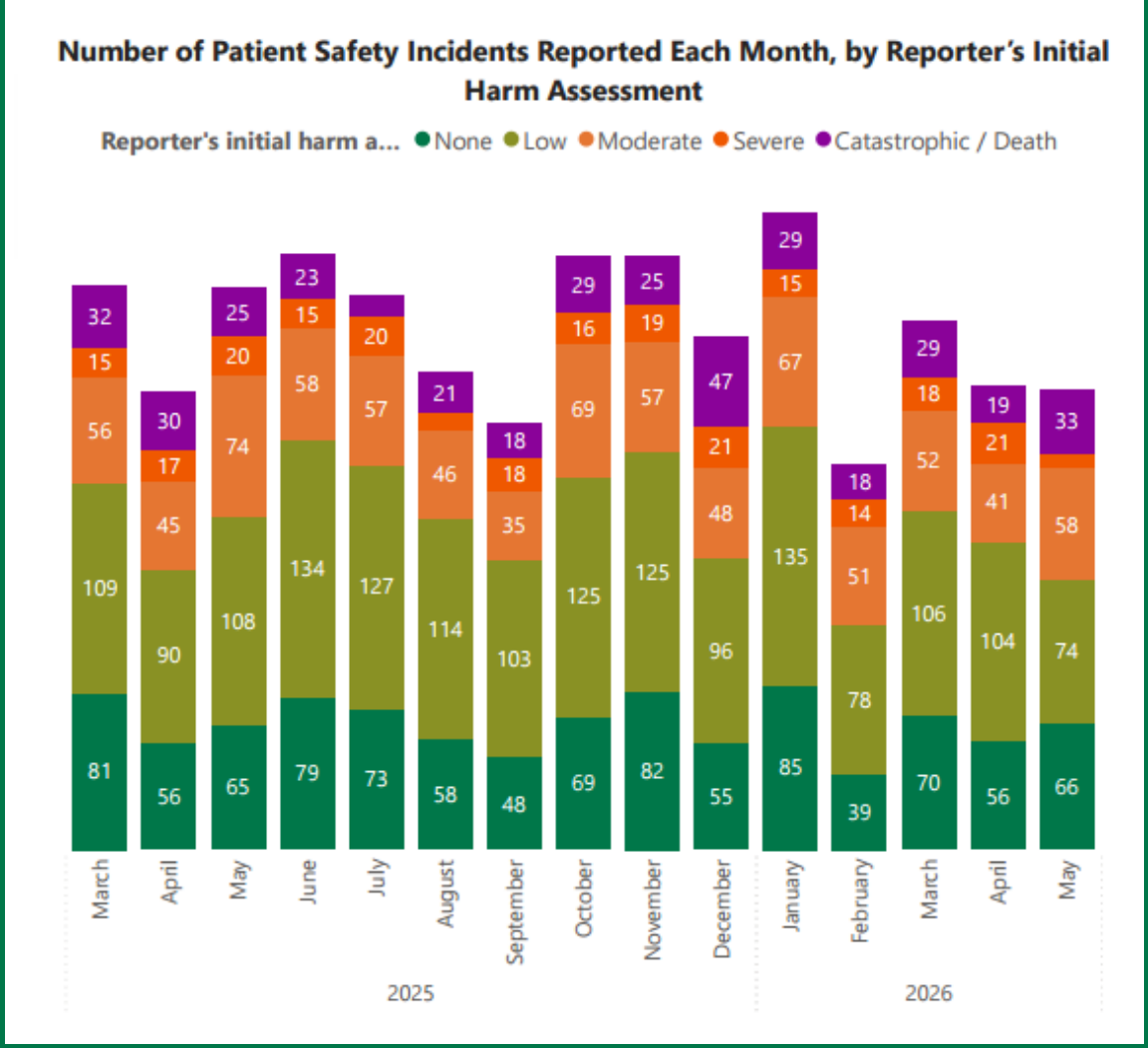
			2025						2026	
KPI	Originating source	Target	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Overdue NRIs	NHS Wales National Patient Safety Incident Policy	0	27	29	23	24	22	15	16	16
Complaints ack'd & listening discussion offered within 5 wd	Listening to People Statutory Guidance	1	95%	59%	74%	58%	100%	100%	Not available	Not available
Stage 1 complaints converted to Stage 2	Listening to People Assurance Framework (proxy metric until definitions confirmed by WG)	Lower is better (proxy metric until definitions confirmed by WG)							16	40
Compliance with 5wd written notification Duty of Candour letters	Duty of Candour Statutory Guidance	1							67%	100%
Overdue Coronial statements	Coroners and Justice Act 2009	0		72	33	18	27	32	22	23
Open Medical Examiner cases	All Wales Mortality Review Model Framework	Lower is better. Internal tolerance of <=50 cases.	190	103	25	10	42	81	109	109
Overdue LFERs	Welsh Risk Pool Procedures	0			13	7	6	1	1	0
Non-compliant Patient Safety Alerts or Notices	NHS Wales Beacon dashboard	0	0	0	0	0	0	0	0	0
Non-compliant Regulation 28 responses	Coroners and Justice Act 2009	0	0	0	0	0	0	0	0	0

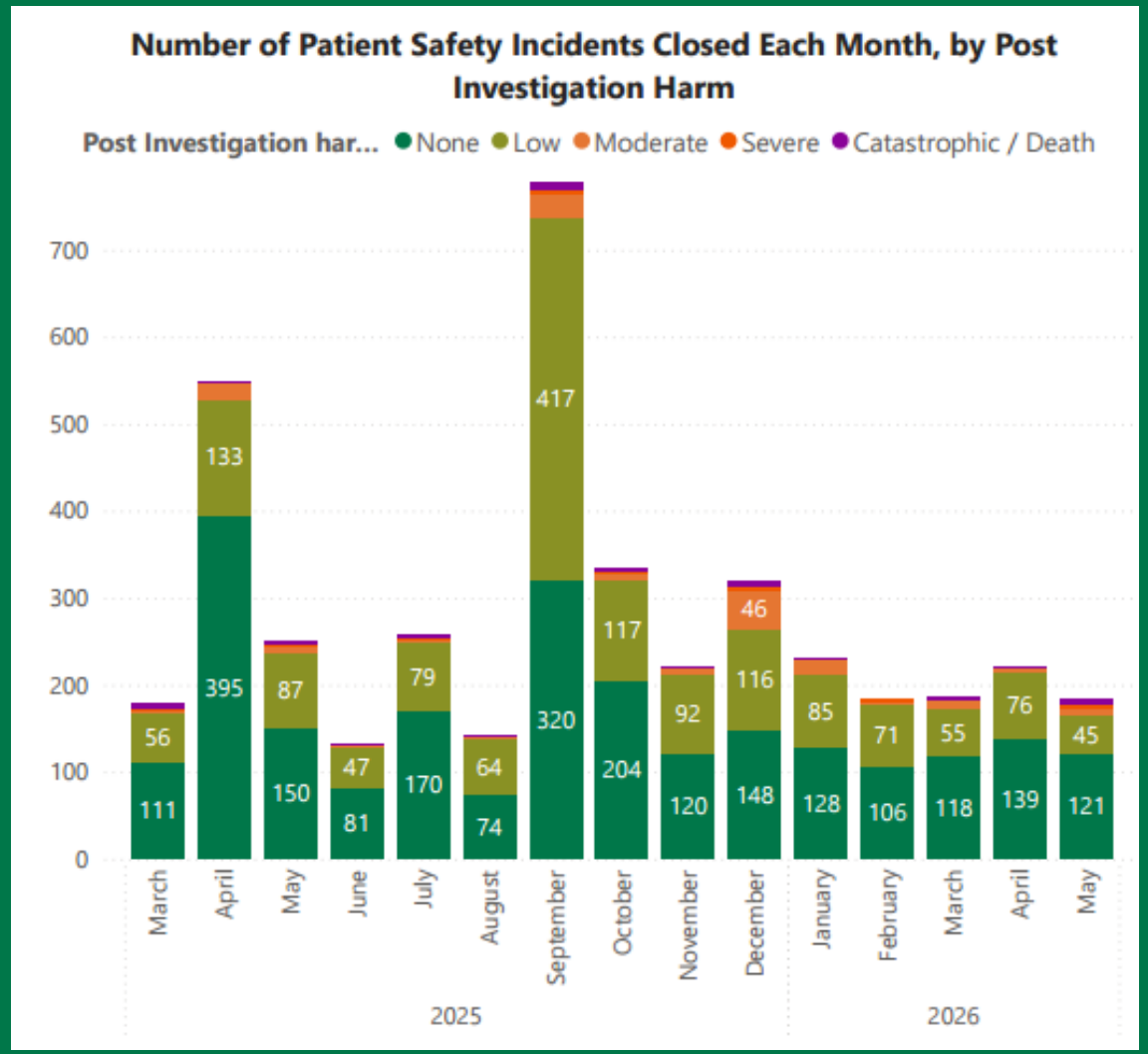
Assurance Profile – Patient Safety Incidents



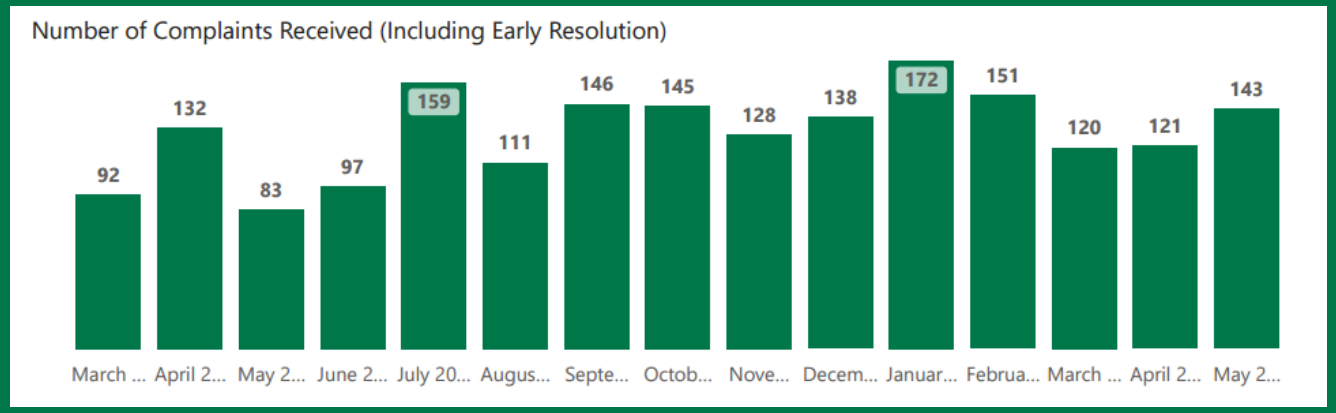


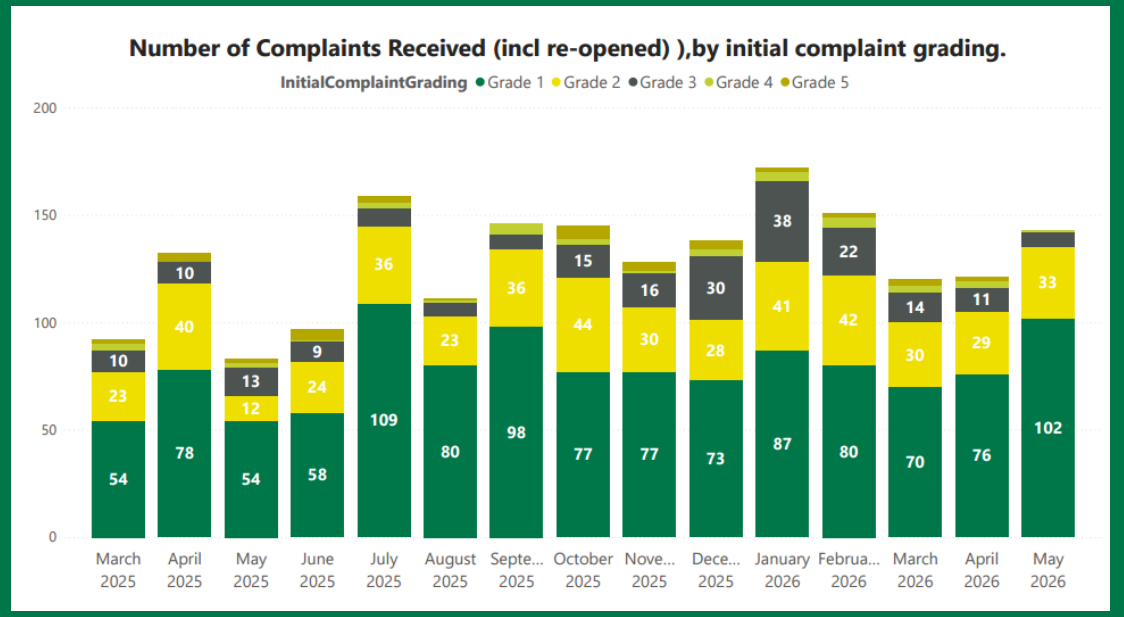
Assurance Profile – Patient Safety Incidents

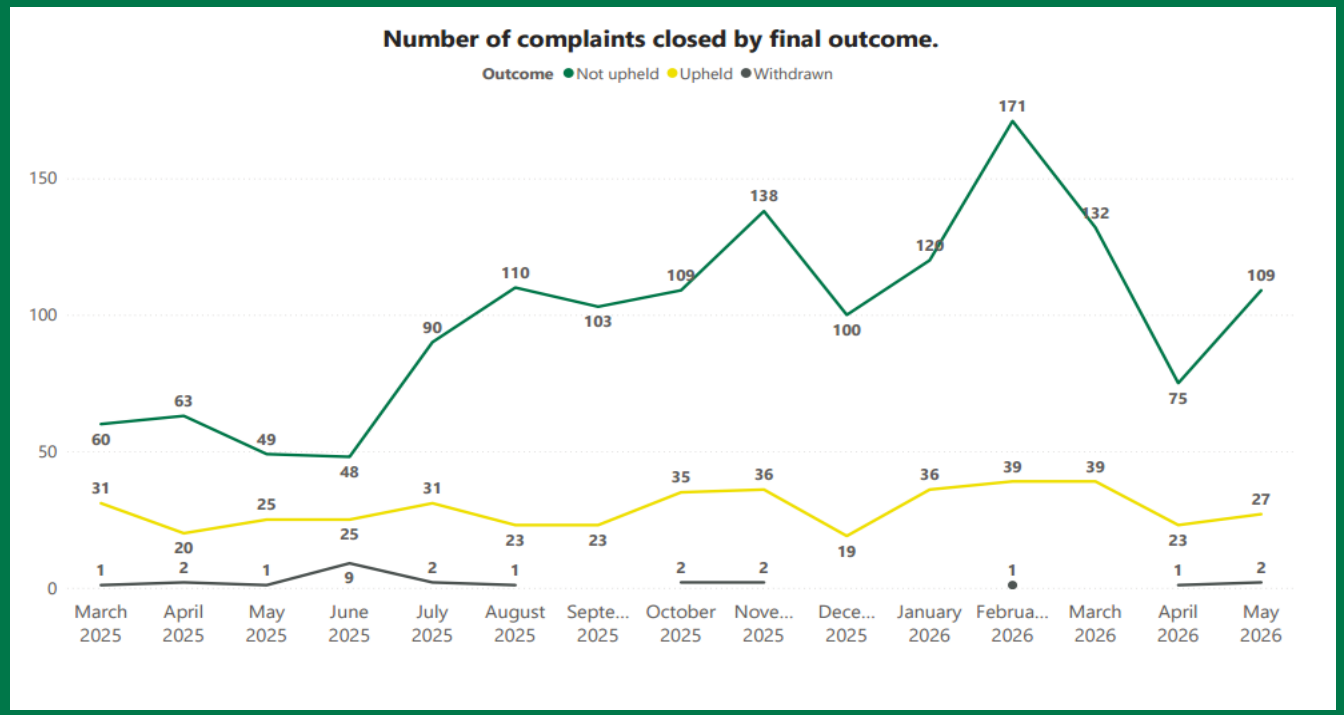




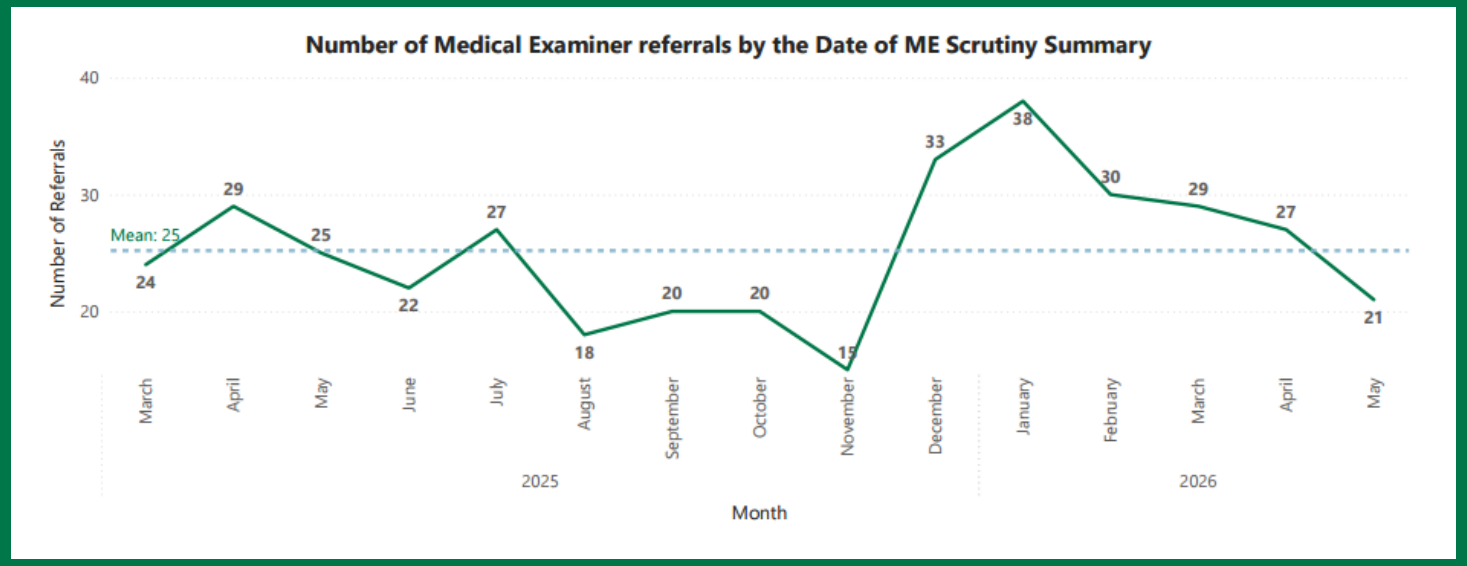
Assurance Profile – Complaints

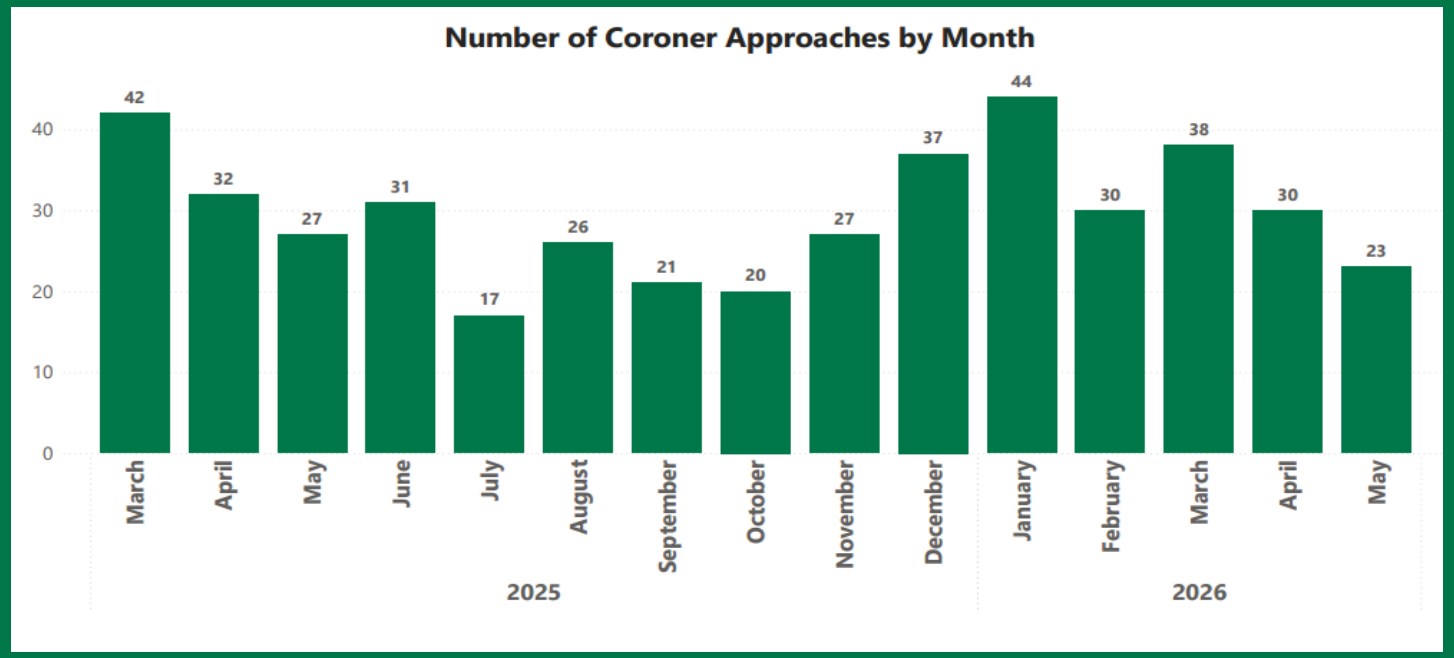






Assurance Profile – Mortality Governance





Agenda Item No.	9.2

REPORT TITLE

Concerns Management Improvement Programme Progress Report

MEETING

Name of meeting	Quality, Patient Experience & Safety Committee
Date of meeting	6 August 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Andy Swinburn, Executive Director of Paramedicine
Author(s) of report	Claire Appleton, Assistant Director of Putting Things Right

PURPOSE OF REPORT

☐ Approval	☐ Endorsement
☒ Assurance	☒ Discussion
☐ Information (goes in consent items)	☐ Noting

REPORT SUMMARY

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

1. This report provides the Quality, Patient Experience & Safety Committee (QuESt) with an update on progress against the Concerns Management Improvement Programme. The Programme has moved from initial recovery into a more structured delivery phase, with revised workstreams, strengthened governance and improved oversight arrangements now in place. There is evidence of progress in reducing legacy backlog, consolidating programme actions and improving data extraction from Datix Cymru to support future reporting and assurance.

2. Overall, the report provides moderate assurance. Whilst governance grip and programme structure have strengthened, sustained improvement is not yet demonstrated and delivery remains fragile. Key risks relate to organisational capacity, workforce readiness, data maturity, leadership continuity and wider system pressures, which continue to affect pace and performance. Continued Executive oversight and organisational support will be required to maintain momentum and translate early recovery into sustainable improvement.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

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

Note the progress made, the residual risks to delivery, and the current moderate assurance position, whilst recognising that sustained improvement has yet to be demonstrated. These risks continue to be actively managed through Programme Board oversight, executive sponsorship, prioritisation of programme activity and ongoing monitoring of delivery milestones.

ADDITIONAL PAPER(S)

Set out here any annexes. See writing and presentation guidance here regarding materiality and use of the Reading Room

n/a

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [link to objectives and what good looks like]	
☒ SO1: Providing the right care or advice, in the right place, every time	☐ SO2: Enabling our people to be the best they can be
☐ SO3: Being at the forefront of innovation and technology	☒ SO4: Developing services in collaboration
☒ SO5: Being quality driven and clinically led	☒ SO6: Delivering exceptional value

RISK(S) THIS REPORT MITIGATES

Where relevant note the local, directorate, corporate or BAF risk number
ID 700 *Failure to implement and deliver the requirements of the revised Concerns Regulations and accompanying statutory guidance 'Listening to People'*

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

Quality Domains (select all that apply) [link to standards]		
☒ Safe	☒ Timely	☒ Effective
☒ Efficient	☒ Equitable	☒ Person Centred
Quality Enablers (select all that apply) [link to standards]		
☒ Leadership	☐ Workforce	☒ Culture
☒ Information	☒ Learning Improvement & Research	☐ Whole Systems Approach

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [link to goals]		
☒ A socially responsible and inclusive employer	☒ An innovative and sustainable organisation	☒ A pro-active, accessible and equitable care provider
☐ n/a	☐ n/a	☐ n/a

IMPACT ASSESSMENTS FOR CONSIDERATION

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

Does this paper require an impact assessment	☒ No ☐ Yes
If yes, what impact assessment is attached	

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
17 July 2026	Clinical & Quality Governance Group

SITUATION

1. This report provides assurance to QuESt on progress made by the Trust's Concerns Management Improvement Programme in respect of quality, governance and patient safety.

BACKGROUND

2. The Concerns Management Programme was designed around a series of deliverables, aligned to a phased delivery undertaken via specific workstreams. The three phases agreed were: Putting Things Right Recovery; Listening to People Transition and Listening to People Implementation and Improvement.

ASSESSMENT

3. The Concerns Management Improvement Programme continues to demonstrate progress in stabilising key aspects of delivery and strengthening its governance approach. Whilst progress has been made, recovery remains fragile due to ongoing structural, capacity and external system pressures that continue to present a material risk to sustained improvement.

4. The Programme has progressed from its initial recovery into a more structured delivery phase. The underpinning workstreams of the Programme have been restructured following completion of the Putting Things Right Recovery Workstream. The revised structure is intended to strengthen organisational grip, pace and clarity of delivery. This revised structure is intended to support the transition from recovery activity towards sustained improvement, recognising that further evidence of consistent delivery is required.

5. The Model introduces a more clearly defined and purpose-led Framework, separating delivery into three distinct but interdependent workstreams: Transition; Improvement; and Data & Digital enablement. This approach has been designed to address previously identified limitations in focus and prioritisation, where competing demands across transition, improvement and data development diluted delivery effectiveness and risked slowing progress against key objectives.

6. Early implementation has established clearer lines of accountability and oversight, supported by continued Programme Board governance, with delivery responsibility delegated to defined workstreams. This structure is expected to support improved decision-making, more targeted escalation of risks and dependencies, and enhanced delivery traction across each priority area.

7. The introduction of a dedicated Data and Digital Workstream provides an improved governance mechanism to progress data extraction and accessibility, a vital enabler for monitoring and reporting capability, which is central to meeting the requirements of the Listening to People Guidance.

8. Whilst implementation of the workstreams is at an early stage, there is assurance that appropriate governance arrangements are now in place to support transition activities, embed process improvements and progress the data infrastructure required for effective oversight and continuous learning. It is too early to demonstrate whether these arrangements will translate into sustained performance improvement. Delivery risks remain in relation to organisational capacity and the complexity of dependencies across the workstreams, with these continuing to be monitored through Programme Board governance.

9. Transfer activity has progressed, with actions, risks and issues from the previous programme arrangements now consolidated into the revised structure. In parallel, there is evidence of a reduction in legacy backlogs. Data infrastructure has also shown modest progress, with new data extraction software proving successful at securing data flow from the Datix Cymru Modules to the Trust's data warehouse. Additional Datix Dashboards now support increased visibility of data quality issues for the central Listening to People Team, albeit with workarounds still required due to functionality restrictions in the national data capture form design.

10. Despite this progress, the programme is not yet operating at a level where recovery can be considered sustainable. Performance remains under pressure, with closure rates below incoming demand, contributing once again to an increased volume of open cases predictive of worsening future performance and limiting the ability to demonstrate sustained improvement. This reflects a consistent theme across reporting periods that, while legacy backlog has been reduced, current throughput is insufficient to maintain momentum without continued prioritisation against other organisational objectives.

11. Whilst now resolved, there have also been challenges in securing sufficient senior leadership capacity to mobilise and sustain workstreams at pace. The departure of the Executive Sponsor (Programme SRO) and, more recently, the Deputy Director of Putting Things Right and Quality, have impacted pace, grip and decision-making and has created a short-term risk to programme continuity, through the loss of programme knowledge and leadership capacity.

12. There remain additional systemic dependencies that continue to constrain delivery. Workforce readiness is not yet at the level required to support consistent implementation of Listening to People Standards, with training uptake and compliance below expected levels. Data and reporting limitations also persist, with incomplete real-time reporting, ongoing data quality issues and restricted dashboard access affecting the reliability of operational oversight and assurance. These factors collectively limit the organisation's ability to confidently model demand, track trajectories and evidence improvement.

13. The most significant programme risks relate to organisational capacity and programme leadership. Delivery remains dependent upon operational and clinical services providing timely information and engagement despite competing operational pressures.

14. Risk to delivery has been further compounded by external system pressures. Heat-related service demand and the requirement to enact business continuity arrangements have resulted in the postponement of key programme workshops and reduced organisational capacity to progress improvement activity. This has delayed elements of programme mobilisation, including metrics development and process redesign, while also reducing operational capacity to respond to and resolve concerns within existing timescales.

15. In summary, the programme can provide moderate assurance to QuESt. Governance arrangements have strengthened and there is evidence of progress in reducing legacy backlog and developing digital infrastructure. Residual risk relating to organisational capacity, workforce readiness and data maturity remain significant and continue to constrain sustainable recovery.

16. Continued executive oversight and organisational support will be required to stabilise leadership arrangements, maintain programme capacity and translate early recovery into sustainable improvement.

RECOMMENDATION

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

NEXT STEPS

18. Programme leadership is being stabilised, with executive oversight and SRO responsibilities realigned to maintain continuity. Delivery plans are being reset to reflect recent system pressures, with workshops reconfigured to support recovery from business continuity impacts.

19. Immediate focus is on restoring performance following recent service escalation, preventing further slippage and recovering lost momentum. In parallel, priority work will progress digital reporting and assurance products, define a sustainable Trust-wide concerns management model, and establish a formal Learning Framework to strengthen accountability and continuous improvement.

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Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
University NHS Trust

Agenda Item No.	10

REPORT TITLE

Clinical Audit Plan Q1 Update 2026-27

MEETING

Name of meeting	Quality, Patient Experience & Safety Committee
Date of meeting	6 August 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Andy Swinburn, Executive Director of Paramedicine
Author(s) of report	Ruth Saele, Clinical Data Specialist

PURPOSE OF REPORT

☐ Approval	☐ Endorsement
☒ Assurance	☐ Discussion
☐ Information (goes in consent items)	☐ Noting

REPORT SUMMARY

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

1. This report provides an update to QuEST on the progress of the 2026-27 Clinical Audit Plan for Q1 (April – June).
2. The report also provides an overview of additional work undertaken by the Clinical Intelligence and Assurance Team (CIAT).
3. The report further demonstrates assurance that learning from clinical audit is being applied and contributing to improved patient outcomes.

RECOMMENDATIONS

See writing and presentation guidance here to inform this section

The Quality Patient Experience and Safety Committee is requested to:

1. Note the work completed outside of the plan; and
2. Note the outcomes relating to previous clinical audits.

ADDITIONAL PAPERS

Set out here any annexes. See writing and presentation guidance here regarding materiality and use of the Reading Room

Annex 1 Clinical Audit Plan Q1 Update (April-June) 2026-2027
Annex 2 Clinical Audit Plan Q4 Update 2025-26 to Clinical Intelligence & Assurance Group 9 April 26

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [link to objectives and what good looks like]	
☒ SO1: Providing the right care or advice, in the right place, every time	☒ SO2: Enabling our people to be the best they can be
☐ SO3: Being at the forefront of innovation and technology	☐ SO4: Developing services in collaboration
☒ SO5: Being quality driven and clinically led	☐ SO6: Delivering exceptional value

RISK(S) THIS REPORT MITIGATES

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

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

Quality Domains (select all that apply) [link to standards]		
☒ Safe	☐ Timely	☒ Effective
☒ Efficient	☐ Equitable	☒ Person Centred
Quality Enablers (select all that apply) [link to standards]		
☐ Leadership	☐ Workforce	☐ Culture
☐ Information	☒ Learning Improvement & Research	☐ Whole Systems Approach

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [link to goals]		
☐ A socially responsible and inclusive employer	☐ An innovative and sustainable organisation	☐ A pro-active, accessible and equitable care provider
☒ n/a	☒ n/a	☒ n/a

IMPACT ASSESSMENTS FOR CONSIDERATION

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

Does this paper require an impact assessment	☒ No ☐ Yes
If yes, what impact assessment is attached	

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
16 July 2026	Clinical Intelligence and Assurance Team (CIAT)

SITUATION

1. The Clinical Audit Plan is presented to the QuEST on a quarterly basis to seek approval for wider sharing.

BACKGROUND

2. The Trust's annual Clinical Audit Plan allows the planning and prioritisation of clinical audits across the financial year. It is a dynamic document, updated quarterly to reflect those audits that are either planned, currently underway, have been completed.

3. Various groups and committees receive quarterly updates, and it is made available on the Trust's intranet.

ASSESSMENT

4. The following audits from the Clinical Audit Plan have been commenced:

   - 26_001 Trauma in older people
   - 26_002 Open fracture – co-amoxiclav

5. Audits halted:

   - 25_003 Appropriate Use of Antimicrobials
     A closure report was presented to CIAG in May 2026 outlining rationales to why the audit was no longer sustainable. The report identified key learning which has been shared with the senior team and as a result several actions were implemented to address some of the issues which had already been identified up to that point.

   - Re-audit ePCR clinical data assurance - ROSC at hospital
     This re-audit was added to the Clinical Audit plan 2023/2024 following a decision to undertake a re-audit when the TerraPACE user interface had matured. Progress has been repeatedly impacted by a variety of dependencies and constraints arising from planned/ anticipated ePCR user interface changes along with clarification of OOHCA definitions and competing priorities. The ePCR refresh is scheduled to be deployed in 2027.

     An audit will be undertaken 6 months following its deployment.

6. During the planned clinical audits outlined above, the following additional intelligence work has been undertaken; 10 clinical intelligence requests have been completed, three of which were submitted under the Freedom of Information Act. All SQL queries supporting these FOI requests were quality assured by the Insight & Data Services Team. This total does not include rolling data requests currently being provided or data supplied for clinical audits.

7. In addition, the Assistant Director of Clinical Development, supported by CIAT, commissioned a review to evaluate and better align the reporting of Out-of-Hospital Cardiac Arrest (OOHCA) and Return of Spontaneous Circulation (ROSC) data with the Utstein 2024 definition of 'attempted resuscitation'. The review highlighted several key findings that required further examination and informed decision-making to support the implementation of a consistent and robust reporting methodology.

8. The technical specification is being updated in line inline with definitions approved at CIAG 16 July 2026.

9. Major Trauma Clinical Indicator reporting will be undertaken through the compilation and publication of EMERG- Major Trauma Annual report. Inaugural meeting has taken place to discuss reporting requirements.

10. Outcomes and Impact from previous Clinical audits:

    The following two clinical audits were initiated through the Ambulance Practice Steering Group (APSG) and delivered by the CIAT. Both audits demonstrate the important role of clinical audit in providing assurance regarding current practice, identifying opportunities for improvement and supporting organisational learning and governance.

    10.1 <u>Ketamine Audit (CIAT25_004)</u>

    The Ketamine audit provided an important opportunity to evaluate clinical practice and strengthen the wider governance arrangements supporting the administration of Ketamine within the Trust. The audit identified that clinicians were using Ketamine to a high clinical standard, providing positive assurance regarding clinical decision-making and the care delivered to patients.

However, the audit also identified that frequent updates to the Patient Group Direction (PGD) had not always been accompanied by timely amendments to the associated Standard Operating Procedure (SOP). This had resulted in some differences between the requirements of the PGD and the guidance contained within the SOP.

Through CIAT's detailed analysis and presentation of the findings, the audit acted as a catalyst for wider organisational learning and prompted a comprehensive review of the relevant governance documentation and training materials. Work has subsequently been completed to ensure improved alignment between the PGD, SOP and associated education and training.

As a direct consequence of the audit, assurance can now be provided that the documentation and guidance relating to the use of Ketamine are consistent, current and clearly support safe clinical practice. This demonstrates the value of CIAT's audit work in moving beyond the identification of issues and actively supporting the implementation of sustainable improvements.

10.2 Magnesium Sulfate Administration Audit (CIAT25_007)

Magnesium Sulfate was introduced to the WAST Paramedic Formulary in April 2025 following an update to the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) clinical guidelines. Following approval of its introduction by APSG, a full clinical audit was requested to evaluate its use and provide assurance regarding clinical decision-making and compliance with the relevant PGD.

The audit demonstrated strong levels of compliance across several key PGD criteria and provided assurance that Magnesium Sulfate was being administered appropriately and safely by clinicians. A small number of opportunities for improvement were identified in relation to documentation. These were minor in nature and did not indicate any adverse impact on patient care.

CIAT translated the findings into clear and proportionate learning messages, which were shared with Trust clinicians to reinforce documentation standards and support continued compliance. The audit therefore provided both clinical assurance and an early opportunity to embed learning following the introduction of a new medication.

11. Wider Organisational Impact

Both audits were positively received by CIAG and APSG. The quality and practical value of the findings led both groups to recommend that a similar clinical audit should be undertaken following the future introduction of any new medication into the WAST Formulary or following significant changes to JRCALC guidance or a PGD.

This represents an important change in organisational practice, with CIAT's work directly influencing the development of a more systematic and proactive approach to medicines assurance. Future audits will help confirm that new medications and clinical guidance have been safely embedded, that clinicians are working in accordance with the relevant requirements, and that any early opportunities for learning or improvement are identified promptly.

Findings from CIAT clinical audits have also positively influenced the work of the ePCR Refresh Group. Audit findings have highlighted areas where improvements to electronic documentation, clinical prompts and data fields could support clinicians to record care more consistently. This demonstrates how CIAT's clinical audit programme contributes not only to retrospective assurance, but also to the development of practical system improvements that support safer care, improved documentation and enhanced clinical practice across the Trust.

RECOMMENDATIONS

12. The recommendations are set out in front cover above.

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Welsh Ambulance Services
University NHS Trust

Welsh Ambulance Services University NHS Trust

Clinical Audit Plan

Q1 update (Apr-Jun)

2026/2027

FINAL Last Updated 08 July 2026

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
- When new drug added to WAST formulary

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	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					
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	Q1	Q2	Q3	Q4
25_007	1	Magnesium Sulfate Administration	Clinical Intelligence & Assurance Team	Regional Clinical Lead SE	December 2025					
25_003	1	Appropriate Use of Antimicrobials	Clinical Intelligence & Assurance Team	Head of Medicine Management	Halted					
TBC	1	ePCR Clinical Data Assurance - Return of Spontaneous Circulation at Hospital Clinical Indicator Re-audit	Clinical Intelligence & Assurance Team	Head of Clinical Intelligence & Assurance	Halted	N/A				
TBC	1	Recording of Failed Pathways in ePCR	Clinical Intelligence & Assurance Team	Assistant Director of Clinical Development	Indicative Q4	N/A	N/A	N/A	N/A	
26_001	1	Trauma in Older People Tool	Clinical Intelligence & Assurance Team	Assistant Director Clinical Delivery	June 2026	N/A				
26_002	1	Open Fracture (Co-amoxiclav)	Clinical Intelligence & Assurance Team	Assistant Director Clinical Delivery	June 2026	N/A				

TBC	1	End of Life Care: Palliative care pathway development and development of EoLC section in ePCR	Clinical Intelligence & Assurance Team	Professional Development Lead Frailty, Palliative & EoLC	Indicative Q4	N/A	N/A	N/A	N/A	
TBC	1	Non-conveyance Form	Clinical Intelligence & Assurance Team	Regional Clinical Lead, Consultant Paramedic (N)	Indicative Q3	N/A	N/A	N/A		
TBC	1	Verification of Death	Clinical Intelligence & Assurance Team	Clinical Lead, Acute Care	Indicative Q3	N/A	N/A	N/A		
TBC	1	Patients Lacking Capacity Who Are Not Conveyed to Hospital >16yrs	Clinical Intelligence & Assurance Team	Senior Safeguarding Specialist	As Safeguarding resource allows	N/A	N/A	N/A	N/A	

Table 2 – Full Information

Ref	Clinical Audit Title	Rationale/Drivers	Clinical Audit Author	Clinical Audit Contact/Support	Audit Start Date	Comments
25_007	Magnesium Sulfate Administration	New PGD January 2025	Clinical Intelligence & Assurance Team	Clinical Intelligence & Assurance Team	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 supply monthly data on its use to Regional HBCL Audit Commenced
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	June 2025 Halted	Preparatory work undertaken. Meeting scheduled 29 05 25 Analysis commenced Awaiting clinical reviews prior to final analysis Closure report presented to CIAG 19 05 26 outlining rationale to why the audit no longer meets its intended purpose. Audit halted.

Ref	Clinical Audit Title	Rationale/Drivers	Clinical Audit Author	Clinical Audit Contact/Support	Audit Start Date	Comments
TBC	ePCR Clinical Data Assurance - Return of Spontaneous Circulation 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 Q1 26/27 Halted	Funding required for these specific changes. Autumn 2024 deployment. The 'Point of closure nudge tool' has been activated to improve outcome compliance. Agreed in CIAG on 12 July to defer to Q3 at earliest. 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. 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
						Unable to progress until ePCR updates implemented. Paper received at CIAG 19 05 26 Termination of re-audit agreed.
TBC	Recording of Failed Pathways in ePCR	Following an update to the ePCR User Interface to record the inability to refer patients onto pathways, an audit would assist in identifying areas for improvement for patient care and avoid unnecessary admission to Emergency Departments.	Clinical Intelligence & Assurance Team	Clinical Intelligence & Assurance Team	Indicative Q4	Required UI changes presented to ePCR CRG 29.05.24 CR0048, likely release Oct/Nov 2024 Revised date for UI changes Spring 2025 Sponsor has requested a clinical intelligence report be generated to inform the need for the audit. On hold as likely implementation is Dec 2025 with wider roll-out Jan 2026. Anticipated roll-out June 2026, anticipated start date Q4 dependent upon data retrieval. Likely testing to commence Winter 2026/27

Ref	Clinical Audit Title	Rationale/Drivers	Clinical Audit Author	Clinical Audit Contact/Support	Audit Start Date	Comments
26_001	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	Clinical Intelligence & Assurance Team	Q1	
26_002	Open Fracture (Co amoxiclav)	This clinical audit will complement the clinical indicator reporting being developed around major trauma, NB not all open fractures are connected to major trauma	Clinical Intelligence & Assurance	Clinical Intelligence & Assurance Team.	Q1	
TBC	End of Life Care: Palliative care pathway development and development of EoLC section in ePCR	Palliative care pathway development and development of EoLC section in ePCR.	Clinical Intelligence & Assurance	Clinical Intelligence & Assurance Team	Indicative Q4	
TBC	Non-conveyance Form	Implementation of Alternative Conveyance Policy	Clinical Intelligence & Assurance	Regional Clinical Lead, Consultant Paramedic (N)	Indicative Q3	
TBC	Verification of Death	Aligns with updates within JRCALC and update to ePCR	Clinical Intelligence & Assurance	Clinical Lead, Acute Care	Indicative Q3	
TBC	Patients Lacking Capacity Who Are Not Conveyed to Hospital >16yrs	Recommendation from Adult Practice Review	Clinical Intelligence & Assurance	Senior Safeguarding Specialist	As Safeguarding Resource allows	

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

Agenda Item No.

REPORT TITLE

Clinical Audit Plan Q4 Update 2025-2026

MEETING

Name of meeting	Clinical Intelligence & Assurance Group (CIAG)
Date of meeting	9th April 2026
Public or Private	Public
If private - rationale	Choose item from below

REPORT SPONSOR

Executive sponsor	Andy Swinburn, Director of Paramedicine
Author(s) of report	Ruth Saele, Clinical Data Specialist

PURPOSE OF REPORT

☒ Approval	☐ Endorsement
☐ Assurance	☐ Discussion
☐ Information (goes in consent items)	☐ Noting

REPORT SUMMARY:

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

1. This report provides an update to CIAG on the progress of the 2025/26 Clinical Audit Plan for Q4 (Jan – Mar).
2. The following audits have been completed:

- 25_007 Magnesium Sulfate Administration

3. The report also provides additional intelligence work undertaken by the Clinical Intelligence and Assurance Team.

RECOMMENDATIONS

The CIAG is requested to:

- Note the work completed outside of the plan.
- Approve the Q4 Clinical Audit Plan.

ADDITIONAL PAPERS

The CIAG is requested to receive the following:

1. Clinical Audit Plan Update Q4 2025/26

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [link to objectives and what good looks like]	
☒ SO1: Providing the right care or advice, in the right place, every time	☒ SO2: Enabling our people to be the best they can be
☐ SO3: Being at the forefront of innovation and technology	☐ SO4: Developing services in collaboration
☒ SO5: Being quality driven and clinically led	☐ SO6: Delivering exceptional value

RISK(S) THIS REPORT MITIGATES

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

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

Quality Domains (select all that apply) [link to standards]		
☒ Safe	☐ Timely	☒ Effective
☒ Efficient	☐ Equitable	☒ Person Centred
Quality Enablers (select all that apply) [link to standards]		
☐ Leadership	☐ Workforce	☐ Culture
☐ Information	☒ Learning Improvement and Research	☐ Whole Systems Approach

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [link to goals]		
☐ A socially responsible and inclusive employer	☐ An innovative and sustainable organisation	☐ A pro-active, accessible and equitable care provider
☒ n/a	☒ n/a	☒ n/a

IMPACT ASSESSMENTS FOR CONSIDERATION

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

Does this paper require an impact assessment	☒ No ☐ Yes
If yes, what impact assessment is attached	

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
9th April 2026	CIAG

SITUATION

1. The Clinical Audit Plan is presented to the Clinical Intelligence and Assurance Group (CIAG) on a quarterly basis to seek approval for wider sharing.

BACKGROUND

2. The Trust's annual Clinical Audit Plan allows the planning and prioritisation of clinical audits across the financial year. It is a dynamic document, updated quarterly to reflect those audits that are either planned, currently underway, have been completed.
3. Various groups and committees receive quarterly updates, and it is made available on the Trust's intranet.

ASSESSMENT

- The following audit from the Clinical Audit Plan has been completed:

    - 25_007 Magnesium Sulfate Administration

- Ongoing audits:

    - 25_003 Appropriate Use of Antimicrobials was commenced in Q2. There has been delay in completing the specialist clinical reviews due to operational demands and will roll over to April 2026

- During the planned clinical audits outlined above, the following additional intelligence work has been undertaken:

    - 11 clinical intelligence requests have been completed, five of which were submitted under the Freedom of Information Act. All SQL queries supporting these FOI requests were quality assured by the Insight & Data Services Team. This total does not include rolling data requests currently being provided or data supplied for clinical audits.

- The ownership of actions and the delivery of associated outcomes commonly reside outside the influence of the Clinical Intelligence and Assurance Team (CIAT) and sits within other responsible teams / directorates, where priorities may not be aligned. Despite these challenges at year end 2025/26 all actions following clinical audits undertaken during the year have been reported as completed, notably;

- Influencing key learning from Drug documentation audit to be included within a review of the Medicines Management Policy.
- Influencing the update of the Ketamine SOP to align with the Midazolam PGD. Improve alignment between PGD, SOP and training.
- Following an audit of older fallers discharged at scene it was an agreed recommendation to develop and implement a clinical indicator (CI) for this group of patients in partnership with key internal stakeholders. The CI went live in January 2026

RECOMMENDATIONS

That the CIAG:

- **Note the additional clinical intelligence work completed outside of the plan**
- **Approve the Q4 Clinical Audit Plan**

NEXT STEPS

To be presented at QuEST

Agenda Item No.	11

REPORT TITLE

Infection Prevention and Control Work Plan Update

MEETING

Name of meeting	Quality, Patient Experience & Safety Committee
Date of meeting	6 August 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Penny Durrant, Director of Nursing (Interim)
Author(s) of report	Sarah Morgan, Head of Infection Prevention & Control

PURPOSE OF REPORT

☐ Approval	☐ Endorsement
☒ Assurance	☒ Discussion
☐ Information (goes in consent items)	☐ Noting

REPORT SUMMARY

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

1. This report provides an update on delivery of the Infection Prevention and Control (IP&C) Work Plan 2026/27 and the associated level of organisational assurance. It outlines progress against key priorities, identifies principal risks and constraints, and describes the actions being taken to mitigate these risks.

2. Overall, the evidence presented demonstrates improving organisational assurance across governance, audit, policy development and vehicle decontamination. Whilst infrastructure investment and workforce capacity continue to constrain some workstreams, risks are well understood, proportionate mitigating actions are in place, and delivery continues to be prioritised according to organisational risk.

IP&C Work Plan Deliverables

IP&C Policy Framework

3. Significant progress has been made in establishing a comprehensive IP&C Framework through completion of a policy mapping exercise and development of an overarching IP&C Strategy. This work supports greater consistency of practice, alignment with national guidance and improved organisational oversight.

Cleaning and Decontamination

4. Assurance relating to cleaning and decontamination is mixed. Vehicle decontamination improvement work is demonstrating positive outcomes through a quality improvement approach supported by microbiological testing, providing evidence that revised processes are improving cleanliness standards.

5. However, the absence of funded Make Ready Depots (MRDs) within current planning assumptions remains a constraint to achieving a fully standardised approach across the fleet.

6. Assurance relating to estates cleaning remains partial. Audit findings have identified gaps in routine cleaning provision, and planned improvements are constrained by infrastructure and funding limitations. Interim mitigating actions are being implemented to reduce risk while longer-term solutions are developed.

Audit Programme

7. The Audit Programme continues to provide good assurance, with improved completion rates, stronger ownership of Action Plans and increasing local accountability.

IP&C Training

8. Progress in IP&C training is variable. Positive developments have been achieved in respiratory protection training through introduction of Respiratory Protective Equipment (RPE) champions and increased operational engagement. However, delivery of Aseptic Non-Touch Technique (ANTT) practical training remains challenged by workforce capacity and competing priorities, resulting in a continuing compliance risk. Mitigating actions are in place, and improvement remains achievable over time.

IP&C Governance

9. Governance arrangements continue to provide strong assurance. The refreshed IP&C Strategic Group has improved organisational engagement, visibility of risks and accountability for delivery, supporting effective monitoring and escalation through a risk-based approach to prioritisation.

10. Based on the evidence presented, the overall assessment remains one of reasonable assurance. Evidence demonstrates improving organisational maturity across governance, audit, policy development and decontamination, providing increasing confidence that key infection prevention and control arrangements are becoming more consistent and embedded.

11. Reasonable assurance is limited principally by infrastructure investment requirements and workforce capacity constraints, which continue to be actively managed through established governance arrangements. Continued oversight of these risks will remain essential.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

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

1. Receive the Infection Prevention and Control Work Plan Update;
2. Take reasonable assurance that delivery of the 2026/27 Infection Prevention and Control Work Plan is progressing, with proportionate arrangements in place to manage the principal infection prevention and control risks; and
3. Note the principal residual risks relating to infrastructure investment and workforce capacity, together with the mitigating actions in place.

ADDITIONAL PAPER(S)

Set out here any annexes. See writing and presentation guidance here regarding materiality and use of the Reading Room

n/a

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [link to objectives and what good looks like]	
☒ SO1: Providing the right care or advice, in the right place, every time	☒ SO2: Enabling our people to be the best they can be
☐ SO3: Being at the forefront of innovation and technology	☒ SO4: Developing services in collaboration
☒ SO5: Being quality driven and clinically led	☒ SO6: Delivering exceptional value

RISK(S) THIS REPORT MITIGATES

Where relevant note the local, directorate, corporate or BAF risk number
Residual risks remain principally in relation to infrastructure investment and workforce capacity. These risks limit the level of assurance that can currently be provided but are actively managed through established governance arrangements.

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

Quality Domains (select all that apply) [link to standards]		
☒ Safe	☐ Timely	☒ Effective
☒ Efficient	☒ Equitable	☐ Person Centred
Quality Enablers (select all that apply) [link to standards]		
☒ Leadership	☐ Workforce	☐ Culture
☐ Information	☐ Learning Improvement and Research	☒ Whole Systems Approach

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [link to goals]		
☐ A socially responsible and inclusive employer	☐ An innovative and sustainable organisation	☒ A pro-active, accessible and equitable care provider
☒ n/a	☒ n/a	☐ n/a

IMPACT ASSESSMENTS FOR CONSIDERATION

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

Does this paper require an impact assessment	☒ No ☐ Yes
If yes, what impact assessment is attached	

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
17 July 2026	Clinical and Quality Governance Group

Agenda Item No 12

REPORT TITLE

Healthcare Inspectorate Wales New NHS Wales Engagement Process: Implementation and Assurance Update

MEETING

Name of meeting	Quality, Patient Experience & Safety Committee
Date of meeting	6 August 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Andy Swinburn, Executive Director of Paramedicine
Author(s) of report	Penny Durrant, Director of Nursing (Interim)

PURPOSE OF REPORT

☐ Approval	☐ Endorsement
☒ Assurance	☐ Discussion
☐ Information (goes in consent items)	☐ Noting

REPORT SUMMARY:

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

1. In February 2026, the Quality, Patient Experience and Safety Committee (QuESt) received a paper outlining the introduction of Healthcare Inspectorate Wales's (HIW) new NHS Wales Engagement Process and requested a further update on how the Trust would implement the revised engagement requirements, any anticipated changes to reporting and assurance arrangements, and any associated risks requiring escalation. This paper provides that update and reflects subsequent engagement between the Welsh Ambulance Servies University NHS Trust (WAST) and HIW regarding the practical application of the Framework.

2. Since the introduction of the new Model, further discussions with HIW have provided greater clarity regarding the intent of the Framework and the expectations placed upon NHS organisations. The revised approach moves beyond the previous Relationship Manager Model and establishes a more structured, intelligence-led system of engagement. This includes strengthened relationships across executive, clinical, operational and independent member leadership groups, greater emphasis on the sharing of organisational intelligence, and an increased focus on how organisations demonstrate learning, improvement and assurance through their governance arrangements.

3. The Trust is well positioned to align with the principles of the new engagement process through its existing Governance Framework, including the Board Assurance Framework, Quality Management System (QMS), Clinical and Quality Governance Group (CQGG), QuESt, and established arrangements for managing inspections, reviews, regulatory intelligence and assurance activity. The Framework is consistent with the Trust's commitment to openness, continuous improvement and the Duty of Quality.

4. Whilst the new engagement process does not require significant structural change within WAST, it presents an opportunity to further strengthen the way regulatory intelligence is received, triangulated and reported. In particular, discussions with HIW have highlighted the value of proactive engagement regarding emerging quality, patient safety and operational risks, alongside more systematic consideration of themes arising from inspections, reviews, concerns, incidents, audits and other sources of external assurance. This supports a more mature approach to organisational learning and provides additional opportunities to demonstrate the effectiveness of the Trust's governance and assurance systems.

5. To support implementation, it is proposed that oversight of HIW engagement and associated learning continues through existing governance structures, with regulatory themes, recommendations and learning incorporated into routine quality assurance arrangements. No additional governance structures are required to support implementation of the Framework.

6. An annual review of HIW engagement activity and organisational learning will also be presented through the Committee cycle to provide assurance that external scrutiny is informing continuous improvement across the Trust. HIW has advised that the Engagement Guidance is currently being reviewed following implementation of the new Framework. Whilst minor refinements are anticipated, no substantive changes affecting the arrangements described within this paper have been identified at the time of writing.

7. Overall, engagement with HIW to date has been constructive and supportive, providing assurance that the Trust's direction of travel aligns with the intent of the new Framework. The revised engagement process should be viewed not solely as a regulatory requirement, but as an opportunity to strengthen organisational intelligence, transparency and assurance maturity, supporting the delivery of safe, effective and continuously improving services.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

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

1. Take assurance that the Trust has established appropriate arrangements to implement the HIW NHS Wales Engagement Process;
2. Note the proposed enhancements to regulatory engagement, organisational learning and assurance reporting arrangements;
3. Support the provision of an Annual Report on HIW engagement activity and associated organisational learning through the Committee cycle; and
4. Note that no Board level risks requiring escalation have been identified at this stage.

ADDITIONAL PAPER(S)

Set out here any annexes. See writing and presentation guidance here regarding materiality and use of the Reading Room

The following paper underpins this report:

Annex 1: Healthcare Inspectorate Wales NHS Wales Engagement Process. Guidance for Health Boards and NHS Trusts

Noting that Healthcare Inspectorate Wales has advised that a revised version is currently being developed following a review of the implementation of the engagement process. At the time of writing, the October 2025 Guidance remains the current published version and therefore continues to underpin the arrangements described within this report.

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [link to objectives and what good looks like]	
☐ SO1: Providing the right care or advice, in the right place, every time	☐ SO2: Enabling our people to be the best they can be
☐ SO3: Being at the forefront of innovation and technology	☒ SO4: Developing services in collaboration
☒ SO5: Being quality driven and clinically led	☐ SO6: Delivering exceptional value

RISK(S) THIS REPORT MITIGATES

Where relevant note the local, directorate, corporate or BAF risk number
No specific local, directorate, corporate or Board Assurance Framework risks have been identified in relation to this report. The paper supports the Trust's wider governance, assurance and regulatory compliance arrangements.

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

Quality Domains (select all that apply) [link to standards]		
☐ Safe	☐ Timely	☒ Effective
☒ Efficient	☐ Equitable	☐ Person Centred
Quality Enablers (select all that apply) [link to standards]		
☒ Leadership	☐ Workforce	☐ Culture
☒ Information	☒ Learning Improvement & Research	☒ Whole Systems Approach

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [link to goals]		
☐ A socially responsible and inclusive employer	☒ An innovative and sustainable organisation	☐ A pro-active, accessible and equitable care provider
☒ n/a	☐ n/a	☒ n/a

IMPACT ASSESSMENTS FOR CONSIDERATION

Where a strategic decision is being sought, an Equality Impact Assessment must accompany this paper. You may need to do other impact assessments also so please refer to this signpost document here for further details.	
Does this paper require an impact assessment	☒ No ☐ Yes
If yes, what impact assessment is attached	

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
17 July 2026	Clinical and Quality Governance Group

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Healthcare Inspectorate Wales NHS Wales Engagement Process

Guidance for Health Boards and NHS Trusts

Version: 1
Review: February 2026

Author: Head of NHS Assurance

Date: October 2025

Contents

Introduction

Healthcare Inspectorate Wales (HIW) is responsible for inspecting, reviewing and investigating NHS Wales services, to seek assurance that healthcare providers deliver safe and quality care to people. We consider how services comply with healthcare regulations and legislation, meet the **Health and Care Quality Standards 2023**, comply with Welsh Government strategy, policy and legislation, and adhere to professional standards and guidance relevant to their area of care.

Establishing and sustaining productive relationships with Health Boards and NHS Trusts is fundamental to the delivery of safe and effective care. In alignment with HIW's strategic priorities, our efforts are dedicated to ensuring that healthcare services throughout Wales are consistently safe, effective, and responsive to the needs of the population. Our key objectives include maintaining a firm emphasis on care quality as individuals access and transition between services, demonstrating agility in identifying and addressing emerging risks to patient safety, and fostering collaborative partnerships across the system to facilitate continuous improvement.

In line with HIW's set priorities and objectives, a review of the assurance process across all healthcare sectors was conducted in 2024. As a result, organisational changes were made, including the establishment of senior leadership positions, such as Head of NHS Assurance and Head of Independent Healthcare Assurance. This led to a revision of the engagement processes with NHS Wales organisations, resulting in the development of a new engagement model to replace the previous Relationship Manager (RM) model. The new NHS Wales Engagement Process will be introduced in October 2025.

Rationale for change

Review of relationship manager model of engagement

Our review of the RM model of engagement identified several areas for improvement. Although a designated point of contact was established for Health Boards and Trusts liaising with HIW, the overall approach to engagement found some inconsistencies, which included:

- Frequency of meetings
- Variability in the content of agendas
- Intermittent review of Committee and Board papers
- Variable stakeholder engagement
- Variability in RM oversight of an organisation's governance processes
- Gaps in understanding how NHS organisations assure themselves of delivering safe and effective care.

To address these issues, we have introduced a new NHS Wales engagement process. This process will provide a standardised, team-based approach to engagement, supported by intelligence and will promote clear communication through an integrated model aligned with HIW's priorities, objectives, and values.

Team-based model for NHS engagement

We have implemented a team-based approach to the NHS engagement process and this is fundamental to:

- **Ensure consistency and continuity**
  Provide a reliable and consistent point of contact between Health Boards, NHS Trusts, and HIW. This enables timely and accurate information flow to the appropriate team, reducing dependency on individual staff members and ensuring continuity during staff transitions.

- **Strengthen collaborative relationships**
  Foster deeper, more effective partnerships with NHS Wales organisations. A team-based approach ensures that engagement is not only consistent across NHS Wales but also more responsive to the unique needs and contexts of each organisation.

- **Build organisational intelligence**
  Maintain a centralised, collective knowledge base within HIW about each NHS Wales organisation. This knowledge will be drawn from multiple sources, including:

  - Direct engagement with Health Boards and Trusts
  - Insights and intelligence from external stakeholders
  - Intelligence from Welsh Government

- National datasets and performance indicators.

- **Enable proactive assurance and planning**
  Through systematic analysis of acquired intelligence, HIW will:

  - Identify emerging trends and risks
  - Respond swiftly to issues requiring immediate attention
  - Inform and adapt assurance planning processes
  - Facilitate two-way sharing of critical information with Welsh Government and other stakeholders, thus enhancing transparency and accountability.

Overview of the new NHS engagement model

With the new NHS engagement model, the Head of NHS Assurance is supported by two clinical teams and HIW's intelligence team. Collectively, they lead a coordinated approach that prioritises not just the gathering of intelligence, but its systematic analysis. This enables HIW to identify themes, trends, and potential risks across the healthcare system in Wales.

Strategic discussions will be held regularly with key clinical leads and executives, ensuring that topics, such as patient safety, governance, and quality are always at the forefront. When concerns arise, the model establishes clear, timely escalation routes so that issues are addressed swiftly and collaboratively. Throughout, there will be a strong emphasis on transparency, partnership, and two-way communication with stakeholders, ensuring that assurance activities are both proactive and responsive to the evolving needs of NHS Wales.

Expectations for Health Boards and NHS Trusts

Strategic and routine engagement

HIW maintains clear expectations for engagement with NHS Wales organisations, whether through in-person visits or remote interactions.

Joint meetings

Health Board and NHS Trusts are expected to engage with HIW through structured meetings as requested. These meetings will vary across HIW's teams and will focus on HIW's intelligence regarding ongoing or emerging risks, findings and follow-up from HIW's assurance activity, governance and leadership, quality of care, fragility of services, and strategic planning.

Transparency and evidence sharing

Health Boards and NHS Trusts must provide HIW with timely, accurate, and comprehensive data to support all HIW assurance work. They must also provide relevant documentation to HIW when requested and by any set deadlines, respond to assurance requests for information and evidence and participate in thematic discussions as required.

Duty of Quality

The Health and Social Care (Quality and Engagement) (Wales) Act 2020 expands the duty on NHS bodies in relation to quality. Health Boards and NHS Trusts are required to engage with Healthcare Inspectorate Wales (HIW) to demonstrate their effectiveness, safety, and care experience improvements. In meeting their quality responsibilities, NHS bodies should consider the Health and Care Quality Standards 2023 when making healthcare service decisions. Organisations are also advised to incorporate HIW's findings into quality reporting and ensure consistency with the Health and Care Quality Standards in service delivery decisions.

Continuous improvement and learning

Engagement with HIW should foster a culture of continuous improvement, including acting on inspection findings, sharing learning across the system, and demonstrating leadership and accountability. NHS bodies are expected to apply quality management systems and use feedback for service improvements. Health Boards and NHS Trusts should also escalate concerns through agreed channels and contribute to resolution processes.

Co-production and stakeholder engagement

HIW expects Health Boards and NHS Trusts to demonstrate how stakeholder views, including those of patients and staff, inform service design and improvement. This co-production approach includes listening to lived experiences and feedback, ensuring

inclusive and bilingual communication, and maintaining a focus on equality, diversity and inclusion.

Authority to enter and inspect

When conducting assurance work, NHS Wales organisation must be aware and respect that HIW staff are authorised to:

- Enter and inspect premises
- Interview people
- Inspect, take copies of and remove documents or records
- Take measurements, photographs and make recordings
- Gain access to any computer and associated apparatus
- Take other action, in accordance with the following legislation:
    - Health and Social Care (Community Health and Standards) Act 2003
    - Care Standards Act 2000
    - Health and Safety at Work Act 1974.

Planned engagement meetings with HIW

The minimum required engagement meetings per year and key attendees are presented in **Table 1** below.

Table 1: Planned engagement meetings - attendees

HIW Team	Health Board or Trust staff	Frequency
• Chief Executive • Director of Assurance • Head of NHS Assurance	✓ Chief Executive ✓ Chair (joint meeting)	Six months
• Head of NHS Assurance	✓ Chief Operating Officer	Six months
	✓ Selected Independent Members	Six months
• Acute Clinical Team	✓ Director of Nursing ✓ Medical Director ✓ Director of Allied Health and Therapies (joint meeting)	Four months
• Mental Health (MH) & Learning Disabilities (LD) Clinical Team	✓ Directors of MH & LD ✓ Clinical Leads for MH & LD ✓ MHA Administrators (joint meeting)	Four months

Meetings will be scheduled for at least one hour, or longer if necessary.

Additional meetings can be requested by either HIW or NHS Wales organisations as appropriate.

All engagement meetings will be structured and documented, and agendas will be intelligence-led and shared in advance.

Meeting outcomes will be recorded and shared with the relevant Health Board or NHS Trust, across HIW teams, and with relevant stakeholders as appropriate.

Correspondence regarding inspections or reviews

HIW has faced challenges in coordinating recipients for inspection correspondence, including reports and letters, within NHS organisations. Challenges arise when staff transition into new roles or when organisations request access for multiple individuals, which may not align with HIW's established procedures. Such situations can lead to outdated contact lists, ambiguity regarding information recipients, and the risk of confidential materials being accessed by unauthorised parties. These factors have the potential to delay communication and complicate follow-up actions following inspections.

For consistency, HIW will send written assurance correspondence concerning inspections and reviews to designated recipients in each NHS organisation. The designated recipients are responsible for disseminating information to their appropriate internal teams. This also applies to assurance activities within Dental and GP practices. The designated recipients are listed in **Table 2**.

Table 2: Recipients of HIW assurance correspondence

- Chief executive
- Chair
- Executive Director of Nursing
- Executive Medical Director
- Executive Director of Therapies and Allied Health
- A nominated team mailbox (such as Governance / Patient Safety Teams)

For clarity, HIW will no longer be sending assurance (inspection or review) correspondence to other individuals, such as primary care and community leads for Dental or GP inspections, neither will the 'other individuals' receive invitations to HIW's secure sharing portal, Objective Connect. The above recipients will be responsible for sharing the relevant HIW documents with applicable organisation teams, and for uploading responses and evidence as appropriate, to the Objective Connect workspace.

It is pertinent to note that for any other correspondence, such as concerns or communications with HIW's Investigation Teams, and ad hoc inspection communications with HIW's Inspection Support team, we will communicate with other relevant individuals as appropriate.

Ongoing engagement with HIW

Communication with HIW staff will vary and will be dependent on the theme of the meeting or topic to be discussed. There will always be occasions when key staff within NHS organisations need to contact HIW and vice versa. This may be for general enquiries, discuss patient safety, care, or clinical issues, and non-clinical issues, such as service or organisational changes. In the first instance, **Table 3** highlights which team in HIW should be contacted, however, where appropriate your email may be directed to a different team to manage. Guidance on how to contact HIW is highlighted in Table 3 below.

Table 3: Guidance on contacting - key HIW teams

Example of Enquiry/ Notification:	Example of engagement need:	Who to contact:
General Enquiries.	Unsure of who to contact at HIW. Obtain team contact details. Query about HIW processes. Logging concerns prior to escalation to the Investigation Team. Raise concerns about HIW.	**HIW First Point of Contact (FPOC)** **Email:** HIW@gov.wales **Tel:** 0300 062 8163 **Link to:** Contact us **Link to:** Learning and Insight page
Enquiries about a planned inspection or following an unannounced inspection.	Query about an upcoming HIW inspection. Query following completion of inspection. Query about accessing the Objective Connect Workspace.	**Inspection Support Team** **Email:** HIW.Inspections@gov.wales **Tel:** 0300 062 8163 **Link to:** Inspecting NHS Services
Review Service for Mental Health.	Use of the Mental Health Act and the interests of people whose rights are restricted under that Act. Requests for, and engagement about HIW's Second Opinion Appointed Doctor (SOAD) Service.	**Second Opinion Appointed Doctor (SOAD) Service** **Email:** HIW.RSMH@gov.wales **Tel:** 0300 062 8163 **Link to:** SOAD documents

Discuss clinical or patient quality and safety issues.	Clinical and/or patient quality and safety discussions.	**Acute Clinical Team** **Email:** HIW.AcuteClinical@gov.wales **Mental Health & Learning Disability Team** **Email** HIW.MentalHealth.Clinical@gov.wales **Tel:** 0300 062 8163
Non-clinical issues. Service or key organisational issues. Internal investigation report findings. Early warning of high-profile media reports.	Discuss urgent or planned operational issues, such as those impacting service delivery. Urgent notice about damage/ issues with the estate. Discuss key findings about internal investigations or reviews, such as culture, behavior and values reviews. An incident has occurred which will likely attract media attention, therefore provide an early notice to HIW.	**Head of NHS Assurance** **Email:** HIW-NHSassurance@gov.wales **Tel:** 0300 062 8163
Death in Custody (DIC) clinical review process.	Query about DIC clinical review process. Submission of key DIC documents, reports, improvement plans to support the review. Query about and ongoing or previous DIC clinical review.	**NHS Assurance Team** **Email:** HIW-NHSassurance@gov.wales **Tel:** 0300 062 8163 **Link to:** Death in Custody
Discuss a new or existing HIW concern case. Provide IR(ME)R incident notification.	Report a new concern. Enquire about an ongoing patient/ public concern. Whistleblowing concern. Submit an IR(ME)R notification.	**Investigations Team** **Email:** HIW.Concerns@gov.wales **Tel:** 0300 062 8163 **Link to:** Complaints about us (HIW) **Link to:** Whistleblowing **Link to:** Notifying IR(ME)R Incidents
Discuss escalation and enforcement process. Discuss Service of Concern (SOC) process.	Enquiry about HIW's escalation and enforcement process. Seek clarity about HIW's SOC process.	**Esacalation & Enforcement Team** **Email:** HIW.Enforcement@gov.wales **Tel:**

Discuss existing/ active NHS Wales escalation case.	Discuss the organisation's designation as a SRSI. Submit information relating to HIW's SOC process or in line with the requirements as a SRSI.	0300 062 8163 **Link to:** Escalation page
Query about the registration of a service, such as dental practice.	Query regarding the registration status of a Dental Practice within a health board's locality	**Registrations Team** **Email:** HIW.Registration@gov.wales **Tel:** 0300 062 8163 **Link to:** Registration Queries
Discuss HIW's communication, publication, media and social media processes.	Discuss HIW's website or social media content Engagement between Communication teams in NHS Wales organisations and HIW.	**Strategy & Communication Team** **Email:** HIW.comms@gov.wales **Tel:** 0300 062 8163 **Link to:** Publication schedule **Link to:** Keep up to date (Bulletins) **Link to:** Social media page

Appendices

Appendix 1: Key changes from Relationship Manager (RM) engagement model

There are several key changes with the implementation of the new NHS Wales Engagement Model which include:

- The former RM role has been discontinued and superseded by an enhanced process designed to strengthen HIW's engagement with Health Boards and NHS Trusts
- The distribution list for HIW assurance correspondence within NHS Wales organisations has been revised to facilitate greater consistency and minimize errors
- Oversight of the NHS Engagement Process has transitioned to the Head of NHS Assurance, supported by two clinical teams and the intelligence team
- HIW clinical teams will conduct regular engagement meetings with executive leaders and key clinical leads, focusing on clinical themes, patient safety, governance, and quality
- The Head of NHS Assurance will hold planned non-clinical engagement meetings with Chief Operating Officers and Independent Members of the Board to discuss operational challenges, and where appropriate key findings from inspection
- The Partnerships Team will hold routine engagement meetings with external stakeholders, such as Llais, Audit Wales, Internal Audit, Royal Colleges, and representatives from NHS Performance and Improvement
- Escalation procedures within HIW have been further clarified and centrally coordinated.

Appendix 2: Sharing and use of information

HIW has several information sharing agreements with other organisations that we work closely with. These agreements set out the rationale for information sharing to assist the organisations in meeting their common statutory objectives and to focus on respective activities. They support the development of work programmes which are complementary, ensuring that there are clear processes in place for sharing information, risks, and concerns.

Where there are potential risks to public, patient or staff safety, HIW will share information with relevant authorities/organisations, such as the police, local authority safeguarding boards, and Health and Safety Executive. You can access the information sharing agreements on our website: **HIW's Memoranda of Understanding with other Organisations**.

All engagement activities and outcomes will be stored securely in HIW's secure electronic systems (known as Pwls and iShare). Evidence and intelligence will be used to inform strategic decisions, identify risks, and support continuous improvement across NHS Wales and the IHC sector.

General Data Protection Regulation (GDPR)

Under GDPR, we have a legal duty to protect any personal information we collect from you. We use leading technologies and encryption software to safeguard your data and keep strict security standards to prevent any unauthorised access to it.

Please see our website for further information on our **privacy policy**.

Appendix 3: Role of HIW teams within NHS Wales engagement

Some teams within HIW may not directly participate in the NHS Wales Engagement Process but will support HIW's relevant teams as appropriate.

Partnership, Intelligence and Methodology (PIM) Branch

The PIM Branch is made up of three teams: Partnership, Intelligence and Methodology. The branch supports HIW by gathering intelligence, assessing risks, developing inspection methodologies, and working with partners to help influence improvement across healthcare services. The branch ensures inspections are targeted and effective, helps manage concerns, and drives system-wide improvements through strategic analysis and collaboration.

Partnerships Team

The Partnerships Team maintains relationships and engagements with external stakeholders and manages HIW's Memoranda of Understanding with other Organisations.

This team also facilitates the bi-annual national Healthcare Summit, to share insights into the quality and safety of healthcare services provided by NHS Wales. Additional details regarding the Summit's purpose, and the participating organisations are available on our **website**.

The role of partnerships within the NHS Engagement Process is key in forging and maintaining strategic relationships between stakeholders to gain NHS assurance. Depending on the stakeholder, the 'purpose' of engagement may change, ranging from intelligence sharing and horizon scanning, to triangulating views on key NHS Wales issues, such as thematic risks or those within individual settings.

The team has developed a stakeholder map to maintain regular engagement, which includes organisations, such as Audit Wales, Llais, and NHS Wales Performance & Improvement. In addition, the team will attend key meetings across Welsh Government, Care Inspectorate Wales (CIW) and Estyn, to gather wider intelligence. The information obtained through these relationships and engagement opportunities will feed into HIW's Weekly Intelligence Group and will help inform proposals to undertake joint assurance work.

Intelligence Team

The Intelligence Team collects and analyses data from inspections, reviews, public feedback, and several external sources to identify risks and trends in healthcare services. The intelligence is used to inform HIW's Strategic Planning Board (SPB) and Risk and Escalation Committee (REC) and Senior Leadership Team (SLT), helping to plan or adjust

inspection priorities and respond to emerging issues. The team maintains dashboards and designs reports to help HIW's SLT to monitor performance and identify areas of concern.

The team also provides inspectors and reviewers with relevant intelligence to guide their work and ensure it is targeted and effective, and develops, analyses, and reports on surveys used during inspections and reviews. Additionally, the team drives transparency and improvement, by supporting HIW's Service of Concern process, enabling rapid action where standards of care are not me.

Intelligence is used to ensure HIW's assurance programme of work focuses on settings where patients are most at risk of not receiving optimal care. The team interprets a wide range of intelligence to make effective and appropriate decisions about how HIW utilises resources. To achieve this, systems and processes are in place to ensure decisions are consistent and based on evidence.

Key information feeds into the intelligence team through various sources (both internally and externally), and this is discussed in HIW's Weekly Intelligence Meetings. The collated information is presented to HIW's key teams, and to SPB and REC, to inform and reprioritise HIW's assurance work as appropriate.

The team also produces a briefing paper to help inform engagement discussions with Health Boards and NHS Trust clinical leads. The brief may include key findings, such as details of the Board, Quality and Safety Committee or Mental Health Legislation Committee meetings, Joint Executive Team meeting papers, or details from Integrated Medium-Term Plans, and data obtained through Welsh Government or nationally.

Methodology Team

The Methodology Team ensures that HIW's inspections, reviews, or investigations are carried out consistently, fairly, and effectively, using robust, evidence-based approaches, and considers the Health and Care Quality Standards 2023 and other regulations and legislation. The team designs and maintains standardised methodologies for assurance work, ensuring consistency and transparency across all HIW activities. Methodologies are also adapted to different healthcare sectors and specialties, considering unique risks and operational contexts, and when applicable, are bespoke to reviews work.

The team adapts to emerging risks and refines methodologies to respond to new challenges, enabling rapid and supportive advice for service improvement. In addition, the team ensures staff are trained in applying methodologies correctly and consistently, promoting continuous improvement in inspection practices.

For transparency, upon request, methodologies are available to healthcare services, and the team ensures they are accessible to stakeholders, reinforcing public trust in HIW's work.

The Methodology Team does not have a direct role in the NHS Engagement Process but may contact organisations if required.

Clinical Branch

The Clinical Branch is made up of two teams: Acute Clinical Team (ACT) and Mental Health and Learning Disabilities Team (MHLDT). The teams play a key role in ensuring that healthcare services across Wales meet high standards of safety, effectiveness, and person-centered care. They have a clinical oversight of HIW's work and provide clinical advice to inspectors and all teams across HIW where necessary. They also contribute to HIW's judgment, particularly in relation to patient safety, clinical governance, and the quality of care. In addition, they help interpret and apply the Duty of Quality in real-world settings.

Acute Clinical Team (ACT)

The ACT has a focus on all clinical settings within NHS Wales and the IHC sector, but excluding Mental Health and Learning Disability Services, which is the focus of the MHLDT.

Mental Health/ Learning Disabilities Team (MHLDT)

The remit of the MHLDT includes Mental Health and Learning Disability Services within both the NHS Wales and IHC sectors. The team focuses on clinical safety, legal compliance with the Mental Health Act (1983) and ensure that care is delivered in accordance with the **Code of Practice for Wales (2016)**.

- **NHS engagement meetings**
  The clinical teams lead on engagement with executive and/or senior clinical leads or managers in NHS Wales organisations. This is key in not only gaining assurance on how Health Boards and NHS Trusts gain their own assurance, but also in intelligence sharing, horizon scanning and gaining assurance on emerging risks and themes. During engagement meetings, there will also be an emphasis on quality, information sharing, early warning & escalation to identify potential problems using intel streams.

  The engagement meetings will provide an informal opportunity to share soft and hard intelligence and will offer a useful way to triangulate and corroborate information HIW is aware of, or to learn new information which may be relevant, and to identify new areas of risk which will be considered during HIW assurance activity. HIW's Intelligence Team will provide a briefing paper to the clinical teams prior to the planned engagement meetings.

The Review Service for Mental Health (RSMH) Team

The RSMH Team is part of HIW's broader assurance role to monitor compliance with the Mental Health Act and ensure high standards of care.

A crucial role within this team is the Second Opinion Appointed Doctor (SOAD) service. The team plays a pivotal role in safeguarding the rights of patients who are subject to the Mental Health Act 1983. When a patient is detained or liable to be detained under the Mental Health Act and refuses treatment (or lacks capacity to consent to treatment), a SOAD is appointed to review whether the proposed treatment is appropriate. This ensures that treatment decisions are not solely made by the treating clinician, adding a layer of independent oversight.

The SOAD process is designed to protect vulnerable individuals by ensuring that their treatment is lawful, ethical, and clinically justified. Therefore, SOADs are required to authorise specific treatments, such as medication beyond three months or Electroconvulsive Therapy (ECT), under sections 57, 58, and 62 of the Mental Health Act 1983.

Regulation and Escalation Branch

The Regulation and Escalation Branch is made up of three teams: Registration Team, Escalation and Enforcement Team and Investigations Team. The branch has a critical role in ensuring that independent healthcare services in Wales are safe, compliant, and meet regulatory standards. Additional it manages HIW's **Service of Concern (SOC) process for NHS Bodies in Wales.**

Registration Team

HIW is responsible for registering healthcare providers and managers of independent healthcare services in Wales, under the Care Standards Act 2000 and associated regulations. This includes Independent Hospitals, Clinics and Medical Agencies, and Private Dental Practices where providers offer private dental services outside of the NHS Framework. The Registration Team assesses whether a service requires registration and ensures that providers meet the National Minimum Standards before granting registration.

Enforcement & Escalation Team

The Enforcement and Escalation Team leads formal escalation processes, such as HIW's SOC process for NHS bodies in Wales. Additionally, when a registered service fails to meet its legal and regulatory obligations, HIW enforces compliance through structured processes appropriate within the Independent Healthcare (IHC) sector.

- **Escalation within NHS Wales**
  HIW prioritises action when standards are not met. To maintain transparency and public assurance about healthcare quality and safety, HIW uses a SOC process for NHS Wales bodies when it identifies significant service failures or systemic issues.

  This process allows HIW to identify and highlight 'Services Requiring Significant Improvement', thereby enhancing transparency regarding the discharge of its responsibilities. It ensures that targeted and timely actions are taken by relevant stakeholders, including Health Boards and Welsh Government, to maintain safe and effective care. Furthermore, this approach is designed to facilitate improvement and promote learning within an organisation's services and across NHS Wales.

  The SOC process and subsequent 'Service Requiring Significant Improvement' designation is distinct and separate to the NHS Wales Escalation and Intervention arrangements. However, this process will inform our view and help our contribution to the discussions on the overall status of NHS bodies in Wales.

Investigations Team

The team is integral to influencing and supporting patient safety and the quality of healthcare in Wales. It manages whistleblowers and public complaints, concerns, and statutory notifications, using this information to identify possible risks to patient safety or issues with standards of care.

- **Proactive intelligence sharing**
  The team helps HIW identify risks early by collecting intelligence from complaints, inspections, and statutory notifications.

- **Supporting escalation and intervention**
  Key intelligence is shared with HIW's Enforcement and Escalation Team in line with HIW's SOC process, and with the Director and Head of NHS Assurance to help inform tripartite discussions relating to NHS Escalation and Intervention Arrangements.

- **Embedding in engagement cycles**
  Investigation findings are integrated into routine engagement with NHS bodies, Llais, and other key stakeholders. This supports the call for continuous involvement and consultation in healthcare service delivery.

- **Driving improvement through insight**
  The team's investigations inform strategic improvement plans, helping HIW gain assurance that NHS organisations meet the Duty of Quality, and the Duty of

Candour under the Health and Social Services (Quality and Engagement) (Wales) Act 2020.

- **Collaborative working**
  The team works closely with HIW's Assurance Teams and Escalation and Enforcement, Intelligence, and Methodology teams, and with NHS bodies to ensure investigation findings are actionable and aligned with national priorities.

  The Investigations Team will directly engage with NHS Wales organisations as required, which is in addition to recipients of assurance correspondence.

Strategy and Communications Branch

The Strategy and Communications Branch is a cross-functional team responsible for strategic planning, policy analysis, communications, and engagement. The branch plays a pivotal role in shaping HIW's direction and ensuring its work is effectively communicated, understood.

- **Strategic responsibilities**
  Strategic planning includes the development of multi-year strategic plans, annual operational plans, and statutory publications such as the annual report. The branch reviews relevant national policy and legislation to assess their impact on healthcare services in Wales, producing internal briefings to support organisational planning and assurance activity. This work is aligned with national priorities, including the Well-being of Future Generations (Wales) Act and A Healthier Wales, and supports HIW's ability to respond to emerging risks and priorities.

- **Communications and engagement responsibilities**
  The branch leads HIW's communications and engagement activity, ensuring transparency in how findings, priorities, and impact are shared with stakeholders, including the public, NHS bodies, and independent healthcare providers. Communications promote improvement by highlighting good practice and lessons learned from inspections and reviews. The branch also manages HIW's website, social media channels, and press activity, ensuring messages are clear, accessible, and aligned with strategic objectives.

  Engagement is coordinated through a range of channels, including newsletters, consultation campaigns, and events, with the Stakeholder Advisory Group playing a key role in shaping inclusive approaches and informing HIW's work.

- **Cross-cutting functions**

Equality, diversity, and inclusion are embedded across all aspects of the branch's work, including the delivery of HIW's Equality, Diversity and Inclusion (EDI) Strategy. The team also provides internal advice and support on EDI, and for workforce development and wellbeing, empowering staff to fulfil strategic priorities with maximum effectiveness.

Business Management, Digital and Corporate Services Branch

The Business Management, Digital, and Corporate Services Branch is responsible for ensuring effective operational delivery across HIW. Responsibilities include finance, recruitment, First Point of Contact service, HR matters, governance, complaints, government business, inspection programme administration and purchasing and maintaining HIW's digital tools and equipment.

Within this branch sits the Inspection Support Team. This team provides administrative and logistical support to ensure HIW's inspection and regulatory activities run smoothly. This includes engaging with clinical peer reviewers and patient experience reviewers for HIW's assurance work, and with healthcare providers for both announced and following unannounced inspections. The team also manages HIW's secure Objective Connect workspaces to share and receive official sensitive documents.

Agenda Item No.	13

REPORT TITLE

Risk Management and Board Assurance Framework Report

MEETING

Name of meeting	Quality, Patient Experience & Safety Committee
Date of meeting	06 August 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Trish Mills, Director of Corporate Governance / Board Secretary
Author(s) of report	Julie Boalch, Assistant Director of Corporate Governance & Risk

PURPOSE OF REPORT

☐ Approval	☐ Endorsement
☒ Assurance	☐ Discussion
☐ Information (goes in consent items)	☐ Noting

REPORT SUMMARY

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

1. The purpose of the report is to provide assurance in respect of the management of the Trust's principal risks, specifically the two risks that are relevant to Committee's remit.

2. A summary of these risks is set out in Annex 1 with a detailed description contained within the Board Assurance Framework (BAF). All updates are highlighted in blue and show changes to the narrative, mitigating actions, controls, and assurances.

3. 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*, have been reviewed in the context of the Trust's operating environment.

4. The ELT approved an increase in the score for Risk 223 from 20 (4x5) to 25 (5x5) which is due to a sustained deterioration in handover lost hours, exceeding staff capacity, reducing available resources and increasing the risk of delayed patient care and harm.

5. Members will note that the score for Risk 224 has remained static at 25 (5x5) noting that internal controls cannot fully mitigate external system constraints, including Emergency Department capacity, patient flow and inconsistent delivery of national handover standards.

6. The BAF extract (Annex 4) for the Trust's two highest scoring risks is included for review. Members are reminded that greater detail is provided through the Actions to Mitigate Avoidable Harm paper presented to the board at each meeting. This includes the current position and treatments for both risks, incorporating pathway specific harm indicators and new Phase 2 of the Ambulance Performance Framework measures including STEMI, stroke, and indicators of deterioration during long waits.

7. The committee continues to provide detailed oversight of these risks, focussing on the effectiveness of controls, the assurance supporting the controls and progress against mitigating actions. Both principal risks have been reviewed in line with the agreed schedule (Annex 3), with particular focus on those scoring 15–25. ELT approved the principal risk activity on 27 May 2026, following reviews undertaken by Risk Owners during the reporting period. This activity was considered by the Audit, Risk and Assurance Committee on 23 June 2026.

8. The Executive Leadership Team (ELT) risk management session scheduled for 8 July 2026 will now take place on 12 August 2026. However, the committee can take assurance that risk reviews have been completed by risk owners in line with the schedule set out in Annex 3, with continued oversight and dynamic monitoring of the Trust's highest rated risks (scores 15–25).

9. This round of reviews have identified several matters that will be progressed through the next reporting cycle, including proposals to add three new risks to the Board Assurance Framework (BAF): Risk 700 – Listening to People Regulations (score 16, 4x4); Risk 706 – Pandemic Response (score 15, 3x5); and Risk 708 – Access to Property (score 20, 5x4). As these risks have not yet been formally considered and approved by ELT, they are not reflected in the Board Assurance Framework presented to the committee at this meeting.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

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

1. Consider contents of the report including:

   a. The increase in score for Risk 223 from 20 to 25;
   b. The controls in place against the risks; and
   c. The actions described to further mitigate the risks.

ADDITIONAL PAPER(S)

Set out here any annexes. See writing and presentation guidance here regarding materiality and use of the Reading Room

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

Annex 1 Summary table
Annex 2 Scoring Matrix
Annex 3 Frequency of Risk review
Annex 4 Board Assurance Framework

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [link to objectives and what good looks like]	
☒ SO1: Providing the right care or advice, in the right place, every time	☒ SO2: Enabling our people to be the best they can be
☒ SO3: Being at the forefront of innovation and technology	☒ SO4: Developing services in collaboration
☒ SO5: Being quality driven and clinically led	☒ SO6: Delivering exceptional value

RISK(S) THIS REPORT MITIGATES

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

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

Quality Domains (select all that apply) [link to standards]		
☒ Safe	☒ Timely	☒ Effective
☒ Efficient	☒ Equitable	☒ Person Centred
Quality Enablers (select all that apply) [link to standards]		
☒ Leadership	☒ Workforce	☒ Culture
☒ Information	☒ Learning Improvement and Research	☒ Whole Systems Approach

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [link to goals]		
☒ A socially responsible and inclusive employer	☒ An innovative and sustainable organisation	☒ A pro-active, accessible and equitable care provider
☐ n/a	☐ n/a	☐ n/a

IMPACT ASSESSMENTS FOR CONSIDERATION

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

Does this paper require an impact assessment	☒ No ☐ Yes
If yes, what impact assessment is attached	

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
27 May 2026	Executive Leadership Team
23 June 2026	Audit, Risk and Assurance Committee

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	Executive Director of Operations	**25 (5x5)** ↑ **20 (4x5)**
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	Executive 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.	Moderate injury/professional intervention. Requires time off work 4-14 days. Increased hospital stay 4-15 days. RIDDOR/Agency reportable incident. Impacts on a small number of patients. Physical injury to self/others requiring medical treatment. Psychological distress requiring formal intervention by MH professionals. Vulnerability to abuse or exploitation requiring increased intervention. Category 3 pressure ulcer.	Major injury leading to long-term disability. Requires time off work >14 days. Increased hospital stay >15 days. RIDDOR Reportable. Regulation 4 Specified Injuries to Workers. Patient mismanagement, long-term effects. Significant physical harm to self or others. Significant psychological distress needing specialist intervention. Vulnerability to abuse or exploitation requiring high levels of intervention. Category 4 pressure ulcer.	Incident leading to death. RIDDOR Reportable. Multiple permanent injuries or irreversible health effects. An event which impacts on a large number of patients.
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.	ocal media coverage - short-term reduction in public confidence/trust. Short-term negative social media. Public expectations not met.	Local media coverage - long-term reduction in public confidence & trust. Prolonged negative social media. Reported in local media.	National media coverage <3 days, service well below reasonable public expectation. Prolonged negative social media, reported in national media, long-term reduction in public confidence & trust. Increased scrutiny: inspectorates, regulatory bodies and WG.	National/social media coverage >3 days, service well below reasonable public expectation. Extensive, prolonged social media. MP/MS questions in House/Senedd. Total loss of public confidence/trust. Escalation of scrutiny status by WG.
Business Objectives or Projects	Insignificant cost increase/ schedule slippage.	<5 per cent over project budget. Schedule slippage.	5–10 per cent over project budget. Schedule slippage.	Non-compliance with national targets.10-25 per cent over project budget. Schedule slippage. Key objectives not met.	>25 per cent over project budget. Schedule slippage. Key objectives not met.
Financial Stability & Impact of Litigation	Small loss. Risk of claim remote.	Loss of 0.1–0.25% of budget Claim less than £10,000.	Loss of 0.25–0.5% of budget. Claim(s) between £10,000 and £100,000.	Uncertain delivery of key objective. Loss of 0.5-1.0% of budget. Claim(s) between £100,000 and £1 million. Purchasers failing to pay on time.	Non-delivery of key objective. Loss of >1 per cent of budget. Failure to meet specification. Claim(s) >£1 million. Loss of contract/payment by results.
Service/ Business Interruption	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours. Some disruption manageable by 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

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	12/05/2026	TREND	OVERALL 25 (5x5)
		Date of Next Review:	12/06/2026	⬆	

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	TBC	TBC	TBC	TBC	TBC	TBC
Current	TBC	TBC	TBC	TBC	TBC	TBC
Target	TBC	TBC	TBC	TBC	TBC	TBC

Strategic objective 1: Providing the right care or advice, in the right place, every time

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.

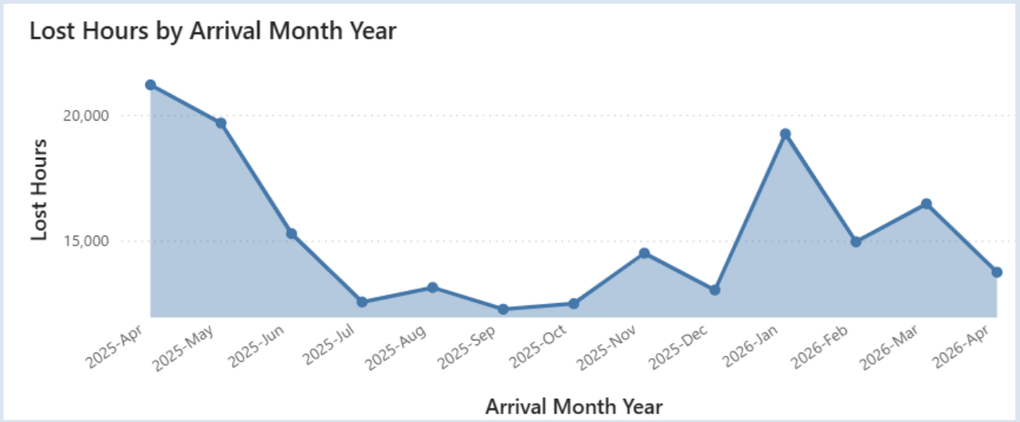
The next steps will include testing separate risk scores for internal and external mitigations, to support the demonstration of the impact of actions taken. This will not affect the overall score of 25 (5x5) which reflects the severity of patient harm and death.

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



This risk remains at the highest possible level, reflecting the enduring impact of significant ambulance handover delays at Emergency Departments and timely access to definitive care. The strategic implications for the Trust are considerable, with patient harm, deterioration, and poor experience continuing to generate regulatory scrutiny, including through Prevention of Future Deaths reports.

The Trust has implemented a mature and embedded internal control environment, underpinned by real-time clinical and operational oversight through the Operational Delivery Unit (ODU), the Clinical Safety Plan (CSP), and system-level escalation mechanisms such as REAP and national risk huddles. These controls are further supported by structured assurance mechanisms including internal and external incident reporting, compliance monitoring, and governance review processes.

Phase one and two of the Trust's Clinical Transformation Model - specifically the new performance framework - has now gone live, representing a key milestone in the delivery of an enhanced clinical model aligned to patient acuity, workforce capability, and risk reduction. In parallel, early adoption of the *45* minute release standard by some Health Boards represents a positive step toward reducing avoidable patient

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	12/05/2026	TREND	OVERALL 25 (5x5)
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harm by supporting more timely transfers of care and improving the overall experience for patients awaiting treatment. In recent weeks, however, we have seen a deterioration in 45MR compliance in those areas such as Swansea Bay that had seen improvement previously and a recent increase in hospital delays is also representative of pressure across the secondary care system.

While the Trust continues to demonstrate high levels of internal assurance, recent national focus on care standards and system performance provides a welcome opportunity to strengthen consistency and improve the effectiveness of wider system responses. Historic variation in adherence to national handover standards and the delivery of improvement plans has limited the extent to which the Trust can mitigate this risk through internal controls alone. However, increasing national scrutiny, greater transparency, and a shift toward more integrated, system-based accountability present a clear opportunity to improve consistency and collective impact across organisational boundaries.

Strategic mitigation therefore remains focused on both internal transformation and system-wide influence. The Trust continues to engage proactively with national and regional programmes - including the Six Goals for Urgent and Emergency Care - to support shared learning, alignment of expectations, and strengthened collective ownership of outcomes.

The received Audit Wales report into the effectiveness of unscheduled care arrangements across NHS Wales provides a critical external perspective on whole-system performance and identifies further levers to drive national consistency and accountability. Achieving the target risk score will ultimately rely on sustained partnership working, improved operational alignment across organisations, and the embedding of nationally agreed standards into routine delivery at every level of the system.

The introduction of 45 Minute Release (45MR) from 1 October and the efforts made by the majority of Health Board in the proceeding months is a welcome step. Several sites, including BCU however continue to be problematic with 45 MR improvements not yet realised. In recent weeks we have seen a deterioration broadly in 45MR compliance in those areas that had seen improvement previously and a recent increase in hospital delays is also representative of pressure across the secondary care system.

10.02.2026 - This trajectory does not yet represent sustained deterioration; however absolute lost hour levels remain unacceptably high even when there has been short term improvement.

SLT recognises there has been a deterioration of 45MR compliance through December and January and on that basis, it is anticipated that there is a trajectory of re-escalation of the risk scoring. It is the intention of SLT therefore, as per previous reviews, to evidence a similar period of deterioration as we did in improvement before consideration of re-escalation of scoring.

12.05.2026 - The likelihood score has been increased due to sustained deterioration in handover lost hours over the last three months, with levels remaining well above what is absorbable within current rosters. Despite mitigating actions, the persistence of lost capacity means the Trust is increasingly unable to reach patients when needed, elevating the risk of harm.

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. The introduction of 45 MR from 1 October and the efforts made by the majority of Health Boards in the proceeding months, is a welcome step. A clinically led Handover-45 taskforce has been formed and workshops hosted by the NHS Wales Performance and Improvement are ongoing to support local improvement plans.
2. Welsh Health Circular	2. Setting national standards for 15-minute patient handover timeframe, clinical practice, quality governance and operational safety mandating actions like early warning score implementation and infection control whilst also embedding legal compliance through frameworks e.g. Duty of Quality. Outcomes are primarily overseen by the Welsh Government through a combination of national audit programmes and governance frameworks. The External Handover Improvement Group has been established consider the elements of the Welsh Health Circular.
3. Mitigating Avoidable Harm Actions	3.. 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.
4. Sustainability of 45 MR in Cardiff and Vale, Cwm Taf and Swansea Bay	4.Performance data confirms that Cwm Taff Morgannwg are consistently meeting the 45MR target. Ongoing regular performance reviews, and exception reporting will provide continued assurance that compliance will be maintained throughout the winter period.
MITIGATE - Internal ***How do we know the controls are***	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***

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	12/05/2026	TREND	OVERALL 25 (5x5)
		Date of Next Review:	12/06/2026		

effective. How will these impact the target risk score?			
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 Audit received June 25, actions being worked through.
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 Audit received June 25, actions being worked through.
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). Interim Medium Term Plan (IMTP)	**Third Line of Assurance** Ministerial Advisory Group, NHS Exec Handover Group, Audit Wales investigation of Urgent and Emergency Care System. Audit received June 25, actions being worked through.
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. Audit received June 25, actions being worked through.
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. Audit received June 25, actions being worked through.

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	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

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.	gaps are aligned and consistent with the gaps in Risk 224 of the Board Assurance Framework. The 45 MR initiative, once embedded across all Health Boards, will help support to address this gap.
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.
4. Inconsistent pathways across Health Boards	4.
5. Local Delivery Units – Hywell Dda and BCU	5. A model to replicate oversight and scrutiny across Health Boards, like the Trust's Operational Delivery Unit (ODU). Activity will be based on the System Escalation Framework actions complemented by Local Action Plans – Date of implementation of LDUs to be confirmed. Moved from Control to Gap in control - SLT will be content to move to control upon completion of implementation of LDUs.
6. Ministerial Advisory Group (MAG)	6.Providing independent oversight of NHS Wales performance and recommending standardise clinical pathways to reduce delays and improve outcomes. MAG promotes better use of data to monitor patient safety, while its recommendations are embedded into national risk frameworks and Board Assurance processes to ensure system-wide impact. Moved to Gap currently - only 1 meeting has taken place so far. SLT content to move to control once meetings are fully established
Internal	Internal
1. Clinical Model Transformation (CMT) not fully implemented	1. Due to the implementation not being fully established there may be gaps in assurance meaning limited evidence currently or certainty that the controls are working as intended, however, as the model progresses the measurable outcomes will be reviewed and any concerns/issues addressed and monitored through actions. Current methods of monitoring the CMT includes CMT Project Board and an approved governance, reporting structure through T&F Groups.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner (Internal only)	Completion / Milestone date	Progress Update
1. 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.	**Jonathan Edwards, Assistant Director of Operations, Coordination and Integrated Care**	**March 2027**	OCT25 - The Clinical Model Transformation (CMT) Programme continues to advance the modernisation of care delivery through the introduction of new 999 call categories, aligned to the 12-month pilot of the new Ambulance Performance Standards. The implementation of these categories is phased, with Phase 1 commencing in July 2025 and Phase 2 in December 2025. These changes represent a significant step towards a more outcomes focused and patient centred model of emergency care. Further detail and supporting rationale are available through CMT Programme reporting. July 25 - The Clinical Model Transformation Programme has made strong progress, including the launch of the Access to Transport for Planned Care initiative, improved emergency call handling with new categories and CAD updates, and the soft launch of the 111.Wales Virtual Assistant. Video consultations are now available for Integrated Care clinicians, and urgent care delivery is being enhanced through new scheduling models, improved Falls Services, and the evaluation of the Mental Health Response Vehicle trial—all contributing to a more responsive, patient-centred system. **May 26 – All the updates are managed through CMT project board**
2. Logistical arrangements for release to Respond	Sonia Thompson	**October 2026**	Clinical logistics team have worked up an approach including costs which have been shared with Welsh government – waiting confirmation from Welsh government on if they will take the costs. Work has been done on the protocol on release to respond approach. Awaiting Welsh Government to approve governance. **16.04.2026 - Following the NHS Leadership Board on 24 March, there was an ambition set by those present to implement R2R by 21 April. To activate the approach, WAST has determined that additional logistics such as vehicles and trolleys must be purchased. This**

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death			Date of Review:	12/05/2026	TREND	OVERALL 25 (5x5)
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			requires funding and Welsh Government have confirmed that no funding will be released and NHS P&I should be approached. Executive DOO to discuss with NHSP&I on 2 April. WAST is preparing its approach but will be unable to implement without the release of funding. 22.05.26 Work is ongoing with SBUHB, ABUHB and BCU.				

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:	15/05/2026	TREND	OVERALL 25 (5x5)
		Date of Next Review:	15/06/2026	→	

IF	THEN	RESULTING IN
patients continue to be significantly delayed in ambulances outside Accident and Emergency Departments	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	patients coming to significant harm and a poor patient experience

	External (LxC)			Internal (LxC)		
Inherent	TBC	TBC	TBC	TBC	TBC	TBC
Current	TBC	TBC	TBC	TBC	TBC	TBC
Target	TBC	TBC	TBC	TBC	TBC	TBC

Strategic objective 1: Providing the right care or advice, in the right place, every time

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 has been embedded.

Testing separate risk scores for internal and external mitigations, to support the demonstration of the impact of actions taken is underway. 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.

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.

EXECUTIVE OWNER	Executive Director of Quality and Nursing	ASSURANCE COMMITTEE	Quality, Patient Experience and Safety Committee

This risk remains at the highest level. **Although improvement has been demonstrated intermittently in some areas**, performance remains variable across Wales and **prolonged** handover delays continue to present a significant risk of delayed access to definitive care, patient deterioration, harm and poor experience, alongside ongoing regulatory and public scrutiny.

The Trust has a well-established internal control environment, including **real-time** operational and clinical oversight, escalation and release processes, and structured clinical governance **arrangements**. Phase 1 and Phase 2 of the Clinical Model Transformation (CMT) Programme have now gone live, representing an important step in aligning response, triage and clinical decision-making to patient acuity, workforce capability and risk reduction.

However, it is too early to determine whether these changes have delivered sustained or system-wide risk reduction and the risk score has therefore been maintained. Internal controls cannot fully mitigate external system constraints, including Emergency Department capacity, patient flow and inconsistent delivery of national handover standards.

Continued engagement with national and regional programmes, including Six Goals and Wait 45, remains essential to support improvement. **Recent deterioration in handover lost hours and variable compliance with 45 Minute Release standards continue to impact system resilience and ambulance availability**. Until sustained and evidenced system-wide improvement is demonstrated, the risk remains above target and appropriately sits on the Board Assurance Framework.

This risk is intrinsically linked to BAF Risk 223 relating to the Trust's ability to reach patients in the community. The impact on staff wellbeing is recognised and managed through linked workforce risk 680.

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) and associated 45 Minute Release expectations.** National handover standard representing an external system control, with delivery and compliance led by Health Boards. **Internal Monitoring** Real-time oversight via ODU and Clinical Safety Plan for extended handover delays. Handover performance monitored through routine performance and quality governance reporting.	1. **External Monitoring / Assurance** • Oversight through Welsh Government, including Six Goals and Joint Commissioning arrangements. • Independent scrutiny via national audit and regulatory inspection.

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:	15/05/2026	TREND	OVERALL 25 (5x5)
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2. **Six Goals for Urgent and Emergency Care Programme** • National system oversight of urgent and emergency care performance, including ambulance handover.	2. External performance assurance through Welsh Government oversight arrangements, including Six Goals and NHS Wales escalation frameworks.
3. **NHS Wales Performance Framework 2024-25** External monitoring of ambulance handover performance through national performance measures.	3. External assurance through NHS Wales performance oversight and escalation arrangements.
4. **NHS Wales Quality and Safety Framework and Duties of Quality and Candour** External assurance through NHS Wales quality, safety and candour frameworks.	4. Statutory reporting and external assurance through Duties of Quality and Candour, supported by national quality and safety monitoring.
5. **Nationally led operational escalation responses** External system escalation arrangements **including NHS Executive oversight and escalation processes, to manage periods of sustained operational pressure and deteriorating handover performance.**	5. Assurance through national operational oversight, escalation **Ministerial Advisory Group (MAG) review and system performance arrangements**.

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, **Release to Respond (R2R) arrangements,** Resource Escalation Action Plan (REAP) and Clinical Safety Plan (CSP) **and Operational Delivery Unit (ODU) oversight arrangements.** These controls are embedded as business-as-usual and provide a consistent approach to managing clinical and operational risk during periods of handover delay. Effectiveness is demonstrated through routine escalation, oversight and governance reporting, providing assurance that risk is actively managed. **Emerging system approaches, including Release to Respond (R2R), may provide additional mitigation; however implementation remains dependent on agreed operational models and funding arrangements.** While these controls strengthen internal risk mitigation, they do not, in isolation, reduce the overall risk score, which remains dependent on external system performance.	**First Line of Assurance (Operational)** Real-time operational and clinical oversight through routine escalation and application of agreed escalation and safety protocols.	**Second Line of Assurance (Internal Monitoring)** Review of handover-related risk and mitigation through internal performance, **patient safety** and quality governance reporting, including senior operational and clinical forums.	**Third Line of Assurance** Independent scrutiny through external audit, regulatory review and national oversight arrangements.
Control 2: Clinical Guidance for staff • Trust-approved clinical guidance and notices to support safe clinical decision-making for patients experiencing delayed handover. This guidance provides a consistent framework for managing clinical risk and escalation during periods of handover delay and is embedded within routine clinical practice. It supports timely identification and escalation of deterioration **during prolonged waits to access definitive care and** reinforces professional accountability within agreed scopes of practice. While this control strengthens clinical safety and mitigates the risk of unmanaged harm, it does not, in isolation, reduce the overall risk score, which remains dependent on system-wide factors outside the Trust's direct control.	**First Line of Assurance (Operational)** Application of clinical guidance and escalation requirements within routine clinical practice.	**Second Line of Assurance (Internal Monitoring)** Review of handover-related clinical incidents, escalation and learning through internal patient safety and clinical governance reporting.	**Third Line of Assurance** External scrutiny through regulatory review and national oversight, including MAG.
Control 3: Clinical Governance mechanisms • Established clinical governance mechanisms to review learning from patient safety incidents, concerns and mortality related to delayed handover.	**First Line of Assurance (Operational)** Identification and escalation of incidents, concerns and mortality	**Second Line of Assurance (Internal Monitoring)** Review and oversight through clinical governance forums, including SCIF and CAG**, mortality review, patient**	**Third Line of Assurance** External scrutiny through regulatory review, national oversight and Ministerial Advisory Group (MAG) arrangements.

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:	15/05/2026	TREND	OVERALL 25 (5x5)
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These mechanisms provide assurance that patient harm associated with delayed handover is identified, reviewed and escalated appropriately, with learning shared internally and, where relevant, with Health Boards to support system improvement. Clinical oversight ensures learning informs risk mitigation and governance decision-making. **These arrangements also support triangulation of confirmed harm, deterioration themes and exposure to harm associated with delayed handover, informing organisational learning, escalation and wider risk mitigation activity.** This control strengthens organisational learning and assurance but does not, in isolation, reduce the overall risk score, which remains dependent on wider system performance.	cases through established patient safety processes.	**safety reporting and triangulated harm intelligence reporting**	
Control 4: Implementation of Duty of Quality, Candour & Quality Standards • Implementation of statutory Duties of Quality and Candour through established internal quality governance arrangements. This control provides assurance that patient harm associated with delayed handover is identified, reviewed and addressed in line with statutory requirements, with appropriate openness and accountability. It supports organisational learning and quality improvement during periods of operational pressure. While this control strengthens internal assurance and transparency, it does not, in isolation, reduce the overall risk score, which remains dependent on wider system performance.	**First Line of Assurance (Operational)** Identification and reporting of harm in line with statutory duties and internal quality processes.	**Second Line of Assurance (Internal Monitoring)** Oversight through internal quality and safety governance arrangements.	**Third Line of Assurance** Welsh Government assurance through Duty of Candour/Duty of Quality annual reporting. Statutory reporting and external assurance through Welsh Government, regulatory oversight and MAG arrangements.
Control 5: Clinical Model Transformation (CMT) • Implementation of the Clinical Model Transformation (CMT) to improve clinical triage**, early clinical intervention,** decision-making and demand management. CMT provides an internal control to reduce avoidable conveyance, improve early clinical intervention and support **more clinically informed prioritisation and support** more appropriate use of ambulance and hospital resources. It strengthens the Trust's ability to manage risk associated with demand and delayed handover, but its impact on the overall risk score is dependent on sustained system-wide improvement.	**First Line of Assurance (Operational)** Operational delivery of the Clinical Model Transformation and associated clinical pathways.	**Second Line of Assurance (Internal Monitoring)** Programme oversight and performance review through established transformation, operational and quality governance arrangements.	**Third Line of Assurance** External scrutiny through national oversight, performance review and MAG arrangements.
Control 6: Integrated Medium-Term Plan (IMTP) • Alignment of IMTP 2025–27 priorities and deliverables with Corporate Risk 224. This control provides strategic assurance that mitigating actions for handover delays are reflected within the Trust's medium-term planning and delivery framework. It supports prioritisation and resourcing of actions but does not, in isolation, reduce the overall risk score. NEW Control – completed Action 29/12/25	**First Line of Assurance** (Operational) Delivery of IMTP actions aligned to agreed priorities.	**Second Line of Assurance (Internal Monitoring)** Oversight of IMTP delivery through established planning and performance governance (STB).	**Third Line of Assurance** External scrutiny through Welsh Government IMTP assurance and performance review arrangements (F&PC).

GAPS IN CONTROLS	GAPS IN ASSURANCE
External	External
1. Inconsistent compliance by Health Boards with national handover standards, limiting WAST's ability to mitigate the risk through internal controls alone.	1. Limited independent assurance on the implementation and effectiveness of Health Board handover improvement actions, resulting in variable confidence in system-wide impact.
2. Ongoing Emergency Department and inpatient capacity pressures limit consistent delivery of national handover standards by Health Boards.	2. Limited independent assurance on how Health Boards are addressing Emergency Department and inpatient capacity pressures that impact ambulance handover performance.
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:	15/05/2026	TREND	OVERALL 25 (5x5)
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1. Limited ability to independently validate the effectiveness of Health Board actions arising from handover-related harm cases shared by WAST.	1. Routine audit of patient deterioration and management during delayed handovers is not yet embedded across all sites, limiting the ability to quantify the full scale of harm and test the effectiveness of mitigation
2.	2. Limited independent assurance on the effectiveness of Health Board actions arising from joint investigations into delayed handover harm; assurance is largely reliant on Health Board feedback. This gap may be strengthened through Audit Wales and MAG oversight.

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 completed with Cardiff and Vale UHB. Evaluation concluded (Sept 2025). National roll-out agreed and to be progressed through the Once for Wales Concerns Management Programme.
2. Delivery and evaluation of the Clinical Model Transformation (CMT)	Assistant Director of Operations, Integrated Care	Q2 2026	Phase 1 go-live completed (July 2025). Phase 2 go-live completed (November 2025). Public communications issued. Programme delivery and evaluation ongoing. Impact on handover risk to be assessed through programme evaluation and system performance data.
3. Audit Wales review of the urgent and emergency care system	Executive Director of Operations	May 2025 (report received); implementation ongoing	Audit Wales recommendations are being taken forward through agreed system and Trust governance arrangements, with delivery led by the Executive Director of Operations and oversight through ELT and the Board.

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

Agenda Item No.	14.1

REPORT TITLE

Audit Tracker 2026-27 Q1 (April - June 2026) Exception Reporting

MEETING

Name of meeting	Quality, Safety and Patient Experience Committee
Date of meeting	06 August 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Trish Mills, Director of Corporate Governance/Board Secretary
Author(s) of report	Lisa Trounce, Head of Compliance and Assurance

PURPOSE OF REPORT

☐ Approval	☐ Endorsement
☒ Assurance	☐ Discussion
☐ Information (goes in consent items)	☐ Noting

EXECUTIVE SUMMARY

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

1. This paper provides the Committee with the 2026/27 quarter 1 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 2026/27. To reduce the volume of papers presented to committee, rather than supply a copy of the tracker, the committee is provided with an audit exception report, of which this is the first version. This will provide the committee with details of high priority audit actions or audit actions from limited assurance audits, where a final revised date has been sought.

4. It is intended that exception reporting will provide committee with the information it requires to receive assurance regarding the mitigation in place to address the risks identified via internal audits, and where appropriate to levy appropriate challenge where further assurance may be needed. The content and format of the exception report will evolve as feedback is received regarding committee requirements.

Internal Audit

5. During 2026/27 quarter 1, there were a total of 17 open internal audit recommendations relevant to the committee. Of the 17 open internal audit recommendations, 13 were due to be completed in quarter, and four were not yet due.

6. By end of quarter, six internal audit actions were confirmed as completed, the remaining seven open actions due in quarter had revised dates applied. Among the six internal audit actions closed in quarter was one high priority key finding – detailed below:

Audit Ref & Description	Original Deadline	1st Revised Date	2nd Revised Date	3rd Revised Date
Audit Ref: 686 [High Priority] 2023/24 Electronic Patient Clinical Records (ePCR): Clinical Compliance Internal Audit [Action 2.2] ~ Develop tenant structure to provide data to assist identification of training needs and compliance.	30/09/2024	31/03/2025	30/09/2025	30/04/2026

7. At the beginning of quarter 1, there was one high priority key finding (Action Ref: 686 reported above) on its 2nd (final) revised date, which was closed. At the end of the quarter a new 2nd (final) revised date was applied to another high priority key finding detailed below:

Audit Ref & Description	Original Deadline	1st Revised Date	2nd Revised Date (final)
Audit ID: 126 [High Priority] 2025/26 Clinical Equipment Internal Audit	31/01/2026	30/06/2026	31/03/2027

Key finding: A key finding from the Appropriately Equipped Paramedics review (WAST-1920-16: Limited Assurance) highlighted the absence of a centralised clinical equipment list. The Trust responded by exploring RFID tracking, and the 2020/21 follow up review (WAST-2021-33), noted progress toward implementing an RFID inventory system for high-value equipment. Meanwhile, electronic records were developed, including a list of high-value items stored at the Hub.

Agreed Actions: There were two agreed actions for this key finding, and it is the first action that is on its final revised date. That is to reassess suitability of RFID; develop Trust-wide centralised database for clinical equipment; and consolidate databases.

Update/Mitigation: The previous update in August 2021 set a target date of March 2022 for RFID implementation, but the recommendation was later removed (closed) from the tracker. RFID has still not been implemented. While individual databases now exist for specific equipment types (e.g. Defibrillators, Mangar Cushion, Lucas Devices and Suction Units), a centralised inventory system remains absent. Such a system would support lifecycle tracking and inform procurement decisions for new or replacement equipment.

The update provided in 2026/27 quarter 1 is that testing of RFID took place in Merthyr on 28 July 2026, and a demonstration of the system by the supplier took place on 29 July 2026. Once the system has been implemented the team will commence evaluation of its effectiveness. The Head of Clinical Equipment has also met with a company 'Integra' who are the suppliers of the asset management system currently used by other UK ambulance services.

External Audit

8. During 2026/27 quarter 1, there were seven open external audit recommendations relevant to the Committee relating to:

- 2024/25 Welsh Risk Pool (WRP) Concerns Assessment 2024 [6 actions]
- 2025/26 Structured Assessment [1 action]

9. Of the seven open external audit actions, two were due to be completed in quarter, and five not yet due.

10. By end of quarter, three external audit actions were reported as completed. Of these, one was completed early before its original agreed implementation date of July 2026, and two by their 2nd (final) revised date.

Year	External Audit	No. Actions Completed	No. Actions Still Open
2024/25	WRP Concerns Assessment 2024	2	4
2025/26	Structured Assessment	1	0

11. There are currently no remaining open external audit actions on 2nd (final) revised dates.

12. At the end of quarter, there were four remaining open external audit actions which are all on their original agreed deadline and due for completion this financial year (by the end of March 2027).

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The Committee is requested to:

1. Review and scrutinise the current position regarding high priority internal audit actions and external audit actions on their final revised date, to ensure that there is sufficient assurance in terms of mitigation of associated risks.

ADDITIONAL PAPER(S)

Set out here any annexes. See writing and presentation guidance here regarding materiality and use of the Reading Room

n/a

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [link to objectives and what good looks like]	
☐ SO1: Providing the right care or advice, in the right place, every time	☒ SO2: Enabling our people to be the best they can be
☐ SO3: Being at the forefront of innovation and technology	☐ SO4: Developing services in collaboration
☐ SO5: Being quality driven and clinically led	☒ SO6: Delivering exceptional value

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

Quality Domains (select all that apply) [link to standards]		
☒ Safe	☒ Timely	☒ Effective
☒ Efficient	☐ Equitable	☐ Person Centred
Quality Enablers (select all that apply) [link to standards]		
☒ Leadership	☒ Workforce	☐ Culture
☒ Information	☐ Learning Improvement and Research	☐ Whole Systems Approach

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [link to goals]		
☒ A socially responsible and inclusive employer	☒ An innovative and sustainable organisation	☒ A pro-active, accessible and equitable care provider
☐ n/a	☐ n/a	☐ n/a

IMPACT ASSESSMENTS FOR CONSIDERATION

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

Does this paper require an impact assessment	☒ No ☐ Yes
If yes, what impact assessment	N/A [DPIA Checklist > DPIA not indicated]

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
n/a	n/a

Agenda Item No.	14.2

REPORT TITLE

Internal Audit Report – Clinical Prioritisation and Assessment Software (CPAS) Group: Governance and Change Management - Audit, Risk and Assurance Committee Feedback

MEETING

Name of meeting	Quality Patient Experience and Safety Committee
Date of meeting	6 August 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Andy Swinburn, Director of Paramedicine
Author(s) of report	Sarah Harland, Corporate Governance Officer

PURPOSE OF REPORT

☐ Approval	☐ Endorsement
☒ Assurance	☐ Discussion
☐ Information (goes in consent items)	☒ Noting

REPORT SUMMARY

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

1. The Audit, Risk and Assurance Committee (ARAC) received and discussed the Clinical Prioritisation and Assessment Software (CPAS) Group: Governance and Change Management Final Internal Audit Report Internal Audit Report at its meeting on 23 June 2026.

2. Felicity Quance, Deputy Head of Internal Audit, presented the CPAS Internal Audit Report, which received an overall rating of ***reasonable assurance***. Members noted that governance arrangements, roles and oversight mechanisms were well established and operating effectively, with robust controls in place to support system testing and approval prior to implementation.

3. The audit identified a key area for improvement relating to post-implementation monitoring, where greater formal assurance was required to demonstrate that system changes were operating as intended. Members noted that five recommendations had been agreed with management, comprising one high-priority and four medium-priority findings.

4. Andy Swinburn, Director of Paramedicine, welcomed the report and thanked Internal Audit for their constructive approach and insights. Andy noted that the increasing volume in CPAS system changes, driven largely by the Clinical Model Transformation Programme, had further emphasised the importance of strengthening post-implementation monitoring arrangements. Andy confirmed that management accepted the audit findings and recommendations and would work collaboratively to further enhance oversight and assurance processes.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The committee is asked to:

(a) note the discussion and feedback from ARAC; and

(b) review the report, noting the agreed management actions and mitigations of risk within the report.

The committee will have an opportunity to monitor the closure of these actions and scrutinise impact of those actions in response to audit recommendations via tracker reports and future assurance reporting on this issue.

ADDITIONAL PAPER(S)

Set out here any annexes. See writing and presentation guidance here regarding materiality and use of the Reading Room

The committee is requested to receive the following:

Annex 1 Clinical Prioritisation and Assessment Software (CPAS) Group: Governance and Change Management Final Internal Audit Report

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [link to objectives and what good looks like]	
☒ SO1: Providing the right care or advice, in the right place, every time	☒ SO2: Enabling our people to be the best they can be
☐ SO3: Being at the forefront of innovation and technology	☒ SO4: Developing services in collaboration
☒ SO5: Being quality driven and clinically led	☒ SO6: Delivering exceptional value

RISK(S) THIS REPORT MITIGATES

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

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

Quality Domains (select all that apply) [link to standards]		
☒ Safe	☒ Timely	☒ Effective
☐ Efficient	☒ Equitable	☒ Person Centred
Quality Enablers (select all that apply) [link to standards]		
☒ Leadership	☒ Workforce	☐ Culture
☒ Information	☐ Learning Improvement & Research	☒ Whole Systems Approach

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [link to goals]		
☒ A socially responsible and inclusive employer	☒ An innovative and sustainable organisation	☒ A pro-active, accessible and equitable care provider
☐ n/a	☐ n/a	☐ n/a

IMPACT ASSESSMENTS FOR CONSIDERATION

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

Does this paper require an impact assessment	☒ No ☐ Yes
If yes, what impact assessment is attached	

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
23 June 2026	Audit, Risk and Assurance Committee

Clinical Prioritisation and Assessment Software (CPAS) Group: Governance and Change Management

Final Internal Audit Report

2025/26

Welsh Ambulance Service University NHS Trust

Reasonable Assurance

Contents

Review Reference	WAS-2526-21
Fieldwork	February 2026 - May 2026
Executive Sign Off	10 June 2026
Audit Committee	23 June 2026
Executive Lead	Andy Swinburn, Director of Paramedicine
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 review the governance arrangements and operational workflows of the Clinical Prioritisation and Assessment Software (CPAS) Group, recognising the high volume and complexity of changes managed through this forum in support of the Clinical Model Transformation Programme, as well as ongoing business as usual activity for the critical 999 and 111 systems.

Overview

In line with the Welsh Government's (WG) strategic vision for healthcare in Wales, including *Together for Health (2011)* and *Achieving Excellence: the Quality Delivery Plan for the NHS in Wales (2012-2016)*, the Welsh Ambulance Services University NHS Trust (the Trust) must continue to improve health outcomes through the ongoing development of high-quality, safe and effective service delivery.

The Trust utilises licensed software systems to support clinically led remote telephone assessments and prioritisation of calls undertaken by non-registrant call-handling staff. These systems include the Medical Priority Dispatch System (MPDS); Emergency Communication Nurse System (ECNS); and Clinical Assessment Software (CAS), which incorporates a call streaming prioritisation functionality and Teleguides (nurse algorithms).

The CPAS Group operates as a key change management forum, responsible for overseeing the quality, clinical integrity and ongoing development of these systems. This includes ensuring that appropriate processes are in place to support system functionality and their effective application in practice, as well the development of clinical guidance, pathways, and improved ways of working. Collectively, this work supports the sustainability and effectiveness of operational delivery across both emergency services (999/MPDS) and Integrated Care services (Clinical Support Desk/111).

The Trust's Dispatch Cross Reference (DCR) table defines the type of clinical response associated with system codes. The CPAS Group has established processes for ensuring safe and consistent maintenance and modification of these response assignments.

Governance arrangements are well established and operating effectively, with clear structures, defined responsibilities and robust pre-implementation controls. In particular, technical testing and approval processes for changes to the DCR Table are robust.

However, the review identified that post-implementation controls are less developed. The absence of structured monitoring, combined with limitations in documentation, tracking and independence of certain controls, reduces overall assurance that changes are consistently embedded and operating as intended.

We have therefore concluded **reasonable assurance** on this area. The following matters require management attention:

- Digitalisation of the change request process to improve completeness, consistency, and auditability.
- Centralisation of DCR change tracking to provide a clear end-to-end view and strengthen oversight.
- Strengthening validation processes to ensure appropriate segregation of duties.
- Development and implementation of a more structured and proactive post-implementation review framework.
- Formalisation of routine review arrangements for DCR changes, supported by updated policy documentation to reflect the expected practices.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

An additional opportunity for enhancement has been identified in reviewing CPAS Group membership. Given the size of the group, a review would help ensure it remains proportionate and supports efficient discussion and effective decision-making. This observation is highlighted for management consideration and does not impact the overall audit opinion.

Scope & Assurance Summary

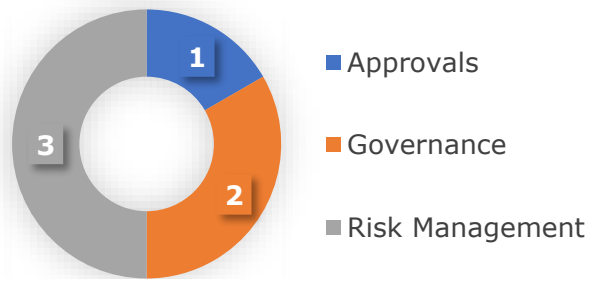
	Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)	Related Findings	Assurance
1	The CPAS Group operates under clear governance with defined roles, responsibilities, decision-making authority, and reporting lines that ensure oversight and escalation.	-	**Substantial**
2	Changes to CPAS systems, pathways, and algorithms are subject to robust change management and clinical assurance to ensure assessment, approval, documentation, and clinical safety prior to implementation.	1 & 2	**Reasonable**
3	Risks from CPAS-related change, including clinical safety, operations and system functionality, are identified, managed, monitored, and escalated in line with the Trust's risk management framework.	3	**Reasonable**
4	Approved changes are implemented consistently, with monitoring to ensure they are embedded as intended and support safe, sustainable delivery across 999 and Integrated Care Pathways.	4	**Limited**
5	The CPAS Group operates transparently with proper documentation and audit trails, enables multi-disciplinary engagement, and aligns with the Trust's strategic objectives and transformation programme.	5	**Reasonable**

Management Actions

1 High Priority

4 Medium Priority

Themes



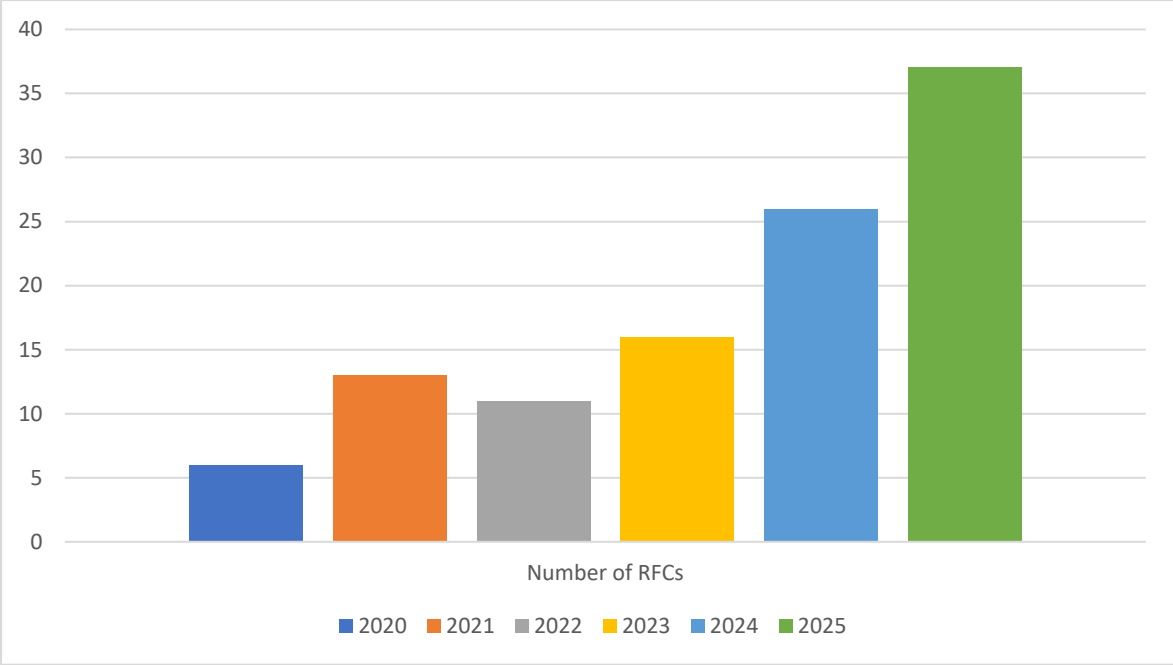
Risk Types

Quality or Safety Issues

Legal & Regulatory Non-Compliance

At A Glance: Changes to the Dispatch Cross Reference (DCR) Table

The following chart illustrates the number of requests for changes (RFCs) to the DCR table that have been processed over the last six years, reflecting the increase in recent years primarily owing to the Clinical Model Transformation Programme.



Findings & Agreed Action Plan

Objective 1: The CPAS Group operates under clear governance with defined roles, responsibilities, decision-making authority, and reporting lines that ensure oversight and escalation.	**Substantial**

To ensure the safe and appropriate use of the Medical Priority Dispatch System (MPDS), including determining the clinical response and resources assigned to each of the determinant codes, as set by the International Academy of Emergency Dispatch (IAED), the Trust is subject to both licensing requirements and a clinical duty to operate within a clearly defined governance framework.

Determinant codes are embedded within the Trust's Dispatch Cross Reference (DCR) table. A formal DCR Table Management Policy is in place to ensure the safe and consistent maintenance and modification of clinical response assignments. The policy, available on Siren, was ratified by the Quality, Patient Experience and Safety Committee (QuEST) in April 2024, and is scheduled for review in April 2027.

Key elements of the policy include:

- defined procedures for making changes to the DCR table;
- clearly articulated roles and responsibilities (overall accountability sits with the Executive Medical Director, with delegated responsibility of Accountable Officer placed with the Assistant Medical Director);
- arrangements for audit and monitoring (further considered under objectives 4 & 5).

The CPAS Group operates under an established Terms of Reference (ToR) as a change management forum. Its responsibilities include to oversee and review changes to the Trust's DCR table and to ensure that the assignment of clinical categories and responses reflects best practice and aligns with national standards, including those applied across UK Ambulance Services and Department of Health guidance.

The CPAS Group reports to the Executive Leadership Team (ELT) via the Clinical Quality & Governance (CQG) Group and Senior Operations Team (SOT), providing clear lines of escalation and oversight.

Membership of the CPAS group, as set out in the terms of reference, comprises 27 core members and a further 12 optional attendees, with quoracy defined as a minimum of five members. While it is recognised that certain decisions may require a broad range of expertise, the overall size of the group is comparatively high. Review of meeting minutes from January 2025 to February 2026 demonstrates that meetings were consistently quorate and generally well attended (for example, 26 members in August 2026), reflecting strong engagement. However, consideration should be given to reviewing the membership to ensure it remains proportionate, supports efficient discussion, and enables timely and effective decision-making

Objective 2: Changes to CPAS systems, pathways, and algorithms are subject to robust change management and clinical assurance to ensure assessment, approval, documentation, and clinical safety prior to implementation.	**Reasonable**

Discussions with the Associate Medical Director (CPAS Chair) and Head of Clinical Development (CPAS Vice Chair) confirmed that a structured process is in place for identifying, assessing, approving, and implementing changes to the DCR table. Proposed changes originate from multiple sources, including system updates, new MPDS releases, benchmarking with other UK Ambulance Services, Welsh Government policy changes, and learning arising from Serious Adverse Incidents.

As set out in the DCR Table Management Policy, proposed changes are initially reviewed by the DCR Review Group. Where supported, they are progressed via a Request for Change (RFC) form to the CPAS Group for formal approval. Following approval, changes are subject to system testing by Operations staff before being implemented by the ICT team within the live environment.

We were advised that the volume of changes to the DCR table has steadily increased year on year, primarily attributed to the Clinical Model Transformation programme (see page 3: At A Glance). Of the 37 RFCs approved in 2025, a sample of ten were reviewed. Testing confirmed that, in most cases, the prescribed process is being followed, with appropriate evidence of CPAS approval and completion of RFC documentation.

However, minor control weaknesses were identified in relation to incomplete RFC documentation. Instances were noted where key fields were not fully completed, including submission dates (two cases), identification of accountable officer (five cases) and Support Desk Reference Numbers (one case). While these omissions did not appear to affect the implementation of changes, they highlight reliance on manual processes and increase the risk of incomplete or inconsistent documentation. Digitisation of the RFC would help reduce this risk (see **Key Finding 1**). In one case, a change relating to National Operations Centre (NOC) code updates to new call priorities was implemented by Operations. Whilst it was verbally confirmed that appropriate processes, including testing prior to go-live, were followed, this was not formally evidenced, and ICT involvement was not clearly documented.

Further review identified multiple teams, including CPAS, ICT and Operations, are involved in managing DCR table changes, each maintaining separate and independent tracking mechanisms. While these trackers provide useful visibility at a team level, and support local management of activities, they are not integrated or routinely shared across the end-to-end process. A high-level reconciliation identified inconsistencies between records, indicating that completeness and alignment of change logs cannot be fully assured. As a result, there is no single, centralised view of changes from initiation through to implementation and post-implementation review. This limits overall transparency, coordination, and effective oversight of the change management process (see **Key Finding 2**).

	Key Findings	Risk & Impact	Agreed Management Action
1	**Digitalisation of the Request For Change Process** The current RFC relies on a manual Word-based template to capture and submit change requests. Sample testing identified instances of incomplete documentation, including missing submission dates, unclear assignment of accountability and evidence of testing prior to go-live. While these omissions did not appear to impact the delivery of changes, they highlight a reliance on manual input and review,	Key governance information may be omitted or inconsistently captured, reducing auditability and weakening oversight of changes.	**Agreed Action:** A digital RFC submission and approval workflow (e.g. via an electronic form or system) will be implemented, including mandatory fields, validation controls, and clear assignment of accountability, to ensure completeness and consistency of all change requests.

	Key Findings	Risk & Impact	Agreed Management Action
	increasing the risk of incomplete, inconsistent or non-standard submissions. There is an opportunity to strengthen control design through digitisation of the RFC process, including a review of mandatory fields and validation controls.		**Expected Evidence of Implementation:** • Live digital RFC form/workflow with mandatory fields enabled • Guidance / standard operating procedure for completion and approval • Sample of completed RFCs demonstrating full completion of required fields • System audit trail showing submission, approval, and timestamps
		Medium Priority	**Officer:** Wyn Morris, Interim Assistant Digital Director **Target Implementation Date:** 30 November 2027
	Theme: Information, Data Quality & Data Accuracy	Control Design	
2	**Centralisation of DCR table change tracking** CPAS, ICT, and Operations teams each maintain separate, independent trackers to record and monitor DCR table changes. While effective at a local level, these trackers are not integrated, routinely shared, or formally reconciled across the full process. A high-level reconciliation identified inconsistencies between records (e.g. differences between ICT tracker entries and RFCs provided), indicating that completeness and consistency of change logs cannot be fully assured. This results in the absence of a single, centralised view of all changes, from initiation through to implementation and post-implementation stages.	Limited transparency, potential gaps or inconsistencies in recorded changes, and incomplete oversight across the end-to-end change process may reduce effectiveness of monitoring and control, increasing the risk that changes are not appropriately tracked or managed.	**Agreed Action:** A centralised DCR change tracker (or shared system) will be developed and implemented, which will be accessible to CPAS, ICT, and Operations, providing an end-to-end view of changes from initiation through to post-implementation review. This will include periodic reconciliation between source records to ensure completeness and consistency.
			Expected Evidence of Implementation: • Centralised tracker/system in place with defined ownership • Evidence of use (e.g. populated records covering full lifecycle of changes) • Documented reconciliation process and evidence of periodic reconciliations undertaken • Access permissions showing cross-team visibility • Reporting outputs or dashboards demonstrating improved oversight
		Medium Priority	**Officer:** Wyn Morris, Interim Assistant Digital Director **Target Implementation Date:** 30 November 2027
	Theme: Information, Data Quality & Data Accuracy	Control Operation	

Objective 3: Risks from CPAS-related change, including clinical safety, operations and system functionality, are identified, managed, monitored, and escalated in line with the Trust's risk management framework.	**Reasonable**

The RFC form currently includes a field intended for the completion of a risk assessment. However, the Head of Clinical Development advised that there is no formal risk assessment template in use. Instead, risks are considered through discussions at the DCR Review Group prior to approval to proceed to the CPAS Group. Recognising the recommendation to digitise the RFC process (see **Key Finding 1**), this presents an opportunity to review and rationalise the content of the form to ensure that risk information is captured consistently and proportionately within the process.

During the implementation of changes to the DCR table, a number of controls are applied by the ICT team to mitigate risks to system functionality and data integrity. These include:

- Review of data quality and system integrity (e.g. formatting and input accuracy)
- Formal testing in pre-live or training environments
- Validated by Operations prior to go-live Testing procedures are considered robust. The ICT team has developed a comparison spreadsheet that enables users to reconcile between pre-export and post-export versions of the DCR table. This is shared with a defined group of operational staff, who undertake detailed validation to confirm that only intended changes have been applied and that no unintended consequences have arisen. This involved a line-by-line review of the dataset.

There are currently five escalation levels (tables) within the 999 setting and one within the 111 setting. Changes to 999 configurations must be applied consistently across all five tables, with corresponding testing undertaken in each instance. Where errors are identified, changes are returned to the requestor for resolution, and the process is repeated until assurance is obtained.

The ICT team has also established a structured file management system to support the retention and traceability of documentation throughout the change process. Sample testing identified clear and well-maintained records, including RFCs, data files, test outputs, and approval documentation. However, it was noted in some instances that those responsible for requesting the changes are also those validating the testing of changes prior to implementation (see **Key Finding 3**).

Key Findings		Risk & Impact	Agreed Management Action
3	**Segregation of Duties** The review identified that, in some instances, individuals responsible for requesting changes to the DCR table are also involved in undertaking or validating the testing of those same changes prior to implementation. While testing controls are in place and require verification that changes have been correctly applied, this overlap in responsibilities reduces the independence of the assurance process.	Insufficient segregation of duties may reduce the effectiveness and objectivity of testing, increasing the risk that errors or unintended changes are not identified prior to implementation.	**Agreed Action:** Establish and enforce clear segregation of duties within the DCR change process to ensure that individuals requesting or implementing changes are not responsible for undertaking or independently validating testing. This will be supported by defined roles, documented procedures, and oversight controls within CPAS/ICT processes.
			Expected Evidence of Implementation: • Updated process documentation or SOP outlining defined roles and segregation requirements • Testing and validation records demonstrating independent review (e.g. different named individuals) • System/tracker evidence showing role allocation across request, build, and test stages • Sample of completed changes evidencing compliance with segregation of duties
		Medium Priority	**Officer:** Grayham Mclean, Head of Clinical Improvement **Target Implementation Date:** 30 November 2026
	Theme: Approvals	Control Operation	

Objective 4: Approved changes are implemented consistently, with monitoring to ensure they are embedded as intended and support safe, sustainable delivery across 999 and Integrated Care Pathways.	**Limited**

As outlined under *objectives 2 and 3*, there is a well-defined process in place for the identification, approval, and implementation of changes to the DCR table. However, this would be expected to be supported by a formalised and systematic post-implementation monitoring process.

The DCR Table Management Policy states that regular audits should be undertaken by the Emergency Dispatch Quality Improvement Manager to assess the impact of changes to on systems use within the Trust.

However, we note that no formal monitoring arrangements are currently in place to consistently assess whether changes are operating as intended or to evaluate their impact following implementation.

Instead, reliance is placed on contact centre colleagues to identify and escalate issues or anomalies encountered during live call handling (see **Key Finding 4**). While this approach offers valuable real-time operational feedback, we are not aware of this feedback being formally recorded or systematically captured. As such. it is inherently reactive in nature and does not constitute a structured or proactive monitoring control.

The absence of a formal post-implementation review framework limits the ability to gain assurance that changes are embedded effectively and continue to support safe and sustainable service delivery across both 999 and Integrated Care pathways.

Key Findings		Risk & Impact	Agreed Management Action
4	**Monitoring of DCR Table changes** There is currently no structured or documented approach to assess whether approved changes are operating as intended once implemented. Monitoring is reliant on informal and reactive feedback from contact centre staff during live operations, and we are not aware of this feedback being formally recorded or systematically captured. While this approach can highlight immediate issues, it does not provide comprehensive, consistent, or auditable assurance over the effectiveness, impact or sustainability of changes.	Errors or unintended consequences arising from changes may not be identified, recorded or addressed in a timely manner, limiting organisational learning and potentially impacting patient safety, system performance, and operational effectiveness.	**Agreed Action:** Design and implement a structured post-implementation review process for DCR table changes, including defined review criteria, timescales, and responsibilities. This will incorporate routine monitoring, formal capture of operational feedback, exception reporting, and escalation mechanisms aligned to the Trust's risk management framework. **Expected Evidence of Implementation:** • Documented post-implementation review process and completed post-implementation review reports for a sample of changes • Defined KPIs/review criteria (e.g. error rates, call outcomes, incident trends) • Mechanism for recording and tracking operational feedback from contact centre staff • Evidence of issues identified, escalated, and actioned through governance routes • Regular reporting to CPAS and/or relevant governance groups

Key Findings		Risk & Impact	Agreed Management Action
		High Priority	**Officer:** Jonathan Sweet, Head of Service (Operations) **Target Implementation Date:** 30 November 2026
	Theme: Performance Monitoring	Control Operation	

Objective 5: The CPAS Group operates transparently with proper documentation and audit trails, enables multi-disciplinary engagement, and aligns with the Trust's strategic objectives and transformation programme.	**Reasonable**

As noted under objective 2, RFCs outline the requirement for amendments to the DCR table, with the increase in changes largely driven by the Trust's Clinical Transformation Programme. This is captured within the '*why is the work being done*' section of the RFC form, supporting alignment between CPAS activity and the Trust's wider strategic objectives.

The DCR Table Management Policy states that a Clinical sub-group, operating under CPAS, should undertake quarterly reviews of the DCR Table to ensure compliance with IAED requirements and alignment with best practice across UK Ambulance Services. We were advised that the Clinical Sub-Group referenced in the policy is the DCR Review Group. However, discussions with the Head of Clinical Improvement (Chair of the DCR Review Group) confirmed that formal audits are not undertaken in line with policy requirements.

Instead, the group undertakes periodic benchmarking exercises, comparing the Trust's DCR table to those shared by Ambulance Trusts in NHS England. These reviews are typically prompted by updates from the Emergency Call Prioritisation Advisory Group (ECPAG) or the MPDS Academy. While these activities provide a degree of assurance, they are informal in nature, undertaken on an ad hoc basis, and not aligned to a defined schedule or structured audit framework (see **Key Finding 5**).

Outcomes from these reviews are captured in meeting minutes and may result in RFCs where amendments are required. However, the absence of a formalised, documented review process reduces transparency and limits the ability to demonstrate consistent compliance with policy and external standards.

In addition, there is misalignment between policy requirements and current practice. As identified under objective 1, there is also an opportunity to review CPAS membership to ensure it remains proportionate and supports effective decision-making.

Overall, while elements of transparency and alignment are in place, improvements are required to formalise review processes and ensure policy accurately reflects current practice.

Key Findings		Risk & Impact	Agreed Management Action
5	**Routine Reviews of the DCR Table** The DCR Table Management Policy requires quarterly reviews by a Clinical Sub-Group to ensure compliance with IAED standards and alignment with best practice. However, no formal, documented audit activity was identified in line with this requirement. Current oversight is achieved through informal and ad hoc benchmarking exercises, which are not consistently documented or undertaken within a defined review framework.	The absence of formal, structured reviews may result in non-compliance with IAED requirements and reduced assurance that the DCR table remains aligned with best practice.	**Agreed Action:** Establish and implement a formal, documented process for routine review of the DCR table, including defined frequency (e.g. quarterly), scope, and reporting requirements. Update the DCR Table Management Policy to reflect the agreed approach and ensure alignment with current operational practice. **Expected Evidence of Implementation:** • Updated DCR Table Management Policy reflecting agreed review arrangements • Documented review schedule (e.g. quarterly forward plan or standing agenda item) • Completed review reports or documented benchmarking outputs

Key Findings	Risk & Impact	Agreed Management Action
		• Meeting minutes evidencing regular review and discussion, including where no changes are required • Evidence of actions arising from reviews, including linked RFCs where applicable
	Medium Priority	**Officer:** Grayham Mclean, Head of Clinical Improvement **Target Implementation Date:** 30 November 2026
Theme: Information, Data Quality & Data Accuracy	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.

Disclaimer

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Welsh Ambulance University NHS Trust and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of the Welsh Ambulance University NHS Trust. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Public Sector Internal Audit Standards

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]

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Agenda Item No. 19

REPORT TITLE

Committee Cycle of Business Monitoring Report 2026/27

MEETING

Name of meeting	Quality Patient Experience and Safety Committee
Date of meeting	06 August 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Julie Boalch, Assistant Director of Corporate Governance and Risk
Author(s) of report	Sarah Harland, Corporate Governance Officer

PURPOSE OF REPORT

☐ Approval	☐ Endorsement
☒ Assurance	☐ Discussion
☐ Information (goes in consent items)	☐ Noting

REPORT SUMMARY

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

1. This report updates the committee on progress against its agreed cycle of business (CoB) which was approved by the committee in February 2026. Each meeting agenda is set by referencing the cycle, together with the forward planner, action log and highest rated principal risks.

2. The monitoring report is at Annex 1. The 'pre-agenda setting' key indicates that items in green show where these are cycled for a particular meeting. Items in beige indicate that these are a prompt at agenda setting and may be ad hoc items such as business cases or external reports.

3. The 'post-agenda setting' key indicates that any items in blue were either on the agenda as scheduled or were an *ad hoc* item which was discussed in agenda setting and scheduled. The orange indicates where an item was programmed for receipt but was deferred to a future meeting.

4. For clarification, Members are asked to note that what was previously known as the Putting Things Right Report, is now referred to as **Concerns, Patient Safety and Legal Services Report**; and The Putting Things Right / Concerns Management Programme (Recovery Plan) Progress Report is now referred to as **Concerns Management Improvement Programme Progress Report.**

5. Members are asked to note that minor amendments have been proposed to the CoB including the incorporation of the suite of annual reports for mental health, safeguarding and infection prevention and control within the Annual Quality Report, changes to committee level metrics reporting, and the transfer of oversight of the Patient Harm Intelligence Dashboard from the Trust Board to committee. Once these proposed amendments have been confirmed and scheduled in agreement with directors, the CoB will be finalised and presented to committee approval.

6. The private meeting scheduled for 06 August 2026 was stood down as there were no changes to report to Risk 620 NHS 111 Online Symptom Checkers.

7. There are no further matters to escalate to the committee.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The committee is requested to take NOTE from the update.

ADDITIONAL PAPER(S)

Set out here any annexes. See writing and presentation guidance here regarding materiality and use of the Reading Room

The committee is requested to receive:
Annex 1 Quality, Patient Experience & Safety Committee Cycle of Business Monitoring Report August 2026

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [link to objectives and what good looks like]	
☒ SO1: Providing the right care or advice, in the right place, every time	☐ SO2: Enabling our people to be the best they can be
☐ SO3: Being at the forefront of innovation and technology	☐ SO4: Developing services in collaboration
☒ SO5: Being quality driven and clinically led	☒ SO6: Delivering exceptional value

RISK(S) THIS REPORT MITIGATES

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

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

Quality Domains (select all that apply) [link to standards]		
☐ Safe	☐ Timely	☒ Effective
☒ Efficient	☐ Equitable	☐ Person Centred
Quality Enablers (select all that apply) [link to standards]		
☒ Leadership	☐ Workforce	☐ Culture
☒ Information	☐ Learning Improvement &Research	☐ Whole Systems Approach

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

Narrative here (select all that apply) [link to goals]		
☐ A socially responsible and inclusive employer	☒ An innovative and sustainable organisation	☐ A pro-active, accessible and equitable care provider
☐ n/a	☐ n/a	☐ n/a

IMPACT ASSESSMENTS FOR CONSIDERATION

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

Does this paper require an impact assessment	☒ No ☐ Yes
If yes, what impact assessment is attached	

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
n/a	n/a

PAPER	PRE C'EE FORUM	FREQUENCY	Q1	Q2	Q3	Q4	LEAD	PURPOSE	COMMENT/COMPLIANCE
QUEST COMMITTEE - CYCLE OF BUSINESS MONITORING REPORT 2026/27									
TERMS OF REFERENCE NOTED IN RED TEXT									
STRATEGY DEVELOPMENT AND DELIVERY									
Quality Plan aligned to Delivering Excellence 2030	CQGG/TB	Initial and cyclical review					EDQN	Approval	It was agreed at the meeting held on 03/02/2026 that the committee supported continued quarterly assurance reporting, with a planned transition towards outcome-based assurance measures as delivery matures.
Clinical Plan aligned to Delivering Excellence 2030	CQGG/TB	Initial and cyclical review					EDP	Approval	
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 to continue to develop from 2025/26 to 2026/27;~~ SH Planning has confirmed this has been removed from the IMTP-~~SH 08/04/2026~~
Clinical Transformation Model Programme updates	**CQGG/STB**	**TBC**					**TBC**	Assurance	**Placement of the update to be discussed; added in post QuEST 030226**
SAFE, EQUITABLE									
Duty of Quality Repor**t** ~~(to include Duty of Candour)~~	CQGG/TB	Annually					EDQN	Endorsement	To include IPC detail
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	
HIW regulatory engagement: new engagement process (2026/27)	CQGG	Annually					EDQN	Assurance	HIW will be holding meetings with us and a desktop inspection is currently ongoing. When published we will need to take this through Committee.
Annual Mental Health Report and dementia standards report	CQGG	Annually					EDQN	Assurance	See Notes re legislative compliance reporting requirement. Regular KPIs being developed 2026/27
~~Annual IPC report.~~	~~CQGG~~	~~Annually~~					~~EDQN~~	~~Assurance~~	To be received as part of the Annual Quality Report; however focus on IPC improvement plan in 26/27 (see action 10-02/26)
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. Q1 The annual Safeguarding Reporrt has now been absorbed into the Duty of Quality Annual Report, which was endorsed at the meeting on 7 May 2026, and therefore will no longer be required moving forward.
MIQPR report	ELT	Quarterly					EDSPP	Assurance	Includes balanced scorecard of all Board level metrics
Concerns Management Report ~~Putting Things Right Report~~	CQGG	Quarterly					EDQN/DP	Assurance	See Notes. **Focus on PTR Recovery plan throughout 2026/27, as well as implementation of Listening to People Regulations. [From April 2026, Listening to People will come in, therefore there will be a hybrid report for Q2&Q3]. - 21/07/2026 Now referred to as Concerns Management**
Near Miss and Low Harm Intelligence Report	TBC	Annually					EDQN	Assurance	Onward assurance is provided to the ARAC regarding these arrangements. This reporting was added in during 2025/26
Patient Harm Intelligence Dashboard (title tbc)	**TBC**	**TBC**					**TBC**	**TBC**	Note: 24/03/2026 wait for Julie to ascertain from Penny if this is coming in May or later
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
EFFECTIVE, TIMELY									
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) Q2 TM requested this is removed.
MIQPR annual review of QUEST metrics	ELT	Annually					EDSPP	Approval	To review and agree Board level metrics for coming year. Q1 defered as not ready, currently in discussions but will take time to filter through SH 10/04/2026 Note: Q1 the MIQPR has the updated metrics agreed by the board for all committees. Q2 MIQPR has been amended and the additional metrics coming to this committee will be developed as part of the wider work with GGI on refresh of Committees and the aligned work on delivery groups. TM 14/05/2026
Concerns Management Report ~~PTR~~ 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 Concerns Management Report ~~PTR~~
Mortality Report	CQGG	Bi-annually					EDQN	Assurance	See Note 12
Value-based healthcare report	CQGG	Annually					EDQN	Assurance	The inclusion of this is subject to the approval to the terms of reference for 2026/27.
PATIENT CENTRED									
PECI report	TBC	Bi-annually					EDQN	Assurance	See note 11
Patient experience	N/A	Quarterly					EDQN	Assurance	Patient experience topical to main issues where possible
Patient experience updates	N/A	Quarterly					EDQN	Assurance	Driver diagram demonstrating feedback loop and learning. Letter of thanks to patient.
RISK AND AUDIT									
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	TORs provide that this is the first meeting of the year. Reports go to Audit C'ee in April and Board May
Review of Terms of Reference	Audit/Board	Annually					BS	Approval	TORs provide that this is the first meeting of the year. Reports go to Audit C'ee in April and Board May
Committee Cycle of Business annual refresh	N/A	Annually					BS	Approval	Q1: Dealt with at February 2026 meeting.
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	**Concerns Management** ~~**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]