Bundle Quality, Patient Experience and Safety Committee 3 February 2026

Agenda attachments
00 QuEST Open Agenda

0 09:30 - OPENING ITEMS

1 Chair's Welcome, Apologies and Quorum

2 Declarations of Interest
Item 02 Board Member Register of Interests

3 Minutes of the Open Meeting 4 November 2025
Item 03 2025-11-04 unconfirmed QUEST Open Minutes

4.1 Action Log & Matters Arising
Item 04.1 Action Log

4.2 Committee AAA Highlight Report 4 November 2025
Item 04.2 Quest Committee Highlight Report November 2025

4.3 FOR APPROVAL, ASSURANCE AND DISCUSSION

5 09:40 - Patient Experience: Roy Davies

5.1 Patient Experience Updates [Alison Clarke]

6 10:10 - Ministerial Advisory Group Wait 45 Taskforce
Item 06 Ministerial Advisory Group Wait 45 Taskforce
Item 06 Appendix 1 Ambulance Handover Accelerated Design Events Integrated Thematic Summary
Item 06 Appendix 2 Ambulance Patient Handover - Release to Respond at 45 minutes - Winter Sprint 2 (23 December 2025)

7 10:30 - Operations Directorate Quarterly Report Q3 2025/26
Item 07 Operations Quarterly Report Q3 2025-2026

7.1 COMFORT BREAK

8 10:50 - Putting Things Right Report Q3 & Recovery Plan
Item 08 Putting Things Right Report Quarter 3, 2025-26, October - December
Item 08 Annex 1 Putting Things Right Report Quarter 3, 2025-26, October - December - Annex 1

9 11:20 - Monthly Integrated Quality Performance Report [MIQPR]
Item 09 MIQPR QUEST November December 2025
Item 09 Annex 1 MIQPR Quest November December 2025

10 11:40 - Infection Prevention and Control Report 2024-25 and Improvement Plan
Item 10 Infection Prevention Control Position Paper
Item 10 Annex 1 IPC Report (March 2024 - April 20205)
Item 10 Annex 2 IPC Service Improvement Plan 2025-2026

11 12:00 - EMERG Clinical indicators
Item 11 EMERG Clinical Indicators
Item 11 Annex 1 EMERG Clinical Indicators Presentation (update to Dec 2025)

12 12:20 - Internal Audit report: Clinical Equipment
Item 12.1 Internal Audit Report Feedback from ARAC to QuEST Clinical Equipment
Item 12.1 Annex 1 Clinical Equipment Final Internal Audit Report

12.1 12:40 - LUNCH

13 13:20 - Strategic Quality Plan 2025/28 Implementation Plan Progress
Item 13 Strategic Quality Plan 2025-2028 Quarterly Update

14 13:35 - Clinical Audit Plan 2026/27 and Action Tracker Q3 (Update) 2025/26
Item 14a Clinical Audit Plan 2026-27 SBAR
Item 14a Annex 1 Clinical Audit Plan 2026- 27
Item 14b Clinical Audit Plan Q3 2025-26 Update
Item 14b Annex 1 Clinical Audit Plan Q3 2025-26

15 13:50 - Health Inspectorate Wales new NHS Wales Engagement Process
Item 15 Healthcare Inspectorate Wales - New NHS Wales Engagement Process
Item 15 Annex 1 - Healthcare Inspectorate Wales - New NHS Wales Engagement Process

Item 15 Annex 2 - Healthcare Inspectorate Wales - New NHS Wales Engagement Process
Item 15 Annex 3 - Healthcare Inspectorate Wales - New NHS Wales Engagement Process

16 14:05 - Risk Management and Board Assurance Framework
Item 16 Risk Management Report

17 14:15 - Audit Tracker Q3 2025/26
Item 17 Audit Tracker 25-26 Q3 Reporting (Oct-Dec25)
Item 17 Annex 1 - Audit Tracker 3.0 - 2526 Q3 Updates - Internal Audit (QuEST)
Item 17 Annex 2 - Audit Tracker 3.0 - 2526 Q3 Updates - External Audit (QuEST)

18 14:25 - Committee Annual Report 2025/26 and Cycle of Business 2026/27
Item 18 QuEST Committee 2025-26 Quality and Governance Review
Item 18 Annex 1 QuEST Draft Annual Report 2025-26 for QuEST 3 Feb 2026
Item 18 Annex 2 QuEST Committee Cycle of Business 2026-27 for approval by QuEST

18.1 CONSENT ITEMS

19 Committee Cycle of Business Monitoring Report and 2025/26 Priorities
Item 19 Priorities and Cycle Monitoring Report February 2026
Item 19.1 Tab 1 Quest Committee Cycle of Business Montoring Report 2025-26
Item 19.1 Tab 2 Quest Committee Cycle of Business Notes

19.1 14:35 - CLOSING ITEMS

20 Key Messages for the Board

21 Reflections and Summary of Decisions/Actions

22 Any Other Business

23 Date & Time of the Next Meeting: 7 May 2026 at 9:30am

Length of Meeting:	05:30	Agreed	[OPEN] QUEST COMMITTEE - 3 FEBRUARY 2026					Deadline for Papers: 23 January 2026			Last good practice Exec Review: 21 January 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									
09:30	00:10	1	Chair's Welcome, Apologies and Quorum	Verbal	Information	Standing	n/a	Chair	n/a			
		2	Declarations of Interest	Verbal	To State Conflicts	Standing	n/a	Chair	n/a			
		3	Minutes of the Open Meeting 4 November 2025	Paper	Approval	Standing	n/a	Chair	n/a			
		4	4.1 Action Log & Matters Arising 4.2 Committee AAA Highlight Report 4 November 2025	Paper	Discussion	Standing	n/a	Chair	n/a			
			FOR APPROVAL, ASSURANCE AND DISCUSSION									
09:40	00:30	5	Patient Experience: Roy Davies	Video	Discussion	CoB	Quality	Liam Williams	Leanne Hawker, Alison Kelly			
		5.1	Patient Experience Updates (Alison Clarke)	Verbal	Assurance	CoB	Quality	Liam Williams	Leanne Hawker, Alison Kelly			
10:10	00:20	6	Ministerial Advisory Group Wait 45 Taskforce	Paper	Assurance	Forward Planner	Quality	Liam Williams	Alison Kelly			
10:30	00:20	7	Operations Directorate Quarterly Report Q3 2025/26	Paper	Assurance	CoB	Operations	Lee Brooks	Judith Bryce Toni-Marie Norman			
10:50	00:15		COMFORT BREAK									
11:05	00:30	8	Putting Things Right Report Q3 & Recovery Plan **[See Cycle of Business Note 1 (Tab 2)]**	Paper	Assurance	CoB	Quality	Liam Williams	Wendy Herbert, Alison Kelly Claire Appleton			
11:35	00:20	9	Monthly Integrated Quality Performance Report [MIQPR]	Paper	Assurance	CoB	SPP	Rachel Marsh	Hugh Bennett, Mark Thomas Mel O'Connor			
11:55	00:20	10	Infection Prevention and Control Report 2024-25 and Improvement Plan **[title to be confirmed]**	Paper	Approval	CoB	Quality	Liam Williams	Penny Durrant, Alison Kelly			Taken to CQGG 13012026
12:15	00:20	11	EMERG Clinical indicators	Presentation	Assurance	CoB	Clinical	Andy Swinburn	Jonathan Chippendale			
12:35	00:20	12	Internal Audit report: Clinical Equipment	Paper	Assurance	CoB	Gov	Andy Swinburn	Gregory Lloyd			
12:55	00:40		LUNCH									
13:35	00:15	13	Strategic Quality Plan 2025/28 Implementation Plan Progress	Paper	Assurance	CoB	Quality	Liam Williams	Kate Blackmore, Penny Durrant			
13:50	00:15	14	Clinical Audit Plan 2026/27 Action Tracker Q3 (Update) 2025/26 **[See Cycle of Business Note 7]**	Paper	Assurance	CoB	Clinical	Andy Swinburn	Jonathan Chippendale			
14:05	00:15	15	Health Inspectorate Wales new NHS Wales Engagement Process	Paper	Assurance	Ad Hoc	Quality	Liam Williams	Alison Kelly	14/01/2026		Taken to CQGG 13012026
14:20	00:10	16	Risk Management and Board Assurance Framework **[To include Risk 224]**	Paper	Assurance	CoB	Gov	Julie Boalch	n/a			
14:30	00:10	17	Audit Tracker Q3 2025/26	Paper	Assurance	CoB	Gov	Trish Mills	Lisa Trounce			
14:40	00:10	18	Committee Annual Report 2025/26 and Cycle of Business 2026/27	Paper	Approval	CoB	Gov	Trish Mills	Julie Boalch, Alex Payne			
			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.									
14:50	00:00	19	Committee Cycle of Business Monitoring Report and 2025/26 Priorities	Paper	Approval	CoB	Gov	Trish Mills	Sarah Harland			
			CLOSING ITEMS									
14:50	00:10	20	Key Messages for the Board	Verbal	Discussion	Standing	n/a	Chair	n/a			
		21	Reflections and Summary of Decisions/Actions	Verbal	Discussion	Standing	n/a	Chair	n/a			
		22	Any Other Business	Verbal	Discussion	Standing	n/a	Chair	n/a			
		23	Date & Time of the Next Meeting: 7 May 2026	Verbal	Information	Standing	n/a	Chair	n/a			
15:00	**05:30**		**CLOSE**									

LEAD PRESENTERS

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

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

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Left Trust
EVANS, Bethan [continued]	**Non-Executive Director** * Chair of Quality, Patient Experience & Safety Committee * Member of Finance & Performance Committee * Member of People & Culture Committee * Member of Remuneration Committee	Company Director - Hawthorn Court Property Limited	Directorships	27 April 2022		
		[Previously called My Choice Healthcare (Three) Limited, Company name changed 12.08.2022 - #13371375]	*Directorships*	*27 April 2022*		
		Company Director - Ocean Living Property Limited	Directorships	22 July 2022		
		Company Director - Hawthorn Court Care Limited	Directorships	22 July 2022		
		Company Director - Glyncornel Property Limited	Directorships	01 July 2022		
		Company Director - My Choice Healthcare (Two) Limited	Directorships	01 July 2022		
		Company Director - Carmarthen Care Limited	Directorships	02 January 2024		
		Company Director - Towy Castle Property Limited	Directorships	01 September 2023		
		Company Director - Glamorgan Care Ltd	Directorships	25 October 2024		
		Company Director - The Mountains Care Ltd	Directorships	09 December 2024		
		Company Director - Alexandra House Care Ltd	Directorships	24 June 2024		
		Company Director - Alexandra House Property Ltd	Directorships	24 June 2024		
		Company Director - My Choice Healthcare Seven Ltd	Directorships	22 October 2024		
		Company Director - Danygraig Property Ltd	Directorships	10 December 2024		
		Company Director - The Mountains Property Ltd	Directorships	09 December 2024		
HITCHON, Estelle	**Director of Partnerships and Engagement**	Member of Academi Wales Expert Panel	Position in Charity or Voluntary Organisation	15 July 2024		
		Independent Governor (Non-Executive Director), Coleg Sir Gar/Coleg Ceredigion	Non-Financial Personal	01 January 2025		
HUTCHINGS, Hayley	**Non-Executive Director** * Member of the Remuneration Committee * Member of the Academic Partnership Committee * Member of the People and Culture Committee	Employed at Swansea University, Professor of Health Services Research	Financial Interest	17 June 1995	31 May 2025	
		Emeritus Professor, Swansea University	Non-Financial Professional	31 May 2025		
		Consultancy (temporary cover for the Director of Operations - Clinical Trials Unit) at Wolverhampton University	Financial Interest	10 October 2025	31 December 2025	
JACKSON, Ceri	**Non-Executive Director & Vice Chair of the Trust Board** * Chair of the People and Culture Committee * Member of the Charity Committee * Member of Audit Committee * Member of Quality, Patient Experience & Safety Committee * Member of Remuneration Committee	Management Consultant primarily working in third sector	Interest in Companies and Securities	01 May 2019		
		Associate Director of SamKat Consulting Ltd in my capacity as self-employed management consultant	Directorships	01 June 2021		
		Charity Trustee - Stroke Association Trustee, Chair Wales Advisory Group.	Position in Charity or Voluntary Organisation	08 October 2020		
		Charitable Company - Stroke Association - Company Director	Directorships	08 October 2020		
KNEESHAW, Carl	**Director of People**	Chartered Fellow of Chartered Institute of Personnel and Development	Personal or Departmental Sponsorship	April 2020		
		Fellow of Institute of Leadership	Personal or Departmental Sponsorship	October 2020		
		Safeguarding Lead for local outreach charity, Brunstad Christian Church – Huntworth, Bridgwater, Somerset	Position in Charity or Voluntary Organisation	September 2018		
LEWIS, Angela	**Director of Culture Change**	Nil Declaration				
MARSH, Rachel	**Executive Director of Strategy, Planning and Performance**	Nil Declaration				
MILLS, Patricia (Trish)	**Director of Corporate Governance/ Board Secretary**	Nil Declaration				
PARRY, Hugh	**Trade Union Partner**	Nil Declaration				
ROBERTS, Edward	**Interim Finance Director (from 09 September 2025)**	Nil Declaration				
ROWAN, Hannah	**Non-Executive Director** * Chair of Academic Partnership Committee * Member of Charity Committee * Member of People & Culture Committee * Member of Remuneration Committee	Director, St Martin's Associates (Business consulting and coaching)	Directorships	04 April 2022		
		Non -Executive Director Qualifications Wales (regulator for all non degree qualifications in Wales)	Any Other Interest	01 April 2021		
		Trustee MAE Cymru (Christian charity which champions gender equality in church of Wales)	Position in Charity or Voluntary Organisation	13 November 2021	November 2023	
		Elected member, The governing body of the church in Wales (Parliament of church in Wales - voting member)	Any Other Interest	01 April 2021		
		Relative (Parent) is a Non-Executive Director for Social Care Wales	Any Other Interest	01 April 2017	31 March 2025	
SAMMUT, Jonathan (Jonny)	**Director of Digital Services [appointed 26.09.2023]**	Fellow of the British Computer Society – FBCS	Any Other Interest	04 March 2024		
		Panel Member of the UK CIO Advisory Panel – Digital Health	Any Other Interest	05 July 2023	2 June 2025	
		Federation of Informatics Professionals - Leading Practitioner	Any Other Interest	25 April 2024		
		Chair of BCS Hub Wales	Any Other Interest	20 June 2025		
		Co-opted into the BCS Community Board	Any Other Interest	12 August 2025	11 August 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**	Treasurer of Royal Gwent Hospital League of Friends.	Position in Charity or Voluntary Organisation	01 February 2022	05 November 2024	
TURNER, Damon	**Trade Union Partner**	Nil Declaration				

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

WELSH AMBULANCE SERVICES NHS UNIVERSITY TRUST
UNCONFIRMED MINUTES OF THE OPEN SESSION OF THE MEETING OF THE QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE
HELD ON 4 NOVEMBER 2025 VIA TEAMS

MEMBERS PRESENT:

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

IN ATTENDANCE:

Hugh Bennett	Assistant Director of Commissioning and Performance
Kate Blackmore	Assistant Director of Quality Governance
Jonathan Chippendale	Assistant Director of Clinical Development
Justine Cosby	Consultant Practioner, Mental Health *(Item11 only)*
Sarah Harland	Corporate Governance Officer
Mark Harris	Assistant Director of Operations NEPTS
Leanne Hawker	Head of Patient Experience and Community Involvement
Wendy Herbert	Deputy Director of Quality and Putting Things Right
Alison Kelly	Business and Quality Manager
Osian Lloyd	Head of Internal Audit
Mark Marsden	TU Partner
Trish Mills	Director of Corporate Governance/Board Secretary
Hugh Parry	TU Partner *(joined at 10:30am)*
Alex Payne	Corporate Governance Manager
Vicky Maxwell	Head of Safeguarding
Liam Williams	Executive Director of Quality and Nursing
Claire Appleton	Assistant Director of Putting Things Right
Andy Swinburn	Executive Director of Paramedicine

APOLOGIES:

Julie Boalch	Assistant Director of Corporate Governance and Risk
Lee Brooks	Executive Director of Operations
Henry Garrard	TU Partner
Rachel Marsh	Executive Director of Strategy, Planning & Performance
Jonny Sammut	Director of Digital Services

OBSERVERS:

Adele Roberts	Head of Quality and Patient Care, NHS Wales Joint Commissioning Committee
Debbie Bell	Patient Safety Manager
Leanne Onslow	Head of Strategy Workforce Planning Systems & Recruitment
Angela Mutlow	Director of Operations, Llais

1. CHAIR'S WELCOME, APOLOGIES AND QUORUM

1.1 The Chair welcomed all attendees, including several new observers and staff members, including Adele Roberts, Dan King, Debbie Bell and Leanne Onslow. Apologies were noted and the Chair confirmed the meeting met quorum.

2. DECLARATIONS OF INTEREST

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

3. MINUTES AND HIGHLIGHT REPORTS

3.1 MINUTES FROM THE OPEN MEETING 5 AUGUST 2025

3.1.1 The Minutes from the meeting held on 5 August 2025 were approved at the Extraordinary Meeting on 10 October 2025.

3.2 COMMITTEE HIGHLIGHT REPORT 5 AUGUST 2025

3.2.1 The Chair drew the Committee's attention to the contents of the AAA Highlight Report for their information; this highlighted the key points from the meeting on 5 August 2025.

3.3 MINUTES OF THE EXTRAORDINARY MEETING 10 OCTOBER 2025

3.3.1 The Minutes from the Extraordinary meeting held on 10 October 2025 were received and confirmed as a correct record.

3.4 COMMITTEE HIGHLIGHT REPORT EXTRAORDINARY MEETING 10 OCTOBER 2025

3.4.1 The Chair drew the Committee's attention to the contents of the AAA report for their information; this highlighted the key points from the Extraordinary meeting on 10 October 2025.

3.4.2 Liam Williams advised Joint Commissioning Committee (JCC) observers that documents on Quality Impact Assessments (QIAs) and Call Categorisation Phases 1 and 2 are available for review if required.

4. ACTION LOG AND MATTERS ARISING

4.1 14-08/25 5 August 202, Clinical Plan Progress Update - Refer the prioritisation of the digital Clinical Plan project back to the Executive Leadership Team (ELT) for review, ensuring it aligns with current organisational priorities and resource capacity (If technical or resource barriers arise, the content can be reformatted into a more traditional format). ***Update 4 November 2025*** *Andy Swinburn proposed closing the current Clinical Plan Progress action, explaining that feedback and new requirements from the Ambulance Performance Framework mean a complete revamp is required. Andy added that the future plan will focus on* aligning *the organisation to deliver against the new framework, which is more clinically led and outcomes driven. Andy clarified that much of the clinical transformation work already covers the intended plan, and future updates will*

be brought to the group as the new approach develops. The group agreed to close the action and await further update.

5. OPERATIONS DIRECTORATE QUARTERLY REPORT Q1 2025/26

5.1 Mark Harris summarised the Operations Quarterly Report, noting the rollout of a Quality Assurance Framework for Clinical Navigators and onboarding ten new Call Prioritisation Streaming System (CPSS) auditors to boost audit volumes. Additional funding has been secured to improve ambulance availability, with monitoring and improvement plans in place. The Wait 45 initiative has reduced handover delays but increased late discharge and transfer requests, occasionally exceeding capacity.

5.2 Hugh Bennett explained that the 2023 demand and capacity review has been revisited in light of ongoing transformation work, and acknowledged that there are areas without sufficient capacity, mainly due to financial constraints and unpredictable demand, presenting challenges, with current efforts focussed on improving system efficiency rather than expanding resources. Hugh also noted that further demand and capacity analysis is planned as part of the Quality and Patient Experience checks after phase two goes live. Work with the JCC and upcoming workshops aim to tackle inefficiencies such as late bookings and cancellations.

5.3 Quality and Support days remain popular, focusing on staff wellbeing and feedback driven improvements. Positive engagement at Ambulance Care roadshows highlighted career structure, capacity pressures and aspirations for a more ambitious vision.

The Committee received and noted the Operations Directorate Quarterly Report Q2 2025/26.

6. PATIENT STORY

6.1 The patient story featured Alison Clarke, a regular NEPTS user who experienced last minute transport cancellations, causing distress and delaying critical reviews. Alison's account underscored the need for improved communication, clearer eligibility criteria, and greater service reliability. Mark Harris outlined systemic issues: rising demand, fewer volunteer drivers, more high acuity journeys, and inefficiencies such as late cancellations. Actions include working with commissioners, improving staff training, better patient communication, targeted investment and plans for a patient survey. Discussion noted staff stress, the need to review eligibility criteria and strategic engagement with partners. The committee agreed broader system changes, including eligibility and funding adjustments, are required.

6.2 Alison's lived experience highlighted the ongoing high demand for NEPTS, which continues to generate complaints about unmet patient needs. Despite Quality Patient Safety and Experience support through emotional mapping, enhanced data visibility, and efforts to encourage on-the-spot resolution, complaint levels have not declined. Members discussed the impact on patient care and have asked the Finance and Performance Committee (FPC) to review current actions and plans to improve service delivery, particularly around eligibility criteria and the challenges patients face due to cancellations and limited capacity. The Chair thanked Alison for sharing her experience.

An action was raised to ask the Finance and Performance Committee to review current actions and plans to improve service delivery, particularly around eligibility criteria and the challenges patients face due to cancellations and limited capacity.

6.1 PATIENT STORY UPDATES

6.1.1 Leanne Hawker provided an update on Sophie Hinksman's story, focusing on improving 111 access for people with learning disabilities and mental health needs. Actions included easy read resources, better communication and reasonable adjustments. Leanne reported of shared learning with Health Boards, a new Learning Disability Clinical Lead appointment, and ongoing work with Digital Services, to enhance accessibility through user centred design, and engagement with local groups. Feedback is actively shaping service improvements.

The Committee received the Patient Story update regarding Sophie Hinksman and were assured by the outcomes.

7. MONTHLY INTEGRATED QUALITY PERFORMANCE REPORT (MIQPR)

7.1 Hugh Bennett presented the MIQPR, noting advanced winter planning with extra 111 staff, demand forecasts, private provision for festive peaks, severe weather plans and paramedic scheduling. Ceri Jackson sought assurance on digital solutions for 111 and impact of improved ambulance response times; Hugh responded that while digital changes are helping, there is no certainty they will fully resolve the demand and capacity gap. The JCC wants to see the impact of these changes before considering further investment. There is a possibility that improvements could increase demand, so the situation is being monitored.

7.2 Conveyance rates are rising due to better ambulance availability, and benefits of Clinical Model Transformation (CMT) will be monitored post call categorisation phase two. The committee considered the impact of the CMT programme and reduced handover delays on Health Boards, with early indications of improved ambulance availability and conveyance of higher acuity patients not necessarily benefiting flow through the front door. A formal

evaluation of the CMT programme has been commissioned, however benefits realisation and performance indicators and trajectories work is underway internally and will be overseen by the Finance and Performance Committee (FPC).

7.3 Rhiannon Beaumont-Wood raised concerns about Betsi Cadwaladr and low Same Day Emergency Care (SDEC) activity; Jonathan Chippendale and Andy Swinburn outlined plans via Six Goals Programme, stressing Welsh Government leadership in response to the Wait 45 Taskforce. The Chair and Liam highlighted monitoring handovers and expanding community pathways.

The Committee agreed that the MIQPR report provided sufficient assurance noting the issues raised above.

8. STRATEGIC QUALITY PLAN 2025-2028 IMPLEMENTATION UPDATE

8.1 Kate Blackmore updated members on the Strategic Quality Plan, confirming it was reviewed and amended by the Clinical Quality Governance Group (CQGG). Corrections were highlighted; second line assurance will be provided quarterly through CQGG and Quest, aligning with the current Audit Wales Quality Governance review requirements, and this frequency can be reviewed after the first 12 months; and for third line assurance, Kate confirmed that an internal audit review will be sought at the midpoint of the strategy, in line with IMTP deliverables, to assess implementation maturity. Kate concluded that otherwise, the paper stands as written.

8.2 Liam Williams outlined that the Strategic Quality Plan is being developed with assurance from Audit Wales and Internal Audit, with a focus on deeper organisational integration as core categorisation work concludes. Liam highlighted new national alignment efforts under the NHS Wales Chief Executive and an All-Wales Quality Management System initiative. While there is good directorate alignment, full integration is ongoing. Liam emphasised clarifying assurance metrics and distinguishing between population health and public health approaches. Liam concluded that the plan demonstrates progress and a clear path forward, supported by recent leadership changes.

8.3 Trish Mills stressed the need to clarify which Strategic Quality Plan deliverables are also in the IMTP to avoid duplication between QuEST Committee and FPC reviews. Trish also highlighted distinguishing action progress from strategic outputs in line with Audit Wales recommendations.

8.4 The Chair sought clarification on the report's reference to partial assurance of progress against delivery of the plan, requesting further detail on the underlying challenges. In response, Kate Blackmore and Penny Durrant explained that the primary constraint relates to limited capacity and capability, particularly in delivering population health ambitions and digital/data support.

Work is ongoing to embed these areas into business-as-usual processes and to utilise available resources pragmatically.

8.5 The Chair stated that the report demonstrates clear progress and substantial work, acknowledging ongoing system wide challenges, and expressed that the committee was assured the organisation is moving in the right direction with the Strategic Quality Plan.

The Committee:

1. **Received assurance on the activity completed to undertake prioritisation of tasks and timeliness associated with the Strategic Quality Plan 2025-28; and**
2. **Received assurance on the implementation approach, governance and prioritisation of deliverables.**

9. PUTTING THINGS RIGHT (PTR) REPORT QUARTER 2 2025/26 (JULY-SEP 2025)

9.1 The PTR Report for Q2 2025/26 was received, highlighting a number of learnings and improvements that have been identified and implemented. While some areas of poor performance are being addressed through the PTR recovery plan, the following points were noted:

- The number of overdue National Reportable Incidents (NRIs) has remained relatively static this quarter. However, there has been a deterioration in the timeliness of complaint responses, with fewer being completed within the statutory 30-day timeframe, this target has not been met in any of the past 15 months reported. There has also been a decline in the number of Duty of Candour letters issued within the required five working days.
- Key themes emerging from NRIs this quarter include issues with call management (such as missed allocation opportunities and delays due to incorrect incident addresses), remote clinical care (including inappropriate call downgrades and challenges in mental health consultations), and operational pressures (notably abstractions and low staffing levels).
- There are ongoing delays in the submission of Learning from Events Reports, which has prompted an intensive support programme from the Welsh Risk Pool. Progress against last year's improvement programme is slipping, as reflected in the audit tracker.
- Additional learning has been captured around complex case management, the impact of the Clinical Navigator role, and developments in gender identity work.

9.2 Discussion covered stress and sickness impacts, on-the-spot resolution, and embedding national approaches. Leadership support has increased, and AI use is planned for 2026/27. Case complexity has risen due to call categorisation

changes, but processes have adapted. No new complaint themes emerged. The committee welcomed the assurance and will monitor progress and funding impact.

The Committee received and took assurance from the Putting Things Right Report – Quarter 2 2025/26 (July-September). No additional assurance requirements were identified.

10. AAA FROM AUDIT RISK AND ASSURANCE COMMITTEE (ARAC) TO QUALITY PATIENT SAFETY AND EXPERIENCE COMMITTTEE (QUEST) – NEAR MISS AND LOW HARM

10.1 Trish Mills presented the AAA report from 2 September 2025 meeting to the committee, explaining that ARAC requires annual assurance from QuEST on the framework for Near Miss and Low Harm reporting. The latest report highlighted challenges in providing full assurance due to current resource and system constraints; however, ARAC accepted this position and requested an interim update in March rather than waiting until September.

10.2 The Chair supported this approach and agreed to this request, noting it was appropriate given recent discussions and that it would be programmed for a future meeting (re QuEST to ARAC), and recognised that Near Miss and Low Harm reporting continues to be constrained by capacity and system pressures.

11. MENTAL HEALTH ANNUAL REPORT 2024/25

11.1 Liam Williams introduced the Mental Health Annual Report 2024/25, confirming its purpose is to assure this committee and Welsh Government on the use of commissioned funding and outline the Trust's mental health approach. Future reports will integrate all mental health work, including safeguarding, and align with the JCC. Justine Cosby summarised her first six months, noting achievements, challenges and an expanded remit covering dementia, CAMHS (Children and Adolescent Mental Health Services), neurodivergence, postnatal mental health, substance misuse and older people. Key developments included new strategies, specialist roles, a mental health response vehicle pilot, and equity initiatives. Challenges remain around service variation, workforce shortages and patient feedback.

11.2 Rhiannon welcomed the breadth of reporting but urged more focus on achievements and assurance. Ceri praised ambition and asked about mental health skills for EMS/111/999 staff and third sector collaboration. Liam stressed WAST should focus on its remit, empower generalists, and improve crisis support through partnerships.

11.3 The Chair raised concerns regarding resource dependencies for delivering the mental health next steps. Andy Swinburn responded by acknowledging the challenge of achieving equity of provision without additional funding and

emphasised the need to balance ambition with available resources. Andy highlighted that financial constraints are a major obstacle to large scale implementation. Justine also responded, noting recent clinician appointments and increased local authority involvement, but explained that some developments were not yet evident due to timing.

11.4 The committee acknowledged the report's value, supported its recommendations, and looked forward to more integrated, resource-aware developments and clearer evidence of local authority involvement in future reporting.

The Committee:

1. **Received the Mental Health Annual Report 2024/25 and discussed and noted the delivery of the assurance report.**
2. **Acknowledged that the continued focus is recommended on:**
   - **Scaling successful pilots like MHRV and remote Triage;**
   - **Enhancing workforce development and recruitment;**
   - **Strengthening partnerships with Health Boards and third sector organisations;**
   - **Advancing digital innovation and data driven evaluation; and**
   - **Ensuring equitable access and consistent quality of care across all regions.**

12. LEARNING FROM DEATHS (MORTALITY REVIEWS) REPORT

12.1 Wendy Herbert presented the Learning from Deaths report, noting 143 Medical Examiner cases in Q2, adding to PTR workload. Progress continues on Level 2 reviews, though 96 cases remain outstanding. Key themes include ambulance delays, lack of end-of-life planning, deconditioning from long waits, and poor patient/family experience, with work underway to link learning to primary care. The report flagged the upcoming Thirlwall Inquiry and referenced the David Fuller Inquiry, with Trust actions implemented. The Chair noted recurring themes and ongoing system pressures; Wendy agreed these issues persist and require continued focus.

The Committee received the Learning from Deaths (Mortality Reviews) Report for discussion.

13. PATIENT EXPERIENCE AND COMMUNITY INVOLVEMENT (PECI) BI-ANNUAL REPORT (APRIL-SEPTEMBER 2025)

13.1 Leanne Hawker presented the PECI report, focusing on improving patient experience through NHS Wales metrics and the new National Framework. The team is embedding experiential data into quality improvement and using real time feedback to drive change. Positive feedback highlighted staff kindness and exceptional care, especially in Ambulance Care and 111 services, while

response times and call-backs remain challenging. Engagement events decreased due to resource constraints.

13.2 Rhiannon Beaumont-Wood queried the absence of Powys in engagement data and the status of SMS texting with the Information Commissioner's Office; Leanne explained resource limitations and reliance on local engagement teams and confirmed that General Data Protection Regulation (GDPR) compliance concerns are being addressed with Information Governance (IG) support.

13.3 The Chair also raised concerns about low engagement in Powys, as well as Cwm Taf Morgannwg and Hywel Dda, calling for more equitable resource allocation. Liam acknowledged resourcing issues and confirmed recruitment and a reset are planned for Q4. Ceri stressed the value of qualitative feedback and asked if experiences of those unable to access services are captured; Leanne noted this is mostly gathered anecdotally and new surveys are being developed. The Chair suggested adding a quick reference to previous scores on slides showing patient feedback (e.g. for 999 and Ambulance Care) so trends over time, such as whether satisfaction is increasing, stagnant, or declining, can be easily seen in future PECI reports. Leanne confirmed data will include trends in the next report.

The Committee:

1. **Received the Patient Experience and Community Involvement (PECI) Bi-Annual Report (April-September)**
2. **Noted the activities undertaken during this reporting period and acknowledged that PECI Reports will be shared publicly through the Trust's People and Community Network.**

14. CLINICAL AUDIT PLAN Q2 2025/26

14.1 Andy Swinburn introduced the Clinical Audit Plan Q2 update, with Jonathan Chippendale providing details. Three audits were completed: hospital transfer care bundles (no issues), St. John's missing records (no new risks but highlighted need for Electronic Patient Care Records (EPCR) for Falls service), and ketamine use (actions to align with Patient Group Direction (PGD). The antimicrobial audit was discontinued and moved to Medicines Management reporting. Clinical intelligence requests have significantly increased, mainly due to FOI (Freedom of Information) and legal/pre-claim activity.

14.2 Rhiannon Beaumont-Wood praised progress and asked about FOI drivers. Jonathan said most stem from universities, PTR follow-ups, and legal cases, with efforts to signpost public data. Liam noted work to align FOI and Subject Access Request (SAR) responses with PTR and workforce processes to improve efficiency. Members commended the team, and Jonathan encouraged colleagues to commission audits, stressing readiness to support new proposals.

The Committee:

1. **Approved the revision as detailed in the report, to the Clinical Audit Plan 2025/26;**
2. **Approved the Q2 Clinical Audit Plan; and**
3. **Noted the additional intelligence work completed outside of the plan.**

15. RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK REPORT

15.1 Trish Mills presented the Risk Management and Board Assurance Framework update, clarifying that Risk Appetite statements would be submitted to the Board at the end of the month.

15.2 The committee discussed the two highest strategic risks; ***Risk 223*** (*The Trust's inability to reach patients in the community causing patient harm and death*) and ***Risk 224*** (*Significant handover of care delays outside accident and emergency departments impacts on access to definitive care being delayed and affects the Trust's ability to provide a safe & effective service for patients*) which remain at a score of 25. These risks are regularly reviewed and updated, with new external controls such as the Wait 45 Taskforce now in place. The risks are managed through both external monitoring and internal management and are frequently reviewed at both ELT and SLT levels.

The Committee considered the contents of the report, including:

1. **The controls in place against the risks; and**
2. **The actions described to further mitigate the risks.**

16. 2025/26 QUALITY GOVERNANCE REVIEWS

16.1 Trish Mills presented the 2025/26 Quality Governance Reviews, covering updates on board and committee responsibilities and a "light" review of QuEST Committee effectiveness. The main proposal is to disband the Academic Partnership Committee, moving oversight of research, innovation, commercialisation and digital to FPC; education and training to the People and Culture Committee (PCC); and resilience, cybersecurity and information governance to the ARAC. These changes are deferred until after an external effectiveness review in Q4, so the committee will continue for two meetings focused on research. Minor membership changes are proposed meanwhile.

16.2 QuEST feedback was positive, with suggestions to strengthen focus on Quality Management Systems (QMS) quality planning and outcome driven plans. Trish recommended prioritising QMS next year alongside national work on QMS and value-based healthcare.

16.3 Members supported the direction of travel, noting caution about overloading agendas. The terms of reference were viewed as suitable and were endorsed subject to changes which transfer responsibility for value-based healthcare from FPC.

The Committee to:

1. **Noted the wider board committee framework changes proposed and provided feedback on the recommendations; and**
2. **Endorsed changes to the terms of reference.**

17. AUDIT TRACKER 2025/26 Q2 REPORTING

17.1 Trish Mills presented the Audit Tracker 2025/26, noting that there was a minor error in the number of internal audits due for the quarter. Over 55% of the quarter's actions were closed, with four audits deferred and two given new dates, including the EPCR audit, which is on its third and final date. Trish expressed concern about having 2023/24 actions still open and plans to review their feasibility with Felicity Quance. Two actions without revised dates relate to the PECI work programme, which is expected to be updated in the next report.

17.2 For external audit recommendations, under 50% were closed, with ten new dates set and four actions without dates, all linked to digital priorities or automated extraction work for Datix. Trish confirmed ongoing follow-up to ensure dates are set for outstanding actions.

The Committee received assurance on the monitoring of management actions to address recommendations in the Tracker, noting any revised dates for actions.

18. POLICIES FOR APPROVAL: PREVENT POLICY

18.1 The Prevent Policy was presented for committee approval. Liam highlighted the importance of the Prevent Policy in safeguarding and public protection, noting ongoing UK and Welsh Government work that may require future amendments to the policy sooner than the standard review period.

The Committee approved the Prevent Policy as recommended.

19. COMMITTEE CYCLE OF BUSINESS MONITORING REPORT AND 2025/26 PRIORITIES

19.1 Trish Mills presented the Committee Cycle of Business Monitoring report, noting that the Infection Prevention and Control (IPC) Annual Report was deferred to the February 2026 meeting. Rhiannon Beaumont-Wood supported the idea of prioritising IPC metrics for assurance rather than just an annual report. Liam added that the IPC team is now fully established and well

qualified, and the next meeting will include a robust discussion on IPC baseline assessment and improvement.

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

20. KEY MESSAGES FOR THE BOARD

20.1 The meeting consistently highlighted the ongoing pressure on staff resulting from persistent operational and resource challenges. A key concern was the limited availability of resources, which continues to hinder progress toward service improvements and broader ambitions, an issue that requires escalation to the Board. Equity in service provision and engagement across regions also emerged as a significant theme and will be addressed in the upcoming Board report. Additionally, the group identified the need for more strategic discussions with partners, particularly regarding eligibility criteria for non-emergency transport services, recommending that FPC review this matter.

21. REFLECTIONS AND SUMMARY OF DECISIONS/ACTIONS

21.1 Trish Mills praised the agenda flow, paper quality and governance support; Rhiannon Beaumont-Wood agreed the meeting flowed well without curtailing discussion and valued the focus on Ambulance Care and patient stories; Ceri Jackson highlighted widespread data and digital challenges affecting governance and thanked Bethan for chairing; Debbie Bell, as an observer, found the session valuable for understanding patient journeys, assurance processes and organisational collaboration.

21.2 The Chair paid a heartfelt tribute to Paul Hollard, a former Non-Executive Director, noting his recent passing and expressing condolences to his family. The Chair emphasised Paul's unwavering advocacy for the Trust, his commitment to staff and his role as a champion for Quality, Patient Experience and Safety. Describing Paul as a "true gentleman" who made a significant impact on the organisation and its people, the Chair acknowledged the loss felt by the Trust community.

22. ANY OTHER BUSINESS

22.1 None declared.

23. DATE OF THE NEXT MEETING

23.1 The next meeting is scheduled for 03 February 2026.

The meeting concluded at 14:30

ACTION LOG - UPDATE
QUEST COMMITTEE

Minute Ref	Date	Agenda Item	Action Note	Responsible	Due Date	Progress/Comment	Status
06.4-11/25	4 November 2025	Patient Story (Alison Clarke had contacted the previous Chief Executive and spoken to him regarding her concerns about NEPTS and her transfers to hospital appointments)	The PTR Report and Alison Clarke's lived experience highlighted the ongoing high demand for NEPTS, which continues to generate complaints about unmet patient needs. Despite QPSE support through emotional mapping, enhanced data visibility, and efforts to encourage on-the-spot resolution, complaint levels have not declined. Members discussed the impact on patient care and have asked the Finance and Performance Committee (FPC) to review current actions and plans to improve service delivery, particularly around eligibility criteria and the challenges patients face due to cancellations and limited capacity.	Lee Brooks	3 February 2026	Update 16 January 2026 Included in agenda at Finance and Performance Committee on 20 January 2026, Item 6 NEPTS Capacity Management. Update 7 November 2025 Lee Brooks confirmed that Hugh Bennett and Mark Harris are preparing an update for the meeting of the Finance and Performance Committee on 20 January 2026.	Closed
09-08/25	5 August 2025	Ministerial Advisory Group WAIT 45 Taskforce	Liam Williams advised that a key meeting with the Cabinet Secretary is scheduled, where all workshop outcomes and improvement plans will be presented, and that the Committee can expect feedback at the next meeting following this session in November 2025.	Liam Williams	3 February 2026	Update 16 January 2026 This has been included on the agenda for the 3 February 2026 meeting, Item 6. Update 27 October 2025 It was agreed to defer this item to the February 2026 Agenda due to lack of relevant information available to provide an update to the November meeting. Update 18 August 2025 Following the ASM, this item has been included in the November 2025 meeting. Action proposed for closure.	Closed

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	27 November 2025
Committee Meeting Date	4 November 2025
Chair	Bethan Evans

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. **A data reporting error** has been identified with two sets of monthly data previously provided to Trust Board on the MIQPR. The June and August 30 working day compliance for Putting Things Right (PTR) has been over-reported, with performance now confirmed as having been much lower. This has been caused by reliance on manual extraction and calculation. The Directorate now has the technical capability to produce this metric in an automated way which will provide improved future confidence in the data reporting accuracy.

2. At the August meeting, members received the **Putting Things Right (PTR) and Legal Services Performance Organisational Recovery Plan**, with progress updates provided at this meeting. Members acknowledged the focused efforts on key challenges, including the increasing complexity and delays in PTR investigations, high sickness rates within PTR teams, and persistent issues with data access and manipulation, alongside the need for enhanced digital resources. The recent passing of new PTR regulations in the Senedd adds further complexity to this landscape, as preparations begin to consider the requirements and upskill staff ahead of implementation in April 2026.

   Members commended the progress made in reducing the time taken for more complex investigations within EMSC and Integrated Care, particularly in light of ongoing high sickness levels. They also noted the non-recurrent financial investment of £155K allocated to support the teams during this financial year. While the committee was assured that substantial work is underway, members requested that the next update provide a clearer assessment of the impact of this financial investment on the recovery plan, along with further detail on improvement trajectories and executive confidence in both recovery and its long-term sustainability.

ADVISE

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

3. Committee received a **Patient Story** from Alison Clarke, a user of the Non-Emergency Patient Transport Service (NEPTS), who described the significant impact of last-minute cancellations on her ability to attend vital medical appointments. She highlighted the emotional toll of not knowing whether transport would be available, the lack of clear communication from the Trust, and the impact on her health and wellbeing when appointments were missed or delayed. Alison's account underscored the need for improved communication, clearer eligibility criteria, and greater service reliability. The discussion highlighted that such cancellations are increasingly common due to a mismatch between demand and available capacity, exacerbated by factors such as reduced volunteer drivers post-pandemic, higher patient acuity, and system inefficiencies such as late bookings and cancellations by Health Boards. Members acknowledged the emotional and practical harm caused to patients and thanked Alison for sharing her experience.

4. The PTR Report and Alison's lived experience highlight the **ongoing high demand for NEPTS**, which continues to generate complaints about unmet patient needs. Despite support from the QSPE directorate through emotional mapping, enhanced data visibility, and efforts to encourage on-the-spot resolution, complaint levels have not declined. Members discussed the impact on patient care and will ask the Finance and Performance Committee (FPC) to review current actions and plans to improve NEPTS service delivery, particularly around eligibility criteria and the challenges patients face due to cancellations and the available commissioned capacity.

5. The Committee received an **update on the patient story** given in August 2025, which was Sophie's story. Since this time the Trust has developed easy-read resources, made progress on reasonable adjustments, and engaged with local learning disability groups to define quality service. The organisation will review learning from Sophie's story and other feedback to inform ongoing service improvements.

6. The committee approved the **Prevent Policy**. The committee received overview of the policy and its alignment with statutory requirements and NHS Wales guidance. The committee discussed the policy's content, its relevance to safeguarding, and the importance of staff training and awareness. Members were satisfied with the policy's clarity and the assurance provided regarding compliance and implementation.

7. The committee noted a proposal to initiate a full revision of the **Clinical Plan** aligned with the new ambulance performance framework. The revised approach will prioritise clinical leadership and outcome-based measures over time-based metrics, noting that much of the transformation is already underway through the CMT programme.

8. The Committee received the **Operational Update for Q2 2025/26,** which members noted:

    - A task and finish group has been established in partnership to develop an action plan that is actionable and sustainable, improve rural recruitment and retention alongside rural capacity and resilience.

- The robustness of transfer and discharge demand and capacity modelling for patient care. It was noted that financial constraints and unpredictable demand continue to present challenges, with current efforts focused on improving system efficiency rather than expanding resources.

9. Members **reflections included** positive comments on the meeting's structure, time management, and the quality of papers; crediting effective agenda planning and governance support. They emphasised that discussions were thorough and not rushed, with particular value placed on the focus given to Ambulance Care and patient stories. A recurring theme was the challenge of data and digital capacity, with concerns about manual processes and their impact on organisational intelligence and staff workload. Observers found the meeting insightful for understanding the Trust's governance arrangements, and the collaborative culture within the Trust. These reflections underscore the committee's commitment to robust assurance, continuous improvement, and transparency in addressing operational and strategic challenges. The committee welcomed an observer from the Joint Commissioning Committee as well as a number of WAST colleagues.

10. The committee **met briefly in private** to receive a confidential risk report.

ASSURE

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

11. The **Monthly Integrated Performance Report (MIQPR)** was received, setting out the metrics for August/September 2025. Performance related to PTR is reported separately below and members noted that the board will receive and discuss the MIQPR at its meeting in November 2025. The committee considered the impact of the Clinical Model Transformation (CMT) programme and reduced handover delays on Health Boards, with early indications of improved ambulance availability and conveyance of higher acuity patients not necessarily benefiting flow through the front door. A formal evaluation of the CMT programme has been commissioned, however benefits realisation and performance indicators and trajectories work is underway internally and will be overseen by FPC.

12. The **PTR Report for Q2 2025-26** was received, highlighting a number of learnings and improvements that have been identified and implemented. While some areas of poor performance are being addressed through the PTR recovery plan referenced above, the following points are noted for the Board's attention:
    - The number of overdue NRIs has remained relatively static this quarter. However, the board will see from the MIQPR that there has been a deterioration in the timeliness of complaint responses, with fewer being completed within the statutory 30-day timeframe. This target has not been met in any of the past 15 months reported. There has also been a decline in the number of Duty of Candour letters issued within the required five working days.
    - Key themes emerging from NRIs this quarter include issues with call management (such as missed allocation opportunities and delays due to incorrect incident addresses), remote clinical care (including inappropriate call downgrades and challenges in mental health consultations), and operational pressures (notably abstractions and low staffing levels).
    - There are ongoing delays in the submission of Learning from Events Reports, which has prompted an intensive support programme from the Welsh Risk Pool. Progress against last year's improvement

programme is slipping, as reflected in the audit tracker.

- Additional learning has been captured around complex case management, the impact of the Clinical Navigator role, and developments in gender identity work.

13. The Audit, Risk and Assurance Committee (ARAC) received the annual assurance report of this Committee regarding the framework supporting the **near miss and low harm** intelligence reporting in the Trust at its meeting on the 02 September 2025. ARAC noted the report provided only limited assurance however did take account of the PTR recovery plan which is focused on the incidents that have taken place and that therefore improvements in near miss and low harm reporting may not be forthcoming in the short term. A further update was sought from ARAC in March 2026.

14. The Learning from Deaths (Mortality Reviews) for Q1 and Q2 was received, with delays in care far outweighing other cases by referral reason. Learning themes include recurrent issues such as:
    - Deconditioning and long lies.
    - Possible opportunities for alternative Pathways and avoiding conveyance.
    - Absence of Advanced Care Planning and end of life care packages, education and preparation.
    - Number of patients opting to self-convey because of long Estimated Time of Arrivals (ETAs).
    - Very poor patient and family experiences, predominately due to delays in responding.
    - Identification of atypical stroke presentations.
    - Caregivers/callers with Learning Disability who find themselves unsupported during long waits.
    - Lack of planning, preparation and support for recognised terminal conditions such as Motor Neurone Disease where death was both anticipated and expected.
    - Consistent volume of concerns from bereaved relatives about CPR instructions being given to callers when a person already has a DNACPR.

15. Partial assurance was provided on the **Strategic Quality Plan Implementation Update**, particularly in relation to the population health and value-based healthcare objectives. This was attributed to ongoing capability and capacity issues. Members noted that resourcing and prioritisation of the digital and data plan remains a challenge given the team's current focus on the CMT programme. Nonetheless, the positive impact of the quality team's work is being felt across the Trust and was evident in the discussions at this committee. Members acknowledged the increasingly mature dialogue around the Quality Management System (QMS) and quality improvement methodology, as well as the emergence of a pan-Wales approach. The committee will continue to receive assurance reports on implementation at each meeting, ensuring a balanced focus on both the progress of individual actions and the strategic outcomes and impact.

16. The **Patient Experience and Community Involvement (PECI) Biannual Report** was received. The committee noted the Trust's progress in embedding experience metrics, with positive feedback on staff kindness and booking systems. The report confirmed compliance with statutory duties and robust processes for real-time feedback and quality improvement. Transparency with reporting, growing interest in patient experience and visualisation, and efforts to ensure equitable engagement were acknowledged. Members were assured the PECI Team is aligning with national frameworks, are pursuing Information Commissioner requirements to increase patient contacts directly through SMS, and planning trend-based data enhancements. Despite resource challenges, the PECI Team remains

committed to meaningful engagement and continuous improvement, with future reports to be publicly shared and adapted during organisational change.

17. The Committee has reviewed the **Mental Health Annual Report for 2024/25**. The report outlines strategic transformation across Wales, with improvements in governance, service delivery, workforce development, and partnerships aligned to Welsh Government priorities. The Trust is moving towards integrated, proactive mental health support, aiming to reduce emergency department pressures and improve care quality. The Gwent Mental Health Response Vehicle pilot has shown positive outcomes and the Trust is considering opportunities for expansion and 24/7 coverage. Specialist roles and advanced training in areas such as learning disabilities, CAMHS, substance misuse, and dementia are strengthening workforce capability and enhancing generalist practice. Challenges including staffing shortages, limited service hours, and data gaps are being addressed through recruitment, training, technology, and performance monitoring. The committee acknowledged the report's value, supported its recommendations, and looked forward to more integrated, resource-aware developments and clearer evidence of local authority involvement in future reporting.

18. The **Clinical Audit Plan and Action Tracker update for Q2 2025/26** was received with no escalations.

19. The Committee held the first part of its **Quality Governance Review** (formerly effectiveness review) for 2025/26. There was broad agreement that the committee's membership is appropriate and diverse, and whilst concerns were raised about the number of attendees, with some questioning the value added by non-contributing participants, wide attendance is encouraged and welcomed by the committee in open session. The committee is seen as effective with high engagement, robust agendas, and strong scrutiny and chairing. However, there is a desire for more focus on the effectiveness of the QMS as a whole, including quality planning, control, and improvement, not just assurance. This will be addressed in the cycle of business and priorities of the committee for 2026/27. The terms of reference are viewed as suitable and were approved subject to changes which transfer responsibility for value based healthcare from FPC.

20. An update was received on the **Audit tracker (internal audit, external audit/reports)** with no escalations to the board.

21. The **cycle of business and monitoring report** were reviewed with members noting the Annual Infection and Prevention Control Report 2024/25 was deferred until January (it was due to be presented in August).

RISKS

Risks Discussed:

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

Discussions during the next round of reviews will centre on whether reductions in handover delays will

translate to a reduction in scores. Handover delays have seen month on month reductions (12,284 in September 2025 compared to 20,693 in September 2024) but are still not close to those upon which are service is modelled, and not currently universal across Wales.

New Risks Identified: The continuing pressures on our people and resourcing challenges to the Trust's statutory duties and ambitions.

COMMITTEE AGENDA FOR MEETING		
Operations Directorate Quarterly Report for Q2 2025-26	Patient story and Updates	Monthly Integrated Quality and Performance Report
Strategic Quality Plan 2025/28 Implementation Update	PTR Report Q2 and Recovery Plan	AAA from ARAC re Near Miss and Low Harm Reporting
Mental Health Annual Report 2024/25	Learning from Deaths (Mortality Reviews) Report	PECI Biannual Report
Clinical audit plan and tracker	Risk Management and BAF	2025/26 Quality Governance Review
Audit Tracker 2025/26 Q2	Prevent Policy (for approval)	Cycle of business and monitoring report

COMMITTEE ATTENDANCE						
NAME	**9 MAY 2025**	**13 JUN 2025[1]**	**5 AUG 2025**	**10 OCT 2025[2]**	**4 NOV 2025**	**3 FEB 2026**
Bethan Evans (Chair)						
Ceri Jackson						
Rhiannon Beaumont-Wood						
Liam Williams						
Andy Swinburn			Jonathan Chippendale			
Lee Brooks	Peter Brown				Mark Harris	
Rachel Marsh			Hugh Bennett		Hugh Bennett	
Jonny Sammut	Keith Williams					
Trish Mills		Julie Boalch		Julie Boalch		
Mark Marsden						
Hugh Parry					From item 6.1	
Henry Garrard						

	Attended
	Deputy attended
	Apologies received
	No longer member

[1] Extraordinary meeting
[2] Extraordinary meeting

Agenda Item No. 06

REPORT TITLE

Ministerial Advisory Group WAIT 45 Taskforce

MEETING

Name of meeting	Quality, Patient Experience & Safety Committee
Date of meeting	3 February 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Liam Williams, Executive Director of Quality and Nursing Andy Swinburn, Executive Director of Paramedicine
Author(s) of report	Liam Williams, Executive Director of Quality and Nursing

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. Quality Patient Experience & Safety (QuESt) Committee members have requested and received verbal updates on the work being completed through the National Handover 45 Taskforce since the summer. These verbal updates continue to reflect the dynamic nature of the work being led through the National Handover 45 Taskforce with NHS Wales Performance and Improvement, Health Boards and the Trust. QuESt Committee members have also requested to receive feedback from the Accelerated Design Events that Trust Executives and Senior Managers supported over the summer with six Health Boards.

2. **Appendix One** is the report generated by NHS Wales Performance and Improvement sharing thematic learning from the NHS Wales Performance and Improvement Accelerated Design Events to support the National Handover 45 Taskforce. This learning has supported the work undertaken by Health Boards and the Trust to facilitate Winter Sprints in December 2025 and January 2026. In turn, these Winter Sprints are expected to improve hospital flow which enable hospitals to reduce delays in the handover of patients from WAST emergency ambulance colleagues to Emergency Departments.

3. **Appendix Two** is the position agreed through National Handover 45 Taskforce, and subsequently the NHS Wales Leadership Board, on the requirements for minimum performance during January 2026 and subsequent achievement of Handover 45 nationally.

4. The Trust Executive Team continue to support colleagues in the Department of Health and Social Care, and NHS Wales Performance and Improvement, secure commitment and improvement to patient experience and reductions in harm experienced through delays.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

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

1. Receive and note papers setting out progress of the National Handover 45 Taskforce and the approach taken by the NHS Wales Leadership Board to sustainable improvement in handover delays being achieved in Wales.

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:

Appendix 1 Ambulance Handover Accelerated Design Events Integrated Thematic Summary

Appendix 2 Ambulance Patient Handover: Release to Respond at 45 minutes/Winter Sprint 2 (23 December 2025)

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

RISK(S) THIS REPORT MITIGATES

Where relevant note the local, directorate, corporate or BAF risk number
BAF Risk 223 & BAF Risk 224

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

Quality Domains (select all that apply) [link to standards]		
☒ Safe	☒ Timely	☒ Effective
☐ Efficient	☒ Equitable	☒ Person Centred
Quality Enablers (select all that apply) [link to standards]		
☒ Leadership	☐ Workforce	☒ Culture
☐ Information	☐ Learning Improvement & 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
13 January 2026	Clinical and Quality Governance Group
3 February 2026	Quality, Patient Experience & Safety Committee

GIG CYMRU NHS WALES
Perfformiad a Gwella
Performance and Improvement

Ambulance Handover Accelerated Design Events Integrated Thematic Summary

NHS Wales Performance and Improvement

01/12/25

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Acknowledgement Statement

On behalf of the National Handover -45 Taskforce and NHS Wales Performance and Improvement, we extend our sincere appreciation to all participating health boards for their engagement in the Accelerated Design Events.

Your commitment to collaborative innovation and system-wide improvement has been instrumental in shaping practical, patient-centred solutions to the challenges of safe and timely handover. These events have demonstrated the power of cross-disciplinary dialogue, rapid prototyping, and shared learning in driving meaningful change across NHS Wales.

We recognise the time, energy, and expertise each team has contributed, and we commend your openness to experimentation and co-design. Your efforts are helping to build a stronger, more resilient system that better supports staff and improves outcomes for patients. Together, we are laying the groundwork for sustainable transformation, and we look forward to continuing this journey with you.

Thank you for your leadership and dedication.

Introduction

This report consolidates findings from six Accelerated Design Events (ADEs) across NHS Wales health boards, which were convened as part of a national programme to address ambulance handover delays and improve urgent and emergency care across Wales. Each event applied an ADE approach and structured based problem solving using the A3 methodology.

These events focused on establishing shared local and national understanding of what actions might be necessary to enable a timely ambulance handover between ambulance crews and emergency department (ED), staff in a hospital anywhere in NHS Wales. This is all while ensuring the other dimensions of care in the Health and Care Quality standards (Welsh Government, 2024); Safe, Effective, Efficient, Equitable and Person-centred are not compromised but enhanced.

The intention was to support a 100-day sprint to enact plans and in some instances some health boards were already undertaking such an endeavour or rose to the challenge to do something in a shorter time frame.

Six separate Health Board events were held between August and September 2025:

1. Aneurin Bevan – 29/08/2025
2. Betsi Cadwaladr – 26/08/2025
3. Cwm Taf Morgannwg – 19/08/2025

4. Cardiff & Vale – 3/09/2025
5. Hywel Dda – 1/09/2025
6. Swansea Bay – 12/09/2025

NB – events focusing for the Wales Ambulance Services Trust and Powys Teaching Health Board have not yet taken place but are being scheduled.

Common Challenges Across Sites

The challenges across sites are not new and have been known in unscheduled & emergency care for some time. While these are common and by no means an exhaustive list, the proceeding pages intend to reveal context specific issues and nuances to address them through a 'wisdom of crowds' approach.

- Ambulance handover delays persist due to internal flow blockages, delayed discharge, and inconsistent escalation processes across a health boards footprint.
- Underutilisation and/or lack of investment in the discharge/transfer lounge concept. Delays experienced due to pharmacy and transport coordination fundamentally stem from a push model all competing for the same resource, rather than a pull alternative built on effective communication.
- Inconsistent pathways and referral processes, especially out-of-hours and across specialties likely due to subjective preference over evidence-based practice or practice-based evidence.
- Delayed diagnostics and reporting impacting discharge and flow.
- Cultural and behavioural barriers, including risk aversion, lack of ownership, and change fatigue.
- Fragmented communication and duplication, leading to inefficiencies and missed opportunities for timely discharge.
- Weekend and out-of-hours service gaps inhibiting flow models, however highly valued general practitioner skillsets and services demonstrate they are a key component.
- Limited use of data for operational decision-making, despite availability. Indicative of a lack of confidence in the data's integrity, rather than a preference for alternative modes of decision making.

Initial Themes

The predominant themes emerging from discussion of the challenges facing organisations were:

1. Discharge Planning
2. Single point of access concept development and delivery
3. Cultural norms and adaptive leadership
4. Digital and Data
5. Governance and Accountability

Cross cutting themes are expanded on at the end of the document. The following breakdown of each event is a high-level description of the salient points supporting the formation of these themes and the proposed actions per site. At the end of this document are suggested national opportunities for improvement.

For a more detailed description of each event and their outputs please refer to the individual health board summary reports.

Health board summaries

Aneurin Bevan UHB

The Aneurin Bevan University Health Board (ABUHB) Accelerated Design Event (ADE) focused on addressing ambulance handover delays and improving urgent and emergency care pathways. With strong executive engagement and structured planning using the A3 methodology, the event consolidated existing work, identified priority actions, and set the foundation for a 100-day sprint aligned to the Six Goals framework.

Site-Specific Highlight

- Transfer lounge operational but underused; standard operating procedures (SOPs) in place to empower nurse-led discharge.
- Emphasis on "Home First" culture and reducing overly safe discharge decisions.
- Testing ringfenced assessment spaces and pull models to spread risk across wards.

Key Challenges
Pre-Hospital • Limited access to Welsh Ambulance Service Trust (WAST) data for Hear & Treat/See & Treat and 111 outcomes: benchmarking with England still pending. • Inconsistent clinical risk thresholds for managing patients in the community; lack of a clear risk framework for out of hours (OOH) and weekends. • Fragmented pathways into Minor Injury Units (MIU), Urgent Primary Care Centres (UPCC), and Same Day emergency care (SDEC); inability to quickly revert to 999 if needed. • Community services not consistently available 7 days; unclear access criteria and outdated Directory of Service. • High demand for falls and acute frailty support; missed opportunities for rapid response. **In-Hospital** • Discharge times slipping later in the day; backlog of legacy patients worsened by weekend gaps. • Ambiguity around patient ownership in assessment spaces; governance gaps. • Overwhelmed ward teams; absence of a structured pull model.

- Multiple patient moves causing deconditioning; underutilisation of transfer lounges (only 20% capacity used).
- Data gaps in predicting demand post-ambulance turnaround; fragmented communication and duplication of calls.
- A lack of a learning system for tracking and understanding delays.

Discharge

- The Grange University Hospital (GUH) does not default to home discharge, reliance on step-down.
- Weekend discharge processes weak; backlog on Mondays.
- Risk-averse decisions influenced by staff and families; myths about early discharge.
- Lack of clarity in step-down criteria; inconsistent application.
- Criteria-led discharge lacks medical engagement, unclear ownership across MDTs.
- Waiting for TTOs, transport, and care packages; intermediate care beds under pressure.

Priority actions

- Development of senior nurse-led discharge supported by standard operating procedures (SOP) and national best practice.
- Increase utilisation of transfer lounge; identify patients for discharge the day before, rather than on the day.
- Implement optimal ward discharge processes and empower MDT for 7-day discharge.
- Local ambulance crew training for long-lie patients; paramedic rotation through Single point of access (SPOA).
- Review falls pathway compliance; utilise Southwest England protocol.
- Establish discharge liaison roles and hospital discharge assistants at GUH.
- Cascade communication and accountability through staff meetings.

Opportunities for improvement

Pre-Hospital

- Strengthen falls response and care home support; embed culture change.
- Integrate SPOA with Flow Centre; enhance MDT support.
- Expand 111 Clinical Support Hub for weekend cover.
- Use Consultant Connect for timely senior advice; review respiratory resources.
- Explore if ABUHB is still a member of the NHS Benchmarking network and access the Unscheduled Care data set to benchmark against other sites across the UK. An opportunity for all health boards to check their involvement as licences often cover whole

sites even if another team is accessing a different project e.g. planned care and utilise data for improvement.

In-Hospital

- Optimise transfer lounge as a pick-up point; empower lounges to book transport.
- Introduce patient navigator role; ringfence assessment spaces.
- Implement system-wide pull model; link board rounds to red/green tracking.
- Explore corridor-based assessment; rationalise echo use.

Discharge

- Reinvigorate criteria-led discharge with medical engagement.
- Public engagement. Apply behavioural science and use posters, apps, and scripts to support staff-family conversations.
- Embed primary care facilitators in board rounds; align workstreams to Goals 5 & 6.
- Redesign pathways for integrated health-social care; expand community bed use.

Reflections

Strong consensus that flow is a system-wide issue, not just the Emergency Department.

Cultural change is critical; risk appetite, family expectations, and shared ownership must shift through communication channels.

Data-driven decision-making and governance clarity are essential for sustainability.

Rapid testing and scaling of improvements through the 100-day sprint will be key to delivering impact all year round and ahead of planning for winter 2026

Betsi Cadwaladr UHB

The Betsi Cadwaladr University Health Board (BCUHB) ADE brought together local leaders and national facilitators to address persistent ambulance handover delays and system flow challenges across North Wales. While engagement was strong, participation from Wrexham site teams was limited due to operational pressures, which highlighted the challenge of balancing improvement work with frontline demands. Despite this, the event surfaced critical themes around pre-hospital conveyance, in-hospital flow, and discharge coordination, setting the stage for targeted interventions and cross-site learning.

Site-Specific Highlight

- Identified gaps in discharge coordination and internal escalation.
- Strong data infrastructure but inconsistent use for improvement site wide.
- Planning cross-site learning and policy review for criteria-led discharge.

Key Challenges

Pre-Hospital

- High conveyance rates, including non-injury falls and anticoagulated patients who often do not require ED care.
- Duplication of assessments and lack of consistent pathways across sites.
- Limited use of alternatives to conveyance (e.g., "call before convey" or remote decision-making).
- Delayed access to community services, especially out of hours.
- Data visibility strong and exemplary but not consistently integrated into real-time decision-making beyond the ED.
- Operational strain: paramedics missing breaks and responding to "red release" without rest creates fatigue effecting decision making.

In-Hospital

- Persistent ambulance handover delays beyond 45 minutes; performance varies across sites, with periods of good practice. Should an ED have to close this would shift the burden to other sites while one site recovers. Data requires insightful balance measures to identify good practice.
- Flow blockages caused by ED congestion and delays in moving patients to wards. This is suggestive of a 'reverse bullwhip' effect found in operational management i.e. a 'supply chain' phenomenon where the supply variability is amplified downstream, resulting in an inadequate availability to meet demand.
- Lack of seven-day service models; weekend gaps create bottlenecks perhaps adding to the above effect.
- Cultural and accountability gaps; inconsistent senior leadership engagement over the last 5 years.

- Data not consistently driving operational decisions across pathways despite availability.

Discharge and Ongoing Care

- Discharge planning not initiated earlier, extended length of stay and increased deconditioning risk.
- Fragmented discharge processes across health and social care; slow community response.
- Significant variation in discharge practices and length of stay across sites.
- Limited community "pull" and in-reach from social care teams.
- Absence of standardised seven-day discharge protocols.
- Staff need support for effective family engagement during discharge planning.

Priority actions

- Audit discharge lounges utilisation across all sites and share findings.
- Review and standardise criteria-led discharge policy with executive and medical leadership support.
- Engage with Swansea Bay UHB for cross-site learning on discharge best practices.
- Reinstate Emergency Care Forum for North Wales to share emerging good practices. Potential to scale this concept nationally for a Network of Practice approach.
- Enhance internal escalation processes for discharge and flow planning accountability. Consider concepts from other health boards utilising reverse bed chain management.

Opportunities for improvement

Pre-Hospital

- Develop clear pathways for falls and frailty, including senior decision support pre-arrival.
- Implement Level 1 & 2 community response models for falls prevention.
- Upgrade e-triage systems and strengthen links to urgent primary care and minor injury units.
- Increase use of remote clinical decision-making and "call before convey" protocols.

In-Hospital

- Align bed availability to demand using real-time dashboards and predictive data suited to open systems.
- Enhance escalation meetings to manage risk based on actual harm in ED, rather than potential risk.
- Reduce reliance on bank staffing; improve workforce stability.

- Explore Same Day Emergency Care (SDEC) and acute frailty models to reduce admissions.

Discharge

- Optimise discharge lounge utilisation and embed criteria-led discharge.
- Standardise discharge processes and introduce QA mechanisms.
- Improve family engagement through training and communication tools.
- Strengthen integration with community services and develop SCP criteria for community beds.

Reflections

Strong appetite for improvement but frustration at past inertia and slow decision-making.

Cultural change and executive visibility are critical to sustaining progress.

Data is abundant but underutilised; needs to drive real-time operational decisions across the health board to reduce the reverse bullwhip effect.

ADE reinforced that ambulance handover delays are a whole-system issue, requiring coordinated action across pre-hospital, in-hospital, and discharge domains.

Cwm Taf Morgannwg UHB

The Cwm Taf Morgannwg University Health Board (CTMUHB) Accelerated Design Event, held on August 19, 2025, brought together a wide range of stakeholders from across the health board and national teams to tackle ambulance handover delays and systemic flow challenges. The day was structured around data sharing, theory of change development, and A3 methodology to create actionable plans for a 100-day sprint. CTMUHB was recognised for considerable progress in handover performance and cultural transformation over the past two years.

Site-Specific Highlight

- CTMUHB has achieved notable improvements in ambulance handover times, positioning itself as one of the strongest performers in Wales, but sustainability and seven-day consistency remain key challenges.
- Significant effort in creating a centralised SPOA and Navigation Hub to streamline referrals and reduce unnecessary conveyance, supported by an increase in paramedic advanced practitioners (from 3 to 17 in 12 months).
- Plans to implement electronic whiteboards and explore AI-driven software to enable real-time patient flow and reverse bed chain logic i.e. identifying a string of patients that if prioritised creates a chain of flow.
- Ambitious target to achieve 50% of discharges "home for lunch" by September and 80% by Christmas, supported by discharge lounges, protocol-led processes, and cultural change initiatives under the Optimise Programme.

Key Challenges
Pre-Hospital • Ambulance handover delays driven by crowded EDs, slow internal flow, and inconsistent discharge processes. While this is true for many hospitals in Wales, there appear to be some nuances bespoke to CTM. • Inconsistent pathways and lack of a co-designed SPOA with paramedics. While the navigation hub exists there were challenges that it is not consistent and works right first-time causing disengagement and lack of use. • Out-of-hours and weekend services not aligned with 24/7 ambulance operations. Co-located OOH GP models that are successful and evidence based do not appear as a wraparound service. **In-Hospital (Pre and Post Arrival)** • Variation in length of stay and pathway access across sites. Believed to be due to a secondary conveyance should a 'walk-in' patient attend one of the three sites, rather than an ambulance convey they to the correct site-

specific speciality, including other health boards e.g. burn injuries to Morriston hospital, myocardial infarction to a coronary catheter lab. These self-presenters may attend due to a lack of ambulance availability creating a 'gridlock' and increasing risk within the ED. This appeared as a pivotal issue to address.

- Lack of standardisation in emergency corridor capacity and SDEC access across sites.
- Delays in moving patients from ED to wards; multiple internal moves required for one admission. Should one move fail, the entire process has to start again resulting in duplication of effort and erosion of morale.
- Limited porter availability and absence of dedicated departmental porters at some sites inhibits flow. Where available this is highly valued and releases nurse time and creates flow.
- Patient flow coordinators exist at one site but not across all sites: however not available 24/7.
- Digital gaps: reliance on paper records and lack of integrated systems for real-time tracking are an identified latent failure also.

Discharge

- Two-thirds of discharges occur after 4pm and are unpredicted, creating risk at the front door and in the community.
- No seven-day discharge model; variation in MDT approach and prioritisation.
- Delays due to transport planning and demand; Non-emergency patient transport service (NEPTS) cancellations create overnight stays but are understandably prioritising more urgent patients somewhere in the system.
- Inaccurate or outdated Expected Date of Discharge (EDD) and electronic whiteboards. Ability to update EDD would help manage caseloads.
- Cultural barriers: lack of ownership of discharge importance; reliance on partners to fulfil their duties once health board has fulfilled theirs.
- Behavioural issues: over-prescription of care from an ED attendance and family expectations are unpragmatically high. Discharge reliant on family availability to pick up after working hours. The idea of a new policy for employers to release family members under a new 'special leave' policy for a hospital discharge pickup was raised.
- Data gaps: difficulty tracking patient journeys and measuring intervention impact.

Priority actions

- Develop and implement a communication plan around the Optimise Programme and discharge goals.
- Design a robust process for updating electronic whiteboards and discharge information.
- Establish discharge lounges on all sites, operational from early morning with dedicated porting in ED and discharge lounges if not already available.
- Create a repository of resources to support the Optimise Programme, accessible to all staff.
- Upskill and support flow teams to capitalise on their discharge expertise.
- Undertake capacity modelling for emergency corridor to determine whether two trollies free for handover at all times improves flow or is prone to Parkinson's Law i.e. it suggests that a resource's available capacity will always be fully consumed by the work, regardless of the actual amount of demand.
- Implement & develop patient flow coordinators providing a wraparound service to aid discharge early the next day.
- Transition to electronic patient records for ED; explore digital mobile devices for coordination and aid in reverse bed chain management to create a pull model.
- Test and embed protocol-led discharge processes seven days a week.
- Strengthen SPOA functionality to operate 24/7 and integrate with remote clinical assessment, all co-designed with WAST.

Opportunities for improvement

Pre-Hospital

- Develop then expand Navigation Hub and SPOA to streamline referrals to and improve the situation of self-presenters attending the inappropriate site, through releasing ambulances sooner.
- Utilise advanced practitioners knowledge beyond operational and embed within SPOA MDT.
- Enhance remote clinical assessment to manage low-acuity cases from for 999/111 calls.
- Develop pull model between SPOA and community services for appropriate cases.

In-Hospital

- Introduce effective electronic whiteboard systems for real-time flow tracking and updating of EDD.
- Expand urgent treatment centres (UTCs) to divert primary care demand from ED.

- Develop geriatric emergency medicine areas and hospital-at-home services.
- Explore investment in software to enable artificial intelligence (AI) driven patient flow and reverse bed chain concepts. Engage with partners e.g. Health Technology Wales to task them with appraising such software to suit needs on behalf of all health boards.

Discharge

- Embed data-driven improvement and systemic learning to reduce unwarranted variation in length of stay through the lens of system dynamics. Consider balance measures to ensure waste transference to community care does not reappear as readmissions or a reduction in patient experience post discharge.
- Strengthen system-wide collaboration with social care for rapid response models and effective discharge.
- Empower staff to engage families effectively through training and communication tools with public engagement initiatives to set expectations.
- Implement regional discharge policy and core principles for consistency.
- Align discharge planning with admission decision. Target "home for lunch" discharges without sacrificing planned complex discharges with NEPTS to reduce the gridlock of other wards. Pilot reverse bed chain management before investing in an AI alternative.

Reflections

CTMUHB has demonstrated noteworthy progress in handover performance and cultural transformation, positioning itself as one of the leaders in Wales.

Sustainability and consistency remain the key challenges, particularly for seven-day service models and integrated discharge processes.

Delegates emphasised the need for behavioural science application, flattened hierarchies, and shared accountability to embed improvements.

Digital transformation and workforce development were seen as critical enablers for future success.

The event closed with optimism and a clear call to maintain momentum, scale best practices, and ensure improvements are embedded into everyday operations.

Cardiff & Vale UHB

The Cardiff and Vale University Health Board (CAVUHB) Accelerated Design Event, held on September 3, 2025, focused on tackling ambulance handover delays and systemic flow challenges through a well-attended cross disciplinary session. This session was able to discuss leadership accountability, with strong contributions and attendance from the Executive Medical Director and Chief Operating Officer. The event highlighted the critical role of discharge timing in unlocking capacity, with internal data showing that shifting discharge activity earlier in the day could release up to 25% additional capacity without resourcing additional beds.

Site-Specific Highlight

- Strong executive engagement and operational clarity.
- Focus on early discharge, standardised referral pathways, and accountability.
- Emphasis on MDT empowerment and reducing variation in ward processes.

Key Challenges

Pre-Hospital

- Lack of a 24/7 out-of-hours service across the health board's specialised and general services to meet the around the clock demand that the ED addresses.
- Primary Care contractual limitations (e.g., 3–4pm cut-off) and insufficient GP resources inhibit the beneficial contribution from general practitioners.
- Limited funding streams for primary care, creating uncertainty and capacity gaps to respond to appropriate demand.
- Unclear roles and responsibilities for 111 and signposting.
- Confusing patient messaging and fragmented pathways leading to inappropriate ED attendances which cannot be turned away without a review, to reduce risk.

In-Hospital

- Poor visibility of patient flow and diagnostics; IT systems which often do not connect to each other. This results in patients repeating their story and reassessment inhibiting flow and patient experience.
- Delays in diagnostics and unclear timeframes for results.

- Ineffective board rounds with limited MDT engagement and unclear ownership of decision making.
- Cultural hesitancy to engage in difficult conversations with patients/families with not understanding of why it is avoided.
- Administrative burden and lack of clarity in roles; poor coordination across teams.
- Staff shortages in non-medical roles and community services identified as constraints.

Discharge

- Late discharge profile: two-thirds of discharges occur after 4pm, creating bottlenecks and stifling momentum into the next day.
- Underutilisation of discharge lounges; reliance on push rather than pull models. Evidence of reverse bed chain management but not sustained practice.
- Lack of confidence in discharging complex patients; avoidance of difficult conversations with families and the patient.
- Resource constraints: community bed shortages , dementia specialist care homes delays. 46% of beds unusable; dementia care beds predicted to increase by 30% in next 3 years with a lack of beds in the community.
- Cultural risk aversion and siloed working; need to reframe discharge as continuation of care.

Priority actions

- Develop a communication plan for discharge goals.
- Build a seamless virtual SPOA for professionals, operating 24/7 building on the CAV247 work.
- Standardise specialty referral pathways and embed them into induction processes while appropriately uplifting the team capacity to accommodate a new model.
- Introduce ED nurse manager role with enhanced training for accountability and flow.
- Implement criteria-led and nurse-led discharge protocols, including weekend planning based on the above being in place.
- Utilise discharge lounges effectively; adopt a pull model for patient movement with supported improvement work in areas such as pharmacy and co-ordinating with NEPTS.
- Identify priority discharge patients daily; set targets for early discharge (e.g. by 8am).
- Strengthen collaboration with social care for rapid response and community pull model.

- Upskill, provide support and organisational backing for staff to manage difficult conversations with families confidently and compassionately.
- Transition to electronic whiteboards that are fit for purpose to enhance decision making and productivity.
- Explore digital solutions for real-time flow tracking.

Opportunities for improvement

Pre-Hospital

- Adopt the "Big Room" (Toyota Production System's Obeya) approach for collaborative problem-solving and data review.
- Enhance SPOA functionality with MDT resources and consultant support.
- Expand remote clinical assessment for 999/111 calls; integrate with community pathways.
- Build IT infrastructure for seamless signposting, referral management and tracking.

In-Hospital

- Develop a 12-month improvement plan for referral and retrieval processes.
- Empower ward teams through exemplar ward testing and shared learning.
- Align operational meetings across departments to foster understanding and system wide co-ordination.

Discharge

- Shift discharge profile earlier in the day; target "home for lunch" discharges with similar considerations in other health boards of ensuring the co-ordination is in place first.
- Implement 'Safe at Home' capacity for IV support and domiciliary care.
- Reduce unnecessary inpatient tests; move suitable investigations to outpatient settings.
- Embed data-driven improvement to reduce unwarranted variation in length of stay.

Reflections

CAVUHB is recognised as a leader in implementing Six Goals but faces challenges in sustaining progress and embedding consistency.

Discharge timing was considered as the single most impactful lever for improving flow and reducing handover delays.

Cultural change particularly around risk appetite and family engagement is essential for success, requiring both communication and organisational development support.

Digital transformation and workforce development were identified as critical enablers for a sustainable future.

The event closed with key messages; make improvement easier for staff by embedding it into routine practice, supported by system-level alignment and leadership that can adapt to the evolving situation. Progress will reveal novel issues that are not indicative of changes not being improvements.

Hywel Dda UHB

The Hywel Dda University Health Board (HDUHB) Accelerated Design Event, held on September 1, 2025, focused on tackling ambulance handover delays and systemic flow challenges across a geographically complex region. The session emphasised cultural change and professional standards, with strong contributions from the Chief Operating Officer and Clinical Care Group Service Director. Delegates explored how improvement requires a whole-system response rather than isolated interventions, particularly in rural settings where service variation and access issues persist. The delegates discussed the preplanned "reset week" and the 30-day sprint to accelerate progress, prioritising early discharge, senior clinical decision-making, and streamlined pathways. Collaboratively participants recognised the need for behavioural shifts, data-driven planning, and integrated working across primary, secondary, and community care.

Site-Specific Highlight

- Launching "(Y)our Next Patient" initiative and a system reset week.
- Strong focus on cultural change, ownership, and visual management systems.
- Exploring regional discharge lounge models and a 7-day service expansion.

Key Challenges
Pre-Hospital • Inconsistent 24/7 service provision; variability across three counties and rural areas. • Limited options for alternatives to ED; reliance on conveyance due to risk aversion. • Clinical Streaming Hub operates only five days a week: inconsistent access for WAST. • Delays in 111 callbacks lead to a default of an ED attendances. • Falls response pathways vary by geography; unclear Level 2 response in some areas. • Respiratory and oncology pathways lack clarity, inconsistent senior decision-making. • Mental health patients experience extended ED stays and a delay in inter-hospital transfers. • Digital gaps: poor connectivity for Consultant Connect; lack of navigation apps in some areas.

In-Hospital

- Discharges often missed before midday due to delays in investigations and reviews.
- Staffing models outdated; insufficient skill mix to meet current demand.
- Duplication of assessments in ED; limited availability of senior clinicians.
- Poor visibility of "next patient;" reactive rather than proactive planning.
- Cultural resistance and burnout; reluctance to involve all grades in decision-making.
- Administrative burden and excessive meetings detract from clinical time.
- Misalignment of job plans and lack of structured training for evolving roles.

Discharge

- Medically fit patients remain on wards for up to two weeks.
- Inconsistent use of discharge lounges; Bronglais lacks a lounge entirely.
- Delayed discharges due to late bloods, investigations, and consultant reviews.
- Gaps between primary, secondary, and community care; unclear pathway arrangements.
- Pathways not consistently maintained when patients move between areas.
- Lack of seven-day working models; cultural mindset of "bring them in" persists instead of alternatives to the ED and direct access pathways.

Priority actions

- Implement "reset week" actions: early senior decision-making, discharge before midday, and cancellation of non-essential meetings.
- Launch "Your Next Patient" initiative to improve visibility and accountability for patient flow.
- Increase utilisation of discharge lounges; trial impact at Bronglais.
- Embed criteria-led discharge with clinical buy-in and engagement.
- Move investigations and consultant reviews earlier in the day to enable timely discharge.
- Develop a business case for seven-day service provision across key pathways.
- Strengthen MDT communication and ownership of discharge responsibilities.
- Establish Big Room forums and daily huddles to replace ineffective board rounds.
- Use targeted infographics and visual management systems to drive cultural change.
- Engage public and staff through behavioural science-informed messaging to reduce inappropriate ED attendances without resulting in unintended

consequences e.g. the extremely sick stay at home to later be conveyed at a higher level of acuity and need.

Opportunities for improvement

Pre-Hospital

- Expand Clinical Streaming Hub to seven-day operation; ensure consistent and reliable access for WAST.
- Develop clear respiratory and falls pathways; provide training for care home staff to aid in decision making of when to call for help and when not to.
- Pilot remote clinical advice for WAST; explore antibiotic prescribing on scene and past initiatives already trialled in other regions.
- Improve digital infrastructure for Consultant Connect and navigation apps.
- Strengthen public health messaging to guide patient behaviour and dampen ED by default.

In-Hospital

- Clarify ownership of patient flow; ensure senior staff presence at the front door.
- Introduce visual tools (e.g. electronic whiteboards) to track patients by specialty and identify blockages early.
- Reduce administrative burden by eliminating non-essential meetings.
- Align job plans with service needs; invest in training and development for evolving roles.
- Implement learning systems supported by visual management and data-driven insights for systemic change.

Discharge

- Prioritising Pathway 0 and Pathway 1 patients perceived as short term wins.
- Embed seven-day discharge processes, aligning social care and therapy services.
- Moving discharge related tasks earlier in the day and setting targets for midday discharge requires safe staffing and the tools described above to understand constraints to ensure tasks can be actioned.
- Strengthen integration between primary, secondary, and community care.
- Explore data science to forecast admissions to plan capacity proactively

Reflections

HDUHB faces unique challenges due to geography and service variation, requiring tailored solutions and strong cross-sector collaboration.

Cultural and behavioural change emerged as a critical enabler, alongside professional standards and visible clinical leadership.

Data-driven planning and digital transformation are essential to overcome systemic constraints and improve flow.

The event reinforced the need for integrated working across all care levels, supported by clear communication and shared accountability.

Delegates expressed optimism about the 30-day sprint and reset week as catalysts for sustainable improvement.

Swansea Bay UHB

The Swansea Bay University Health Board Accelerated Design Event, held on September 12, 2025, focused on consolidating progress and accelerating system-wide improvements in urgent and emergency care. The session brought together health board leaders, national facilitators, and regional partners, including the West Glamorgan regional partnership board (RPB), to showcase how they addressed persistent challenges in pre-hospital access, in-hospital flow, and discharge. Building on 18 months of cultural transformation and operational redesign, the event emphasised governance, empowerment, and digital innovation as enablers of sustainable change. Key discussions included SPOA standardisation, discharge planning reforms, and embedding initiatives like "Your Next Patient" and Discharge to recover then assess (D2RA).

Site-Specific Highlights

- SBUHB was commended during a recent Get it right first time (GIRFT) visit and showcased at the Senedd for sustainable improvements in ambulance handover and patient flow.
- The "Your Next Patient" initiative has transformed ED dynamics by pulling patients into wards, reducing overcrowding and improving patient experience.
- The deputy COO highlighted that releasing ambulances increased ED arrivals, revealing the true nature of emergency care flow rather than reacting to a perceived surge in demand. This is an example of recognising a system dynamic. They also identified that the opening of a ward to improve flow could be regarded as a work around and assured the audience it required other actions to ensure this approach was not absorbed into the everyday capacity and resulted in no benefit.
- The event featured active participation from the West Glamorgan RPB, reinforcing integrated governance and joint accountability for discharge and community pathways.

Key Challenges
Pre-Hospital • Fragmented access routes and multiple SPOAs causing confusion and inefficiency for WAST. • Lack of standardisation and clarity in SPOA terminology and governance. Discussions revealed multiple interpretations of the concept and different practices, both with advantages and disadvantages. • Weekend handover delays due to inadequate planning and transport scheduling.

- Service gaps in respiratory and frailty pathways; absence of robust criteria and mismatching data between health board and WAST. Diagnostic discordance to be considered as an explanation i.e. a mismatch in rates for the same symptoms with underlying co-morbidities. For example, the same patient presenting with breathlessness coded as respiratory pre-hospital and diagnosed as a pulmonary embolism in-hospital, then coded as cardiovascular. At scale this would account for mismatches. This is to be expected given the complex conditions encountered, differences in presenting condition versus diagnosis with specialised tests available in-hospital. These concepts need integrating into planning efforts to avoid the consequence of mis-categorisation.
- Funding uncertainty and strategic planning challenges; RPB funding due to end in 18 months.
- Limited integration of virtual wards and remote monitoring into SPOA models.

In-Hospital

- Reactive operational approach: bed allocation in batches creates bottlenecks as observed in the reverse bullwhip effect.
- Board rounds lack action focus; pharmacy and therapy cut-off times hinder same-day discharge.
- Weekend operations constrained by reduced staffing and service availability.
- Inappropriate ED attendances assumed to be driven by complex pathways and patient behaviour.
- Workforce issues: misaligned rotas and apparent lack of senior decision-making out of hours.
- Cultural barriers: disempowered ward staff, fear of risk-taking, and excessive administrative burden.

Discharge

- Significant variation across sites; Neath Port Talbot more agile than other areas.
- Mental health discharge delays due to workforce and training gaps.
- Fragile system resilience; the smallest of staff absences impact discharge performance.
- Risk aversion and over-testing prolong patient stays unnecessarily.

- Expectation management challenges with families; cultural perception that a hospital stay equals safety, rather than the potential for deconditioning.

- Lack of standardisation across local authorities and care teams; exclusion of mental health and learning disability from community support.

Priority actions

- Redefine and standardise SPOA across regions; consider a unified "no wrong door" model while ensuring WAST staff consistently get the right access.
- Launch SPOA development roadmap with phased milestones (1 month, 3 months, 1 year).
- Enhance weekend and out-of-hours pathways; improve remote care coordination.
- Implement governance reforms and strengthen operational engagement for SPOA.
- Optimise board rounds using SAFER and Red2Green principles, trial proof of concept on selected wards.
- Empower ward staff through operational leadership training and financial accountability.
- Embed D2RA and integrated discharge hub processes; standardise SOPs across sites.
- Shift discharge profile earlier in the day; set targets for midday discharge and create conditions to enable it to happen.
- Upskill staff in QI methodology; deliver on-the-job training to embed improvement culture.
- Reduce administrative burden by streamlining meetings and escalation processes.

Opportunities for improvement

Pre-Hospital

- Develop SPOA as a centralised hub integrated with navigation and flow centres.
- Expand remote patient monitoring and frailty prevention initiatives.
- Secure recurrent funding for falls and acute frailty work; align with measurable outputs.
- Strengthen communication and engagement across partners to build trust and buy-in both externally and internally.

In-Hospital

- Introduce ward buddying and peer reviews to share best practice and build improvement capability.

- Implement deterioration tools and Red2Green coding enhancements in SIGNAL IT system.
- Empower ward managers to make decisions and manage budgets; reduce reliance on senior sign-off.
- Use visual management systems and dashboards to track delays and escalation triggers.

Discharge

- Standardise discharge processes and criteria across health board and local authorities.
- Extend community care support to mental health and learning disability services.
- Develop public health messaging to reframe discharge as continuation of care not the end of it.
- Embed resilience through cultural change, empowerment, and trust-building initiatives.

Reflections

SBUHB is at a pivotal point: strong foundations have been laid, but the next phase requires deeper cultural and structural change.

Empowerment and trust emerged as recurring themes; staff need autonomy to act without fear of criticism.

Governance and integrated leadership through the RPB have strengthened collaboration, but operational alignment must continue.

Digital innovation and QI capability are critical enablers for sustainable improvement.

The event reinforced the importance of continuity planning over reactive winter planning, with a focus on embedding improvement into routine practice.

Cross-Cutting Themes

The following have been identified as themes across NHS Wales:

1. System Flow and Integration

Ambulance handover delays are a symptom of poor internal flow. Need for whole-system coordination from pre-hospital to discharge.

Supported by: ABUHB (flow blockages between ED and wards), BCUHB (reverse bullwhip effect), CTMUHB (reverse bed chain logic), HDUHB (whole-system response), SBUHB (SPOA fragmentation and batching issues).

2. Leadership and Accountability

Visible executive leadership highlighted as critical

Lack of ownership and accountability noted as a barrier.

Supported by: CAVUHB (executive engagement), HDUHB (COO-led reset week), SBUHB (RPB governance), BCUHB (leadership gaps over 5 years).

3. Culture and Behaviour

Risk aversion and resistance to continual change are common, but no change fatigue due to passion and professionalism stood out.

Supported by: ABUHB (risk-averse discharge decisions), CAVUHB (hesitancy in discharge conversations), HDUHB ("bring them in" mindset), SBUHB (fear of risk-taking, disempowerment).

Staff wellbeing, empowerment, and psychological safety are recurring concerns, with risk of voluntary discretionary effort diminishing and the situation becoming worse.

Avoidance of difficult conversations with patients and families is a recurring barrier to timely discharge (ABUHB, CAVUHB, SBUHB).

Cultural norms around hospital as a "safe place" influence patient and family expectations, prolonging stays (CAVUHB, SBUHB).

4. Data and Decision-Making

Rich data exists but is underutilised when it cannot be trusted. Need for reliable dashboards, grounded in thorough analytics, and meaningful metrics that provide valid and useful information.

Supported by: BCUHB (strong data but poor operational use), CTMUHB (electronic whiteboards, AI-driven flow), SBUHB (integrated dashboards), HDUHB (forecasting via data science).

5. Discharge Planning and Execution

Discharge is often reactive, not planned or pre-emptive. Criteria-led discharge and midday targets are key levers with varying levels of maturity across health boards but are ineffective in isolation without considering staffing levels across wards, specialities and departments. Blockages can identify areas for investment.

Supported by: CTMUHB (midday discharge targets), CAVUHB (discharge curve analysis), HDUHB (reset week prioritising midday discharge), SBUHB (variation and fragility in discharge processes).

6. Workforce and Capacity

Staffing models are outdated and often misaligned with demand.

Weekend and out-of-hours gaps undermine continuity and dampen any momentum of flow.

Supported by: HDUHB (misaligned job plans), CTMUHB (weekend gaps, NEPTS cancellations), SBUHB (reduced weekend processing power).

7. Communication and Coordination

Duplication and fragmentation in communication. Need for streamlined referral pathways and true to name SPOA models.

Supported by: ABUHB (duplication of calls), SBUHB (SPOA confusion), CAVUHB (poor communication between clinical teams and families).

8.Innovation and Learning

Collective learning and social learning systems emerged as critical enablers for sustainable improvement. Health boards valued opportunities for cross-site collaboration, peer review, and shared problem-solving forums (e.g., Big Room approaches, integrated discharge hubs). These mechanisms fostered transparency, accelerated adoption of best practices, and built a culture of continuous improvement across organisational boundaries (ABUHB, BCUHB, CTMUHB, CAVUHB, HDUHB, SBUHB).

9. *Digital Transformation*

Digital enablement is a critical enabler for flow and discharge improvement. Boards referenced electronic whiteboards, AI-driven patient flow systems, and integrated dashboards to support real-time decision-making and predictive analytics (CTMUHB, SBUHB, HDUHB).

10. *Governance and Strategic Alignment*

Integrated governance structures and strategic alignment emerged as key drivers for sustainable change. Examples include RPB involvement at SBUHB and would be complimented by Big Room forums as proposed by HDUHB to replace ineffective board rounds and communicate with partners.

11. *Financial Sustainability*

Financial recovery and sustainability were highlighted as essential for embedding improvements. Deloitte's engagement at SBUHB and HDUHB's cost-benefit considerations underscore the need to align operational redesign with financial viability.

National Opportunities for Improvement

- **Criteria-led discharge**
  All sites identified this as a priority but noted the need for clinical engagement and standardisation.
- **Single Point of Access (SPOA)**
  Health boards are at varying stages of developing SPOA models to streamline referrals and reduce unnecessary conveyance. SPOA currently has two interpretations, revealed in an ADE discussion between different professions.

  - A single-entry point for WAST to access the correct pathway within each health board.
  - Multiple SPOAs within one health board, which can lead to repeated hand-offs for a paramedic crew between a SPOA and another SPOA. This results in WAST staff having to default to an ED attendance

  To achieve the intended "no wrong door" approach, health boards must integrate internal SPOAs to eliminate hand-offs and ensure first-time resolution for patient and paramedics. A national effort to define, standardise, and operationalise SPOA practice is a key opportunity.

- **Patient Flow Coordinators**
  CTMUHB piloting this role to improve bed allocation and reduce internal delays. With established maturity in other health boards, a forum for this role to be developed and supported, would help generate good practice in this area.
- **Falls and Frailty Pathways**
  ABUHB, HDUHB, and BCUHB are focusing on care home training, MDT response models, and rapid assessment. With exemplar work being recognised, collaborative efforts focused on this domain would benefit all health boards.
- **Meeting Model Redesign:**
  HDUHB proposing "Big Room" forums and daily huddles to replace ineffective board rounds and improve coordination. Local and national support to implement this repurposing would take relatively small effort in return of a large effect.
- **Digital Solutions**
  CTMUHB exploring electronic whiteboards and AI-driven systems (e.g. Nerve Centre) to support real-time flow and discharge planning. Advice related to this technology and national whitelisting of it for NHS Wales would help with benefits realisation and return on investment.
- **Data-Driven Improvement**
  All sites emphasised the need for better data to track patient journeys, measure impact, and reduce unwarranted variation. Exploring what 'better' looks like is required to determine at what degree each site's data

is flawed, uncertain, scarce or distant from the source i.e. is it measuring what is believed to be measured, and if so , it can then be used for decision making and planning.

- **Cross-site learning**
  BCUHB to engage with Swansea Bay UHB to adopt proven discharge practices. SBUHB have been identified before the events as a positive deviant and were transparent in their approach, support mechanisms and learning. Further opportunities for other health boards to learn from SBUHB and share their own exemplary practices with each other should be facilitated through the appropriate learning system.
- **Governance and Strategic Alignment**
  Develop national frameworks for refreshed integrated governance and accountability.
- **Social return on investment**
  Align improvement actions with social return on investment analysis and resource optimisation.
- **Reverse Bed Chain Flow**
  Several boards (CTMUHB, CVUHB, ABUHB, SBUHB) referenced the concept of reverse bed chain or pull models to improve flow. A national approach to appraise, test and standardise this could accelerate adoption and could be enhanced with AI.
- **Integrated Discharge Hubs**
  SBUHB and HDUHB highlighted integrated discharge hubs as critical for reducing delays and improving coordination. National guidance on hub design and governance would support consistency.
- **Expectation Management Framework**
  Cultural and behavioural challenges around family expectations were common (ABUHB, CAVUHB, SBUHB). A national framework for expectation setting, including scripts and public messaging, could reduce discharge delays.
- **NEPTS Coordination Standards**
  Delays caused by non-emergency patient transport cancellations were noted (CTMUHB, CAVUHB). Engagement with NEPTS colleagues to coordinate with discharge planning as part of the 'big room' approach could address this.
- **Improvement Capability Building**
  SBUHB and CTMUHB stressed the need for on-the-job improvement training and ward-level empowerment. Access to appropriate improvement capability building would embed an improvement culture.
- **Public Health Messaging for Admission Avoidance**
  HDUHB and SBUHB demonstrated the need for behavioural science-informed campaigns to reduce inappropriate ED attendances while ensuring patients receive the right care. National messaging could standardise this approach.

- **Operational Leadership Development**
  Leadership training for ward managers and Band 6+ roles were highlighted (SBUHB, HDUHB). Attending national leadership development programmes would strengthen accountability and empowerment.
- **Digital Interoperability Standards**
  Fragmented IT systems and lack of integration were recurring issues (CAVUHB, CTMUHB, HDUHB). Further national standards for interoperability and real-time data sharing would enable flow.
- **Mental Health and Learning Disability Pathway Integration**
  SBUHB and HDUHB flagged gaps in discharge and community support for MH and LD patients. National work to integrate these pathways into urgent and emergency care planning is suggested and integration with the Strategic Mental health Programmes work on Open Access.

See appendix 1 for the national enablers for service improvement aligned to the cross-cutting themes.

Next Steps

- The ADEs will conclude with delivery of two further events, with WAST and Powys Teaching Health Board (PTHB) with dates to be confirmed.

- Individual organisations are responsible for taking any local action raised and identified as appropriate from these events, and any other national or local means to ensure timely ambulance handover.

- Offers of follow up support from NHS Performance and Improvement have been made to each health board individually. Follow up meetings are in progress to discuss next steps and are available upon request.

Appendix 1: Cross cutting themes and aligned opportunities

Theme	Aligned Opportunities
System Flow and Integration	SPOA standardisation, Patient Flow Coordinators, Meeting Model Redesign, Reverse Bed Chain Flow, Integrated Discharge Hubs, MH & LD Pathway Integration.
Leadership and Accountability	Governance and Strategic Alignment, Workforce Development, Operational Leadership Development
Culture and Behaviour	Workforce Development and Empowerment, Expectation Management Framework, Public Health Messaging
Data and Decision-Making	Data-Driven Improvement, Digital Solutions, Digital Interoperability Standards
Discharge Planning	Criteria-led discharge, Discharge before midday, Falls and Frailty Pathways, Integrated Discharge Hubs
Workforce and Capacity	Workforce Development and Empowerment, Improvement Capability Building
Communication and Coordination	SPOA standardisation, Meeting Model Redesign, NEPTS Engagement.
Innovation and Learning	Cross-Site Learning, Social Learning Systems, Meeting Model Redesign
Digital Transformation	Digital Solutions, Data-Driven Improvement, Digital Interoperability Standards
Governance and Strategic Alignment	Governance frameworks, SPOA integration, Integrated Discharge Hubs, MH & LD Pathway Integration.
Financial Sustainability	Social Return on Investment.

Appendix 2: Alignment of ADE Improvement Opportunities with the NHS Wales Six Goals

Narrative Summary

This document provides a refined alignment of improvement opportunities emerging from the Accelerated Design Events (ADEs) with the official Six Goals for Urgent and Emergency Care in NHS Wales. The mapping exercise was informed by the detailed descriptions of each goal, ensuring that recommendations were logically associated.

Alignment Logic:
Improvement opportunities were assessed against the Six Goals based on their primary intent and operational impact. For example, initiatives such as Single Point of Access (SPOA) standardisation align strongly with Goal 2 (Signposting people with urgent care needs to the right place, first time), while discharge-focused actions such as Criteria-led discharge and Integrated Discharge Hubs align with Goals 5 and 6.

Key Insights:

1. Most improvement opportunities revealed from the events cluster around Goals 5 and 6, reflecting a strong national emphasis on improving discharge processes and reducing readmissions.
2. Digital and data-driven initiatives (e.g., electronic whiteboards, AI-driven flow systems) support Goals 5 and 6 indirectly by enabling real-time decision-making and operational efficiency.
3. Few improvement opportunities explicitly address Goal 4 (Rapid response in a physical or mental health crisis), requiring further engagement to highlight good practice and share learning.
4. Mental Health & Learning Disability Pathway Integration, Cross Site Learning and Social Learning Systems are the only improvement opportunities that span all six goals, underscoring its systemic importance.

Strategic Gaps:

- Financial Sustainability is not explicit as part of the Six Goals, although it is widely accepted as a critical enabler for long-term improvement.
- Limited direct alignment with Goal 3 (Clinically safe alternatives to admission) suggests an opportunity for future efforts to explore this area.
- This analysis can inform prioritisation, resource allocation, and targeted improvement efforts across NHS Wales, ensuring that national opportunities for improvement are strategically aligned with the Six Goals framework and ongoing work.

Alignment of ADE Improvement Opportunities with NHS Wales Six Goals

Recommendation	Goal 1: Co-ordination planning and support for populations at greater risk of needing urgent or emergency care	Goal 2: Signposting people with urgent care needs to the right place, first time	Goal 3: Clinically safe alternatives to admission to hospital	Goal 4: Rapid response in a physical or mental health crisis	Goal 5: Optimal hospital care and discharge practice from the point of admission	Goal 6: Home first approach and reduce the risk of readmission
Criteria-led discharge					✓	✓
Single Point of Access (SPOA) standardisation	✓	✓				
Patient Flow Coordinators					✓	✓
Falls and Frailty Pathways	✓	✓	✓			✓

Meeting Model Redesign (Big Room, huddles)					✓	✓
Digital Solutions (whiteboards, AI-driven flow)					✓	✓
Data-Driven Improvement					✓	✓
Cross-site learning and social learning systems	✓	✓	✓	✓	✓	✓
Governance and Strategic Alignment					✓	✓
Reverse Bed Chain Flow					✓	✓
Integrated Discharge Hubs					✓	✓
Expectation Management Framework					✓	✓

NEPTS Coordination Standards					✓	✓
Improvement Capability Building					✓	✓
Public Health Messaging for Admission Avoidance	✓	✓	✓			
Operational Leadership Development					✓	✓
Digital Interoperability Standards				✓	✓	✓
Mental Health & Learning Disability Pathway Integration	✓	✓	✓	✓	✓	✓

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GIG CYMRU NHS WALES
Perfformiad a Gwella
Performance and Improvement

Grŵp Iechyd a Gwasanaethau Cymdeithasol
Cyfarwyddwr Gweithrediadau, GIG Cymru

Health and Social Services Group
Director of Operations, NHS Wales

Llywodraeth Cymru
Welsh Government

Chief Executives
Health Boards and Welsh Ambulance Services NHS Trust

23 December 2025

Dear colleagues,

Ambulance Patient Handover: Release to respond at 45 minutes / Winter Sprint 2

I am writing about the NHS Wales Leadership Board meeting held on 16 December regarding ambulance patient handover performance.

Firstly, I want to express my gratitude for your collective leadership, collaboration, and dedication throughout the recent Winter Sprint. The teamwork between you, your staff, local authorities and social care partners has played a vital role in enhancing patient flow, enabling earlier discharges, and maintaining system capacity during one of the year's most demanding periods.

As we move further into the winter pressure period, I want to acknowledge the significant planning and risk-mitigation work your organisations have undertaken. This preparation is vital as we enter a phase where demand pressures, seasonal illness, and workforce constraints will continue to intensify.

Reflection on the NHS Wales Leadership Board discussion: 16 December 2025

At the Leadership Board on 16 December 2025, the Board reviewed the national readiness and local risk assessments undertaken across all Health Boards as part of the Handover-45 programme.

I want to formally recognise that **every Health Board responded to the ask** made by the Handover-45 clinical taskforce and completed the required assessment. At the Leadership Board, this was supplemented by the taskforce's review and reflections in terms of areas each plan would need to cover.

The Board noted that, except for one organisation, all Health Boards expressed their support in principle for 'release to respond' at 45 minutes and intend to implement this measure by the end of January 2026.

Deterioration in performance and the expectation for January

The latest ambulance patient handover analysis shows that, compared with **October 2025**, performance has deteriorated in several areas during November and December, with rising

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average ambulance patient handover times and increasing hours lost across Wales. October remains the strongest baseline month in the recent period.

Given the forecast system risk over the next six weeks, and the projected hours lost for January without intervention, the Board discussed the "**Bridge Proposal**". **The proposal requires each organisation to meet either its October 2025 performance, or its best month since then, in January 2026. If it is unable to do so, the organisation should be prepared to implement 'release to respond' within 45 minutes.**

This is essential to prevent further increase in system risk and ensure the availability of timely emergency ambulance response in the community.

I am, therefore, asking each organisation to:

- **Deliver your October 2025 position, or your best performing month, as a minimum for January 2026**; (see separate data pack); or
- **If this cannot be achieved, bring forward your agreed plan for 'release to respond' at 45 minutes ahead of the end of January timeline preferred by Health Boards.**

This is necessary to avoid a significant rise in ambulance hours lost, emergency ambulance capacity and the associated patient safety risks in the community, as highlighted in the risk assessment and performance analysis.

Second Winter Sprint: 21 January – 4 February 2026

Data from the first Winter Sprint show encouraging evidence of progress against the targets set of Health Boards by Welsh Government, particularly an increase in earlier discharges, and a reduction in ambulance patient handover delays and long stays in emergency departments. This will have supported better experience and outcomes.

Historical trends suggest performance tends to improve during the 'Sprint' period but deteriorate in the weeks that follow. We anticipate January and early February to be operationally very challenging, and a further Winter Sprint to refocus energetically on achievement of the targets set for the initial Sprint is intended to support delivery of our collective Q4 ambition for urgent and emergency care as outlined above.

To this end, a **second Winter Sprint will run across the fortnight 21 January – 4 February 2026**. Repeating the Sprint again allows us to collectively learn, in real time, about those areas of change from the first Sprint that have been maintained and those that have dropped off. This will allow us to collectively focus our future efforts on **sustainable improvement** and longer-term system and process change.

As before, success will depend on **close and proactive joint working with social care partners**. I am, therefore, asking you to continue strong local engagement and collaboration with Directors of Social Services and Regional Partnership Board leaders. We will reinforce this nationally through the Office of the Chief Social Care Officer.

Thank you again for your leadership and the sustained efforts of your teams. The coming weeks will be challenging, but with coordinated action, shared risk ownership, and a

collective focus on delivering safe ambulance patient handover and timely patient flow, we can protect service users and maintain system resilience.

Please ensure your operational and clinical teams are fully briefed on these expectations and that any risks to delivery are escalated early.

Yours sincerely,

Jeremy Griffith

Director of Operations
NHS Wales

Cc:

Directors of Social Care
Albert Heaney, Chief Social Care Officer, Welsh Government
Taryn Stephens, Deputy Chief Social Care Officer, Welsh Government
Welsh Government Executive Director Team
Chris Clayton, Managing Director, NHS Performance and Improvement
Richard Bowen, National Director, Six Goals for Urgent and Emergency Care

OPERATIONS DIRECTORATE
QUARTERLY REPORT FOR COMMITTEES
2024-25 Q3 (October – December 2025)

National Operations & Support

General Update

Covid Inquiry - Public Accounts and Public Administration Committee (PAPAC)

The Trust was invited to appear at the PAPAC to provide evidence on 10 December. The Executive Director of Operations and Executive Director of Paramedicine appeared at the Senedd's Committee alongside representatives from two Fire and Rescue Services to respond to Module 1 of the Covid Inquiry. The Committee replaces the former Special Purpose Committee and will focus on Welsh Government's preparedness, response structures and progress since the Covid19 Pandemic. Considerable work was undertaken in preparation for the Committee with a written submission presented ahead of the session.

Exercise Pegasus

A unit debrief was conducted concerning the national tier 1 exercise 'Pegasus.' The goal of Exercise Pegasus was to assess our preparedness for a pandemic situation. While the exercise successfully showcased multi-agency collaboration and overall emergency response capabilities, it did not necessarily test our internal Pandemic Response Plan. The most critical finding was that the exercise did not trigger or validate WAST's Pandemic Response Plan, indicating a gap in assurance concerning pandemic-specific processes, structures, and decision-making. To address this and provided there is capacity, WAST will implement a series of targeted objectives and an exercise in Autumn 2026 to test the Pandemic Response Plan. Additionally, training and familiarisation sessions will reinforce awareness and usage of action cards, SOPs, and pandemic-specific documentation across all relevant teams.

SORT Uplift

Following the release of funding from Welsh Government, training is now complete for 222 SORT operatives of the 290 required. Training is now paused during the winter pressure period, resuming in Q1/2 of the next financial year to reach full complement of 290 operatives.

HART Drone

Our HART drone capability is now live from 23 December. This is the Trust's first drone capability and a great advancement for our HART and incident management capability. Live streaming accounts have been set up for the ODU and NILOs for incidents with accounts for commanders to follow. Our first deployment of the drone was very soon after go live – on 26 December. The drone was deployed at the scene of a high velocity road traffic collision to search a large, wooded area for other occupants of the vehicle who could have been at risk of major trauma or deterioration. The drone was successfully deployed in this multi-agency incident and a large area searched, making full use of the drone's thermal imaging capability to establish no further occupants from the vehicle. Each deployment will be monitored and reported in line with other KPIs.

Resourcing, EMS Coordination and Quality

Challenges

Go Live 2nd December

EMSC played a pivotal role in the successful launch of the new Ambulance Performance Framework on 2nd December. This included the implementation of revised protocols, processes and coordination mechanisms to enhance service delivery and resilience during a period of increased demand. The transition was managed collaboratively, ensuring minimal disruption to operations. Revisions of the Clinical Safety Plan, training and various SOPs have been undertaken to compliment Go Live across the EMSC service area.

Business Continuity Plan

Following changes introduced by the Clinical Model Transformation (CMT), EMSC reviewed and updated their Business Continuity Plan. The main focus on this review was addressing scenarios involving a total loss of staffing within the clinical navigator team. The team ensured that contingency measures were robust and actionable.

Texting

EMSC, with key internal stakeholders, implemented and facilitated the integration of texting solutions from Computer Aided Dispatch direct to our 999 callers and patients to enhance communication and manage expectations once the call had been assessed by the Clinical Navigator following Rapid Clinical Screening. This initiative supported real-time updates and improved coordination especially during operational surges, when benefits of less duplicate calls being presented and managed by the organisation, which releases the call handlers to answer new incoming 999 calls, and increase the Clinical Navigators capacity.

Socialised a proposed dispatch framework

EMSC Leaderhship team socialised a proposed dispatch framework, ensuring that staff were informed and engaged in the development of a proposed new deployment approach. This collaborative approach supported the teams being involved and engaged from the onset and gauging their appetite for this change going forward.

Revision of the Powys and other boundary works

EMSC contributed to the revision of operational boundaries, including Powys and other areas. This work aimed to optimise coverage and resource allocation, addressing cross-boundary challenges and supporting equitable service provision. This work continues to progress, with engagement with EMS colleagues.

IMTP

E-Timesheets & GRS Cloud

During this quarter, the E-Timesheet groups merged and held workshops to develop the timesheet SOP and technical specifications for implementing WAST Agenda for Change payments for unsocial hours and overtime. The technical specification is expected to be submitted to the February Project Board in quarter four. Progress continues on updating the timesheet SOP, with TU colleagues agreeing to revise the current Excel timesheet and publish the SOP before implementing E-Timesheet.

111 to GRS

Weekly meetings are underway to review and align processes with new rostering methods from the Optashift project and updates to self-rostering through GRS. The group will produce an Integrated Care Resourcing SOP and training materials for the transition. Staff engagement briefings to share a high-level overview of these changes are scheduled for January 2026.

General Update

Resourcing Christmas production

Focus by the team during this quarter are the collation and updates subsequent publication of Christmas rosters from across the operations directorate.

Resourcing Culture

During this quarter, the OD team facilitated listening sessions with full participation from the team. A Teams feedback session was held to discuss key themes, and a team away day workshop is being planned for quarter four.

Emergency Medical Service

Challenges

Performance

Following the introduction of phase 1 of the Ambulance Performance Framework, the median and 90th percentile have mostly been within required ranges. Further rural work is required to consolidate response and availability of community resources. Phase 2 commenced on 02nd December, and it is too early to directly feedback on response elements which have initially been impacted by elevated call demand.

45 Minute Release

The Welsh Government 45MR initiative commenced on 01st October 2025 and since then there have generally been improvements in the lost time at hospital EDs. However, BCU have remained an outlier with only a very recent improvement towards the end of December with the introduction of actions that have made a difference in line with the Winter Sprint Metrics exercise. Aneurin Bevan HB compliance with 45MR has been inconsistent but mostly continuing to experience handover delays. NHS Wales has provided direction to health boards that in January, they must return to their best position from either October, November or December and they have also set out that an approach to 45MR is to be activated come the end of January.

IMTP

APP roster review

OMDA have now been awarded the tender to produce modelling data for APP rosters. APP response codes, demand data and core principles have been shared with ODMA with weekly touchpoints introduced. Cardiff and Vale will be the first Health Board to receive the modelled data with estimated timescales of December/early January, with subsequent Health Boards receiving data monthly thereafter.

Increasing Capacity in Rural Areas

A Task & Finish Group is focussed on an action plan to work through short-, medium- and long-term actions to increase capacity in rural areas. Focus on staffing levels and specifically recruitment and retention are key drivers.

Fleet Review T&F Group

A request for volunteers to support the Fleet Review was placed on Siren in November, with an overwhelming number of volunteers coming forward. 16 staff from all grades and all service areas across Wales were selected to support the workshop in January.
TUP's, Quality, Health and Safety and Clinical Logistics will also support the work alongside Fleet colleagues. The aim of the piece of work is to review the layout and equipment within

the rear of the ambulances for both EMS and Ambulance Care, and to identify if any changes can be made to support clinicians, improve patient care and enhance patient experience.

General Update

Quality and Support Day November 25

Questions in relation to overruns were incorporated across all areas to ensure information is captured from all staff who experience a shift overrun whether frontline staff or contact centre based capturing feedback, lessons learnt and additional actions which may help reduce overruns. The group will then consider these responses which will feed into the program of work to reduce overruns.

Smart tethering

This initiative can utilise a tool to calculate the total job cycle time which compares to the remaining shift time to predict if a resource will overrun. A dashboard will display resources in order of least to most likely to overrun, supporting real-time allocation decisions within EMSC. First iteration of smart tethering is currently being developed for use.

Alternative Dispatch Arrangement Framework: Clinical and Operational Considerations

The framework is being developed to support non-clinical response coordinators in making out-of-time deployment decisions with clinical backing. The group is expanding to include more clinical and quality input to ensure a robust and safe process.

Ambulance Care

Challenges

Discharge and Transfer

Throughout the quarter we have continued to see sustained pressure in discharge & transfers. The level of completed journeys in October was higher than any other recorded month as Health Boards worked to attain 45MR standards. December also saw the busiest day of the year both in terms of demand and output. The service has also been working with system partners as part of a system reset process with the aim of increasing the volume of early discharges and activity on a weekend. Indications from this process were that some progress has been made, but this has not been consistent. The period has provided some learning with a number of process changes which will be implemented to support wider system awareness and efficiency.

IMTP

NEPTS Roster Review

The service has continued to progress its work on the implementation of new rosters and will recommence working parties in January 2026. The proposal, which is modelled to improve output by upto 300 additional journeys per week to be worked through involves an extension of the original proposed shift times and a reduction in weekend working, which shoud imrpove the work life balance of colleagues.

A number of pre-engagement events have been held with managers, TU partners, support teams and working party representatives to feedback on the adjustments made and the process to be adopted. These have been overwhelmingly positive and should support a more efficient and expeditous process. This is now a good example of taking on board feedback from our people.

General Update

Waiting List Initiative Contract Delivery

The service has continued to support the provision of an additional 200,000 outpatient appointments across Wales through the provision of additional transport provision at weekends and evenings. Despite significant weekly variation to demand both in terms of volume and geography, delivery has been overwhelmingly positive with no issues of note and patients receiving the transport they require to attend their appointments. The service has achieved this using the support of our plurality of external providers, volunteers and additional WAST employees and continues to deliver within the provided budget.

Culture Review

This year, WAST commissioned an external Culture Review to address the need for improvements in the working environment and morale within the NEPTS team. Resolution at Work led the review, providing staff with a confidential space to share their honest perspectives on critical issues such as workplace culture, leadership, management, communication, behaviours, training, and current practices.

The analysis from the review has now been returned and shared with staff. The management team will use this feedback and the resulting recommendations to develop a structured plan for service improvement, which will be communicated and implemented in the new year.

Integrated Care

Challenges

111 Online Outage

On 20th of October, 111 Online experienced a major outage from around 07:30, making the service unavailable. The incident response process was activated immediately, with technical teams working closely with the web host, providing updates through strategic on-call channels and hourly incident calls. Core systems such as CAD remained fully operational,

and although minor Microsoft 365 issues were noted, no direct link to the outage was identified. Cyber security monitoring was increased due to wider global service instability.
Call demand on 20th of October was noticeably higher, with a 20–25% rise in peak morning activity, particularly between 07:00 and 10:00. Although the data does not conclusively demonstrate causation, this pattern suggests the outage may have diverted more users to the phone service, adding pressure to operations. The Integrated Care team managed the impact through CSP oversight and normal escalation processes.

IMTP

First Line OCP

As part of the consultation process, 1:1 meetings were held in October and November to address staff queries and capture first and second role/location preferences. On 25 November, it was confirmed that all colleagues will receive their first-choice role and location, with no competitive selection required. Formal confirmations have been issued.
In early December, a small number of colleagues requested changes to their preferences. To accommodate this, the deadline for any further changes was extended to 18th December. Adjustments will be made where vacancies allow; a competitive process may apply if multiple requests target the same role.

Working groups will be established in Q4 to progress roster planning and confirm the revised go-live date, currently anticipated for February.

General Update

Phase 2 Training and Engagement

Training and engagement sessions were delivered in October and November for all Integrated Care teams to prepare for Phase 2 of the Clinical Model Transformation (CMT), implemented on the 2nd of December. The Ambulance Performance Framework Phase 2 engagement session complemented planned training by introducing new categories, providing an overview of Time, Purpose, and Skill, outlining role implications, and detailing available support. Over three weeks, 170 staff attended these sessions. Additional drop-ins were offered for further queries, but minimal attendance indicated the effectiveness of initial training and engagement.

Care Planning Desk

The Care Planning Desk was relaunched on the 7th of October with a redefined structure to improve workload management. The service was reorganised into three distinct queues to support Care Planners, as follows:

- Remote Community Monitoring
- Falls Desk
- Extended Waits

As part of the relaunch, a new Assessment Quality Module (AQM) for remote monitoring was also introduced into the Care Planning function. The new AQM allows for more efficient patient touchpoints without requiring a full clinical assessment if the patient's condition is unchanged. CWR utilisation has shown improvement, increasing from 42% in July to 60% in November and 63% (as of 15th December). In real terms, July saw 162 verified incidents attended with 140 on-scene rate, compared to November's 261 verified incidents and 231 on-scene rate, enhancing service capacity and response

Falls Desk Trial

Following a successful bid for Welsh Government funding, a dedicated Falls Desk resourced with Integrated Care Clinicians, and a Response Coordinator (from EMSC) was launched on the 12th of November as a trial. The service operates 7 days a week from 07:00 to 19:00.

As of the 12th November, the Falls Desk:

- Managed care for 782 patients, ensuring rapid clinical assessment, remote management, and prompt allocation of a Falls Responder.
- Assisted 102 patients off the floor prior to face-to-face response, preventing prolonged time on the floor that would otherwise have occurred.

Falls Responder utilisation has improved significantly, rising from 52% in June/July to 65% as of 12th of November, and has remained consistently at this level since. We have however been engaging with St John Ambulance to fulfil the falls responder requirements.

Single Point of Access

Single Point of Access (SPoA) commenced in Hywel Dda University Health Board, Swansea Bay University Health Board and Cwm Taff Morgannwg Health Board on the the 1st of October focussing on 'consult before dispatch'. This process enables WAST remote clinicians to collaborate directly with Health Board clinicians for patient referrals, reducing the need for ambulance dispatch. As of the 12th of December, 279 calls have been jointly assessed, with 28% resulting in a consult-and-close outcome.

Datix Backlog

On 11 September 2025, the Datix Lead presented the Operations Datix incident backlog to the Senior Leadership Team (SLT). The review highlighted a significant accumulation of unresolved incidents, requiring urgent intervention. A strategic response plan was implemented to address the backlog and prevent recurrence through improved incident management processes. Progress continues to be monitored and reported via the Senior Operations Team (SOT).

The backlog position as of 1 September 2025 stood at 3,205 incidents. The largest areas were:

- EMSC: approximately 55% of the backlog
- EMS: approximately 23% of the backlog

A total of 39 actions were identified to address the backlog. To date 26% of actions have been completed, 44% are in progress, and 33% are yet to start. Toward the end of November and into December, a small number of planned activities were cancelled due to the increase in winter pressures, with rescheduling planned for January to maintain momentum and ensure delivery of key improvements.

As of the week commencing 8th December, 49% of the backlog was closed. Closures peaked during September and October, showing strong early momentum; however, there has since been a decline in November and December, which correlates with increased winter pressures.

The next phase will focus on completing all outstanding actions and rescheduled activities to maintain progress. In addition, the implementation of the Datix Dashboard to provide real-time compliance monitoring, with a particular emphasis on ensuring new incidents are closed within 30 days, will also be critical to preventing future reoccurrence of a backlog. Regular reporting to both the Senior Leadership Team (SLT) and the Senior Operations Team (SOT) will continue to ensure accountability and sustained improvement.

Quality and Support Days

Quality and Support Days were delivered across Operations during October and November, with sessions held on 22nd and 23rd of October and on the 19th and 20th of November for Integrated Care only. These sessions were paused in December due to anticipated winter pressures. Across October and November, a total of 1,123 MS Forms were completed, demonstrating strong engagement from staff.

The purpose of these days was to prioritise staff wellbeing while addressing both Trust-wide themes and local service priorities. Key areas of focus included:

- Emotional wellbeing status

- NHS Wales Staff Survey
- Clinical Model Transformation Programme
- Infection Prevention and Control
- Ambulance Care Capacity Management Plan and Performance Standards
- Overruns and Shift Start and Finish SOP
- Statutory and Mandatory Training including MIST
- Compliance
- Communication

Feedback gathered during these sessions is actively shaping local action plans and informing national programmes, driving meaningful improvements. Among the actions taken are:

- Engaging in supportive conversations with staff who may benefit from additional support
- Increasing PADR compliance
- Supporting staff in accessing ESR training through iPads
- Influencing MIST training to ensure consistency and relevance across roles,
- Contributing to work aimed at reducing overruns.

Additional priorities include reinforcing understanding of guidance and legal requirements such as seatbelt use and Shift Start and Finish SOP, promoting completion of the NHS Staff Survey, and offering support to encourage participation.

Feedback also highlighted communication challenges, particularly difficulties navigating Siren to locate essential information and documents. This insight is being considered to guide improvements in communication channels and accessibility.

Staff Survey

At the close of the NHS Wales Staff Survey 2025, the Operations Directorate achieved a closing response rate of 43.1% (1,931 responses), marking a significant improvement from last year's 35.2% and reflecting strong engagement across teams. It is also highly likely that Operations staff contributed to the rates exceeding 100% for the Clinical Directorate. Weekly updates and targeted communications, including the use of Teams backgrounds and reassurances about anonymity, steadily increased participation. Notably, EMS South East (54.1%) and Integrated Care North (54.9%) led response rates, while incentives such as prize draws for teams reaching 50% further motivated staff. This improved engagement ensures that the directorate's feedback will more accurately inform future actions on culture, leadership, development, and wellbeing, with final validated figures and prize arrangements set for early December and full results expected in Spring 2026.

Agenda Item No. 08

REPORT TITLE

Putting Things Right Report: Quarter 3, 2025/26, October - December

MEETING

Name of meeting	Quality, Patient Experience & Safety Committee
Date of meeting	3 February 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

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

PURPOSE OF REPORT

☐ 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 the Quality, Patient Experience & Safety Committee (QuESt) on the key areas of activity and performance related to its Putting Things Right (PTR) and Legal Services functions.

   The Report for Quarter 3 2025/26 highlights:

   - Ongoing challenges in extracting and analysing Datix Cymru data
   - A decrease in the number of joint investigations, comparative to last year.
   - Sustained increase in complaint volumes since last year, largely driven by high demand for non-emergency transport
   - Updates in respect of the organisational Putting Things Right and Legal Services Recovery Plan to address performance
   - Learning around Functional Neurological Disorder and pregnancy loss
   - Information about the revisions to the Concerns Regulations

2. The most recent update to the Putting Things Right and Legal Services Recovery Plan has not yet progressed through the full governance process, including review by the Clinical Quality Governance Group and the Executive Leadership Team. The Executive Leadership Team is scheduled to consider the plan in detail on 18 February, and any matters arising that require escalation will be subject to the appropriate escalation route.

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 Putting Things Right and Legal Services portfolio
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 Putting Things Right Report Quarter 3, 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
Risk ID TBC: Inability to meet regulatory and statutory responsibilities related to Putting Things Right (Concerns Regulations), Ombudsman, Inquest management, Welsh Risk Procedures, Mortality Reviews

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
20 January 2026 (Virtual circulation of paper outside of a meeting)	Clinical and Quality Governance Group
3 February 2026	Quality, Patient Experience & Safety Committee

SITUATION

1. This PTR Report covers the period from 1 October 2025 - 31 December 2025. This report covers the PTR functions which broadly include:
   - Patient Safety (proactive & reactive), including Low harm and Near-miss reporting
   - Complaints management and resolution
   - Ombudsman relationships, information sharing, reports, and responses
   - Coroner relationships, information sharing, reports, and responses
   - Redress management
   - Claims management, including Clinical Negligence, Personal Injury, Road Traffic Accident and Damage to Property
   - Organisational learning (including Learning from Events and Welsh Risk Pool submissions)
   - The PTR and Legal Services Team also lead the learning from mortality agenda. This is covered in detail within the twice-yearly Learning from Mortality Report to this Committee.

BACKGROUND

2. The Report consists of a written report and a slide deck of data visualisations. The Report comprises a succinct overview of three core areas: Assurance, Performance and Learning. Content is drawn from the data slide deck (**Annex 1**) as well as qualitative organisational intelligence flowing through the Trust's Quality and Safety Governance Groups. The data slide deck includes a compliance heatmap (enabling focused attention on statutory requirements), assurance overview (a more detailed picture of statutory and regulatory functions), and a performance overview (indicative of potential risks to future assurance).

ASSESSMENT

ASSURANCE

External Assurance

3. The Trust has not received any Public Services Ombudsman for Wales (PSOW) Reports, or Regulation 28 Prevention of Future Death Reports in the last quarter.

4. The Trust has received one Schedule 5 notification from the Coroner. This was related to the provision of commercially sensitive information belonging to another organisation that was resolved the same day.

5. Most assessments for the Annual Welsh Risk Pool (WRP) Assessment Programme have been completed, and the draft Report is anticipated in the coming quarter.

Internal Assurance

6. The ability to analyse our quality and safety data remains constrained by challenges with data extraction and manipulation. The release of a Datix semantic environment for Feedback & Incident Modules was proposed by IDS and Datix Leads as a short-term resolution for providing critical performance and assurance data in respect of statutory/mandatory quality and safety responsibilities. The delivery of the semantic product was delayed from October 2025 to end of December 2025, and the full scope of the initial product has not yet been achieved (additional data fields required). The root cause of delay relates to IDS capacity and competing priority of Phase 2 of Ambulance Performance Framework and this work is now being completed.

7. No patient safety incidents associated with harm have been reported or otherwise identified as directly relating to the introduction of the second phase of the Ambulance Performance Framework, the Patient Safety Team will continue to monitor to ensure early identification of learning.

Compliance Heatmap

8. As a result of the additional funding and focus on improvement, in addition to providing support because of significant sickness within the team, we have recruited additional staff to support the interim Deputy Head of Patient Safety to focus on overdue National Reportable Incidents (NRI) investigations. This has had a positive benefit, and we are seeing a marked reduction with closure forms and learning identified.

9. Performance against the five-working day Welsh Government target to register and acknowledge complaints has dropped markedly. This is due to high levels of sickness absence within the PTR administration function and a sustained increase in complaint volumes during the last year.

10. Complaint response times remain the focus of the PTR and Legal Services Recovery Plan. Low monthly compliance figures are expected because of investigation capacity within the Operations Directorate, and this will continue until the balance of in-date to overdue concerns is addressed.

11. Sickness absence in the Trust's Patient Safety Team continues to have an impact on meeting the five working day target for issuing Duty of Candour initial letters after the 'in-person' notification. The Senior Team are working closely with People Services to ensure that each member of staff off on sick leave has a return-to-work plan in place.

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

13. The Trust has received no Regulation 28 Reports since October 2024.

14. Compliance with Welsh Risk Pool Procedures has not yet been incorporated into the Compliance Heatmap due to changes in the reporting fields, recently implemented at national level. This metric will be revisited once data cleansing has been completed.

15. Significant progress is noted in the number of overdue Learning from Events Reports (LfERs). Out of thirteen cases which were subject to an intensive support programme, three cases remain outstanding. The quality of submissions remains positive, with relatively few cases being *Red deferred*. The team are continuing to support the Health and Safety Team as LfERs are a relatively new area for them and we are anticipating further improvement in this space.

Assurance Profile

16. The number of joint investigations being shared with other NHS Wales organisations is lower than last winter, however, early evidence in January demonstrates an increase from the historically low figures seen in Quarter 3. The reduction can be directly attributed to the Handover 45 initiative that significantly improved patient flow and reduced system pressures and, from the evidence contained in the Trust performance data for the Ambulance Performance Framework and Clinical Model Transformation, particularly the Rapid Clinical Screening and Integrated Care functions.

17. The number of NRIs and Joint Investigations being completed and closed on the Datix system continues to be an area of concern and challenge. The Quality Team are working with the Operational Team and Health Board partners to close incidents and improve compliance. The increased number of incidents being closed with Moderate harm is also subject to analysis with operational colleagues.

18. The volumes of complaints received demonstrates a significant upwards shift since last year. Work is in progress with Ambulance Care colleagues to make improvements in the communication of eligibility criteria and cancellations which is expected to reduce the level of formal complaints received.

19. For both complaints and incidents, learning from the Ambulance Performance Framework changes is that there has been an increase in the length of time taken to complete investigations. This is in large part due to the increased number of interactions that take place within the EMSC environment that require review and consideration.

20. The PSOW continues to open a higher than usual number of cases with the Welsh Ambulance Services University NHS Trust (WAST). Of note, there have been no instructions to issue financial early settlements this quarter resulting from delayed responses.

21. Absence in the Legal Services Team has impeded progress in further reducing open case volumes through data cleansing and timely closure after limitation expires. The Trust's Solicitor is due to leave the organisation in February 2026 with interim cover from, and options for future legal provision being appraised with, NHS Wales Shared Services Partnership Legal and Risk Services.

PERFORMANCE

22. The PTR, Legal Services and Operations Directorate are subject to an Organisational Improvement Plan. A recent Sitrep Report highlights areas where improvements and progress has been achieved eg Medical Examiner and LFER targets. We have seen a positive shift in the number of closed NRIs. However, the organisation continues to require recovery work to achieve statutory compliance against complaint, and coroner-based activity.

23. The most recent update to the Putting Things Right and Legal Services Recovery Plan has not yet progressed through the full governance process, including review by the Clinical Quality Governance Group and the Executive Leadership Team.

24. An enhanced governance and oversight structure has been established and will drive accountability through the PTR and Legal Services Recovery Plan Programme Board. An Assurance Assessment has recently been completed, noting Limited Assurance against three objectives, Moderate Assurance against three objectives, Substantial Assurance against one objective, one objective fully Achieved and one objective that could not be assessed as there is no data available. The Executive Leadership Team is scheduled to consider a deep dive on the plan on 18 February, and any matters arising that require escalation will be subject to the appropriate escalation route.

25. The number of open overdue complaints and, the comparative proportion of overdue cases continuing to outweigh those in date, indicates the ongoing delivery challenge that the PTR Recovery Plan was intended to address.

26. Incident management remains of organisational concern due to the number of unreviewed and/or uninvestigated incidents (1431); this is a very slight increase on last quarter's profile (1426).

27. There is a significant improvement noted in contemporaneous learning review of Medical Examiner Referrals.

LEARNING AND IMPROVEMENT

Functional Neurological Disorder (FND)

28. The Patient and Family Relations Team have recently managed a small cohort of complaints relating to FND. The team were unaware of this condition and the way it can affect patients, and it appears from patient and family feedback that this had also been their experience with staff attending too. One of the Trust's Health Board Clinical Leads reached out directly to an affected family and the discussion has helped to inform a suite of improvement actions for the Trust and beyond; the need for better awareness, learning materials and guidance around FND, including potential additions needed to the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) Guidelines which do not currently contain any information on FND. These will be developed through collaboration with FND organisations and academic contacts. The affected family also intend to

create a short information booklet about the patient's condition, so that crews attending in future will have a better understanding of her needs.

Pregnancy loss

29. Learning was identified during a complaint investigation about pregnancy loss. Our commitment to learning and improving on the experience of the parents affected includes the Trust engaging with the International Academy of Emergency Dispatch (IAED) on a Protocol review, to ensure guidance reflects situations where a miscarriage occurs, the mother remains pregnant, and bleeding is present. The Trust's Maternity Specialist Clinician has identified an opportunity to work with IAED to develop more sensitive statements for use by Call Handlers in such distressing circumstances. The opportunity to contribute to these discussions to support improved compassionate communication within future Medical Priority Dispatch System (MPDS) updates was offered to the parents in our response letter.

Joint investigations

30. Themes following joint investigations remain the same with over-crowded Emergency Departments and wider system pressures resulting in high levels of escalation, lack of End-of-Life Care or ceilings of care planning and discharge delays.

31. The Trust continues to pilot the Joint Investigation Module within the Once for Wales Concerns Management System (OfWCMS) and await an update from the OfWCMS Programme Board on next steps.

National Reportable Incidents

32. The incidents that have been reported as NRIs this quarter related to:
    - Call management: incorrect MPDS protocol selection, length of call waiting times for remote clinical consultation
    - Clinical: conveyance decision and provision of basic life support, clinical assessment, treatment and decision to discharge at scene.

Implementation of The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) (Amendment) Regulations 2025 and 'Listening to People' statutory guidance.

33. The Senedd passed revisions to the existing Concerns Regulations in October 2025, for full implementation of changes from 1 April 2026. The revised Concerns Regulations place additional legislative responsibilities on all NHS Wales bodies. The Listening to People Statutory Guidance is still being drafted by Welsh Government, with a planned publication date not yet released.

34. National Delivery Groups at both a strategic and operational level have been established as well as seven Implementation Workstreams. There is good cross-organisational support for national consistency wherever possible, facilitating the sharing of preparatory work such as Impact Assessments, written control documents, training packages, workforce reviews and job descriptions.

35. An investment proposal for the Integrated Medium-Term Plan (IMTP) has been put forward covering capital and revenue expenditure required to deliver against the corporate Quality, Safety & Patient Experience responsibilities. Other Directorates have been alerted to the key anticipated changes and encouraged to submit similar Proposals. The Trust-wide impact will be primarily felt in the new requirement to offer in-person listening meetings to all complainants. The current PTR and Legal Service Investment Proposal is premised on low uptake of in-person meetings and will need to be reviewed as impacts are realised.

36. The successful implementation and compliance with the new Regulations will depend heavily on the Trust achieving the performance measures and objectives of the current PTR Recovery Plan.

RECOMMENDATION

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

NEXT STEPS

38. The Executive Leadership Team is scheduled to consider the PTR recovery plan in detail on 18 February, and any matters arising that require escalation will be subject to the appropriate escalation route.
39. Implementation information for Listening to People, including appropriate Impact Assessments, will be provided to Committee members once the Statutory Guidance is published.

Welsh Ambulance Services University NHS Trust

PTR & Legal Services – Quarterly data

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

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

by Claire Appleton
Assistant Director of PTR & Legal Services

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

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

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

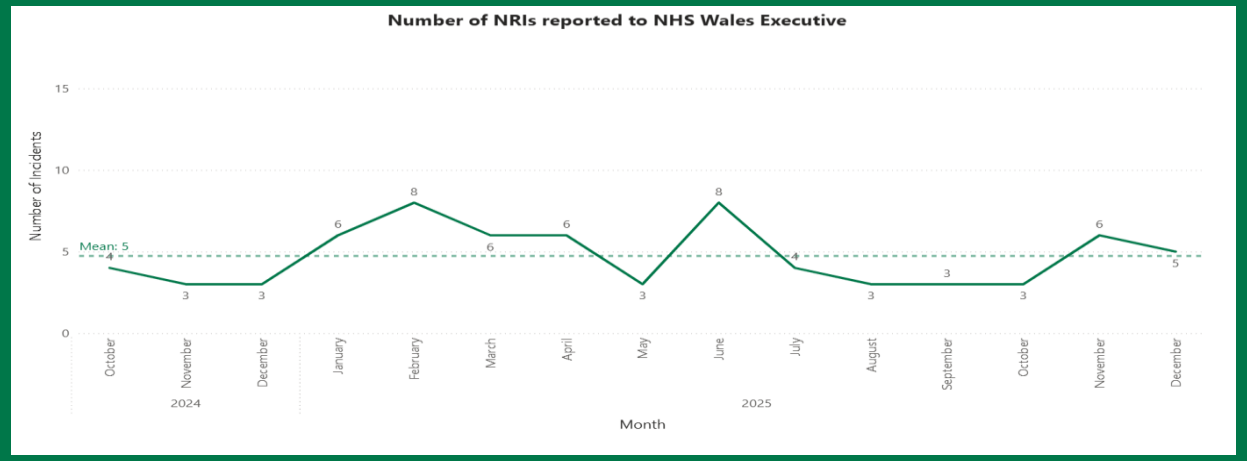
Data contained within this report is accurate at the time of reporting.

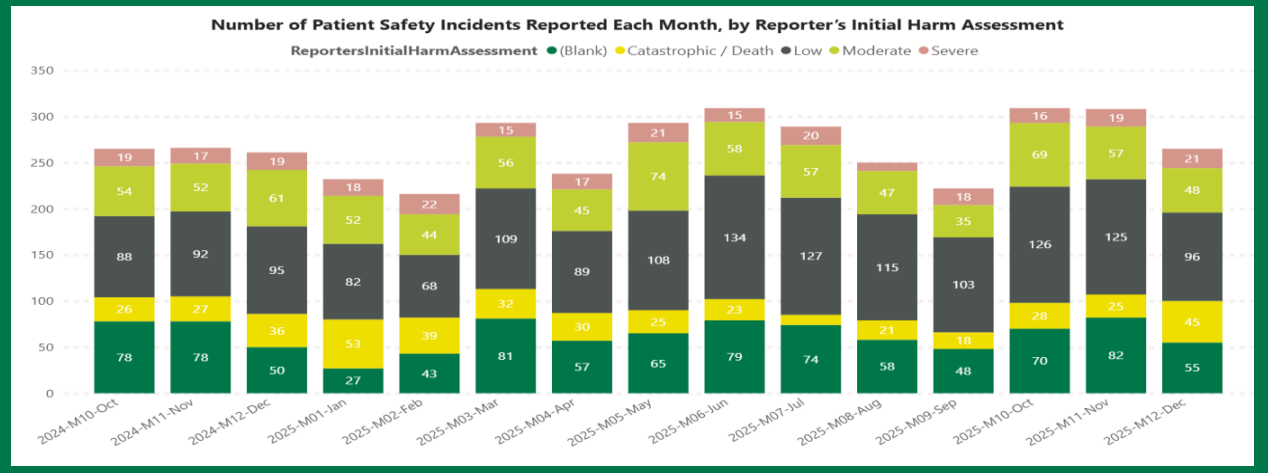
Data may be subject to change following validation, retrospective reviews and audits and ongoing clinical governance processes including regrading of incidents.

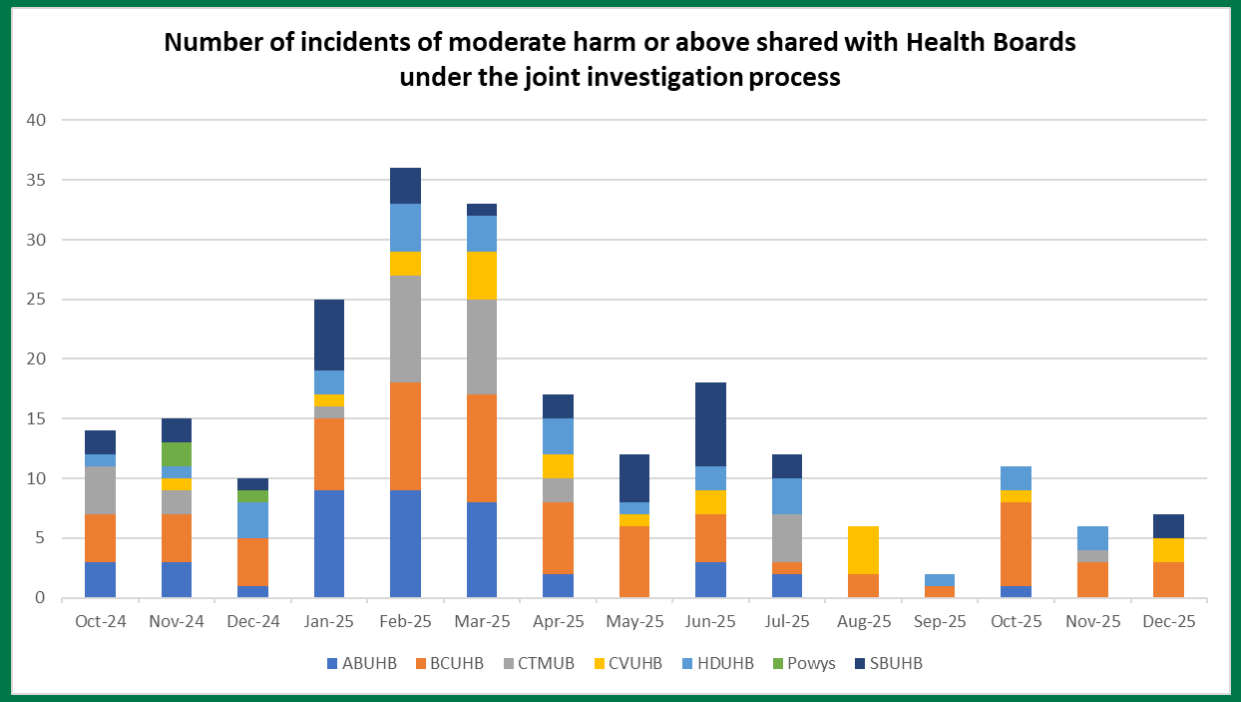
Compliance heat map

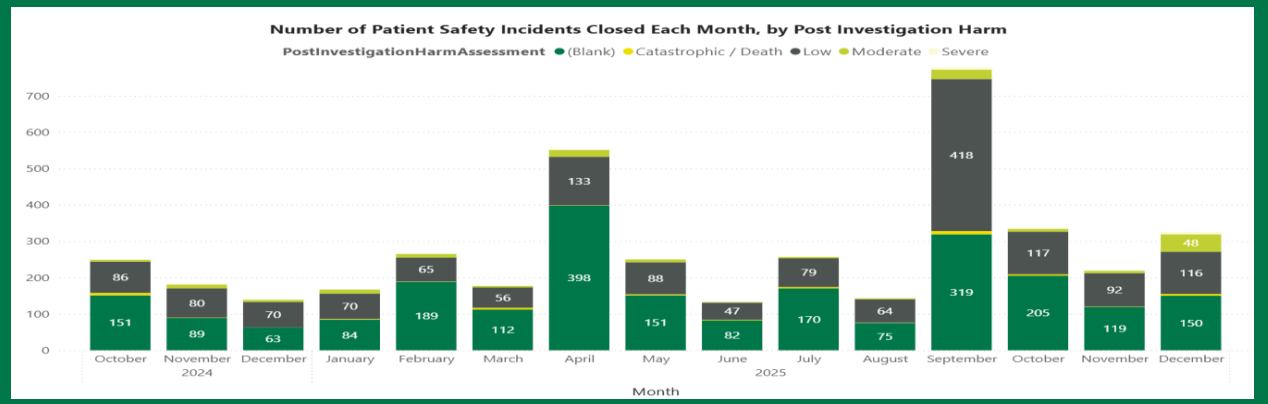
MEASURE	Scoring	Q3 2024-25			Q4 2024-25			Q1 2025-26			Q2 2025-26			Q3 2025-26		
		Oct	Nov	Dec	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Overdue NRIs	R: 10 A: 1 G: 0	34	29	30	28	29	29	30	32	34	38	32	34	27	29	23
Patient Safety Alerts/Notices overdue	R: 2 A:1 G: 0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Complaints ack'd within 5 working days	R: 80% A: 90% G: 98%	99%	95%	98%	99%	98%	100%	99%	89%	99%	99%	98%	100%	95%	59%	74%
Complaints responded to within 30 working days	R:<65% A: 65% G: 75%	65%	72%	73%	64%	52%	55%	68%	72%	50%	55%	60%	56%	62%	43%	44%
Duty of Candour letters issued within 5 working days	R: NO G: YES	NO	YES	YES	NO	YES	YES	YES	NO	NO	Yes	NO	NO	NO	NO	NO
Regulation 28 PFD reports responded to on time	R: NO G: YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Public Interest reports published by the PSOW	R: >1 A: 1 G: 0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0

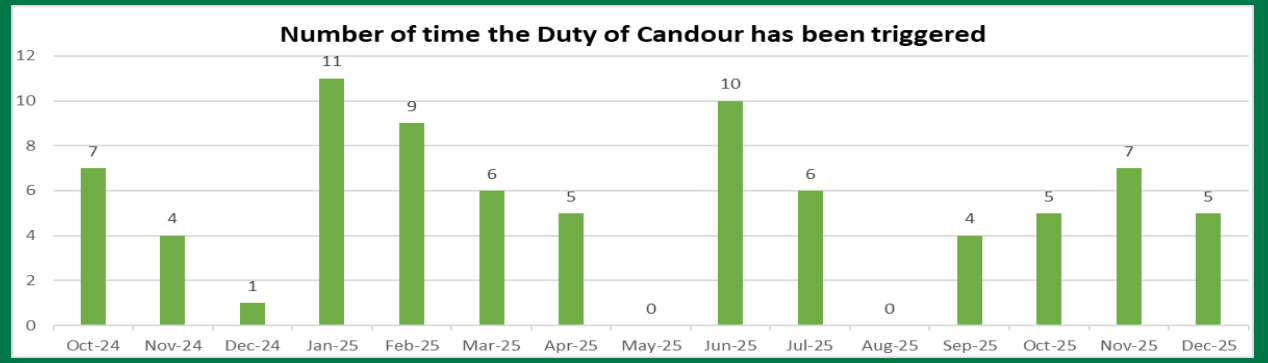
Assurance Profile – Incidents & Duty of Candour



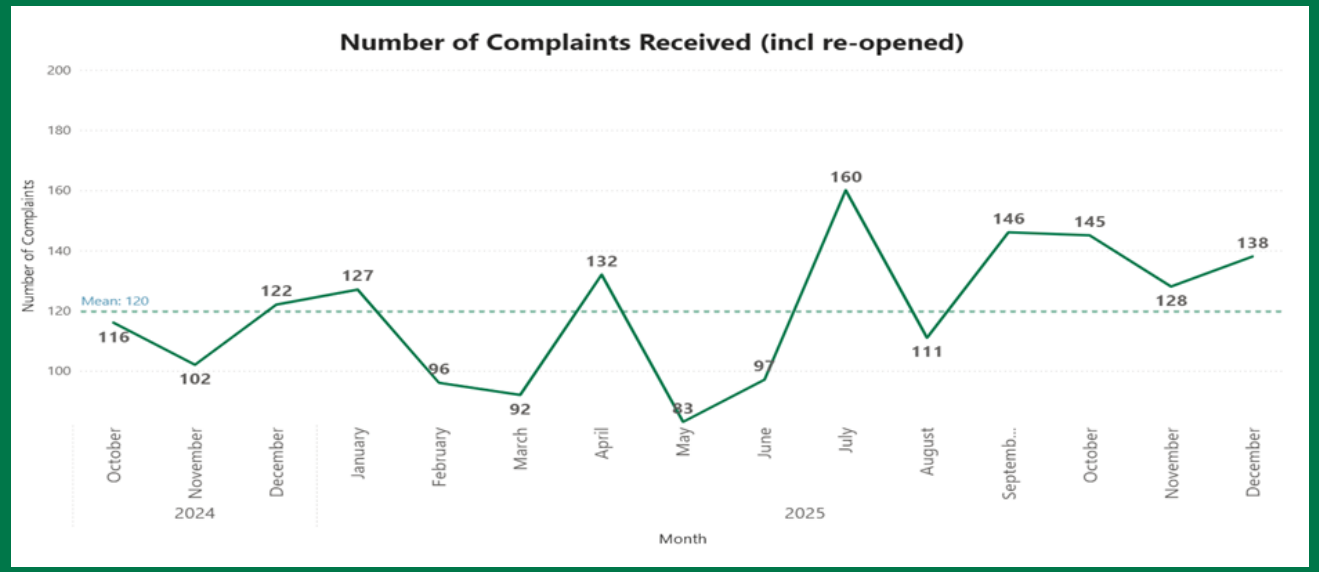


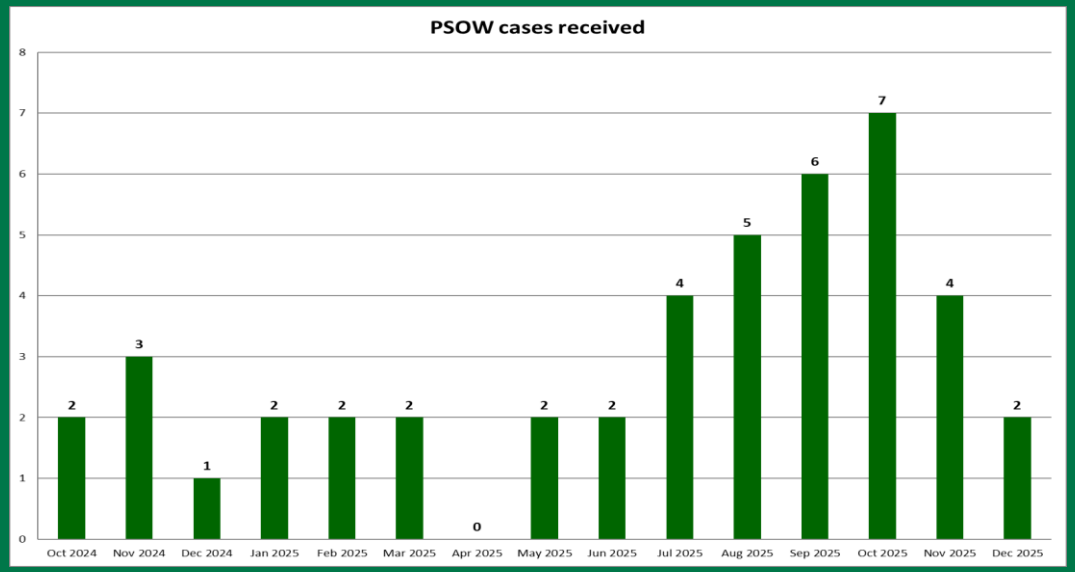


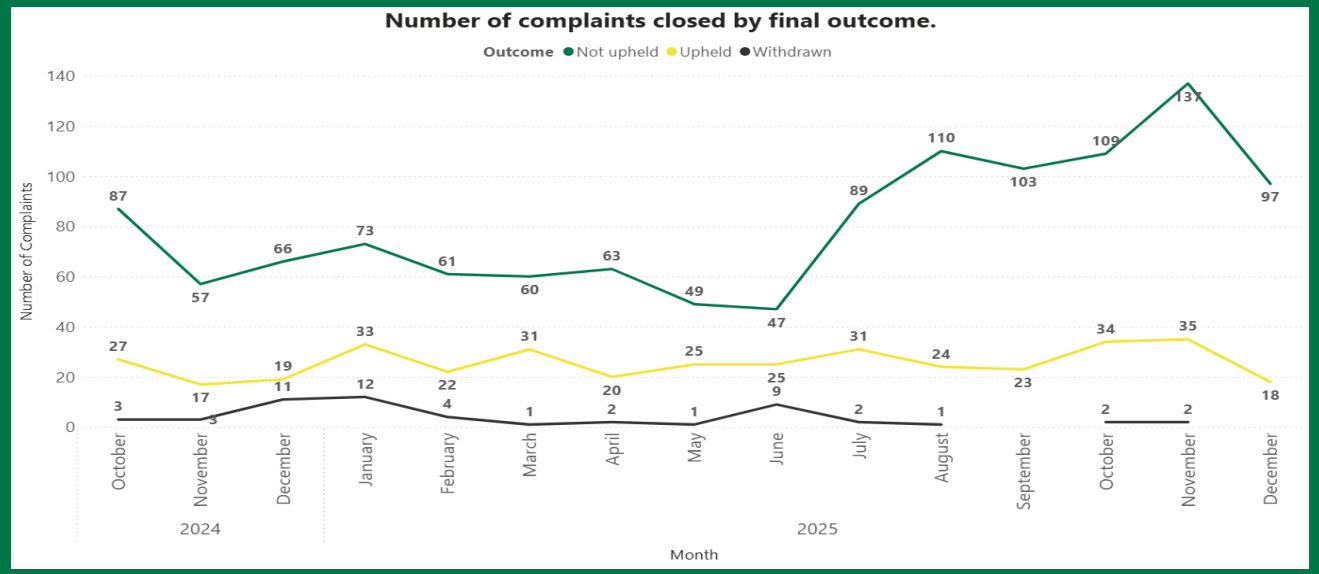


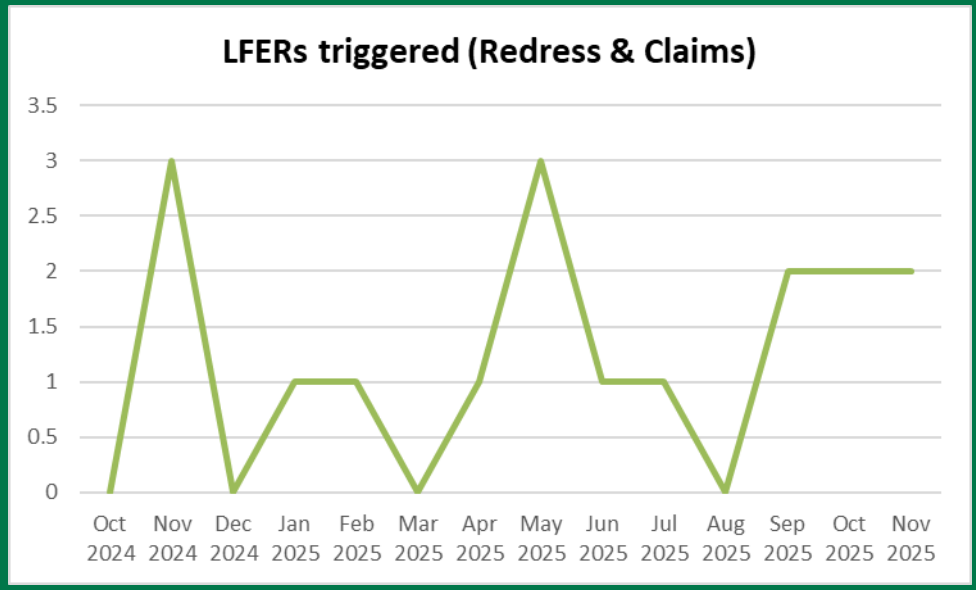


Assurance Profile – Complaints, PSOW and LFER outcomes





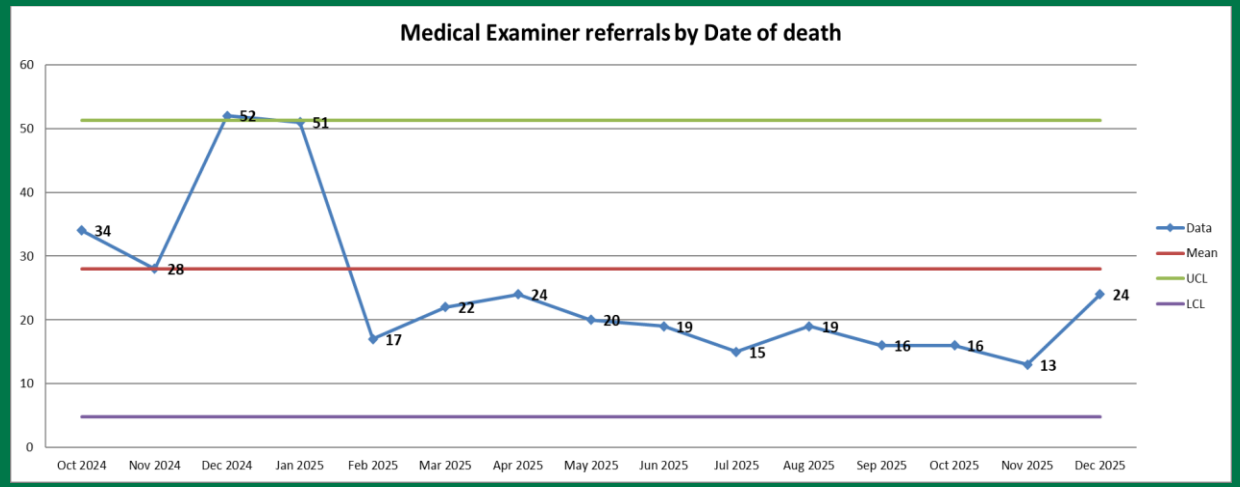


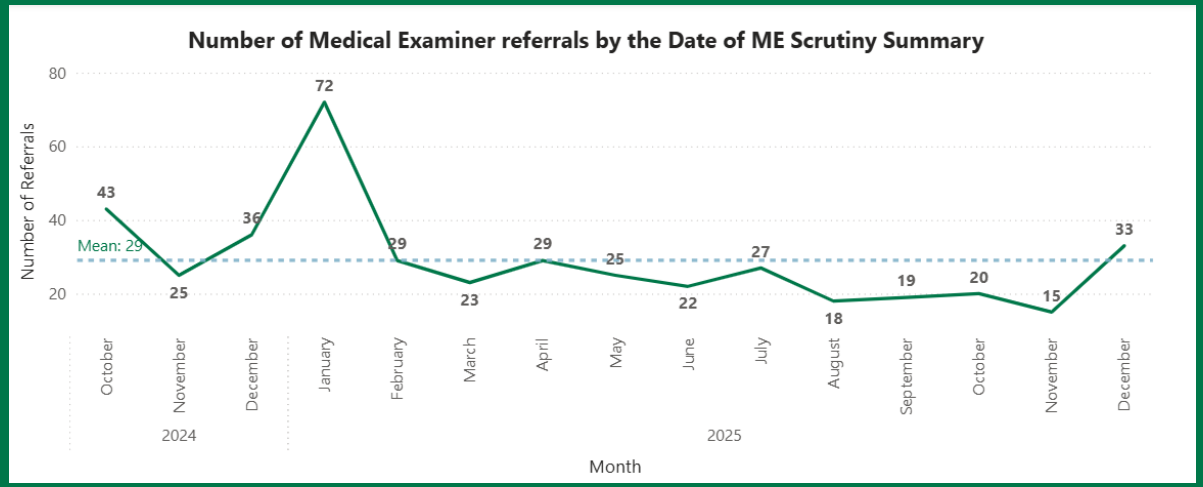


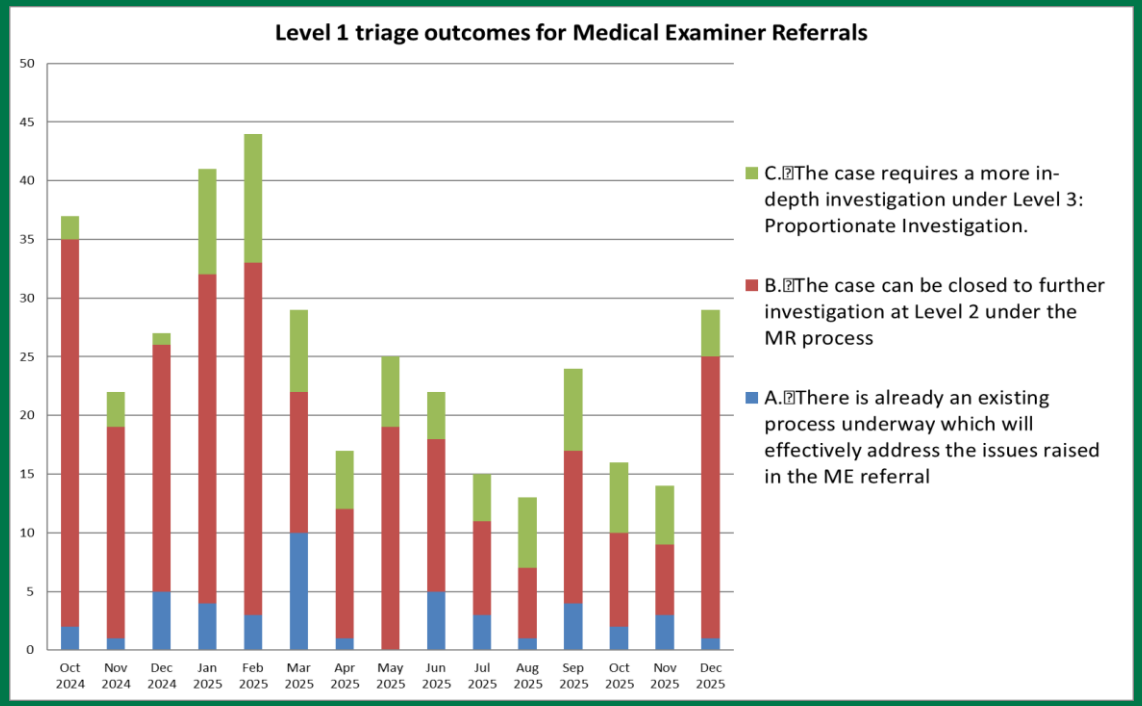
Assurance Profile –Legal Services

		Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	June25	July-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec -25
Claims opened	**Personal Injury (PI)**	3	1	2	4	2	2	5	1	3	2	0	0	0	1	0
	PI Road Traffic Accident	0	1	0	2	0	1	1	0	0	1	0	0	1	0	0
	Clinical Negligence	5	2	3	1	4	3	5	4	4	5	4	6	3	1	1
	Road Traffic Accident	26	16	14	23	11	19	21	17	28	22	19	10	15	14	13
	Damage to property	5	1	4	3	3	3	7	6	2	4	4	8	9	13	5
Claims closed	**Personal Injury (PI)**	0	6	8	9	2	0	--	30	9	3	2	8	1	0	1
	PI Road Traffic Accident	1	0	5	8	0	0	--	9	1	0	0	6	1	0	1
	Clinical Negligence	3	0	0	1	1	10	6	3	3	1	2	29	1	1	1
	Road Traffic Accident	30	27	9	12	27	11	--	39	58	51	12	22	26	21	15
	Damage to property	6	11	2	2	5	5	--	6	11	8	2	9	10	6	7
Claims open at the end of the month	**Personal Injury (PI)**	93	85	78	73	73	75	88	50	60	62	60	50	50	51	50
	PI Road Traffic Accident	67	56	51	45	45	46	46	37	44	46	46	39	42	41	40
	Clinical Negligence	182	184	186	186	189	178	174	176	177	181	183	161	161	161	160
	Road Traffic Accident	225	211	216	227	217	225	240	205	196	175	184	175	162	156	155
	Damage to property	23	13	14	15	18	16	19	13	10	9	12	11	9	17	14
		590	***549***	***545***	***546***	***542***	***540***	***567***	***486***	***487***	***473***	***485***	***436***	***424***	***426***	***419***

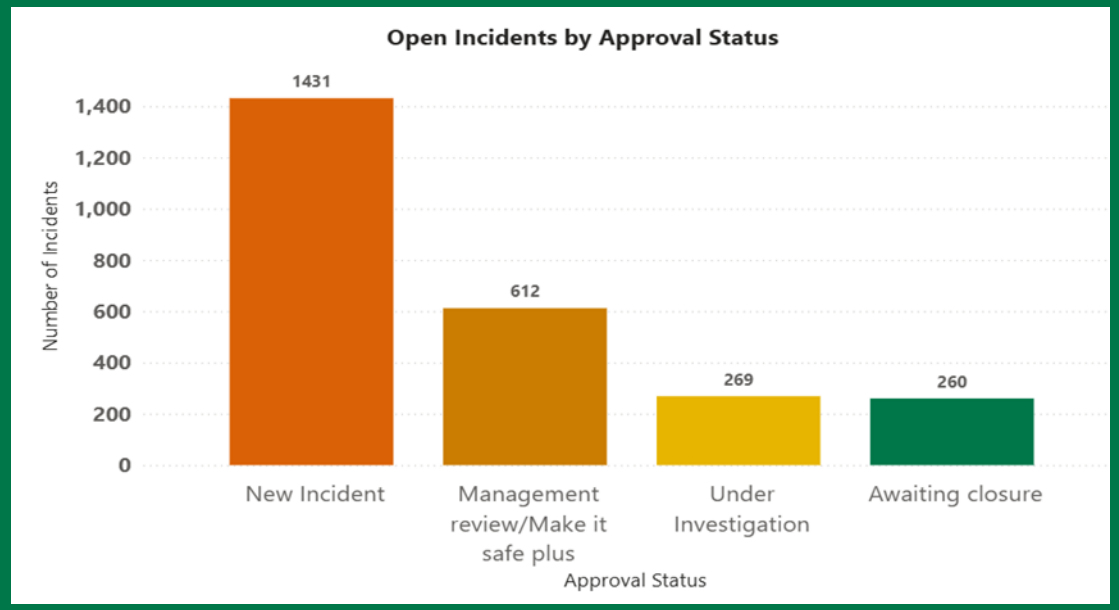
Assurance Profile – Mortality Governance

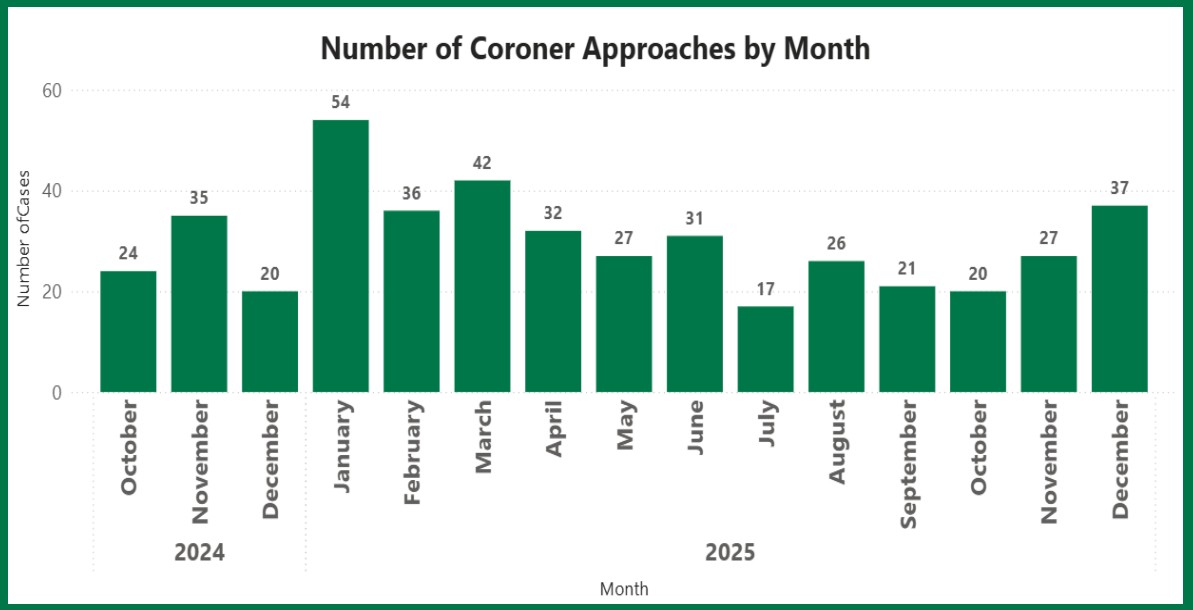


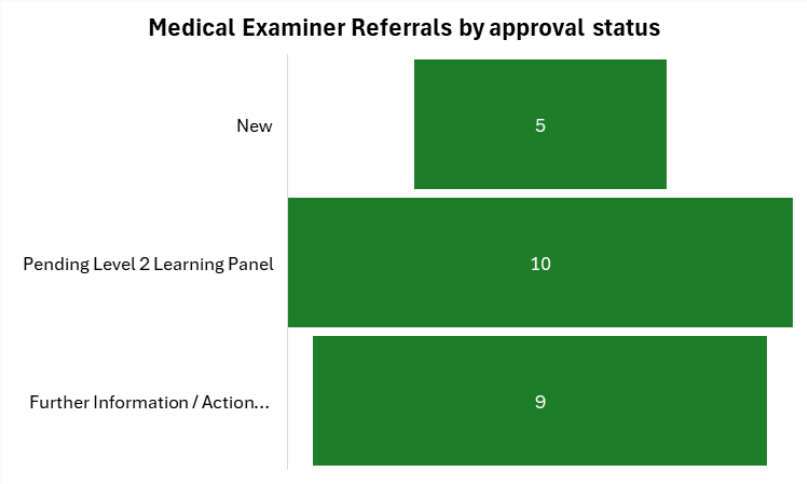


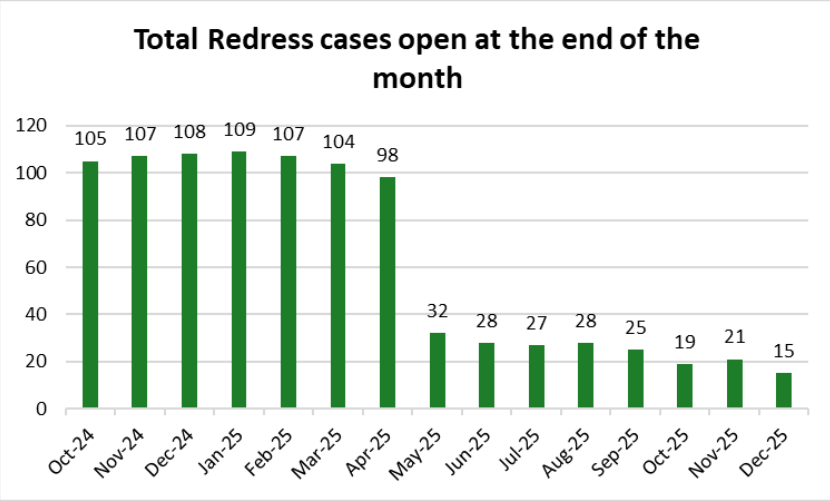


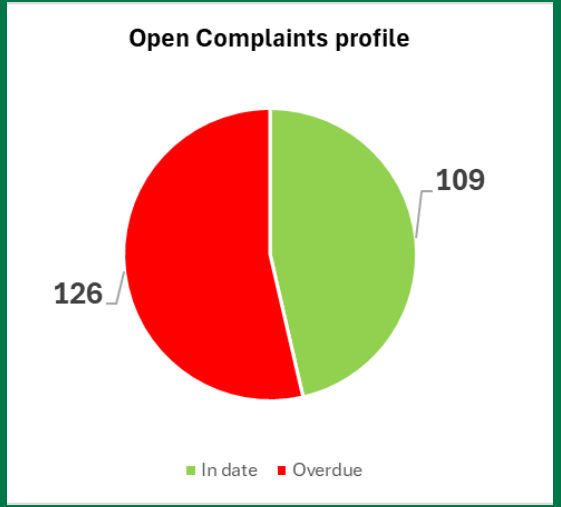
Performance Profile











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

Agenda Item No.	09

REPORT TITLE

Monthly Integrated Quality Performance Report – November/December 2025

MEETING

Name of meeting	Quality, Patient Experience and Safety Committee
Date of meeting	3 February 2026
Public or Private	Public
If private - rationale	N/A

REPORT SPONSOR

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

PURPOSE OF REPORT

☐ 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 **November/December 2025.**

2. The general data quality in the report is good (and the amount of data comprehensive), but a number of specific data quality issues have previously been identified. Some have been resolved, and others are being worked through with a clear Executive focus on Phase 2 of the Ambulance Performance Framework, which went live at the beginning of December. Additional capacity is being sought for the Insight & Data Services (IDS) function with a number of appointments into new posts being made, but onboarding and then a lead in time for these new staff to come up to speed is required. In the interim, IDS capacity is being actively managed by senior IDS managers and also through a CMT Metrics workplan.

3. The new Purple Arrest and Red Emergency categories went live, as planned, on 01 July 2025 and data from the first six months of reporting is contained within this report.

4. The Trust saw 13,044 hours lost to hospital handover during December 2025, compared to 25,195 lost hours in December 2024. This follows on from significant month-on-month reductions seen since June 2025 pan-Wales. Whilst this reduction is very welcome, it is by no means universal, and the ambition is for all health boards to reduce handover to levels which improve patient experience and outcomes, and which are sustainable.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The Trust Board is requested to:

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

ADDITIONAL PAPER(S)

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

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
21 January 2026	Hugh Bennett – Assistant Director Commissioning & Performance
21 January 2026	Rachel Marsh – Executive Director Strategy, Planning & Performance
3 February 2026	Quality Patient Experience and Safety Committee

SITUATION

1. The purpose of this report is to provide senior decision-makers within the Trust with an integrated dashboard (Our Patients, Our People, Value and Partnerships/System Contribution) focused on the "vital few" key metrics. This report is for **November/December 2025.**

BACKGROUND

2. This Integrated Quality & Performance Report contains information on key indicators at a highly summarised level, which aim to demonstrate how the Trust is performing across four integrated areas of focus:

   - Our Patients (Quality, Safety and Patient Experience).
   - Our People;
   - Finance and Value; and
   - Partnerships and System Contribution.

ASSESSMENT

Our Patients – Quality, Safety and Patient Experience

3. **Ambulance Response** (safety / patient experience): on 1 July 2025, the Trust's new ambulance response model was implemented, and two new response categories replaced the previous (old) Red category. The new categories are Arrest (Purple), for cardiac and respiratory arrests, and Emergency (Red), for major trauma and other incidents where patients are at significant risk of cardiac or respiratory arrest if they do not receive a rapid response. In December 2025, there were 957 purple calls to the ambulance service, around 2.51% of all calls, and 5,469 (Emerg) red calls, around 14.36% of all calls. The main measure for Purple Arrest calls is the Return to Spontaneous Circulation (ROSC) rate which was 21.9% in December 2025 compared to 19.5% in November 2025. The median response times for purple and red calls were 7 minutes 34 seconds and 9 minutes 19 seconds respectively, with the required range being 6- 8 minutes.

4. On 2nd December, Amber was replaced by the Orange (Now) and Yellow (Soon). The changes are designed to improve patient safety and patient outcomes by better stratifying patient demand. The median response time in December 2025 for Orange Now incidents was 1 hour and 19 minutes. The Clinical Safety Plan will protect Arrest and Emergency demand, but Orange Now is where the impact of handover lost hours is most felt i.e. there is a strong correlation. These response times still remain too high and have a known impact on avoidable patient harm.

5. Traditionally, the main factors which affect response times are demand and capacity (recruitment and lost hours). EMS production has been good and increased to 92% in December, and handover lost hours have significantly improved; with this improvement particularly feeding through into the Amber/Now category's performance. Health Boards are implementing new actions in order to further reduce handover lost hours. The Trust's main focus is to continue to implement a material change in how it responds to patient demand by evolving its clinical model through the Clinical Model Transformation (CMT) programme. Areas of focus for 2025/26 include:
    - Further investment into remote clinical capacity;
    - Further investment in APPs;
    - Development of the remote integrated care service (111 clinicians and CSD clinicians);
    - Continued focus on a range of responses that support non-conveyance, where it is clinically safe and appropriate to do so: use of volunteers, mental health response pilot, Falls response etc.; and
    - The transformation of the various clinical model categories as per the previous paragraph.

6. As above, the level of lost hours to **handover outside Emergency Departments** remains a critical component of long waiting times and patient safety incidents. 13,044 hours were lost during December 2025; a 48.2% reduction compared to December 2024 and is the fifth lowest monthly figure since December 2021. This follows on from significant month-on-month reductions seen since June pan-Wales. Whilst this reduction is very welcome, there is variation across Wales, with Betsi Cadwaladr health board remaining high, with 5,568 hours being lost within the health board during December 2025. The ambition is for all health boards to reduce handover to levels which improve patient experience and outcomes, and which are sustainable. WG has re-iterated to health boards the critical importance of improvements in this area and the reduction of all over 45-minute waits was a recommendation from the recent Ministerial Advisory Group on Performance and Productivity. The W45 initiative would see handover lost hours reduce to approximately what the EMS rosters are designed to cope with.

7. **National Reportable Incidents (NRIs) / Concerns Response**: the Trust reported six NRIs to NHS Wales Performance & Improvement in November 2025, increasing from the previous two months, and six serious patient safety incidents were referred to health boards under the Joint Investigation Framework. In November 2025 complaint response times decreased to 43%, compared to the 62% recorded in October 2025, not achieving the 75% target. Data accuracy issues have been identified and addressed. However, a PTR recovery plan remains in place, recognising that cases continue to be complex.

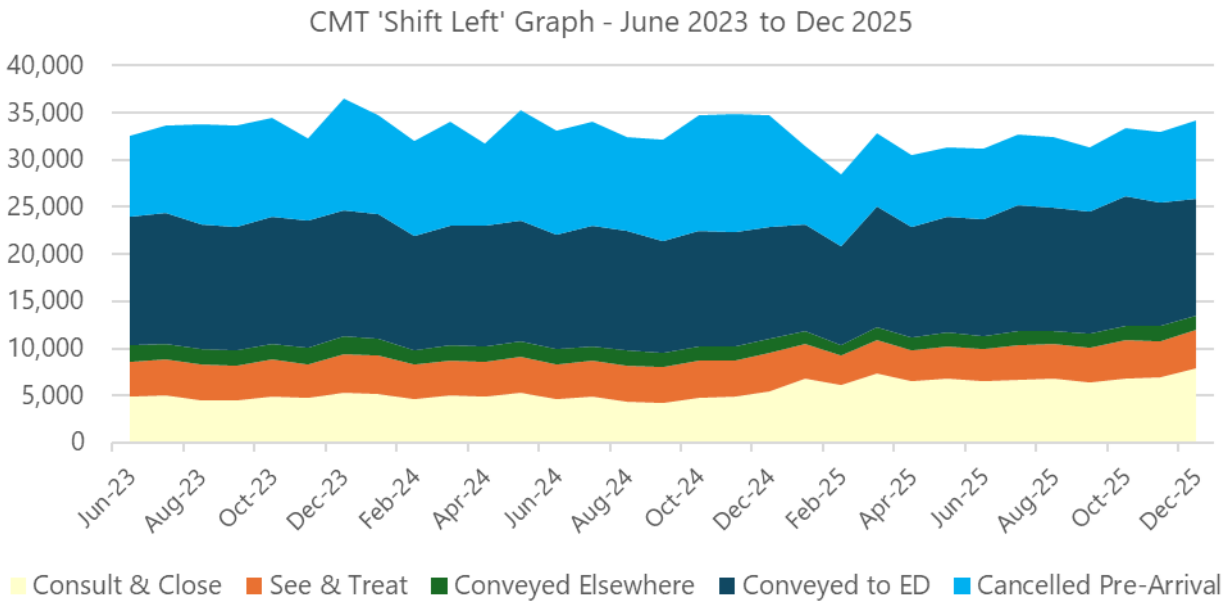
8. **Clinical outcomes**: The percentage of of suspected stroke patients who are documented as receiving an appropriate stroke care bundle was 92.1% in December 2025, increasing from the previous month (88.3%), and remains below the 95% performance target. Work is ongoing to improve reporting and compliance through the ePCR system, and this improvement is clearly being seen in most of the clinical indicators.

9. For December 2025, the Trust saw call to hospital door times of two hours and 25 minutes for stroke patients and two hours and fifty-five minutes for STEMI. Clearly these times remain too long and are representative of the longer response times, because of the pressures and issues outlined earlier within this report, notwithstanding recent improvements in hours lost to handover.

10. In December 2025, 6,020 patients **cancelled** their ambulance (this figure excludes patients who refused treatment), which is a significant reduction on previous levels but a slight increase from November 2025 (5,603). This reduction is likely to be the impact of switching on RCS although caution is required at this stage, as a longer run of data is required in order to properly evaluate the changes made. The Trust changed its Clinical Safety Plan in December, removing the "can't send" application, with the option remaining at the strategic commander's discretion in the new plan.

Partnerships & System Contribution

11.



RECOMMENDATION

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

Welsh Ambulance Services University NHS Trust

Monthly Integrated Quality & Performance Report

November/December 2025

Annex 1 – Top Indicator Dashboard

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

Annex 1 – Top Indicator Dashboard
Version 1.0
Released: January 2026

by Commissioning & Performance Team

Section 1: Monthly Indicators / Top Indicator Dashboard

Top Monthly Indicators	Target 2025/26	Sep-25	Oct-25	Nov-25	Dec-25	2 Year Average	RAG
Our Patients							
Timeliness Indicators							
NHS111 Call Handling Abandonment Rates	< 5%	10.5%	12.0%	14.6%	21.8%	10.9%	R
111 Clinical Triage Call Back Time (P1)	90%	99.1%	97.9%	94.6%	89.1%	97.0%	A
999 Call Answer Times 95th Percentile	00:06	00:18	00:10	00:15	00:36	00:22	R
Arrest (Purple) Median	6-8 Minutes	07:15	07:29	07:05	07:34	N/A	G
Emerg. (Red) Median	6-8 Minutes	08:36	08:49	08:27	09:19	N/A	R
Now (Orange) Median		N/A	N/A	N/A	01:19	N/A	
999 Amber 1 Median		01:21	01:27	01:38	N/A	01:38	
Oncology Journeys arriving within 45 mins and up to 15 minutes after appointment time	70%	77.8%	81.1%	78.4%	79.9%	75.9%	G
Advanced Discharge & Transfer journeys collected less than 60 minutes after booked time (NEPTS)	90%	80.6%	82.1%	82.7%	72.0%	79.8%	R
Clinical Outcomes / Quality Indicators							
Return of Spontaneous Circulation (ROSC)	25%	23.7%	20.4%	19.5%	21.9%	20.4%	R
Stroke Patients with Appropriate Care	95%	88.5%	86.7%	88.3%	92.1%	86.7%	A
Stroke Call to Hospital Door Times	Reduction Trend	02:09	02:21	02:22	02:25	02:24	R
ST-Elevation Myocardial Infarction (STEMI) with Appropriate Care	95%	67.5%	75.9%	74.7%	74.0%	64.3%	R
National Reportable Incidents reports (NRI)		3	3	6	N/A	4	
Can't Send & Cancelled by Patient Volumes	Reduction Trend	5,314	5,651	6,021	6,479	7,849	R
Concerns Response within 30 Days	75%	56%	62%	43%	N/A	58%	R
Enactment of the Duty of Candour Total		4	5	7	N/A	5	
Capacity							
Hours Produced for Emergency Ambulances	95-100%	89%	91%	93%	92%	93%	A

Top Monthly Indicators	Target 2025/26	Sep-25	Oct-25	Nov-25	Dec-25	2 Year Average	RAG
Sickness Absence *(all staff)*	6.0%	7.81%	7.87%	8.35%	9.23%	7.92%	R
Mental Health Absence Rates	Reduction Trend	2.96%	2.81%	2.78%	3.02%	2.51%	R
Staff Turnover Rate	Reduction Trend	8.02%	7.99%	8.12%	7.98%	8.32%	A
Statutory & Mandatory Training	>85%	84.61%	85.56%	87.21%	88.00%	84.95%	G
PADR/Medical Appraisal	>85%	75.35%	76.32%	76.53%	76.48%	74.61%	R
Number of Shift Overruns	Reduction Trend	3,292	3,583	3,538	3,537	3,780	G
Inclusion & Engagement / Culture							
NEPTS % of Total Calls Answered in Welsh	Increasing Trend	1.50%	1.40%	1.40%	1.60%	1.9%	A
Value							
Financial balance - annual expenditure YTD as % of budget expenditure YTD	100%	100%	100%	100%	N/A	100%	G
EMS Utilisation Metric (CHARU)	Increasing Trend	26.4%	27.3%	28.5%	31.4%	28%	G
Average Jobs per Shift (All Vehicles)	Increasing Trend	2.39	2.88	2.85	2.86	2.46	A
NEPTS on the Day Cancellations	Reduction Trend	14.3%	15.2%	14.8%	13.1%	13%	G
Partnerships / System Contribution							
Inverting the Triangle							
Successful Consult & Close Outcome	22% benchmark	18.7%	18.9%	19.5%	20.8%	16.7%	A
% Of Total Conveyances taken to a Service Other Than a Type One Emergency Department	Increasing Trend	10.20%	10.30%	10.70%	10.25%	10.9%	G
Number of Handover Lost Hours	7,500	12,284	12,477	14,501	13,044	19,701	R
NHS111							
NHS111 Dental Calls	Increasing Trend	8,852	9,016	8,577	8,932	8,315	R
Consult & Close Volumes by NHS111	Increasing Trend	1,940	2,035	1,883	2,414	1,588	A

In-Month RAG Indicates = TBD: Status cannot be calculated (To Be Determined)
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)
Increasing/Reducing Trend is over the last 3-month period

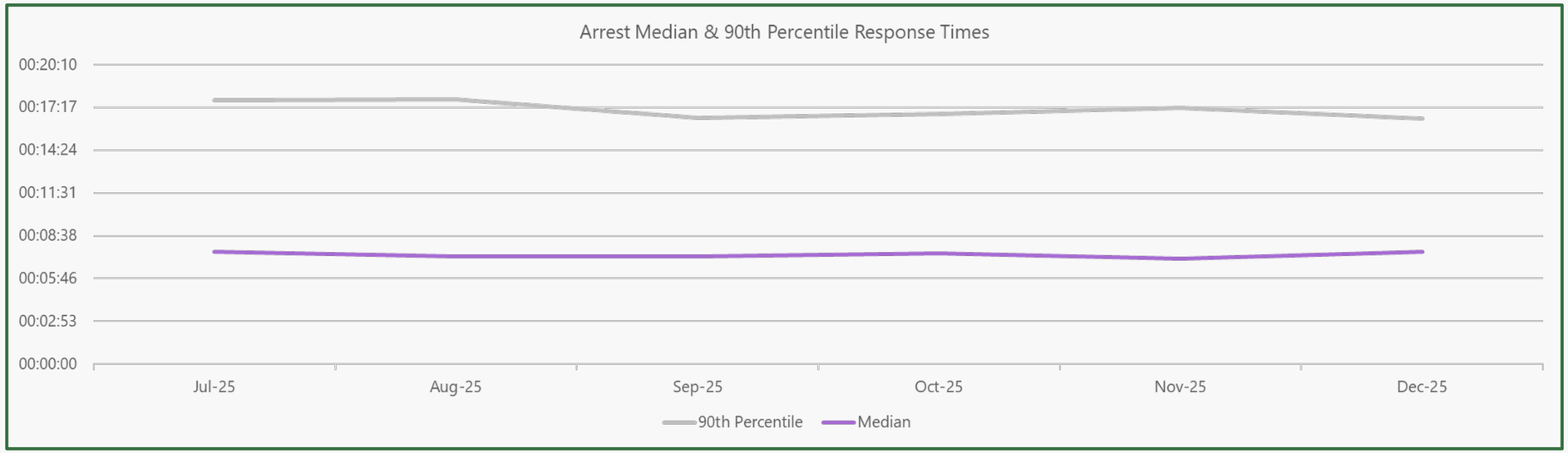
Our Patients: Quality, Safety & Patient Experience
Arrest Purple Performance Indicators

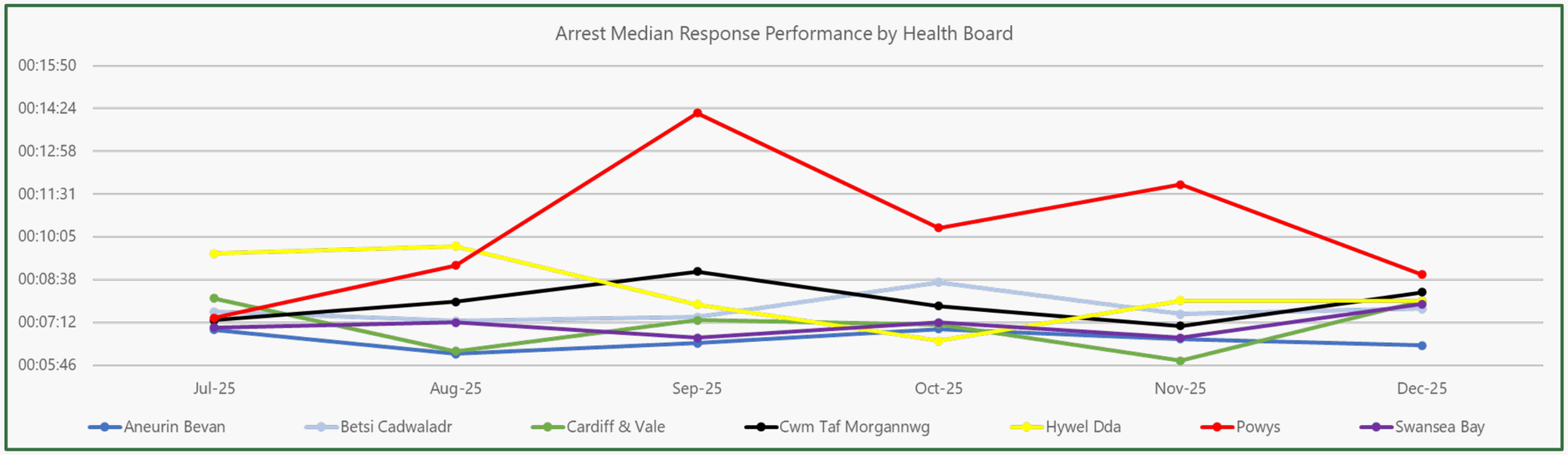
(Responsible Officer: Lee Brooks)

G

CI

Influencing Factors – Demand, Hours Produced and Hours Lost



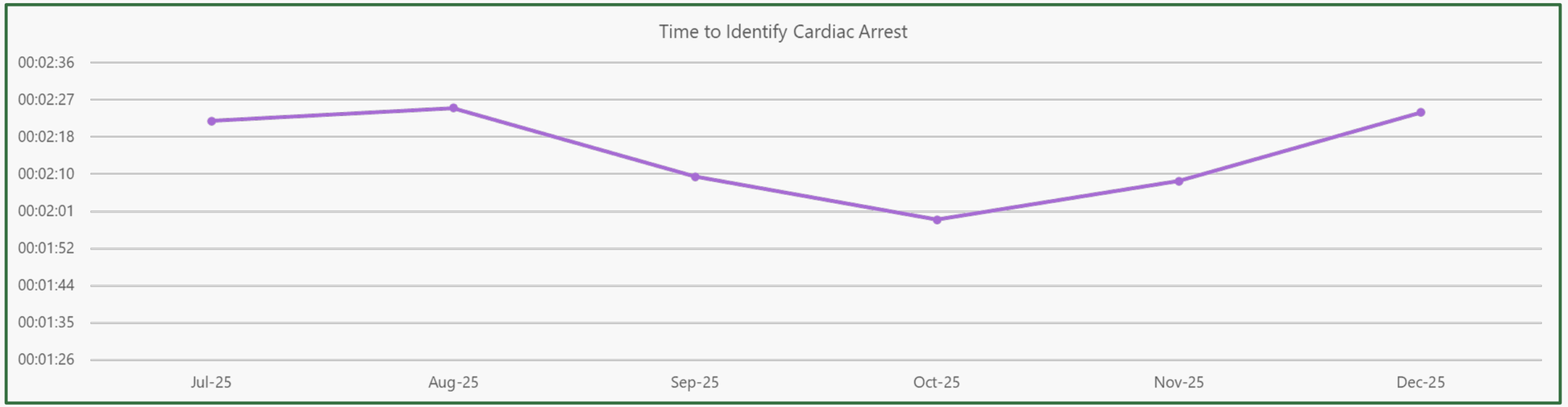


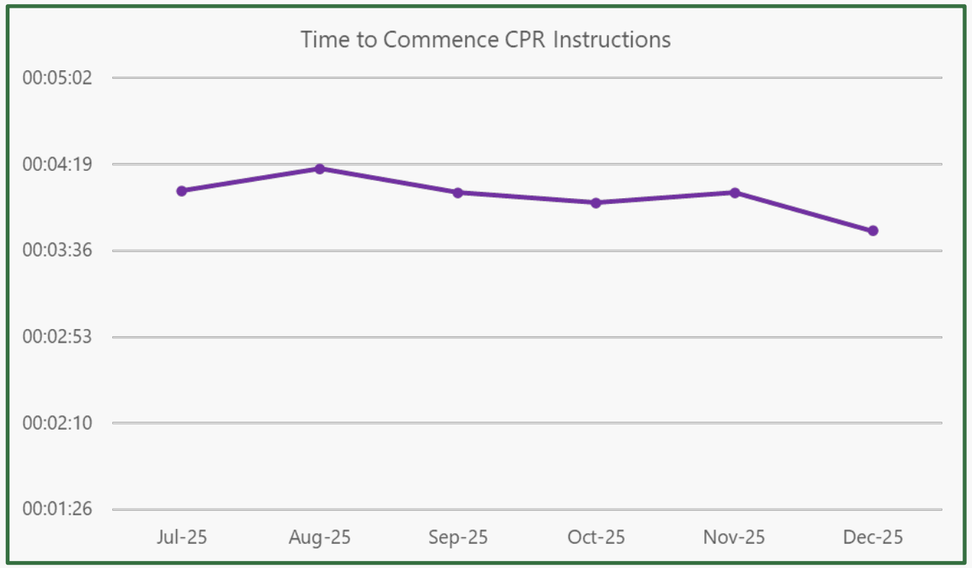
Our Patients: Quality, Safety & Patient Experience
Arrest Purple Performance Indicators

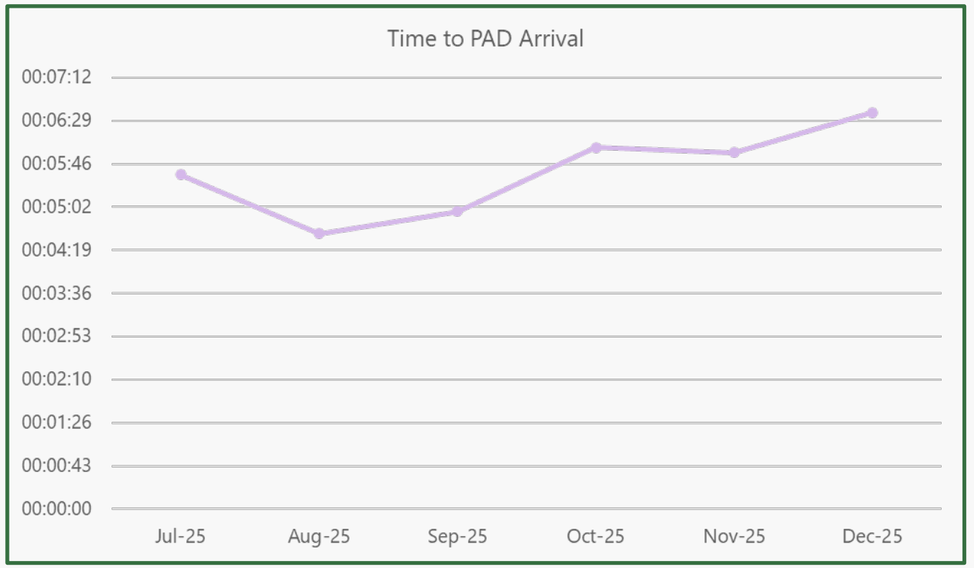
Influencing Factors – Demand, Hours Produced and Hours Lost

(Responsible Officer: Lee Brooks)

CI





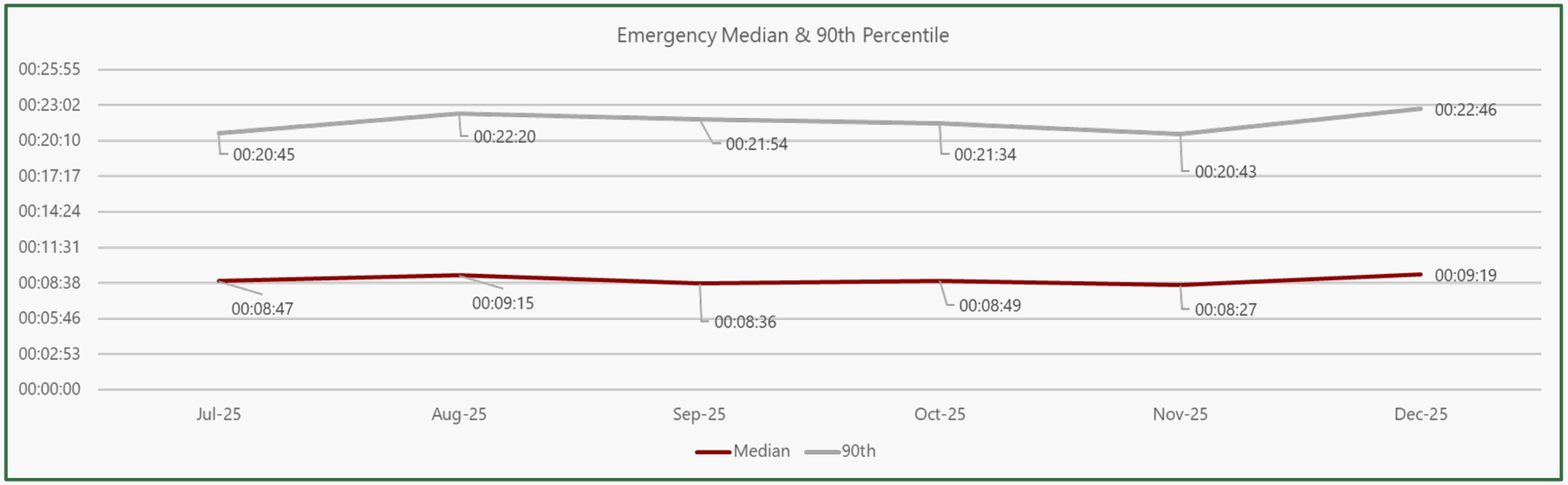


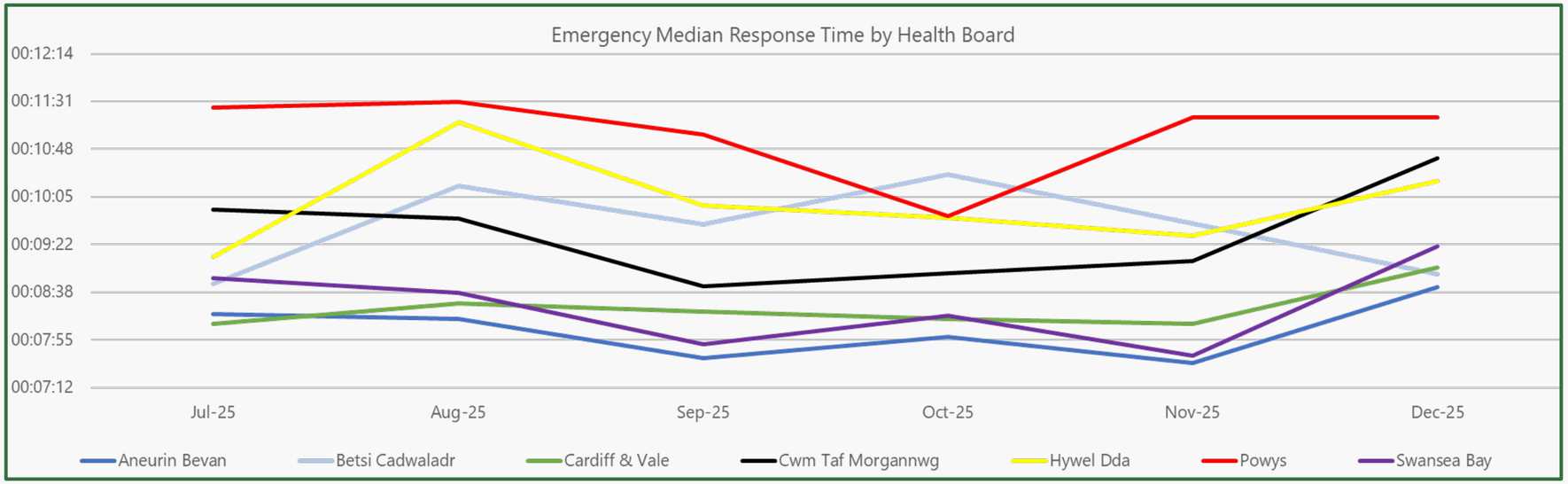
Our Patients: Quality, Safety & Patient Experience
RED EMERG Performance Indicators
Influencing Factors – Demand, Hours Produced and Hours Lost

(Responsible Officer: Lee Brooks)

R

CI





Analysis

In December 2025 there were 5,469 Emerg (Red) calls, around 14.36% of all calls.

The median response time in December 2025 for Emerg incidents was 9 minutes 19 seconds. Aneurin Bevan health board had the lowest median time of 8 minutes and 43 seconds, and Powys had the highest at 11 minutes and 17 seconds.

For Emerg calls, the 90th percentile response time was 22 minutes 46 seconds. Cardiff and Vale had the lowest time of 19 minutes and 43 seconds, and Powys had the highest at 32 minutes and 28 seconds.

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

Remedial Plans & Actions

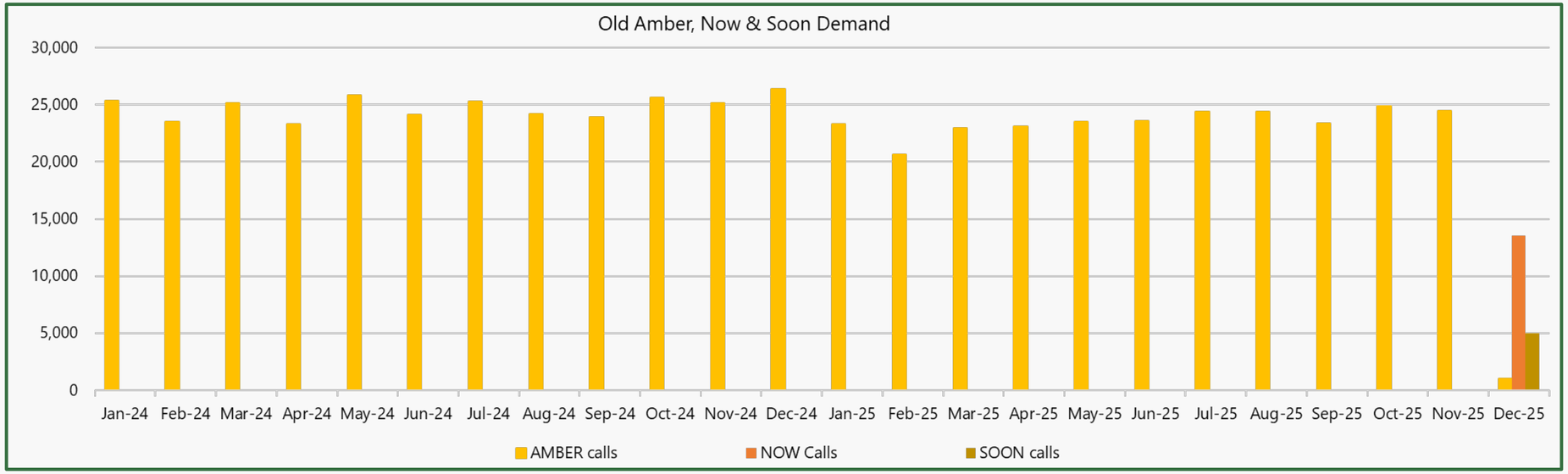
Arrest is performing better than the Trust modelled, but Emergency performance is worse than the Trust modelled. Although analysis was carried out on this discrepancy along with several workshops no definitive reason was established. There is a view that the difference in volumes between Arrest and Emerg adversely affected the Emerg response times.

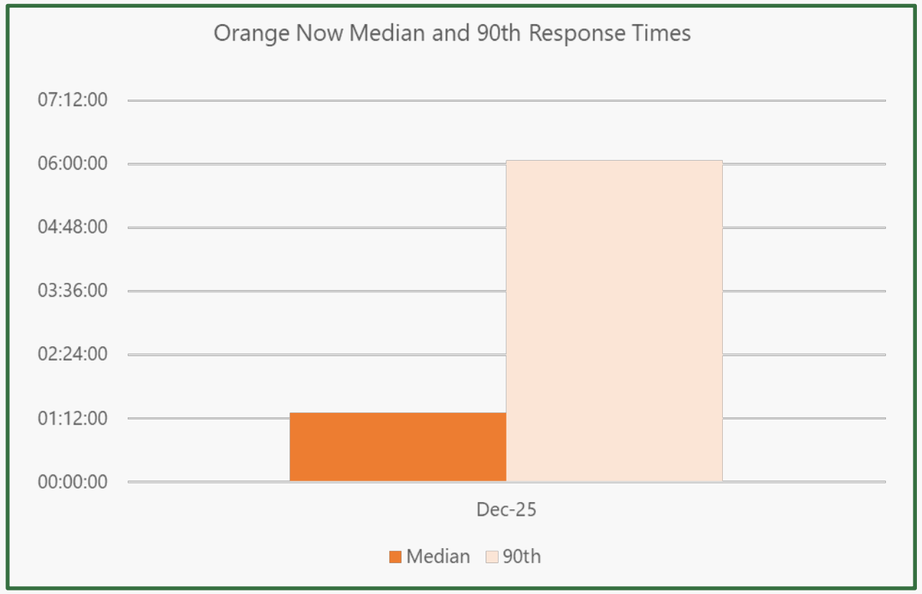
Our Patients: Quality, Safety & Patient Experience
Amber Performance Indicators

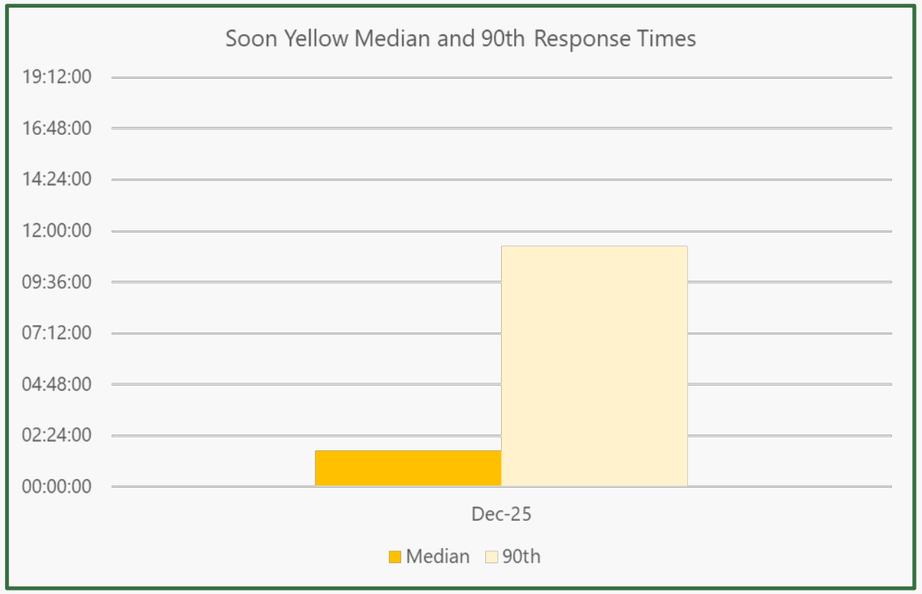
Influencing Factors – Demand, Hours Produced and Hours Lost

CI

(Responsible Officer: Lee Brooks)







Analysis

In December the existing Amber category, was replaced by Orange (now) and Yellow (soon). However, some calls were recorded as the old Amber category.

The median response time in December 2025 for Orange Now incidents was 1 hour and 19 minutes. Betsi Cadwaladr health board had the lowest median time of 38 minutes and 1 second, and Aneurin Bevan had the highest at 2 hours,18 minutes and 34 seconds.
For Orange Now calls, the 90th percentile response time was 6 hours and 4 minutes. Betsi Cadwaladr had the lowest time of 3 hours and 8 minutes, and Aneurin Bevan had the highest at 7 hours and 38 minutes.

The median response time in December 2025 for Yellow Soon incidents was 1 hour and 43 minutes. Betsi Cadwaladr health board had the lowest median time of 1 hour and 46 seconds, and Aneurin Bevan had the highest at 2 hours 53 minutes and 49 seconds.
For Yellow Soon, the 90th percentile response time was 11 hours and 18 minutes. Betsi Cadwaladr had the lowest time of 5 hours and 32 minutes, and Cwm Taf Morgannwg had the highest at 15 hours and 25 minutes.

Remedial Plans and Actions

Welsh Government announced further changes to the Ambulance Performance Framework. Monitoring of phase 2 will continue via Now and Soon categories.

Expected Performance Trajectory

The Trust's commissioned level of production (its rosters) is designed to cope with 6,000 hours of handover lost hours. The application of W45 would see the level of hospital lost hours to be close to this level, estimated to be just under 7,000 hours.

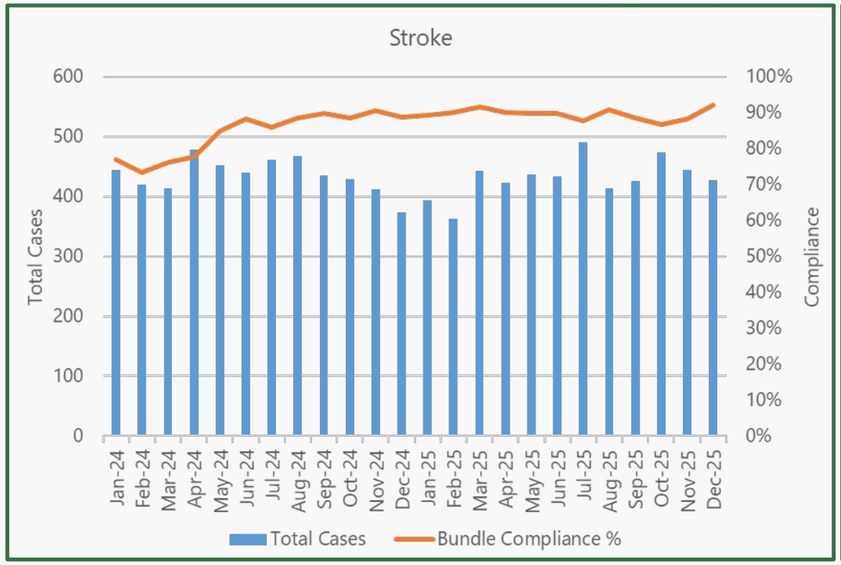
Our Patients: Quality, Safety & Patient Experience
Clinical Indicators

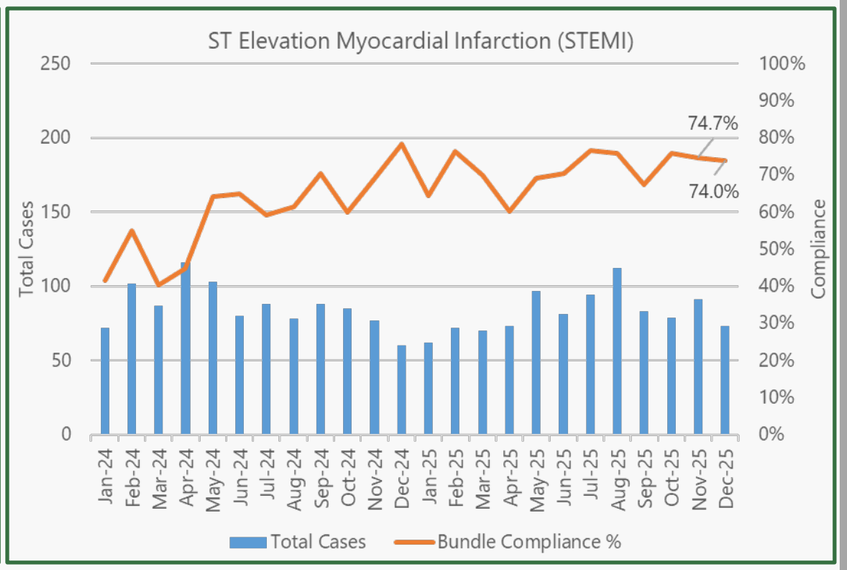
Suspected Stroke Patients with Appropriate Care, ST-elevation myocardial infarction (STEMI) with Appropriate Care and Time-Based metrics.

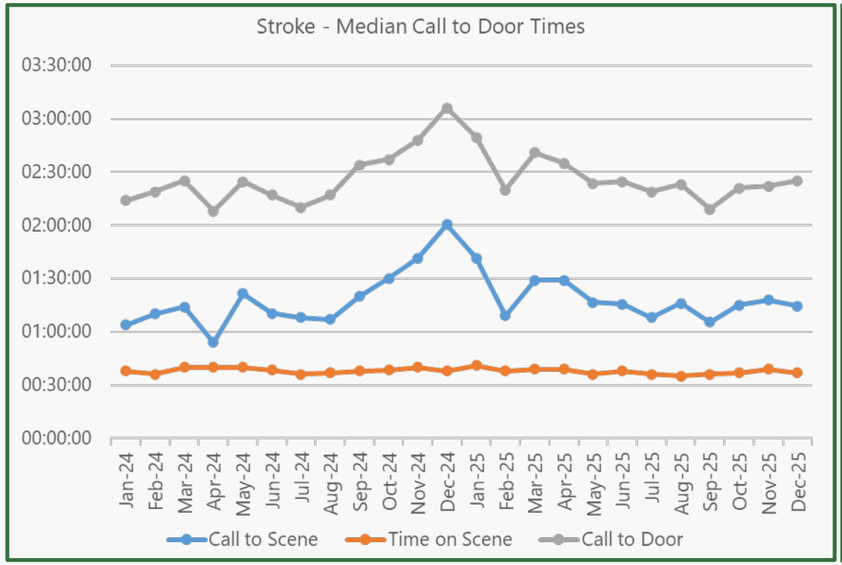
Stroke	Stroke Call to Door	STEMI
A	R	R

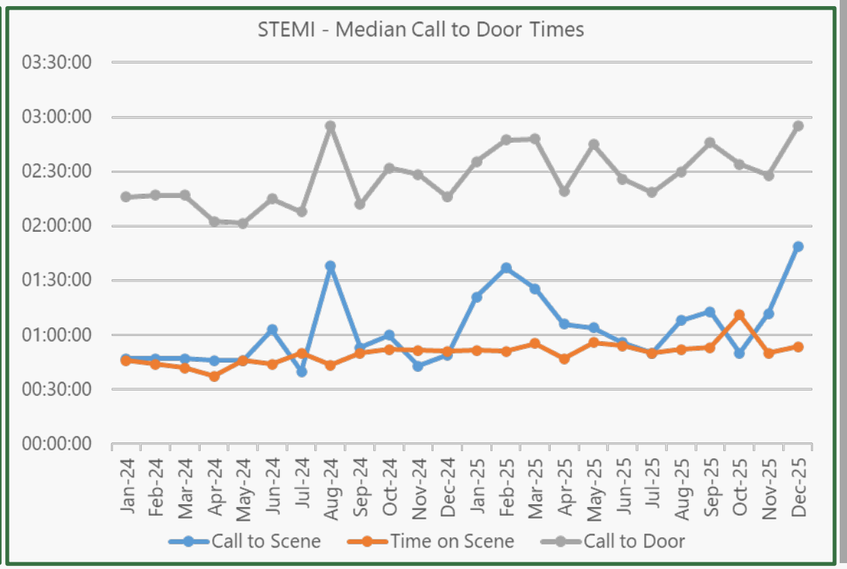
Self-Assessment: Strength of Internal Control: Moderate

(Responsible Officer: Andy Swinburn)









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

Stroke – 92.06% - performance has consistently remained at or above 85% since May 2024. There is a close correlation between documenting FAST (a test to detect symptoms of stroke) and care bundle compliance. Pre Alert is not counted towards CI compliance.

STEMI (heart attack) – 75.97%, a slight reduction from Nov2025. There has been good compliance across most of the care bundle elements. The number of cases remained low (73) therefore, increasing the volatility of the compliance data so this could be natural variance. A recent clinical update has removed GTN as part of the treatment of ACS. This will be removed from Jan 2025 to prevent guideline-driven practice reducing the reported bundle score.

Call to door times for Stroke – call to door times increased marginally for stroke in December. All three elements of the bundle have seen consistency on time.
Call to door times for STEMI – Call to door time has increased since last month. This could in part be driven by calls being sent for RCS prior to dispatch.

Remedial Plans and Actions:
A recovery plan implemented from April – September 2024 and remains BAU monitored through CIAG to maintain the improvements:

- Continued focus on communication with clinicians to use the bespoke electronic Patient Clinical Record fields (in addition to the narrative).
- Provided weekly non-compliant data to support Senior Paramedics conversations with clinicians to improve compliance.
- Promoted Clinical Indicators, care bundles and electronic Patient Clinical Record completion at Health Board area focussed workshops.
- Review of the ePCR interface led by the Digital Directorate.
- Ongoing development of the Tennant Structure within ePCR to facilitate clinical feedback to clinicians.

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

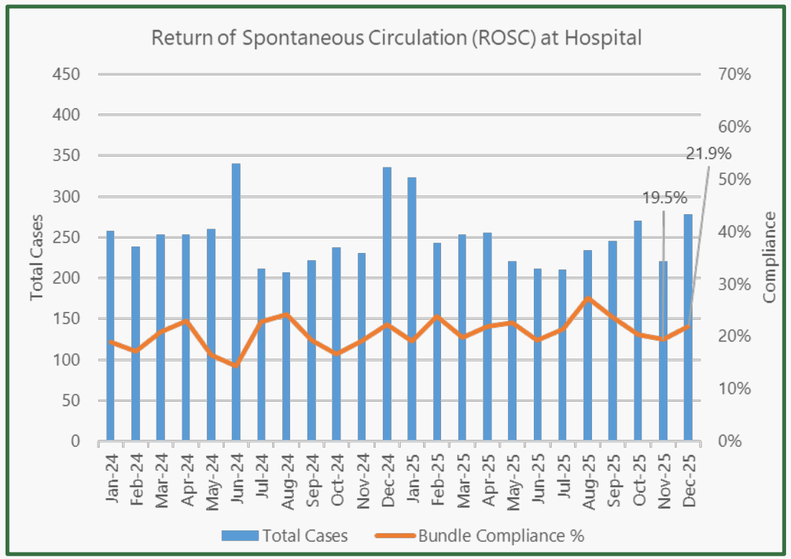
Our Patients: Quality, Safety & Patient Experience
Clinical Indicators

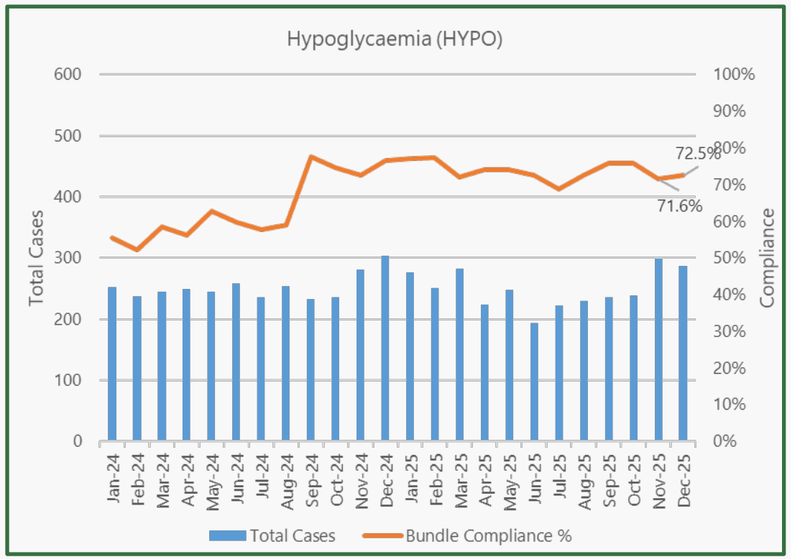
Return of Spontaneous Circulation, Hypoglycaemia, Fractured Neck of Femur (#NOF) and Time-Based metrics (#NOF)

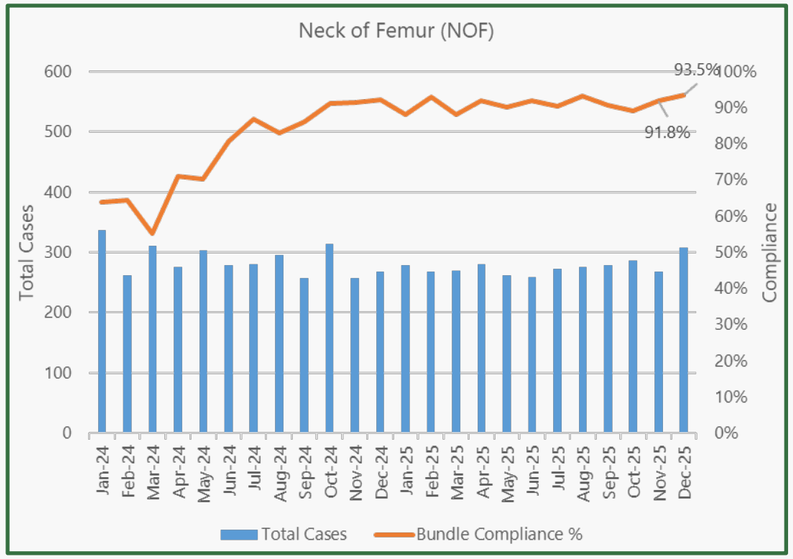
(Responsible Officer: Andy Swinburn)

ROSC
R

Self-Assessment: Strength of Internal Control: Moderate







#NOF Call 2 Door in development

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

Hypoglycaemia (diabetic patients with low blood glucose) – 72.47%, a slight increase since last month. Compliance has remained consistently around 73% compliance across the bundle.

Fractured Neck of Femur (hip fracture) – 93.49%, an increase in performance from November (91.79%). A slight increase in compliance which is evident across the care bundle.

Return of Spontaneous Circulation at hospital (from cardiac arrest) – 21.94%, an increase from 19.46% in November. An update was made to the ROSC coding scripting which affected the data from July 2024. This resulted in a step change with August 2024 being the highest since ePCR was implemented. A 'nudge' to improve documentation for specific fields including outcome was implemented in October 2024. Low case numbers means a volatile percentage dataset.

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

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

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

Further electronic Patient Clinical Record User Interface changes are planned for the next update, scheduled for Spring 2026

Our Patients: Quality, Safety & Patient Experience
Patient National Reportable Incidents & Duty of Candour

(Responsible Officer: Liam Williams)

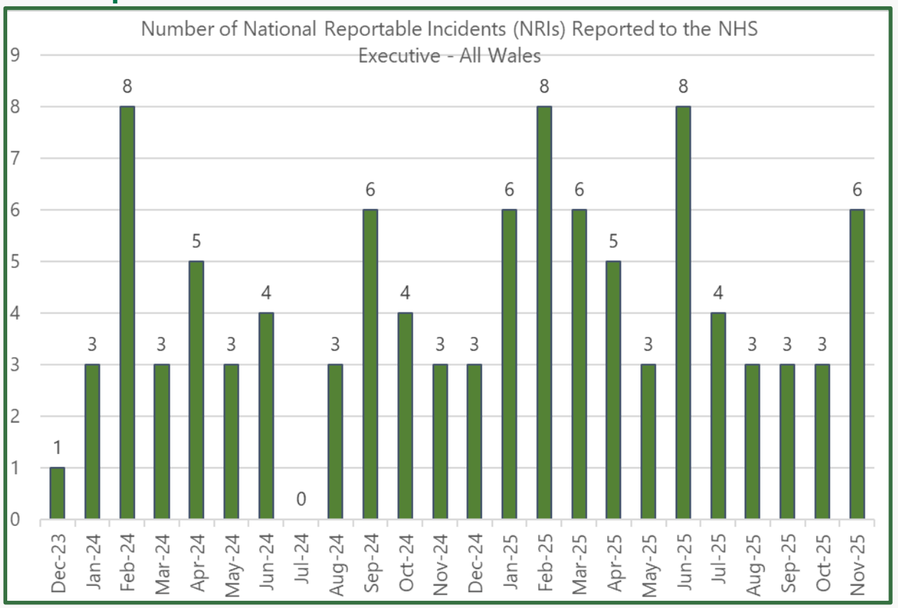
Concerns.

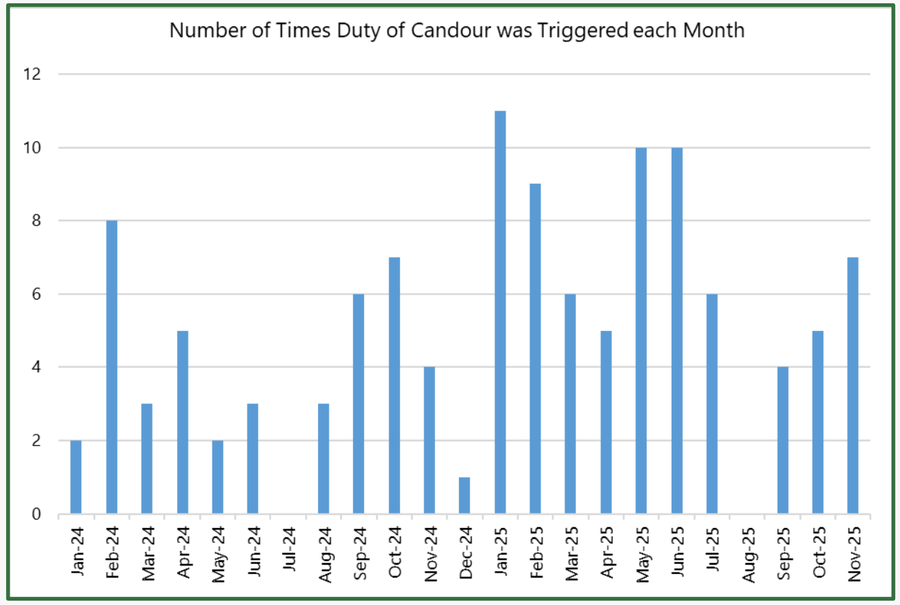
R

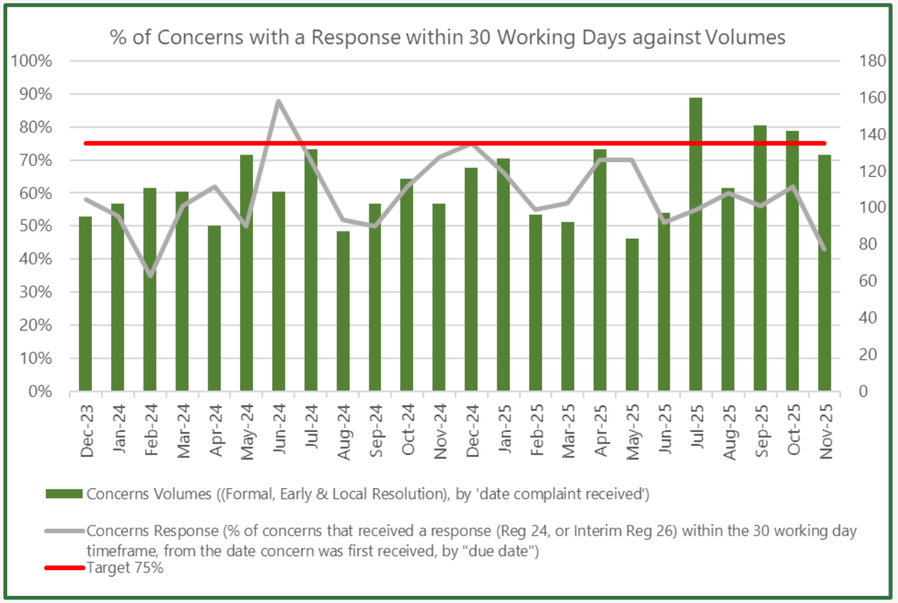
Self-Assessment: Strength of Internal Control: Moderate

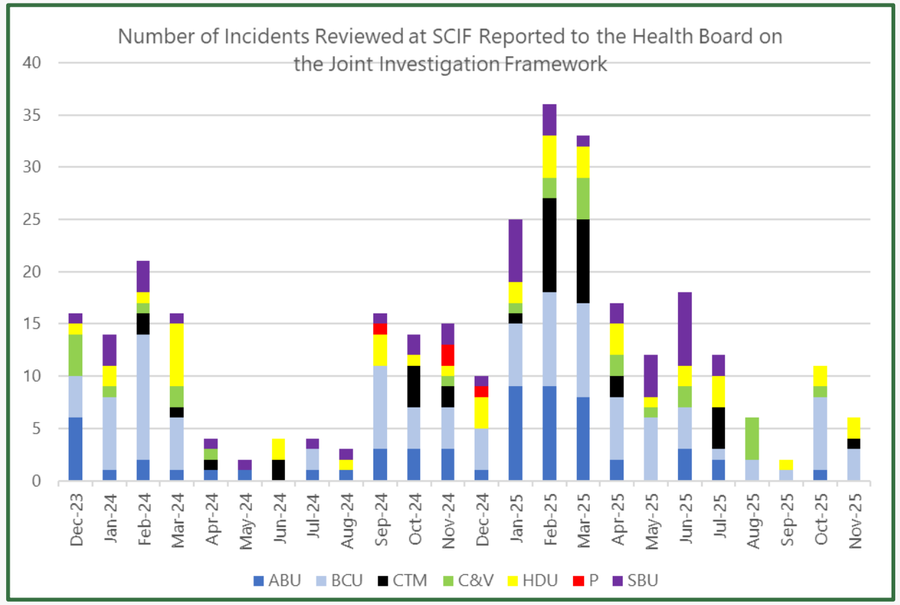
Health & Care Standard
Health - Safe Care / Timely Care

Responses Indicators









Analysis
Complaint response times remain significantly longer than the Welsh Government target. There are early signs of improvement from the PTR Recovery Plan, but this will take some time to be demonstrated in the response time target due to the lagging nature of this metric. Whilst larger numbers of complaints have been closed in the last quarter, a much-improved position in reducing open overdue complaints will be required to provide acceptable performance against this key performance indicator.

The number of complaints received by the Trust continues at high levels. As commented on in last month's report, this is being driven by an increased volume of complaints about Ambulance Care Services.

The Serious Case Incident Forum agreed for 6 incidents to be reported as NRIs.

Remedial Plans and Actions
A Putting Things Right and Legal Services Recovery Plan has been developed to address the number of overdue concerns (complaints and incidents). Governance and oversight of the improvement plan has been strengthened through the implementation of a dedicated Programme Board until end of March 2025. Additional non-recurrent investment is expected to deliver the required improved at increased pace, building on structural workforce changes and a shift to proportionate approaches that have already begun to demonstrate benefit.

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

Expected Performance Trajectory
As service areas focus on reducing the number of open overdue complaints, it is expected that the 30-working day performance will decrease. This is predicted to last until the number of open in-date complaints makes up the majority of open cases and, depending on the success of Recovery Plan actions, may take many months before it picks up again. Support from QPSE to Ambulance Care colleagues in terms of experiential emotional mapping, data visibility and the need to focus on 'on-the-spot' resolution is underway but does not yet appear to have impacted complaint volumes.

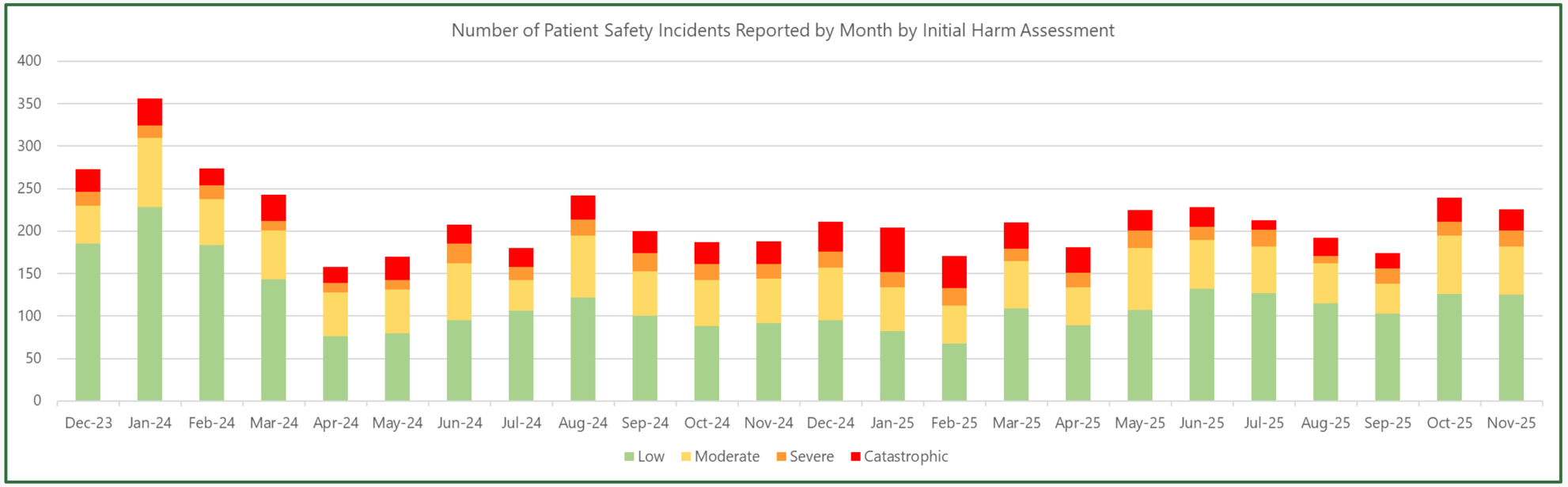
*NB: Data correct on the date and time it was extracted; therefore, these figures are subject to change **NB: 30 Day Compliance reported from Power BI and therefore data is not yet validated

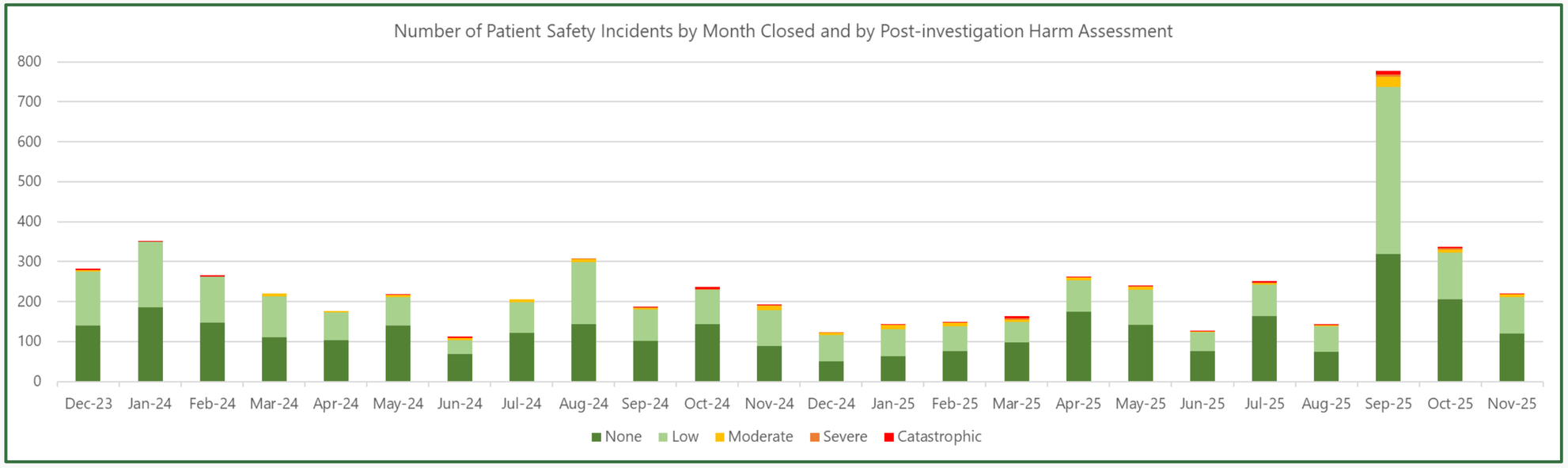
Our Patients: Quality, Safety & Patient Experience
Patient & People Safety Indicators

(Responsible Officer: Liam Williams)

Self-Assessment: Strength of Internal Control: Moderate

Health & Care Standard
Health – Safe Care





Analysis
The number of investigations needing to be shared with other NHS Wales organisations has reduced again since last month and is lower this winter than the previous year, with handover delays being experienced across fewer Health Boards and concentrated in others. This is being monitored closely through the 'Release 45' initiative and will remain an area of focus as to whether initial improvements are sustained during Winter. Incident reporting volumes have increased back to baseline levels however the number of investigations being completed and closed has reduced. Closed incidents continue to demonstrate that validated levels of severe or catastrophic harm remain consistently low.

Remedial Plans and Actions
Incident closures are being monitored through Quality Management Group.

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

Data source: Datix

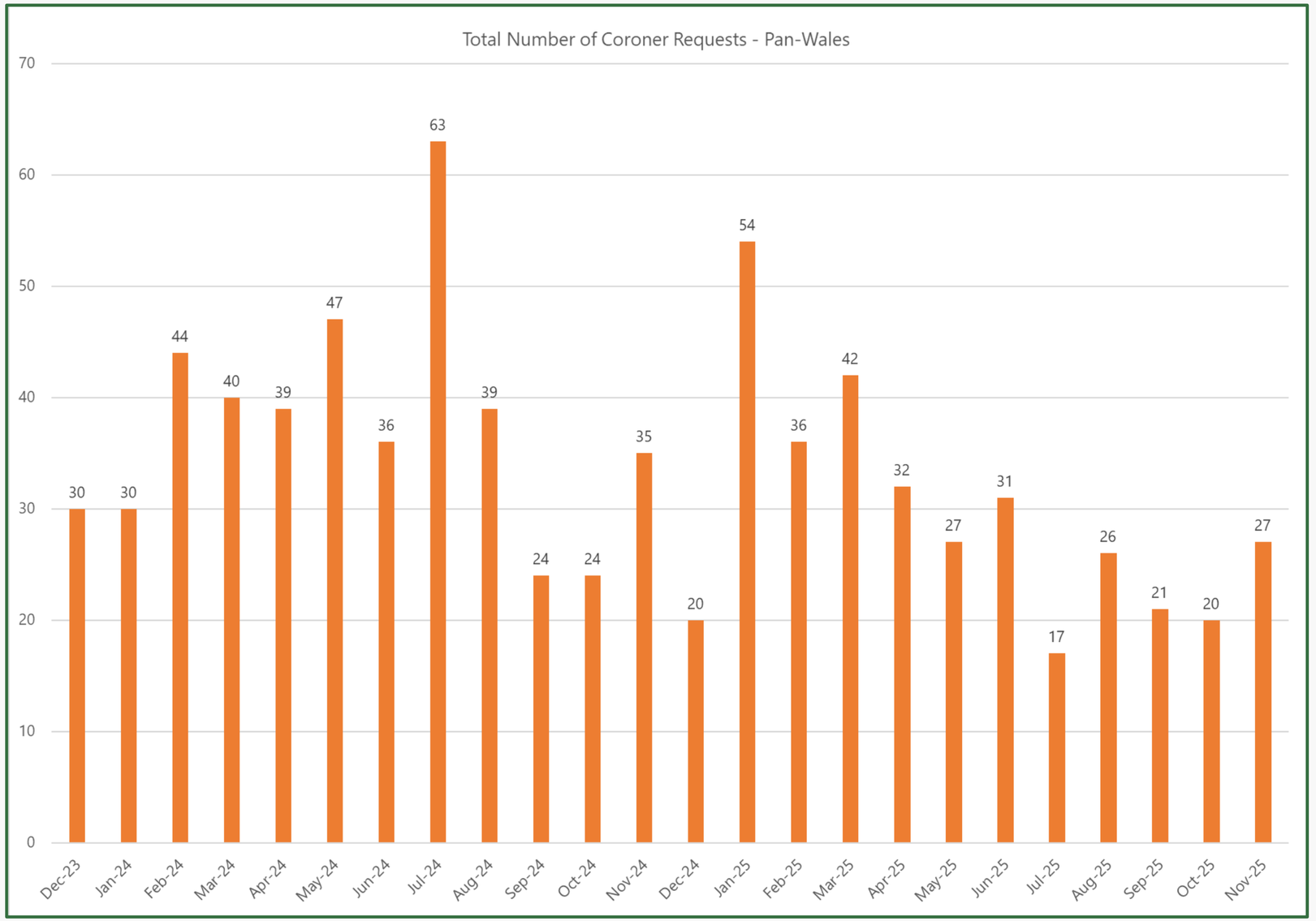
Our Patients: Quality, Safety & Patient Experience
Coroners, Mortality and Ombudsmen Indicators

(Responsible Officer: Liam Williams)

Coroners Self-Assessment: Strength of Internal Control: Moderate

Mortality Self-Assessment: Strength of Internal Control: Moderate

Health & Care Standard
Health – Safe Care



Analysis

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

Level 1 triage of Medical Examiner referrals proceeds at fortnightly intervals with all Q1 and Q2 cases triaged. Progress is being made in reducing delays in reviewing cases at Level 2 Learning Panel with the majority of the backlog now eliminated. Internal review of referrals at Medical Examiner Learning Panel continues to identify learning relating to delays in attending in the community, alongside improvement opportunities for Advanced Care Planning and enhanced end of life care in the community to guide family expectations, avoid admission where not indicated and provide dignified and personalised care.

Remedial Plans and Actions

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

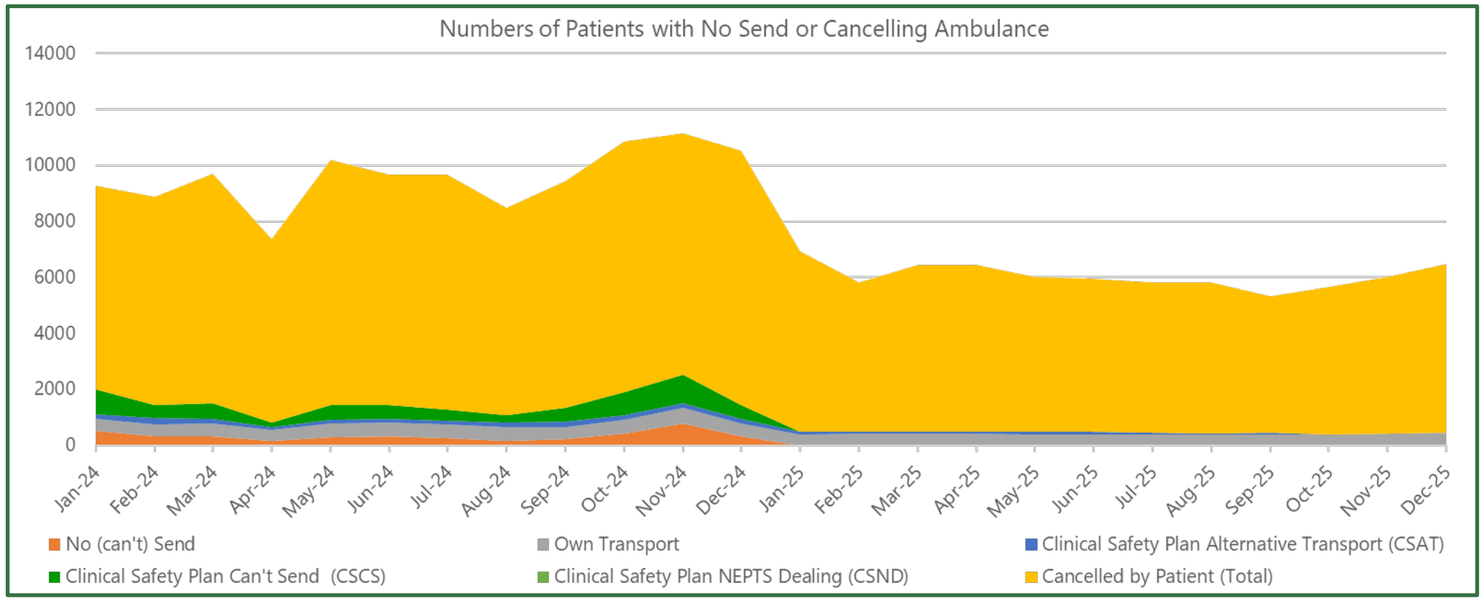
Expected Performance Trajectory

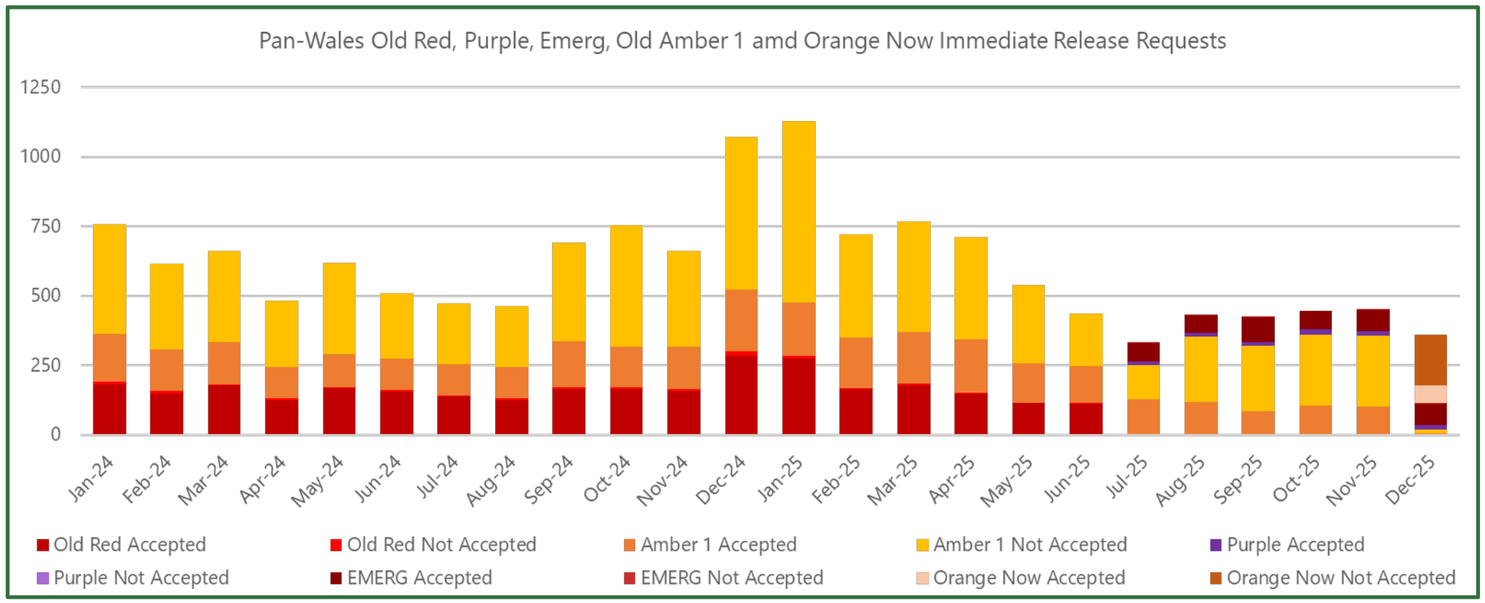
- Coroner activity will continue to be monitored and delays in statement gathering escalated and prioritised internally as appropriate. Cross directorate teams continue to work together to ensure cases are prioritised, and the coroner is provided with estimated times of completion.
- The ability to provide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

Mortality Reviews Data source: Internal Web Application

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

(Responsible Officer: Andy Swinburn) R





Analysis

In December 2025, zero ambulances were stopped due to Clinical Safety Plan alternative transport (CSPT). In addition, 6,020 ambulances were cancelled by patients an increase from the 5,603 in November 2025. There has been a downward trend in patient cancellations since December 2024 which the Trust believes is connected to the implementation of Rapid Clinical Screening during the winter.

There were 360 requests made to Health Board EDs for immediate release of Arrest, Emergency, Amber 1 and Orange Now calls in December 2025. Of these 18 were accepted and released in the Arrest category, with none not being accepted, 75 were accepted in the Emerg category, with 2 not accepted, 5 ambulances were released to respond to Amber 1 calls, but 14 were not and 69 were released for Orange now but 196 were not.

In December 2025 CSP levels for the Trust were:

Remedial Plans and Actions

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

Expected Performance Trajectory

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

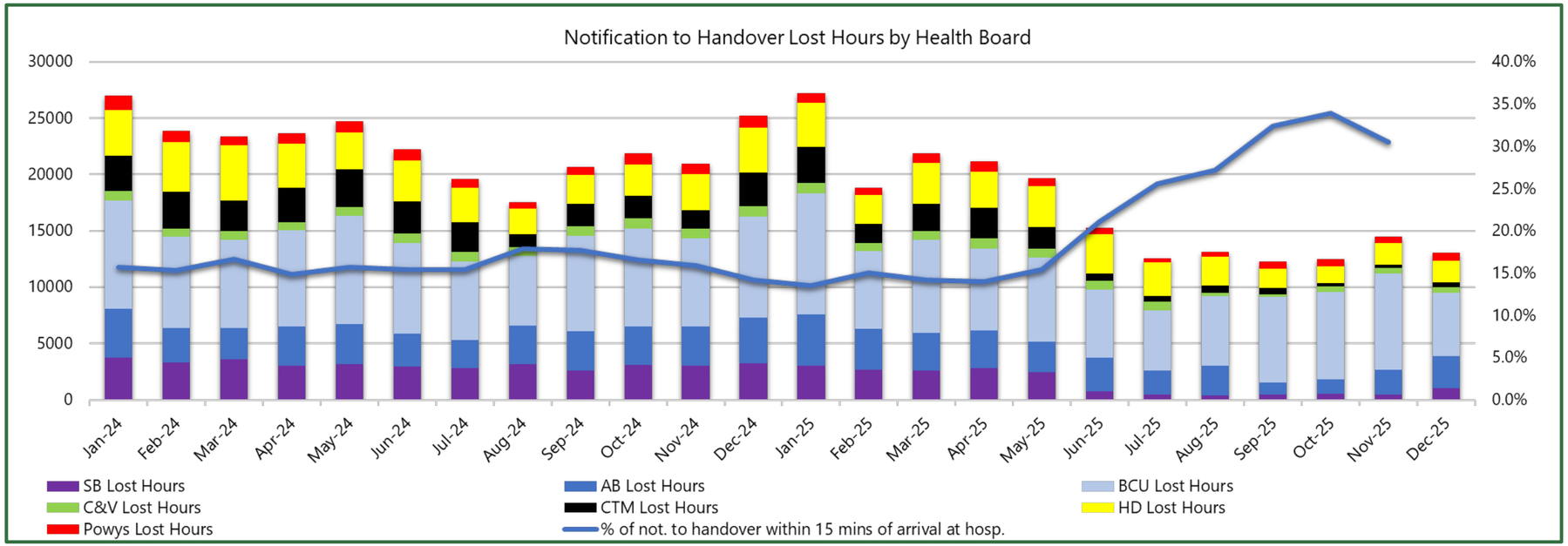
**NB: Data correct on the date and time it was extracted; therefore, these figures are subject to change*

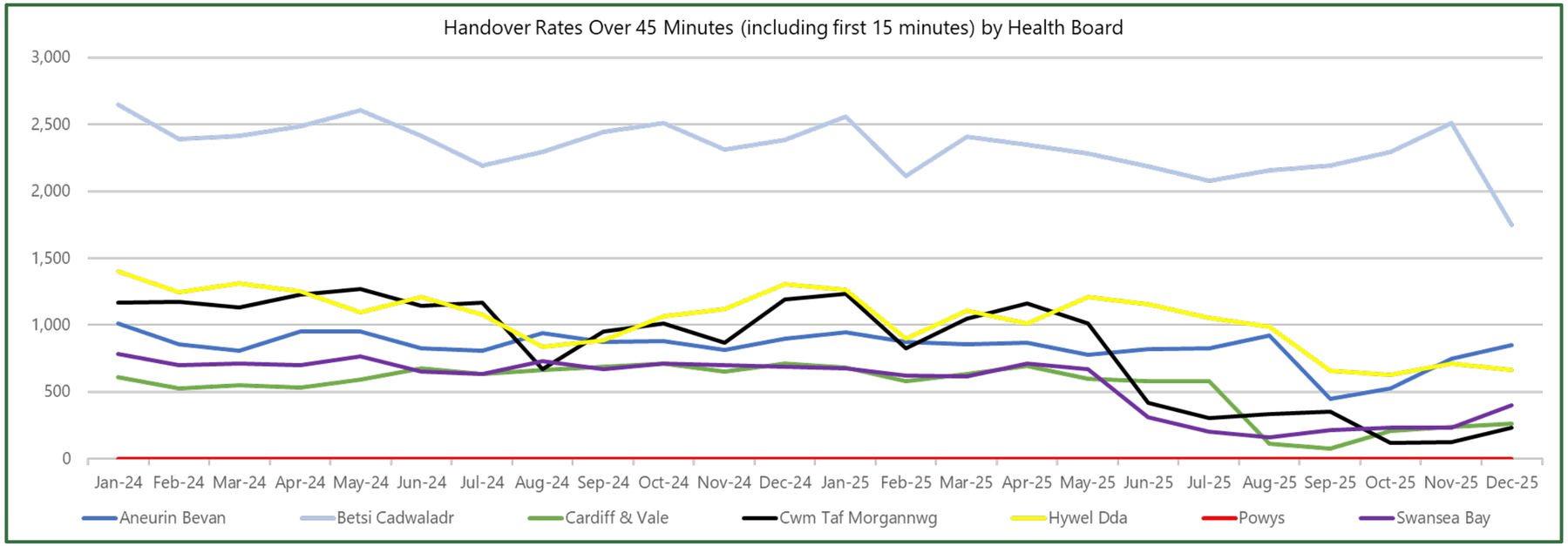
Partnerships / System Contribution Handover Indicators

(Responsible Officer: Health Boards)

Lost Hours R

CI





Analysis

202,043 hours were lost to Notification to Handover, i.e. hospital handover delays, over the last 12 months (Jan-25 to Dec-25), compared to 270,801 hours over the same timeframe the previous year. There were 13,044 hours lost in December 2025, which is 48.2% lower than the 25,195 hours lost during December 2024 and is the fifth lowest monthly figure since December 2021. One health board has seen further reductions, compared to last month, Betsi Cadwaladr (34.42%).

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

- Grange University Hospital (ABUHB) at 2,856 lost hours
- Ysbyty Gwynedd Hospital (BCUHB) at 2,345 lost hours
- Ysbyty Maelor Hospital (BCUHB) at 1,901 lost hours
- Glangwilli Hospital (HDUHB) at 1,186 lost hours
- Ysbyty Glan Clwyd (BCUHB) at 1,176 lost hours

Notification to handover lost hours averaged 420.7 hours per day during December 2025 (31 days) compared to 483 hours per day (30 days) in November 2025.

In December 2025, the Trust could have responded to approximately 4,115 more patients if handovers were reduced, which highlights the impact these numbers are still having on the service.

Remedial Plans and Actions

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

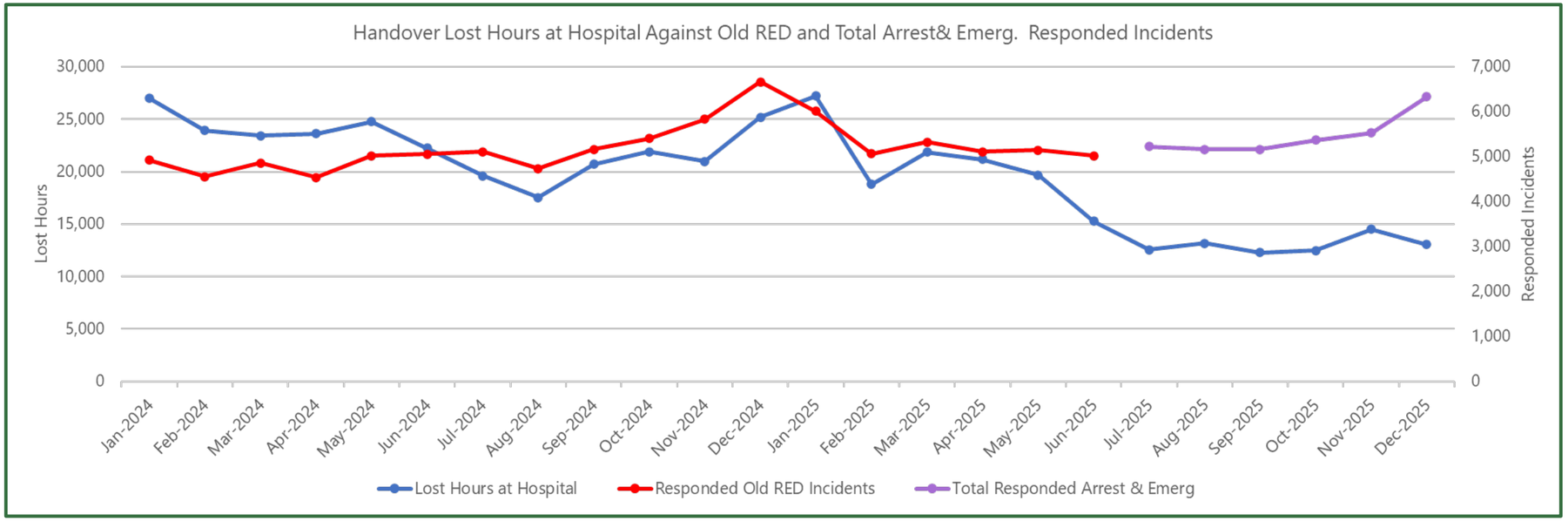
Expected Performance Trajectory

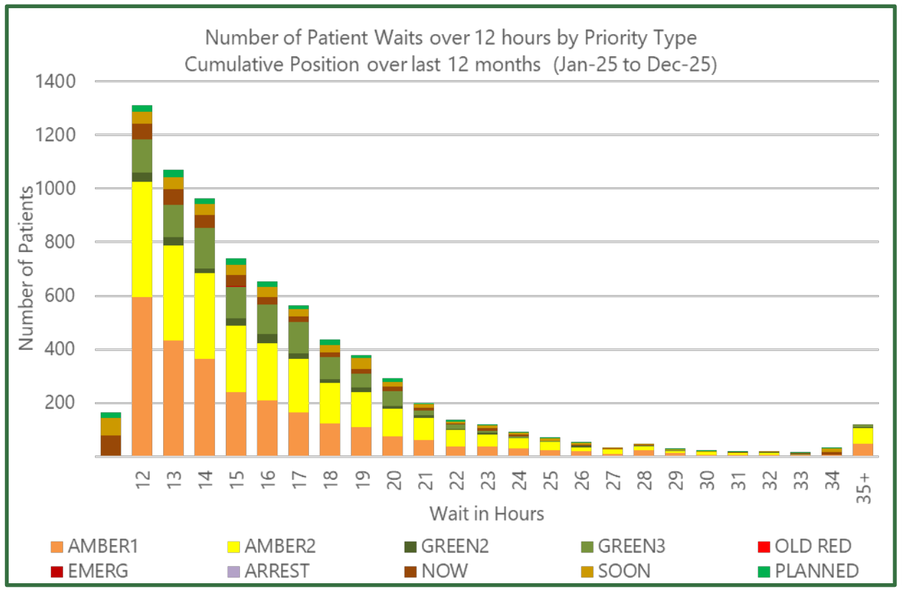
The likely expected ambition from Welsh Government is no waits over 45 minutes. W45 workshops have been facilitated with each health board by NHSWales Performance & Improvement (previously the NHS Executive).

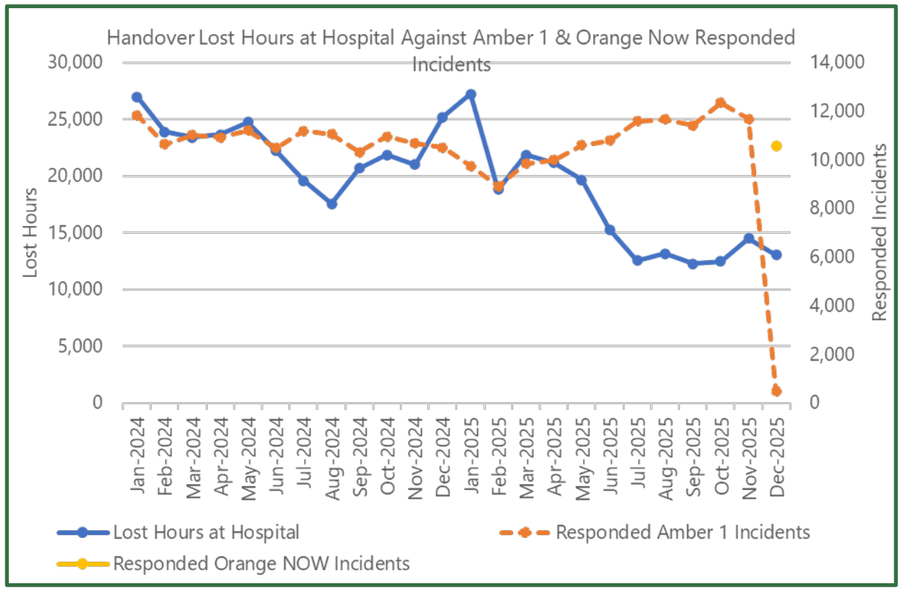
Partnerships / System Contribution
Handover Lost Hours Against Red & Amber 1 Responded Incidents

(Responsible Officer: Health Boards)

CI







Analysis

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

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

In December 2025, 1,175 patients waited over 12 hours for an ambulance response.

Remedial Plans and Actions

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

Expected Performance Trajectory

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

**NB: Data correct at time of abstraction*

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

Definition of Indicators

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

Agenda Item No.	10

REPORT TITLE

Infection Prevention & Control Position Paper: Insights and Next Steps Following the Infection Prevention & Control Annual Report (April 2024 - March 2025)

MEETING

Name of meeting	Quality, Patient Experience & Safety Committee
Date of meeting	3 February 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Liam Williams, Executive Director of Quality & Nursing
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 position paper provides an overview of progress since the last Infection, Prevention & Control (IP&C) Annual Report for April 2024 to March 2025, and outlines plans for the upcoming financial year 2026/2027.

2. As reported to the quality, patient Experience & Safety (QuESt) Committee previously, the Annual Report for 2024-25 was deferred from submission due to key staff absence and turnover. The Report attached sets out the work completed in the period and the identified priority areas for IP&C.

3. During the period 2025-26, during which time this report was generated, the Trust engaged a senior external contractor as the (Interim) Head of Infection, Prevention and Control to review the Trust's approach and support team changes. A substantive Head of Infection, Prevention and Control is now in post, and the team is at full establishment with appropriately qualified professionals. This Report to QuESt is a consolidation of the previous team's work and work undertaken to support key areas of delivery further to their commencing.

4. The Annual Audit Programme is underway and scheduled for completion by the end of the financial year. The IP&C Team has audited ambulance stations, assessed the use and storage of Personal Protective Equipment (PPE), and identified areas for improvement. The final quarter of the program will focus on non-emergency vehicles to ensure compliance and consistency across all service areas, with the support of Adenosine Triphosphate (ATP) swabs to validate cleaning effectiveness.

5. Audit results have varied across different localities in Wales, highlighting examples of excellent practice as well as areas requiring additional support. Common themes have been identified and consolidated into an overarching Operational Action Plan, which will be owned and delivered by the Operations Directorate, with support from the IP&C Team. The Estates and Facilities Team will also play a critical role in addressing audit outcomes, as a cleaning tender is required to standardise cleaning provision across stations, rectify issues identified during audits and incorporate the National Standards of Healthcare Cleanliness 2025.

6. As part of the national clostridium difficile collaborative work, an Improvement Project has been developed to address vehicle cleanliness between patient conveyances. Furthermore, the IPC Team will support an organisational Task and Finish Group to inform Make Ready Depot (MRD) proposals for organisational consideration.

7. As a newly established but experienced IP&C Team, there has been a focus over the last quarter on strengthening relationships with key stakeholders across the Trust, building confidence in the service, and expanding professional networks. These efforts have laid the foundation for collaborative working and improved engagement. This approach will become business as usual and continue to grow throughout the next financial year, promoting stakeholder engagement and shaping the future direction of infection prevention and control.

8. The IP&C Team has successfully updated the induction training package, which is well received and embedded across the Trust. In the upcoming financial year, the IP&C Team will work alongside the Learning and Development Team, to transform and deliver the annual IP&C training and relaunch the Aseptic Non-Touch Technique (APTT) Training Program. These

initiatives remain critical to embedding infection prevention principles into everyday clinical practice, ensuring staff maintain the competencies required to deliver safe care, and reducing the risk of Healthcare Associated Infections (HCAIs). By enhancing staff knowledge and refining techniques, we will provide assurance to the Board and Welsh Government that staff are fully compliant with National Standards. This approach will enhance patient safety and demonstrate the Trust's continued commitment to high-quality infection prevention and control.

9. The Policy and Guidance review will continue into the next financial year. A comprehensive mapping exercise is required to identify all existing documents, followed by a structured update process. Once documents have been revised and approved, a full refresh and alignment of SharePoint resources will be undertaken, to ensure accessibility and version control.

10. Audit findings and identified areas of non-compliance are formally escalated through operational governance routes, with responsibility for action planning and delivery residing with the Operations Directorate and support provided by the IP&C, Estates, Maintenance and Fleet Teams. Where Audit Action Plans are not submitted, or where sustained improvement is not evidenced, this is escalated through executive oversight and informs corporate risk consideration via the Board Assurance Framework. This approach ensures that audit activity translates into organisational grip, accountability, and Board-level assurance.

11. Following the considerable changes made to the team over the last eighteen months, significant progress has been made. The newly formed team has concentrated on establishing a strong baseline for the service and laying the foundation for future development and improvement. The Head of Service is developing an IP&C Work Plan for 2026-2027 based on the baseline assessment completed by the external support and the 2025/26 Plan. This new Plan will underpin the IP&C Service Improvement Plan and align with a Board Assurance Framework that is anticipated to be published by Public Health Wales. It will also incorporate findings from Internal Audits conducted in 2020 and 2023, to ensure lessons learned are embedded into future priorities.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

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

1. Review and take assurance from the content of this report.
2. Recognise the significant changes made to the team and their work since the start of the 2024 financial year.
3. Acknowledge that the refreshed IP&C approach is in its initial phase and will require extensive partnership and coordinated action moving forward.
4. Note the escalation and governance arrangements in place to address non-compliance with IP&C Audits, including the role of operational ownership, executive oversight, and Board Assurance Framework alignment.

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 and Safety Committee is requested to receive the following:

Annex 1 IP&C Report (March 2024 - April 2025)

Annex 2 IP&C Service Improvement Plan 2025-2026

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
This report provides assurance against the Board Assurance Framework risk relating to healthcare associated infection, environmental cleanliness, and compliance with Infection Prevention and Control Standards across operational, vehicle, and estate settings.

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
13 January 2026	Clinical and Quality Governance Group
3 February 2026	Quality, Patient Experience and Safety Committee

Welsh Ambulance Services University NHS Trust

Infection Prevention & Control Report

1st April 2024 - 31st March 2025

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

Infection Prevention and Control
Version 1.0
Released: July 2025

Marisa Alexis
Head of Infection Prevention and Control [Interim]

1. Quality Assurance Audit Report

The primary objective of the WAST IPC audit programme is to minimise the risk of infections acquired by patients during pre-hospital care. This is accomplished by ensuring adherence to the organisation's established standards and guidelines.

The audit process helps identify areas where IPC measures may be insufficient or improperly applied, such as inadequate hand hygiene, incorrect use of personal protective equipment (PPE), or substandard cleaning of emergency vehicles.

The data collected through audits is instrumental in informing staff training, promoting best practices, and reinforcing proper IPC procedures. The WAST IPC team undertook hand hygiene and vehicle cleanliness audits during the fourth quarter of 2024-2025.

2. Quality Assurance Audits- Hand Hygiene Audit Overview

- ❑ Total audits conducted- **60**
- ❑ Staff audited – **60**
- ❑ Sites audited- **6**

North Wales	South Wales-
Ysbyty Glan Clwyd	Morriston Hospital
Ysbyty Gwynedd	Prince Charles Hospital
Wrexham Maelor Hospital	Grange University Hospital

- ❑ Localities covered

  - Conwy & Denbighshire
  - Flintshire & Wrexham
  - North Gwynedd & Ynys Mon
  - Bridgend
  - Swansea
  - Neath Port Talbot
  - North Cwm Taf
  - Aneurin Bevan (all areas)

A total of 60 hand hygiene audits were conducted during the reporting period, assessing 60 staff members across 6 acute hospital sites. These audits formed part of the IPC team's approach to monitoring and promoting best practice in hand hygiene, a cornerstone of infection prevention in healthcare settings. Audits were conducted across both North and South Wales, covering a broad geographical footprint and ensuring representation from multiple operational areas. Results demonstrated a high level of variation across the Trust and confirmed a requirement to secure significant improvements in core standards compliance. While the number of audits (60) provides a reasonable baseline for a single quarter or re-established programme, expanding the number of audits per site and per locality would strengthen the dataset and improve the reliability of compliance trends.

3. Quality Assurance Audits- Hand Hygiene Action Plans

As part of the hand hygiene audit programme, action plans were requested from localities where areas of non-compliance were identified. These action plans are intended to outline corrective measures, support local accountability, and drive improvements in hand hygiene practices.

Total Action Plans Requested	8
Action Plans Received: 2	**Outstanding Action Plans: 6**
Neath	Aneurin Bevan, Flintshire & Wrexham
Swansea	Bridgend, North Cwm Taf
	Conwy & Denbighshire, North Gwynedd & Ynys Môn

- The 75% non-submission rate represents a significant gap in the IPC governance process. Timely submission of action plans is essential to close the audit loop, provide assurance, and monitor whether improvements are being implemented at a local level.
- Failure to submit or implement local action plans is escalated through Operations directorate management structures. Persistent non-compliance is subject to executive oversight and informs organisational risk assessment, ensuring that audit findings are translated into corrective action and sustained improvement.
- Common areas of non-compliance
  - Bare below the elbow compliance **(56% average compliance)**
  - Hand hygiene compliance **(48% average compliance)**
  - Handwashing technique **(50% average compliance)**
- Analysis of audit feedback and the limited number of submitted action plans identified several recurring issues:
  - **Limited or absent hand decontamination** following patient contact or contact with the clinical environment
  - **Improper disposal of clinical waste** without use of gloves
  - **Wearing of wristwatches**, indicating non-adherence to bare below the elbow policy
- Implications and risks includes patient safety, professional standards, assurance. Suboptimal hand hygiene poses a direct risk to patient safety, increasing the likelihood of healthcare-associated infections. Low compliance undermines adherence to national IPC guidance. The lack of timely action plan submission creates a governance gap, limiting the organisation's ability to demonstrate accountability and sustained improvement.

4. Quality Assurance Audits- Vehicle Cleanliness Overview

- Total vehicles audited- **27** Sites - **9**

North Wales	South Wales
Ysbyty Glan Clwyd	Grange University Hospital
Ysbyty Gwynedd	Morriston Hospital
Wrexham Maelor Hospital	Prince Charles Hospital
Wrexham ambulance station	Aberystwyth ambulance station
	Bridgend ambulance station

- Localities covered

  - Ceredigion
  - Conwy & Denbighshire
  - Flintshire & Wrexham
  - North Gwynedd & Ynys Mon
  - Bridgend
  - Swansea
  - Neath Port Talbot
  - North Cwm Taf
  - Aneurin Bevan (all areas)

A total of 27 ambulance vehicles were audited across 9 sites in both North and South Wales as part of the 2025 IPC assurance programme. This audit reviewed IPC standards and cleanliness across a broad geographical footprint, reflecting service delivery diversity and regional risk.

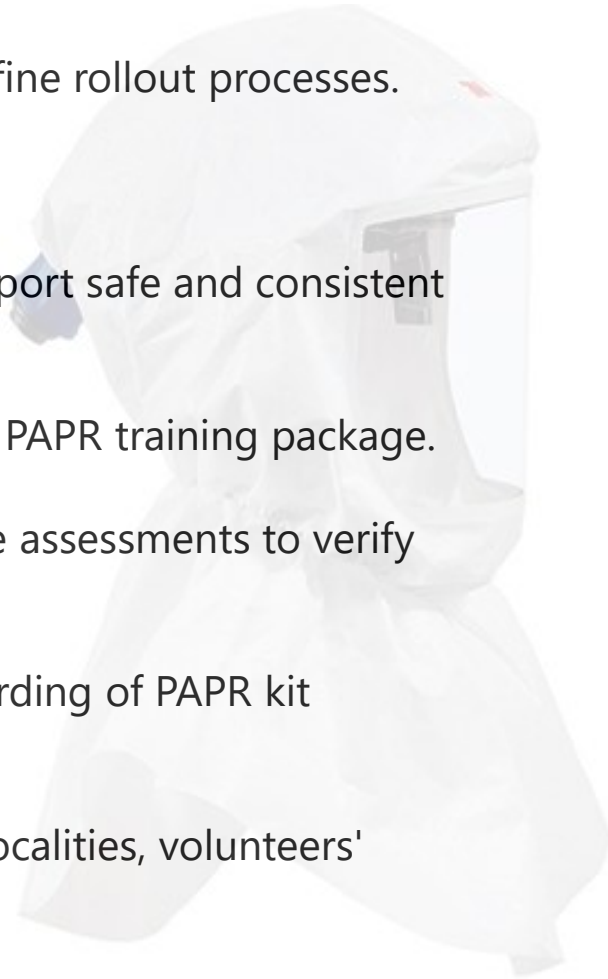
- 50% of vehicles achieved scores ≥90%, demonstrating strong compliance.
- 25% of vehicles fell below 80%, necessitating immediate corrective action.

Findings from these audits have provided valuable insight into vehicle cleanliness compliance, supported local improvement actions, and informed broader IPC strategies across WAST. Where vehicle cleanliness audits identify significant or repeated non-compliance, local action plans are required and monitored through Operations directorate management . Failure to demonstrate improvement is escalated through executive oversight and informs ongoing risk management and Board assurance.

5. Respiratory Protective Equipment Roll Out

The IPC team played a central role in the strategic rollout of Respiratory Protective Equipment (RPE) across the organisation. Key activities included:

- Design and management of a pilot programme in the North Wales region to test and refine rollout processes.
- Coordination of the full organisational rollout from the Hensol distribution hub.
- Development and authorship of the Powered Air Purifying Respirator (PAPR) SOP to support safe and consistent use.
- Collaboration with the Learning and Education department to compile a comprehensive PAPR training package.
- Training of multiple staff cohorts to become PAPR trainers, followed by quality assurance assessments to verify competency.
- Oversight of equipment documentation and stock management, including detailed recording of PAPR kit allocations.
- Processing and distribution of 930 PAPR kits to frontline EMS vehicles, ambulance care localities, volunteers' sector, response capable officers, and HART.

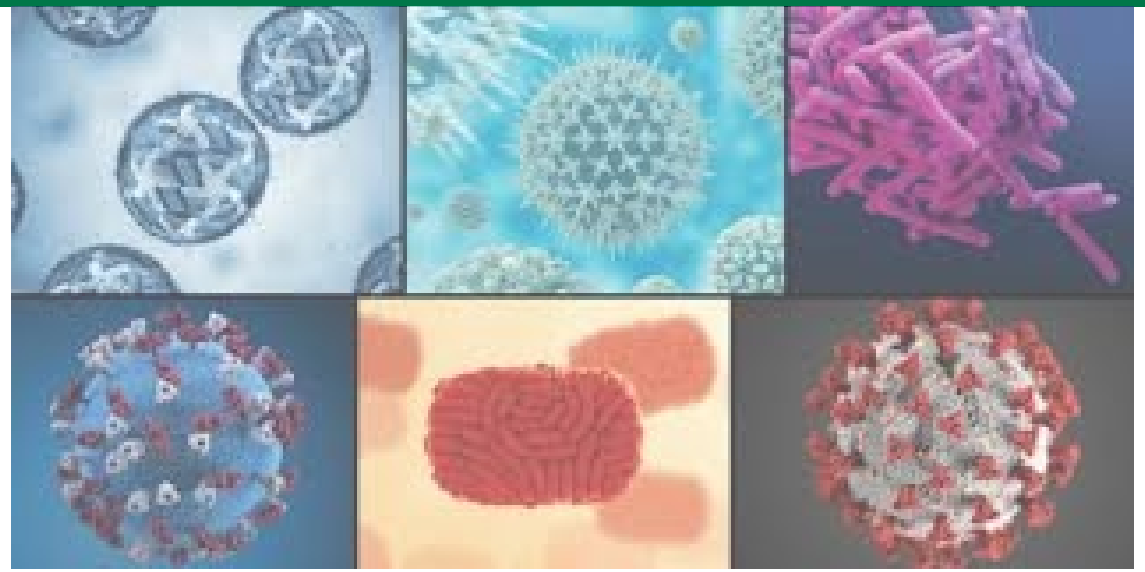


This coordinated and quality-assured approach ensured consistent access to and safe use of respiratory protection across the organisation.

6. Incidents and Outbreaks

One of the key functions of the IPC team is to provide leadership in managing IPC related incidents and outbreaks within the Trust. The following exposure incidents were managed in Quarter four:

- Meningococcal disease - **5 cases**
- Invasive Group A streptococcus (iGAS)- **4 cases**
- Lassa fever - **1 case**



* ***This data was not collected in Quarters 1-3***

7. Directorate Notices

Issuing IPC notices are a vital mechanism for maintaining high standards of safety, awareness, and accountability across WAST. These notices play a key role in reinforcing existing policies, procedures, and professional responsibilities, while also drawing attention to breaches, risks, or recurring issues that demand urgent focus. During the reporting period, the IPC team developed and published **three directorate notices** and **one CEO report**, addressing a range of critical topics including:

- Winter illnesses
- Mpox derogation
- Sharps safety
- Launch of the WAST Audit Programme (CEO report)

These communications ensured timely dissemination of essential information, supported frontline staff in safe practice, and underlined the organisation's commitment to continuous improvement in infection prevention and control.

Quality, Safety & Patient Experience Directorate Official notice

7 April 2025

Derogation of Clade I Mpox

Following advice from the Advisory Committee on Dangerous Pathogens the Chief Medical Officers from the four UK nations have decided that mpox (clade I and clade II) will no longer be managed as a high consequence infectious disease (HCID) within healthcare settings. This includes pre-hospital care provided by WAST. The decision was taken because the related evidence no longer meets the criteria for an HCID.

This decision does not diminish the seriousness of clade I mpox for some individuals and it remains a World Health Organization public health emergency of international concern (PHEIC). The UK's strategic goal continues to be to eliminate person-to-person transmission of mpox in the UK. Therefore, there will be ongoing public health management of cases and contacts, including vaccination where appropriate.

The WAST mpox guidance document has been withdrawn and the WAST A-Z has been updated in line with Public Health Wales National infection prevention and control manual NIPCM - Public Health Wales. Amber personal protective equipment is to be used for the management of suspected and confirmed cases of mpox. Further information about the changes in mpox cases management can be found at Derogation of clade I mpox - GOV.UK

Page 1 | 1

Ref: 005

Approved by: Liam Williams, Executive Director of Quality & Nursing

8. Policies and guidelines

The IPC team continues to lead the systematic review of all WAST IPC policy documents and standard operating procedures (SOPs), ensuring they remain streamlined, up to date, and grounded in current evidence. This work is essential to support safe, consistent, and effective practice across the organisation.

Documents reviewed the past quarter included:

- PAPR Standard Operating Procedure
- Mpox Policy

Welsh Ambulance Services University NHS Trust

Infection, Prevention and Control Service Improvement Plan 2025-26

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

Presentation Title
Version 5.0
Released: January 2025

by Sarah Morgan, Head of IP&C

Strategy

Task	Aim	Description	Assurance and governance	Timeframe	Update
Develop a fully engaged, collaborative strategy for the WAST IPC service. Encourage continuous quality improvement and act as a change agent. Implement board assurance processes	To improve the WAST IPC service by way of transforming the existing provision to better serve the needs of the organisation. To deliver a high quality and effective IPC service. To ensure the WAST IPC service's core infrastructure is resilient and performant. Improve organisational culture and approach IPC practice.	Service improvement requires a systematic approach to quality improvement, efficiency and service delivery. Align to the evolving strategies in the wider organisation and work with partners internally and across the system. Identify priority areas for service redesign.	IPC monthly team meetings IPC strategic group	January 2026	Develop an IP&C Work Plan 2026-2027. The Work Plan will incorporate the strategic aims/ metrics outlined in this plan and the Board Assurance Framework (BAF). It will also include the findings from internal audits conducted in 2020 and 2023, to ensure lessons learned are embedded into future priorities.

Workforce

Task	Aim	Description	Assurance and governance	Timeframe	Update
Improve the IPC team capacity through recruitment. Provide education and training for current IPC team members.	To create an agile and expert team with integrated working practices to meet the needs of the organisation.	Developing capability and talent within the IPC team. Improving the culture by focusing on team structure, governance, interprofessional relationships, and collaborative working.	IPC strategic group.	Ongoing	Successfully appointed into the (1.0 WTE) B6 position within the team – checks ongoing. ?whether we can use the 0.5WTE B6 monies to uplift B5. Ongoing discussion with the Peoples Services team. Head of IP&C, B7 and B5 currently undertaking a Master's degree in IP&C.

Audit Programmes

Task	Aim	Description	Assurance and governance	Timeframe	Update
Develop and implement a Trust wide IPC audit programme with a clear reporting structure that monitors compliance for sustained improvement of IPC standards. Use results to drive improvement.	To improve patient outcomes by minimising the risk of healthcare associated infections tran smission through IPC compliant clinical practice.	Utilising audits to conduct objective reviews of specific infection prevention practices. To measure staff adherence with IPC standards and processes designed to improve patient care. To identify strengths and areas for service improvement.	IPC strategic group.	Completed	-The Quarter 3 audit program continues. We have changed the audit report template to an action plan. -IPC priority Estates/Facilities action plans for ambulance premises have been circulated for North & South Wales. -An overarching operational action plan has been developed and presented in EMS management group. The action plan will be further discussed in SLT.# -In the process of adding the IPC audit tools to DocWorks.

Surveillance System

Task	Aim	Description	Assurance and governance	Timeframe	Update
Create a surveillance system to manage, report and track infection prevention and control incidents.	Establishing a surveillance system with a process for identifying, managing and reporting IPC incidents that minimises the risk of healthcare associated infections to patients and staff.	Robust surveillance is essential process to the prevention and control of infections. It is important for the organisation to have a system in place to manage reports of infections that aligns with the WAST outbreak policy process.	IPC strategic group	Ongoing	- The IP&C team have implemented a rota system to manage PHW alerts and Datix reports, ensuring timely attention, investigation, and follow-up actions. - The Head of IP&C has provided feedback and comments on the draft High Risk Record Policy.

Policy Review

Task	Aim	Description	Assurance and governance	Timeframe	Update
Review, update, consolidate and align all WAST IPC policy and guidance documents. Ensure that policy and guidance documents are utilitarian and easily accessible to staff.	Providing a suite of IPC policies that aligns with current national guidance and best available evidence.	Policies and procedures provides employees with information they need to protect themselves and the patients they care for against infectious diseases by providing guidelines on management, control measures and risk assessment.	IPC strategic group	Ongoing	-A to Z of pathogen resource SOP and Monkeypox guidance approved in IPC strategic group. -In the process of updating the sharps safe use and disposal policy. -Need to map out the existing IPC policies/procedures and guidelines in use across the Trust.

Decontamination

Task	Aim	Description	Assurance and governance	Timeframe	Update
Review existing vehicle and equipment decontamination processes. Refine the current quality assurance process.	Establish a decontamination programme and processes that minimises risk from contaminated environments and equipment.	Decontamination of medical devices and the environment play an important role in the prevention of health care-associated infections.	IPC strategic group	Ongoing	-The Head of IP&C has visited the MRD in Cardiff. Awaiting dates to visit Barry and Tredegar MRDs. -The Senior IP&C practitioner is leading on a collaborative quality improvement project with Cwm Taf North; improving cleanliness of the vehicle cab & saloon area between conveyances. -The Head of IP&C visited the MRD in Shrewsbury to support service improvement initiatives. -The MRD SOP for Hygiene Pro Clean vapour machines needs to be reviewed and updated.

Training

Task	Aim	Description	Assurance and governance	Timeframe	Update
Review and mapping of IPC training programmes currently delivered. Strengthen collaboration and co-production with Learning and Development team on the development and delivery of all IPC related training packages.	Deliver an IPC training programme that promotes high standards of practice among WAST staff to minimise the opportunities for health cares associated infections to spread and for antimicrobial resistance to develop.	Training programmes are fundamental to improving the safety and quality of care provided to patients. It is vital that all staff have the necessary knowledge, understanding and skills to provide safe clean care.	IPC strategic group	TBC	-IP&C annual training package to be reviewed. -Update ANTT levels (levels 0 & 1) on ESR, SBARN in progress. -Revise the ANTT (level 0) training slides to create concise, bite-sized modules that are user-friendly and easy to understand.

IPC Quality Leads Programme

Task	Aim	Description	Assurance and governance	Timeframe	Update
Create a programme that empowers staff to facilitate the rapid dissemination of education, conduct localised audits and act as a conduit to the IPC team. Formal competency assessments	Improve staff confidence as IPC Quality leads and encourage an organisational culture where all staff accept responsibility for IPC.	A train the trainer approach to IPC. This model will create a chain of knowledge transfer within the organisation.	IPC strategic group		The IPC team is actively networking and building relationships with employees across the Trust to foster collaboration and understanding of IPC priorities.

Agenda Item No. 11

REPORT TITLE

EMERG Clinical Indicators – Update to December 2025

MEETING

Name of meeting	Quality Patient Experience & Safety Committee (QuEST)
Date of meeting	3 February 2026
Public or Private	Public
If private - rationale:	N/A

REPORT SPONSOR

Executive sponsor	Andy Swinburn – Executive Director of Paramedicine
Author(s) of report	Vince Baglole – Head of Clinical Intelligence & Assurance

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. Three EMERG indicators are now publishing on the WASUT Clinical Indicators (CI) Dashboard (from Sep 2025, retrospectively to Jul): These are: Diagnostic Codes, Pain Management (pain score change) and Breathing Problems (SpO_2 change). Front Cover - Clinical Indicators Dashboard - Power BI

2. Key positive insight: high-volume diagnoses are clearly visible (e.g., Convulsions 2,058; Dyspnoea 1,782) enabling targeted clinical improvement focus.

3. Key issues: data completeness limits episode 'change' reporting - many records do not contain two time-separated measures (pain/SpO_2/NEWS2). These are necessary to enable the system to compare readings and indicate changes. In an early snapshot of the Pain CI, 13.5% received analgesia (721/5,326) but only 33.3% had a recorded post-analgesia pain score (240/721) and were included in the reporting.

4. Several indicators remain dependent on ePCR / User Interface changes and/or Subject Matter Experts input (e.g., maternity newborn observations, major trauma, convulsions). NEWS2 change reporting remains constrained by implementation and observation-set completeness; automated anaphylaxis reporting is planned from Jan 2026.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The forum is requested to:

1. Note progress and success of current publication status of EMERG indicators.

2. Discuss and support actions to improve repeat-measure recording (pain, SpO_2 and NEWS2) to increase reportable coverage.

3. Note dependencies for remaining indicators and the planned next steps (including automated anaphylaxis reporting from Jan 2026).

ADDITIONAL PAPER(S)

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

The forum is requested to receive the following:

Annex 1 EMERG Clinical Indicators presentation (update to Dec 2025)

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

☐ SO1: Providing the right care or advice, in the right place, every time	☐ SO2: Enabling our people to be the best they can be
☒ 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
TBC (improves assurance on EMERG clinical effectiveness and data quality).

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

☒ 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

☐ 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	N/A

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
3 February 2026	Quality Patient Experience and Safety Committee (QuEST)

Welsh Ambulance Services University NHS Trust

EMERG
Clinical Indicators

GIG CYMRU NHS WALES

Ymddiriedolaeth Brifysgol GIG
Gwasanaethau Ambiwlans Cymru

Welsh Ambulance Services
University NHS Trust

Emerg Indicator progress to December 25

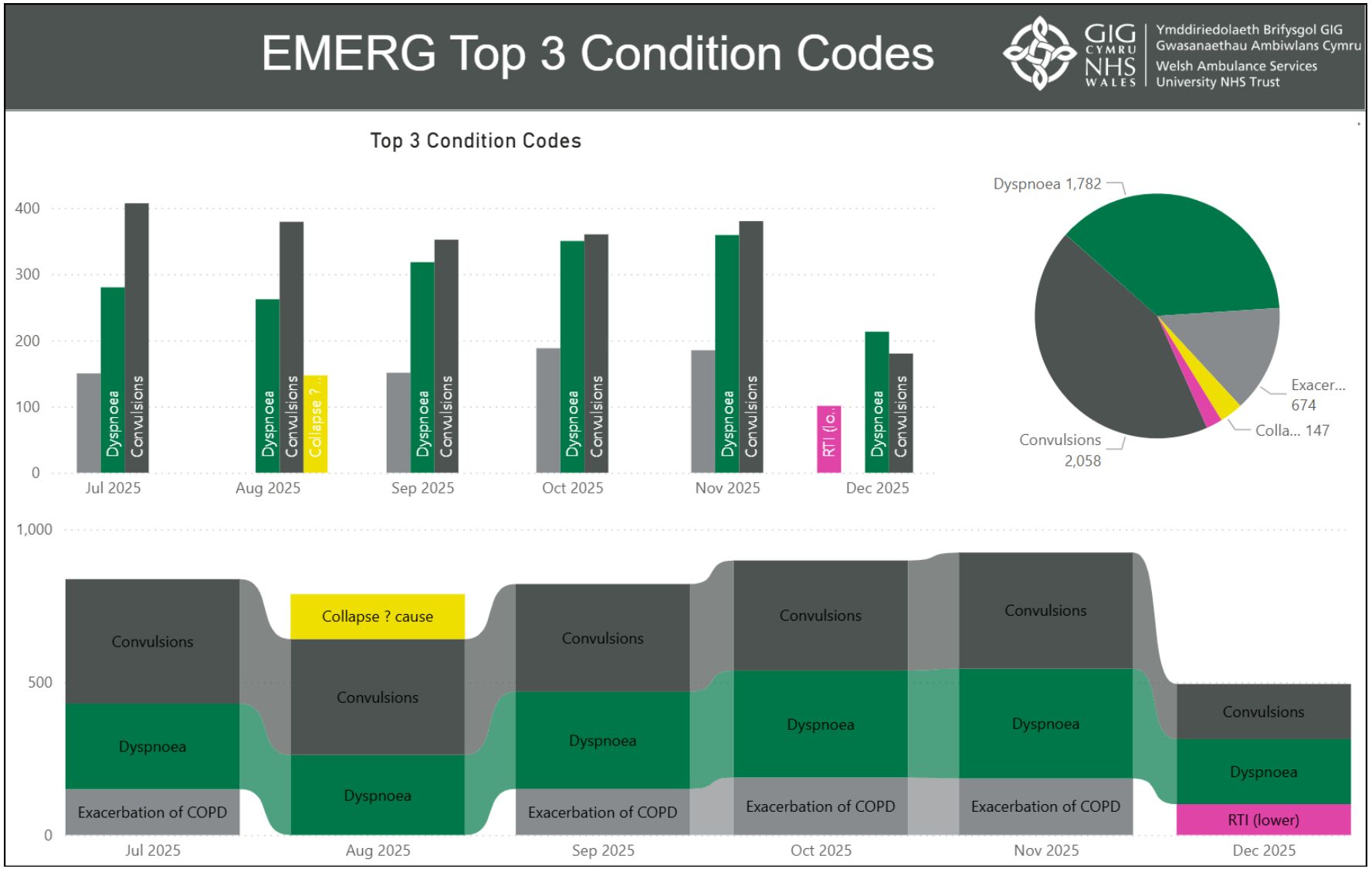
This represents the current progress towards the initial agreed 'Emerg' clinical indicators. Three indicators began publishing September (retrospectively to July) with further indicators to begin reporting from January 26 due to implementation of NEWS2 and the low prevalence of some conditions such as anaphylaxis.

CI	Description	Anticipated complexity	Priority	Tech spec expected by 19/09	Tech spec In Progress	Tech spec Completed	Indicator completed
Generic	Pain Management	2 / 5	2	✓	✓	✓	✓
Generic	Physiological Scoring (NEWS(2))	3 / 5	4	✓	✓	✓	
Generic	Diagnostic Codes	1 / 5	1	✓	✓	✓	✓
Maternity	Observations of newborn	4 / 5	Awaiting ePCR bodykit changes	CIAT not in a position to progress	Proposal for existing Maternity dashboard use (Needs design Spec QA)		
Anaphylaxis	Adrenaline, O_2, IV fluids	3 / 5	5	✓	✓ Automated with 6/12 publishing (@ ?01/26)	✓	✓
Breathing problems	SpO_2 change	2 / 5	3	✓	✓	✓	✓
Major Trauma	Trauma desk consultation Pre-alert, Use of triage tool Conveyance to Major Trauma Centre	5 / 5	Awaiting SME information	CIAT not in a position to progress	Proposal for an annual report		
Convulsions	SME suggestion: Anticonvulsant Tx Observations (esp SPO_2 and BM) Referred to epilepsy pathway Conveyance rates	5 / 5 (No single field to record patient actively fitting)	Need SME input	Inclusion criteria confirmed 17/09	✓	✓	Tech spec sent to IDS on 31/12/2025

Diagnostic Code

This Clinical Indicator illustrates the **'Top Three'** recorded Diagnostic Codes recorded on WAST ePCRs for each month within the Emerg priority.

The Diagnostic Code is the code assigned to the patient record by the attending clinician. This may often differ from the MPDS Code assigned to the incident.



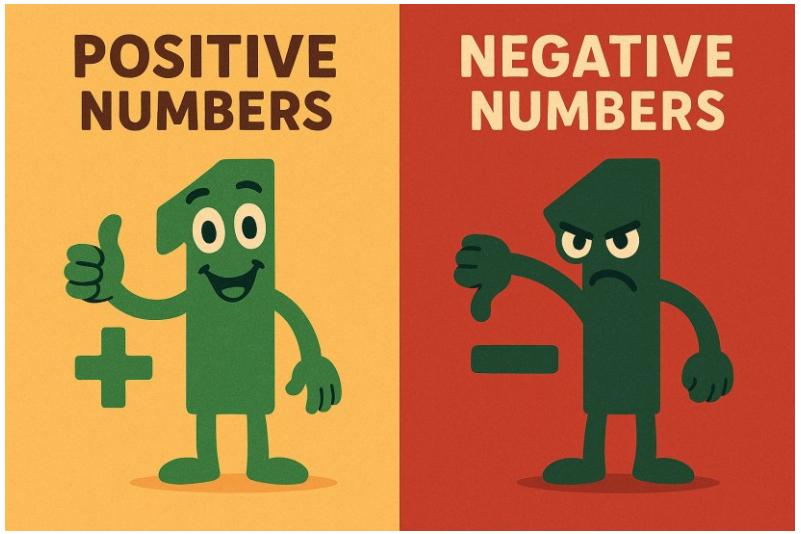
Emerg Indicators that measure “change” across the care episode

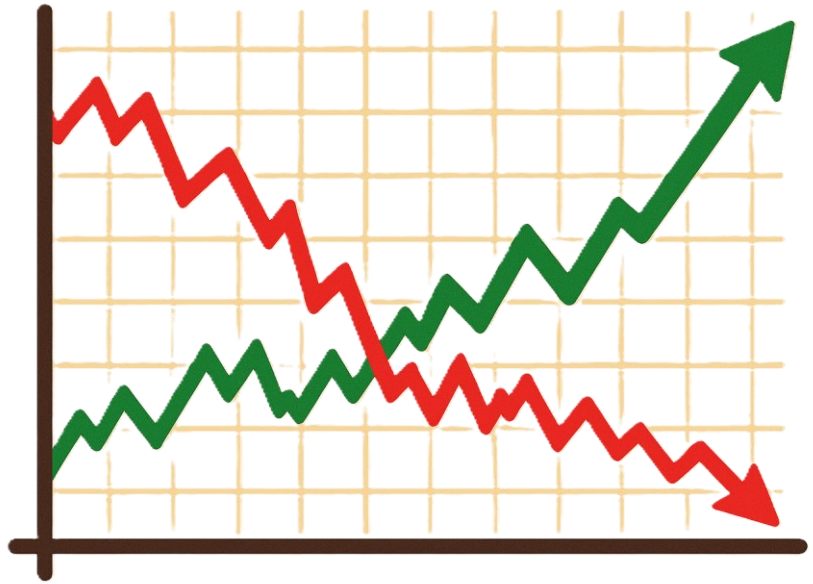
Several of the new indicators report a “change” across a care episode so we can demonstrate an impact of practice delivered by WAST while the patient is in our care.

This was a move away from recognising a prescribed way of care, such as a particular drug or treatment and to shift reporting towards an “outcome” from whatever the clinician has either delivered or assessed for the patient.

In some cases, we are looking to reduce a score, such as pain. In others we are looking to increase or maintain, such as GCS or SPO2.

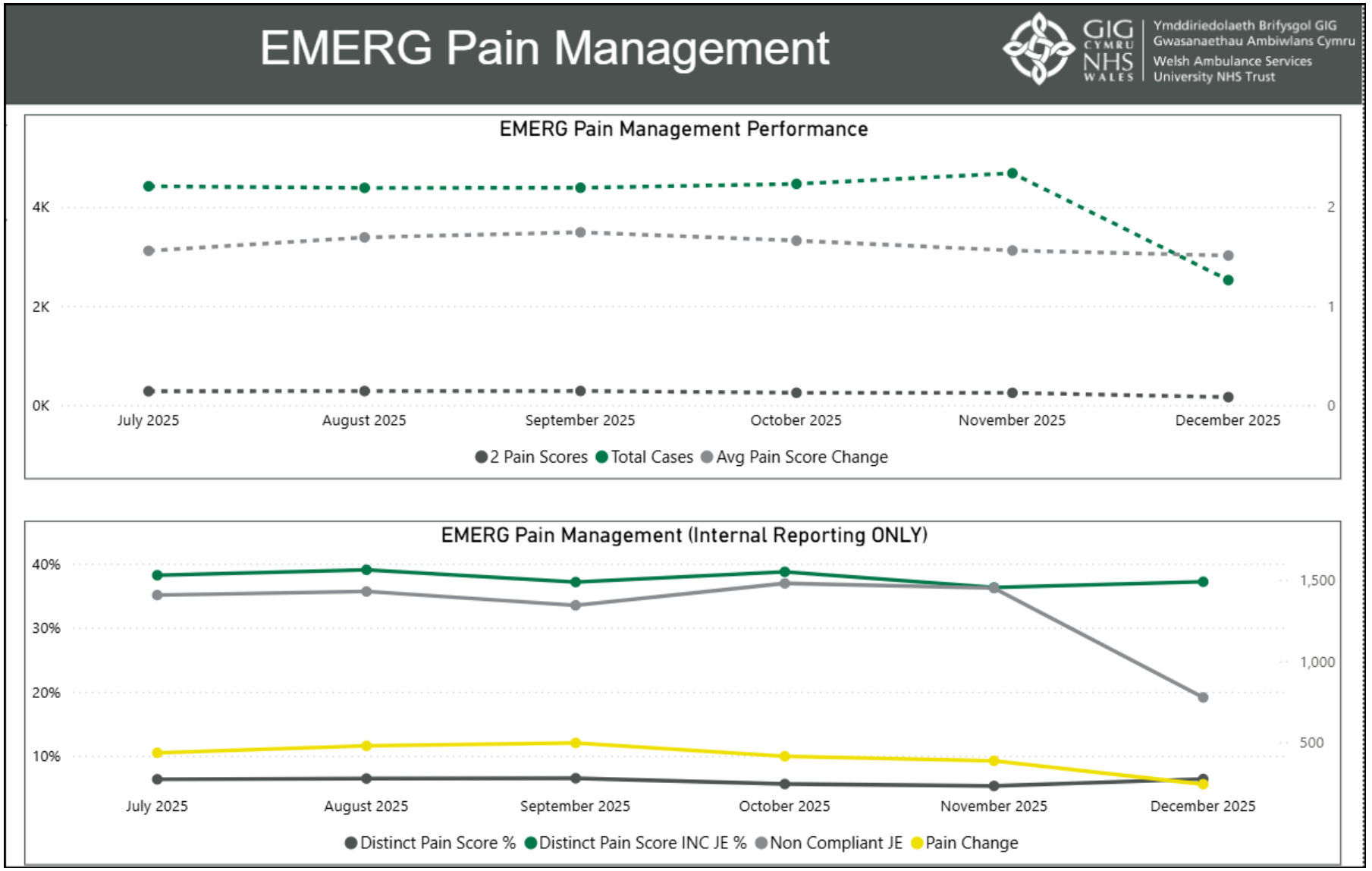
For all reporting of change, a positive number is a positive indicator. So, in respect of pain for example, a **positive** number represents a **decrease** in score.





Pain Score

According to JRCALC guidelines; All patients with pain should have at least two pain scores taken, the first one before treatment and subsequent measurements afterwards. Scoring and systematic assessment increases awareness of pain management, reveals previously unrecognised pain, and improves analgesic administration. There is no gold standard objective measurement of pain severity. It is important to remember that the pain experienced cannot be objectively validated in the same way as other vital signs.
For adults, the Numeric Pain Rating Scale (zero to ten) or the Adjective Response Scale (No Pain, Mild, Moderate or Severe Pain) should be used. The following is generally accepted for the purpose of equivalence: No Pain = 0 Mild Pain = 1-3 Moderate Pain = 4-6 Severe Pain = 7-10
The CI represents, where a patient is in pain, the average reduction in that pain score across the care episode.



Pain management - considerations

Consideration	Scoping	Proposed approach

Case inclusion
• Need ≥ two pain scores / timestamps
  • (and where at least 5 minutes apart)
• Other 'Compliant' cases with JEs have **no** pain score change
	• Most multiple pain score entry records score first Examination-Pain point as highest, or all rated with same pain score
	• So there are not many records with clusters if different pain scores at the start of the Exam-Pain table.
	• **Defensive coding** (to catch other types of behaviours) – would be much more complex, and so will not be used in the first iteration.
		Reporting metric (average of) :-
		• First / last pain score change – cases with ≥ two pain scores, and ≥5 minutes apart
		
		Internal monitoring metrics
		Pain assessment compliance % :-
		  • ≥ two pain scores
		  • where at least 5 minutes apart
		Reported as both
		  • **Raw** (no JEs)
		  • **Standard** (including JEs)

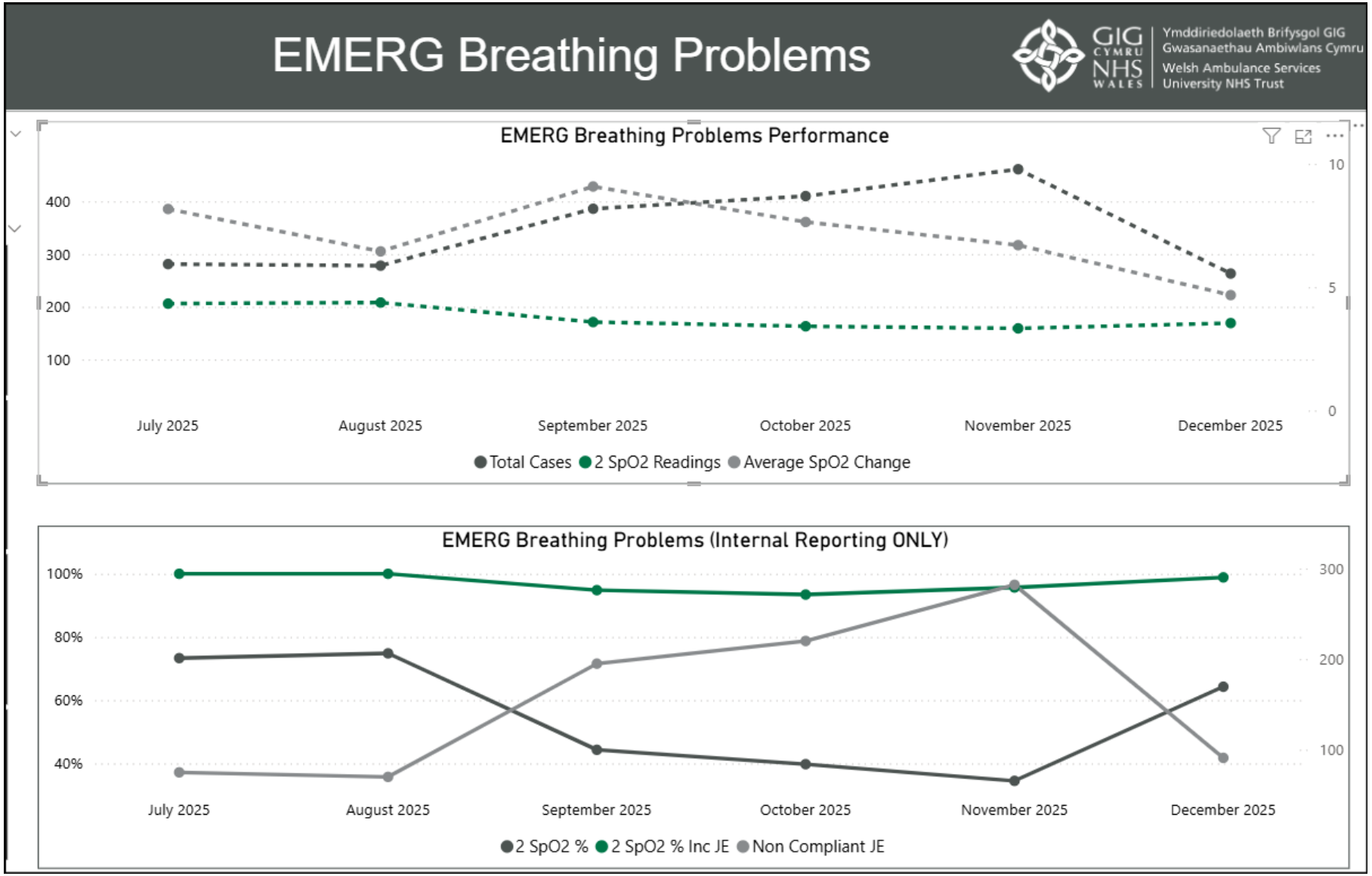
Case inclusion - Is 'pain management' relevant only where analgesia administered ?
Options
• All **analgesia** patients – requires complex tech spec and scripting, and captures < 15% of Emerg patients
  • **Less comprehensive and onerous**
• All **Emerg** patients
  • **Comprehensive and pragmatic**
	@ 06/08/25
	• 5,326 Emerg patients
	  • 721 (of 5,326) had analgesia (**13.5%**)
	  • 240 (of 721) recorded a **Pain after** analgesia (**33.3%**)
		Include all **Emerg** patients

Use of **Pain Comparison Tool** (low numbers) • If first comparison is **'worse'**, score of **10** recorded • If next comparison is '**same**' (as last time asked), score of **5** recorded • Will negatively impact on meaningful results.		Exclude patients using the Pain Comparison Tool

SPO² (Breathing Metrics)

Oxygen saturation is a simple, non-invasive measurement that tells us how much oxygen your red blood cells are carrying, expressed as a percentage. Essentially, it's a way to check if your body is getting enough oxygen to function properly. For a healthy person at sea level, the normal range is typically 94% to 100%. A reading below 90% often signals a condition called hypoxemia (low oxygen in the blood) and may require medical attention. Oxygen saturation is considered a vital sign in medicine because low oxygen levels can quickly harm essential organs like the brain and heart. Measuring oxygen saturations therefore often guides the treatment the ambulance clinician will consider.

This CI reports the average increase in [percentage] points across the care episode where a patient presents in the EMERG category with a condition code reflecting a respiratory presentation.



Breathing problems – SpO_2 change - considerations

Consideration	Scoping	Proposed approach

Case inclusion
• Asthma or COPD section or
• Diagnosis codes:
  • 147 Acute asthma attack
  • 148 Acute epiglottitis
  • 149 Acute Laryngotracheitis
  • 153 Croup
  • 154 Exacerbation of COPD
  • 155 Dyspnoea
  • 158 Hyperventilation
  • 159 Pulmonary Embolism
  • 160 Pulmonary oedema
  • 161 Respiratory arrest
  • 162 RTI (upper)
  • 163 RTI (lower)
  • 165 Tachypnoea
	Data Quality
	• 0.2% of SpO_2 readings are **< 30%**
	
	Reporting Sense check
	• SpO_2 is a percentage, and not directly linear
	• SpO_2 change may be relevant for an individual patient, and is a difference in two percentages, which may be positive or negative.
	• Averaging **SpO2 change** is therefore **averaging percentage** difference (positive or negative) and has no precedent.
	• This may not reflect a clinical meaningful measure.
		Reporting metric (average of) :-
		• First / last SpO_2 – cases with ≥ two SpO_2 scores, and ≥5 minutes apart
		
		Internal monitoring metrics
		SpO_2 compliance % :-
		  • ≥ two SpO_2 scores
		  • where at least 5 minutes apart
		Reported as both
		  • **Raw** (no JEs)
		  • **Standard** (including JEs)

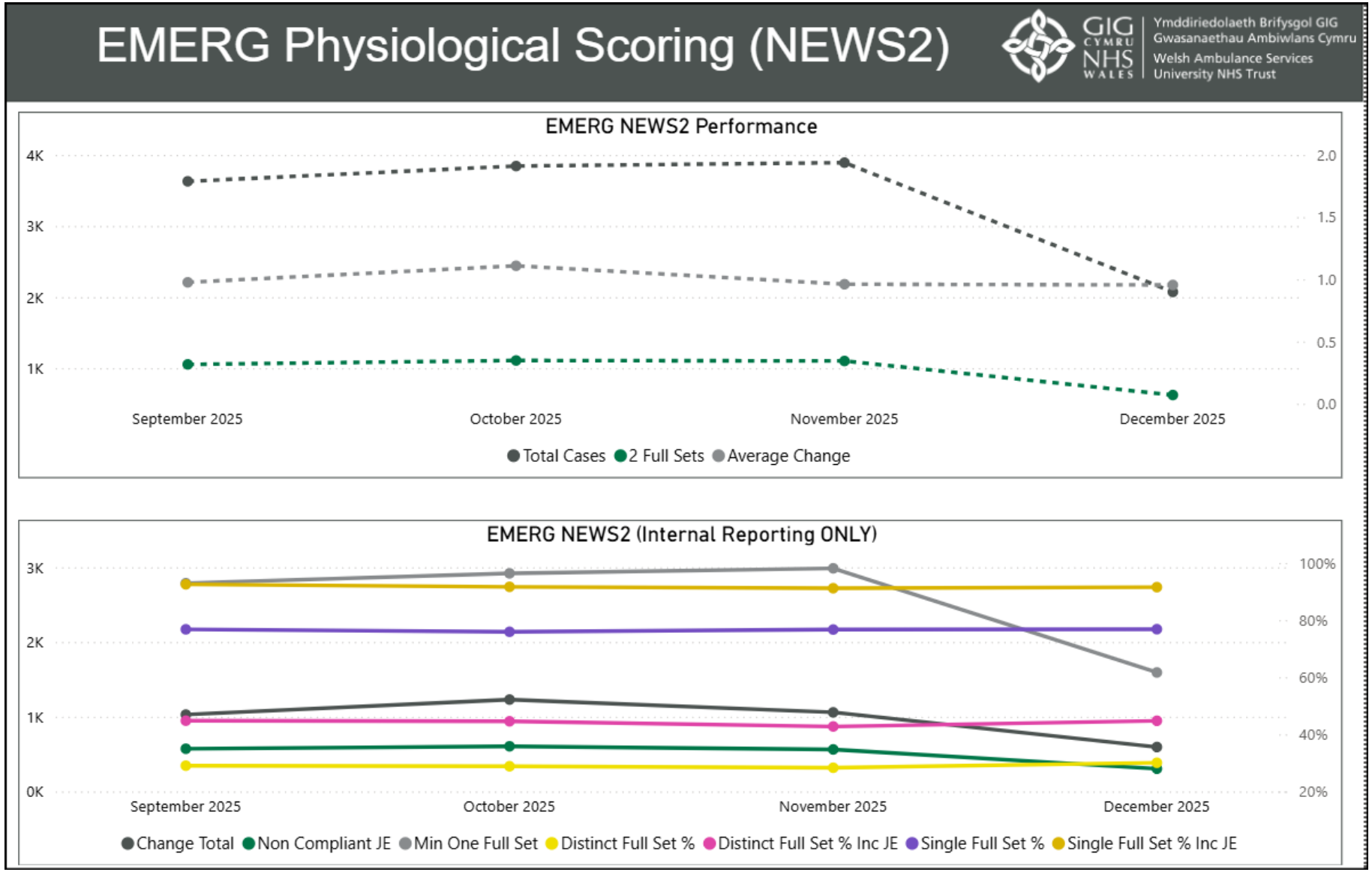
NEWS2 Physiological warning score

The NEWS is based on a simple aggregate scoring system in which a score is allocated to physiological measurements, already recorded in routine practice, when patients present to, or are being monitored in hospital. Six simple physiological parameters form the basis of the scoring system with the addition of an assessment of “confusion”:

respiration rate
oxygen saturation
systolic blood pressure
pulse rate
level of consciousness or new confusion
temperature.

It has been adopted across NHS Wales to detect early signs of patient deterioration—particularly due to sepsis, respiratory failure, or shock.

Score charts and more information can be found on the Royal College of Physicians site here.



NEWS2 - considerations

Consideration	Scoping	Proposed approach

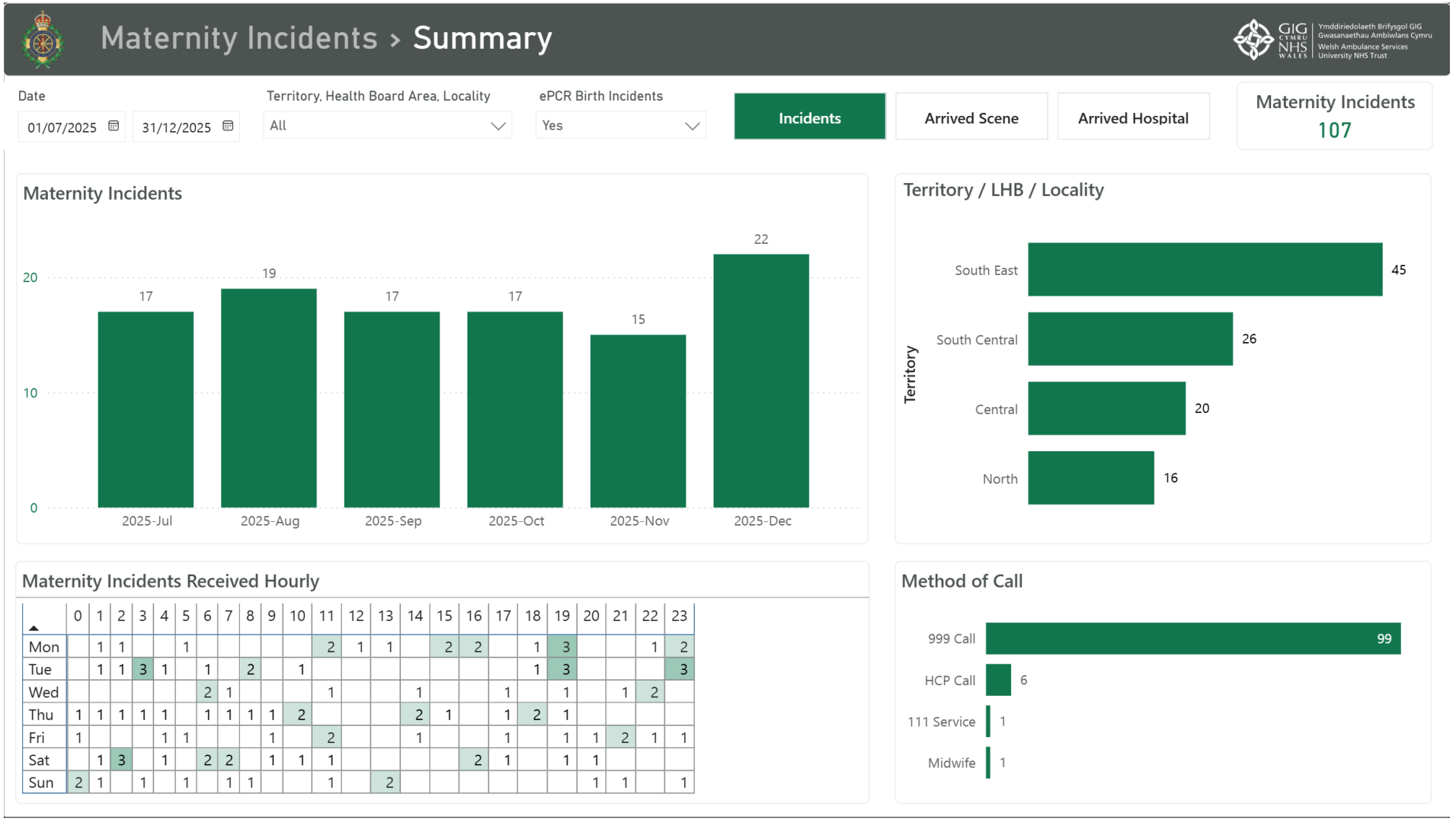
Case inclusion
• Need ≥ two full sets of NEWS2 scores / timestamps
  • (and where at least 5 minutes apart)
• NEWS2 live on 9th September 2025, to date
• **Full NEWS2 total** requires 8 data points and all recorded under same Obs set :-
  • Respirations
  • SpO_2
  • Confirmation of SPO_2 scale to be used
  • Supplemental O_2
  • Systolic BP
  • Pulse
  • ACVPU
  • Temperature
	Temperature recording @ 31/08/25
	• 6.5k Emerg records
	• Only 2.5k had two temperature readings.
	• At best (if every temp is part of a full set of Obs) – NEWS2 indicator will only report for ~ **40%** of the category until user behaviour improves.
	• Temperature recorded as a new Observation, with same timestamp as an otherwise full set, will **not** generate a full NEWS2 score.
	• Recent temperature being included in new set of Obs – being considered by supplier (would require global change across all customers)
	
	SpO2 scale 2 use @ 12/09/25
	• 330 scores entered (133 patients)
	• Average of 2.5 scores per patients
	
	Observation / NEWS2 data quality
	• Observations are not always recorded in the correct fields e.g. **Resp rate = 36.9**.
	• A quick data quality check of a selection of cases highlighted this is <u>both</u> user and system behaviour
	• Tightening of data field limits and system debugging has improved this.
		Justified Exceptions:
		• Where EMRTS / Doctor on scene (and patients do not have two distinct NEWS2 scores)
		• These will remain in the denominator for NEWS2 change.
		
		Defensive coding for unusual / edge cases – would be much more complex, and so will not be used in the first iteration.
		
		Reporting metric (average of) :-
		• First / last full NEWS2 score change – i.e. cases with ≥ two NEWS2 scores, and ≥5 minutes apart
		
		Internal monitoring metrics
		NEWS2 compliance % :-
		  • ≥ **two** full NEWS2 scores
		  • where at least 5 minutes apart
		NEWS2 compliance % :-
		  • ≥ **one** full NEWS2 scores
		Reported as both
		  • **Raw** (no JEs)
		  • **Standard** (including JEs)

Maternity

Although maternity related incidents can receive different priority outcomes dependant on the call type, those identifying as likely imminent birth or patients with high risk of complications are included in the “Emergency” priority categorisation.

77 of the 107 ePCR birth incidents in the timeframe opposite were in the “Emergency” priority category.

The Trust already reports internally through a dashboard developed by Consultant Paramedic and the Specialist Clinician (Maternity) which focuses down to birth incidents.

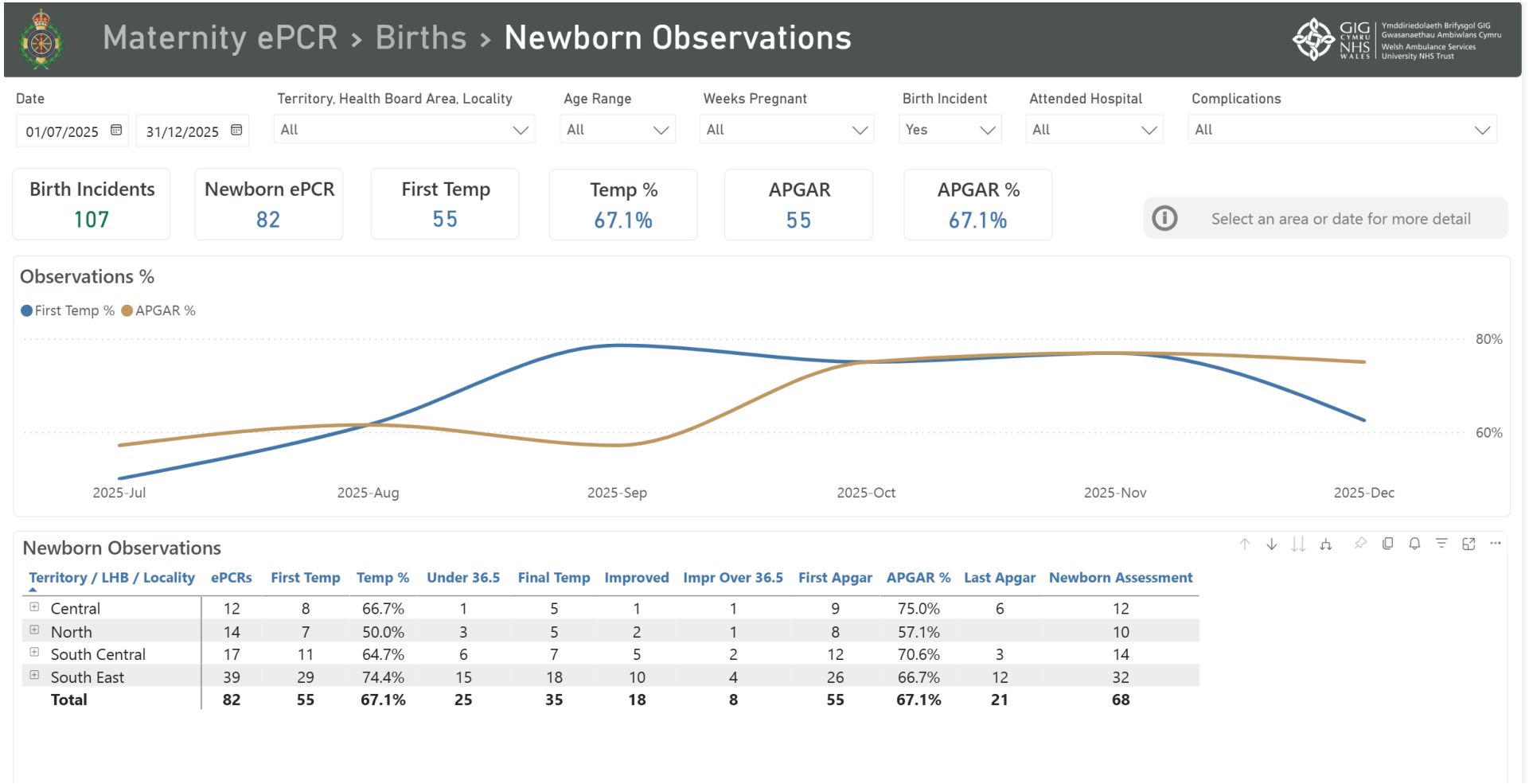


Maternity

The initial suggestion from subject matter experts as to the subject of a maternity indicator was to focus on newborn assessment to include temperature management and AGPAR score.

Although JRCALC removed the AGPAR score as a lone assessment score for newborns it remains within the ePCR function in WAST but moving forwards consideration is being given to the adoption of nationally agreed scores for specific patient groups.

Prior to external publication the team need to complete another QA and data validation prior to sharing externally.



Territory / LHB / Locality	ePCRs	First Temp	Temp %	Under 36.5	Final Temp	Improved	Impr Over 36.5	First Apgar	APGAR %	Last Apgar	Newborn Assessment
Central	12	8	66.7%	1	5	1	1	9	75.0%	6	12
North	14	7	50.0%	3	5	2	1	8	57.1%		10
South Central	17	11	64.7%	6	7	5	2	12	70.6%	3	14
South East	39	29	74.4%	15	18	10	4	26	66.7%	12	32
Total	**82**	**55**	**67.1%**	**25**	**35**	**18**	**8**	**55**	**67.1%**	**21**	**68**

Thank you for listening

Agenda Item No.	12

REPORT TITLE

Internal Audit Report: Clinical Equipment
Feedback from the Audit Risk and Assurance Committee (ARAC)

MEETING

Name of meeting	Quality Patient Experience and Safety Committee (QuEST)
Date of meeting	3 February 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. The Audit Risk and Assurance Committee (ARAC) received and discussed the **Clinical Equipment Internal Audit Report** at its meeting on 2 December 2025. This report summarises the discussion from this meeting in reference to this report. The assurance opinion given was 'reasonable'.

2. ARAC Members were assured that the audit found significant improvement since the 2019 review. One high and three medium priority findings were identified, mainly around policy clarity, inventory management and maintenance records. The lack of a centralised inventory and inconsistent maintenance documentation, especially for defibrillators, were highlighted as ongoing issues.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The Quality Patient Experience and Safety Committee (QuEST) is requested to receive and take assurance from the Clinical Equipment Internal Audit and note and from the discussion at the meeting of the Audit, Risk and Assurance Committee on 2 December 2025.

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 Equipment 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
2 December 2025	Audit, Risk and Assurance Committee
3 February 2026	Quality Patient Experience and Safety Committee

Clinical Equipment

Final Internal Audit Report

2025/26

Welsh Ambulance Service University NHS Trust

Reasonable Assurance

Contents

Review Reference	WAS-2526-05
Fieldwork	July 2025 - September 2025
Executive Sign Off	5 November 2025
Audit Committee	2 December 2025
Executive Lead	Andy Swinburn, Executive 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 evaluate the effectiveness of the arrangements put in place to record, monitor and replace clinical equipment within the Trust.

Overview

A medical device or item of clinical equipment is defined as any apparatus, appliance, software, material or other article, whether used alone or in combination, intended by the manufacturer to be used for a medical purpose. A systematic approach to the acquisition, deployment, maintenance (preventative and performance assurance), repair and disposal of such equipment, alongside appropriate training, is essential to ensure safe, competent and effective use in patient care, and maintain compliance with relevant legislation and guidance.

This review focussed on portable clinical equipment used in patient care and transport. Equipment permanently integrated into vehicle configurations (e.g. stretchers and spinal boards) is managed by the Fleet department in line with the vehicle's seven-year lifecycle and was therefore excluded from the scope of this review. The acquisition, deployment, maintenance and disposal of vehicles was not considered at this review. Further, due to the specialist nature of their equipment, the Hazardous Area Response Team (HART) was also excluded from this review.

We have previously considered clinical equipment at the Trust, and it being safe and effective at the point of use, in the Appropriately Equipped Paramedics report (WAST 1920-16, issued November 2019, limited assurance). It is pleasing to report that significant improvements have been noted in relation to the health and safety concerns that were raised (see objective 4) as well as improvements regarding acceptance testing and the maintenance records held. At this review, we have concluded **reasonable** assurance and the matters require management attention include:

- Policies and Procedures – key gaps were identified in the Medical Devices Policy and associated procedures, including unclear maintenance requirements, reference to a non-existent standardisation policy, and an overdue review of the Disposal Procedure.
- Inventory Listing – the Trust has not implemented the previously agreed recommendation to introduce Radio Frequency Identification (RFID), or as an interim measure, a single centralised clinical equipment list. The absence of an conclusive inventory list was noted to have a wider impact on other objectives, particularly those related to maintenance planning, asset lifecycle management and disposals.
- Equipment Maintenance – maintenance records for clinical equipment remain inconsistent, with gaps in service history, age profiling, and location tracking, particularly for defibrillators, despite improvements since previous audits.
- Datix Reporting – as previously reported incident reporting via Datix is limited at the Clinical Equipment Working Group, reducing visibility of equipment-related issues.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	The Trust has appropriate policies and procedures in place for the management of clinical equipment, which clearly outline the required roles and responsibilities.	1	**Reasonable**
2	The Trust has a recommended list of clinical equipment from which staff are required to order from.	-	**Reasonable**
3	There is an inventory listing of clinical equipment which is regularly maintained and reviewed.	2	**Limited**
4	Clinical equipment is maintained and kept in an appropriate state of repair; and stored in a safe and secure location when not in use.	3	**Reasonable**

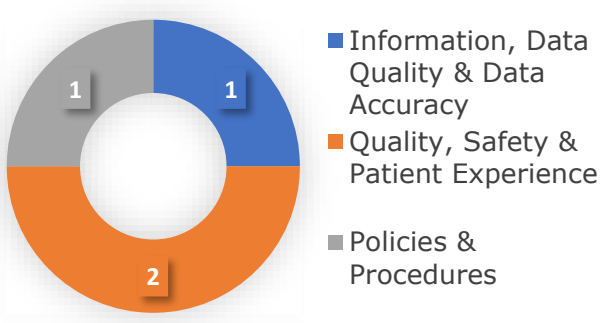
5	Staff receive appropriate training before using medical equipment and devices.	-	**Reasonable**
6	Clinical equipment is appropriately disposed of at the end of their useful life and replaced appropriately.	1	**Reasonable**
7	All incidents, defects and faults relating to clinical equipment are recorded on the Datix incident reporting system; and this information is used to inform future purchasing decisions.	4	**Reasonable**

Management Actions

1
High Priority

3
Medium Priority

Themes



Risk Types

Quality or Safety Issues

Findings & Agreed Action Plan

Objective 1: The Trust has appropriate policies and procedures in place for the management of clinical equipment, which clearly outline the required roles and responsibilities.	**Reasonable**

The Trust has the 'Management of Medical Devices' policy in place, which sets out the procedures and responsibilities necessary to ensure the safe, effective and compliant use of clinical equipment across the organisation. Key elements of the policy include:

- Governance Structure – roles and responsibilities are defined for the Chief Executive Officer, Executive Directors, Head of Clinical Logistics, Service Managers and Line Managers.
- Device lifecycle management – guidance on device evaluation, acceptance testing, servicing and replacement; and medical devices inventory and record system (see objective 3).
- Training and Implementation – requirements for user training and safe operational practices.
- Reporting Mechanisms – processes for fault reporting, incident logging and escalation.
- Clinical Equipment Working Group –a brief outline of its remit and reporting lines.

The policy followed the required governance process and was ratified by the Quality, Patient Experience and Safety Committee (QuEST) in August 2024 before publication on the Trust's SharePoint site (Siren). It is led by the Head of Clinical Logistics and overseen by the Executive Director of Paramedicine, with the next review scheduled for August 2027.

Review of the policy noted that it states *equipment purchases should follow a 'standardisation policy'*; however, we were informed that no such policy currently exists. This presents an opportunity to enhance the document by either developing a standardisation policy or revising the reference to reflect current practice (see **Key Finding 1**).

In addition to the policy, is the Trust maintains a dedicated Clinical Equipment section on Siren, which includes user guides for the various devices, such as Mangar lifting cushions.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Gaps in Medical Devices Policy and Associated Procedures** A review of the Management of Medical Devices Policy identified a reference to an equipment 'standardisation policy'; however, it was confirmed that no such policy currently exists within the Trust. It was also noted that the policy does not specify which items of clinical equipment require regular maintenance.	Missing and outdated guidance may result in inconsistent equipment management, safety risks, and	**Agreed Action:** • Update the Management of Medical Devices Policy to ensure it reflects current practice within the Trust, including: clarifying the scope, frequency and responsible parties for equipment maintenance by means of an appendix; and amending the reference to an equipment standardisation policy to clarify the standardisation process managed by clinical equipment working group.

Key Findings	Risk & Impact	Agreed Management Action
Additionally, the Disposal Procedure (see objective 6) is overdue for review, with its last scheduled update dated September 2023.	regulatory non-compliance.	• Conduct a formal review of the Disposal Procedure and update as necessary to ensure alignment with current operational and regulatory requirements. **Expected Evidence of Implementation:** • Management of Medical Devices Policy: Evidence of policy review and updated document for approval by Policy Group • Disposal Procedure: Evidence of procedure review and, if applicable, updated and approved document.
	Medium Priority	**Officer:** Jonathan Wilson, Head of Clinical Logistics / Jason Collins, Head of Financial Management
Theme: Policies & Procedures	Control Design	**Target Implementation Date:** 31 March 2026

Objective 2: The Trust has a recommended list of clinical equipment from which staff are required to order from.	**Reasonable**

Recommended List of Equipment

A list of standard consumables and clinical equipment is maintained within the Trust, developed in line with guidance published by the Joint Royal Colleges Ambulance Liaison Committee (JRCALC). These lists specify recommended products, suppliers, order codes, and quantities issued. Amendments to the list are approved at the Clinical Equipment Working Group (CEWG), with evidence of review and approval noted at five meetings held during 2024/25 and 2025/26 to date .

In addition to the overarching list, the Logistics Hub (the hub) maintains tailored equipment lists for each vehicle configuration within the Trust, including Emergency Ambulances, Rapid Response and Non-Emergency Patient Transport. All lists are accessible via the Clinical Equipment section on Siren.

The Head of Clinical Logistics oversees purchases of clinical equipment, with all procurement routed through NHS Wales Shared Services Partnership (NWSSP) Procurement Services. We were informed that any purchase requests initiated outside this process are referred to the Head of Clinical Logistics for approval prior to authorisation.

New Equipment

Selection and procurement of new equipment are made in line with current JRCALC clinical guidelines to ensure alignment with service needs and compatibility with existing assets. The absence of an asset register limits the ability to verify that new equipment is being replaced in accordance with expected lifecycle standards (see **Key Findings 2 and 3**). We evidenced SBAR reports submitted to the CEWG for proposed new equipment, including the NeoMate (a paediatric restraint system), Posey Wrap (for fastening flexible transducers and probe sensors onto patients), and Compact Power Chair), all of which were approved for recommendation to the Ambulance Practice Steering Group.

The CEWG, a workstream of the Ambulance Practice Steering Group, meets quarterly and is responsible for reviewing new equipment proposals, supply chain issues, updates to the consumables and accessories lists; and device-related concerns (see objective 7 for further detail). Proposals are assessed against a range of criteria, including:

- Initial purchase cost (via NWSSP Procurement)
- Ongoing revenue implication, including costs and savings
- Servicing arrangements and associated costs
- Installation requirements
- Training needs and costs
- The cost and availability of consumables and spare parts
- Warranty coverage and cost
- Sustainability and waste considerations

Staff may also submit a ‘Clinical Equipment Proposal Form’ to formally suggest new equipment based on perceived benefits to staff and/or patients, including examples from other Ambulance services. While submissions are infrequent, one example was noted in the July 2024 CEWG meeting, where the introduction of SAM Splints into solo responder Rapid Response Vehicles was proposed and subsequently approved.

Objective 3: There is an inventory listing of clinical equipment which is regularly maintained and reviewed.	**Limited**

Section 6.6 of the Medical Devices Policy (see objective 1) states that *the Clinical Logistics Hub will maintain a comprehensive inventory of all medical devices that have been commissioned via the clinical logistics hub, which includes detailed service history information. This also includes information on items of equipment placed on External Service Contract with outside contractors. A Trust approved contractor may hold this information on the Trust's behalf with an appropriate monitoring system of compliance.*

The '*Appropriately Equipped Paramedics*' internal audit review (WAST-1920-16), highlighted the absence of a single, centralised register of clinical equipment within the Trust. At the time only a defibrillator database maintained by the supplier and accessible via a web portal, was in place. In response, management advised that a business case for an electronic tracking system was being developed, with recognition that significant resources would be required to support equipment identification and tagging.

Review of the internal audit recommendation tracker noted that this recommendation has been marked as closed, citing progress towards implementing a Radio Frequency Identification (RFID) inventory solution for high value clinical equipment. In the interim, electronic records were reportedly developed, including a list of high value items stored at the Hub. However, we were unable to verify the existence or operational use of either control during our review (see **Key Finding 2**).

The Head of Clinical Logistics advised that the Trust is in the early stages of implementing a tagging system for high-value items such as defibrillators, stretchers, carry chairs, and drug boxes (primarily to secure contents rather than the containers themselves). However, no formal timeline for implementation has been established.

Progress has been made at the Hub, where individual equipment lists are maintained for specific items including the Mangar lifting cushions, LUCAS devices (to provide mechanical chest compressions to patients in cardiac arrest), suction units and defibrillators. These lists include identifiable details such as serial numbers and the locality where each device is currently held. However, due to frequent movement between vehicles, precise tracking of equipment location remains challenging. Devices are expected to remain associated with their original issuing station, though this is not always reliably maintained.

A review of the defibrillator database identified 10 units currently marked as 'location unknown', which are considered missing (see **Key Finding 2**.)

Key Findings		Risk & Impact	Agreed Management Action
2	**Lack of Centralised Clinical Equipment Inventory** 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. The last 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 lack of a centralised clinical equipment inventory reduces visibility of assets, hindering effective tracking, maintenance and replacement planning. This may lead to equipment related risks, inefficiencies, and missed opportunities for strategic decision making.	**Agreed Action 1:** • Reassess the suitability of RFID to assist in centralised asset management of clinical equipment; • Develop and maintain a Trust-wide centralised database for clinical equipment. Details to include equipment type and location, condition, maintenance schedule, expected lifecycle; and replacement planning. • Consolidate individual databases (Defibrillators, Mangar Cushion, LUCAS devices, suction units) into the centralised system. **Agreed Action 2:** • Implement an Asset Management Software system (such as eQuip) ahead of Scan for Safety Wales.
			Expected Evidence of Implementation 1: • Evaluation of suitability of RFID system against asset management criteria • Populated and active centralised database for all clinical equipment **Expected Evidence of Implementation 2:** • Evidence of an implemented Asset Management Software System.
		High Priority	**Officer:** Jonathan Wilson, Head of Clinical Logistics / Aled Williams, Assistant Director of Digital **Target Implementation Date:** (1) 31 January 2026; (2) 30 June 2026
	Theme: Information, Data Quality & Data Accuracy	Control Design	

Objective 4: Clinical equipment is maintained and kept in an appropriate state of repair; and stored in a safe and secure location when not in use.	**Reasonable**

Acceptance Testing

The Management of Medical Devices Policy requires all new equipment to undergo acceptance testing at the Hub before use, in line with the Provision and Use of Work Equipment Regulations 1998 (PUWER). Testing is supported by standardised forms and instructional videos. Failed items are returned to the manufacturer for replacement. Once testing is complete, equipment testing results are added onto the Trust's database (Dynamic system). A secondary test is conducted before deployment to account for delays between initial testing and issue. Batteries are disconnected during storage to preserve charge, with periodic checks scheduled and spare batteries held on-site for contingency purposes. These processes represent an improvement compared to the findings of our previous internal audit in this area.

Maintenance

Servicing is carried out either in-house at the Hub or via external contracts, with records maintained by both the Trust and contracted providers; again, an improvement compared to the findings of our previous internal audit The current policy does not specify which items require regular maintenance (see **Key Finding 1**). The arrangements for the following items were considered during audit fieldwork:

- **Mangar Lifting Cushions**: These are serviced in-house on a rotational schedule by locality. The Hub coordinates exchanges, verifies serial numbers (reporting any missing items), and logs outcomes using standard forms, including pass/fail status and parts replaced. Our review of the maintenance records provided during the audit confirmed that all items were within their valid inspection or service dates. An age profile database is also maintained to support timely replacement planning.
- **Defibrillators**: These are serviced externally, with monthly reports from the supplier detailing upcoming service dates. Servicing is arranged based on the station of original issue, based on the assumption that while devices may move between vehicles, they remain linked to their issuing station. Replacement units are sent to stations to facilitate the return of those due for servicing. A review of the August 2025 supplier report showed 59 of 550 units were overdue for servicing. The report does not include age profiling (see **Key Finding 3**).
- **Lucas Devices**: These items are serviced externally, with service history and upcoming service dates recorded in a database accessible to the Trust. Our review of the database confirmed that all items were currently within their valid service periods.

Storage

Opened in 2020, the Caerphilly Clinical Logistics Hub provides secure, climate-controlled storage with restricted access and capacity for up to 490 pallets. Compared to the previous Hensol facility, the new purpose-built hub offers improved conditions for equipment, PPE and uniforms. A visit to the Caerphilly Logistics Hub identified that the equipment was stored safely and securely whilst awaiting placement.

Equipment in the field is mainly stored on Trust vehicles, with limited spares held at ambulance stations for urgent replacements. A site visit to Cwmbwrla station confirmed secure practices, including locked storage areas and designated zones for faulty equipment awaiting return.

The Trust has effectively addressed the health and safety concerns identified during our previous internal audit. Furthermore, our recent site visits did not reveal any additional areas of concern.

Key Findings		Risk & Impact	Agreed Management Action
3	**Inconsistent Maintenance Records** Servicing of clinical equipment is carried out either in-house or via external contracts, with records maintained by both the Trust and suppliers—an improvement from previous audit findings. However, gaps remain: • Defibrillators: Serviced externally, with monthly reports listing only upcoming service dates. The August 2025 report showed 59 of 550 units (11%) overdue for servicing. The report lacks service history and age profiling, limiting oversight of lifecycle status. • Mangar Lifting Cushions: Serviced in-house on a rotational schedule. Records reviewed during the audit confirmed all items were within valid service dates. An age profile database is maintained to support replacement planning. • Lucas Devices: Serviced externally, with service history and upcoming dates recorded in a Trust-accessible database. All items were within valid service periods at the time of review. The current policy does not specify which equipment requires regular maintenance (see Key Finding 1), and 10 defibrillators were listed with 'unknown' locations, indicating potential loss or tracking issues.	Equipment is not serviced regularly to ensure it is fit for purpose and is therefore more likely to fail, potentially compromising patient safety and clinical effectiveness.	**Agreed Action:** • Improve maintenance records to ensure service reports include both historical and upcoming service dates. • Investigate the defibrillators overdue for servicing and ensure prompt scheduling • Include details of equipment age and expected lifecycle within the centralised database to support replacement planning (see **key finding 2**). • Clarify maintenance requirements to specify which items require regular servicing and by whom (see **key finding 1**). • Investigate missing equipment and strengthen location tracking controls (see **key finding 2**). **Expected Evidence of Implementation:** • Updated service reports showing both historical and upcoming service dates. • Confirmation that overdue units have been serviced or scheduled, with supporting records. • Database entries showing equipment age and expected lifecycle details. • Revised Medical Devices Policy specifying maintenance requirements and responsible parties. • Updated inventory records resolving 'unknown' locations and documentation of tracking enhancements.
		Medium Priority	**Officer:** Jonathan Wilson, Head of Clinical Logistics **Target Implementation Date:** 28 February 2026
	Theme: Quality, Safety & Patient Experience	Control Operation	

Objective 5: Staff receive appropriate training before using medical equipment and devices.	**Reasonable**

Operational staff receive training relevant to their respective roles, including the use of clinical equipment.

The approach to training varies depending on whether the equipment is entirely new or a modification of existing tools. Delivery methods include clinical bulletins, Mandatory In-Service Training (MIST) days, e-learning modules; and local instruction by clinical team leaders or operational tutors.

Recent examples include:

- Ferno NeoMate: A paediatric restraint system designed to safely and securely transport infants and young children on ambulance cots. To support its rollout, a clinical bulletin was issued to inform staff and a dedicated e-learning module was made available on Learn 365.
- PAX Carry Sheet: A lightweight and versatile rescue aid procured for every emergency vehicle across the Trust following recommendations from the Manchester Arena Inquiry. Training was incorporated into the 'Safer Handling' session of the 2024/25 MIST days via a PowerPoint slide.

Through our audit of MIST (WAS-2526-17) we have raised findings regarding routine attendance at the scheduled days; and have not sought to replicate at this report.

Objective 6: Clinical equipment is appropriately disposed of at the end of their useful life and replaced appropriately.	**Reasonable**

The Trust has a standard operating procedure for the disposal of both clinical and non-clinical equipment, ensuring compliance with relevant legislation, including the Environmental Protection Act, Waste (England & Wales) Regulations 2011, Hazardous Waste Regulations 2005; and the Control of Substances Hazardous to Health Act (COSHH). The expected useful economic life of clinical equipment is seven years.

The guidance details disposal routes and methods (general waste, contractor collection, manufacturer returns, and auction) and includes a comprehensive item list and departmental contacts. Although issued in September 2022 with an annual review cycle, the procedure is now overdue for review (see **Key Finding 1**).

As highlighted in our Appropriately Equipped Paramedics review (WAST-1920-16), the Trust does not have an asset replacement programme in place. In the absence of a comprehensive equipment inventory (see **Key Finding 2**), there is a risk of unnecessary expenditure due to premature replacement—particularly for vehicle-installed equipment, which is expected to last the full vehicle lifecycle (approximately seven years).

Disposal Log

The Hub maintains a monthly disposal log capturing equipment details, reason for disposal, evidence of damage or negligence, disposal date, and the authorising officer. A sample review of ten items (four Mangar cushions and six suction units) confirmed appropriate logging and disposal following maintenance failure.

Income Maximisation

The Head of Clinical Logistics recently amended the disposal route for decommissioned Corpuls defibrillators due to reduced auction value and demand. An SBAR submitted to, and approved by, the Executive Director of Finance & Corporate Services supported a supplier buy-back arrangement for the decommissioned items. This generated £93k for 35 units, exceeding the auctioneer's reserve price and providing a consistent income stream.

Objective 7: All incidents, defects and faults relating to clinical equipment are recorded on the Datix incident reporting system; and this information is used to inform future purchasing decisions.	**Reasonable**

Incidents, defects or faults relating to clinical equipment should be reported via the Datix incident reporting system. However, during fieldwork, we were not provided with a report to support that this process is consistently followed. A review of the CEWG papers and associated AAA reports failed to identify regular reporting on Datix incidents (see **Key Finding 4**). That said, we did note that a recent presentation was given to the group prompted by an increase in Datix entries related to failures of the Optical Airtraq (a disposable optical laryngoscope). The presentation outlined that the Trust sought advice from the manufacturer as well as undertaking their own testing, with conclusions and possible solutions recommended to the CEWG for discussion. It is anticipated that any such issues will help inform future purchasing decisions – there was no evidence available that suggested otherwise

Issues with equipment will typically be identified through safety notices or field summary notices issued by the NWSSP Procurement Team. These are sent to the Head of Clinical Logistics via the Clinical Logistics central email address and subsequently disseminated across the organisation with appropriate actions outlined. For example, in June 2025, a recall notice was issued for Intersurgical Guedel Airways OPAs (which maintain an airway in unconscious patients by lifting the tongue). The Hub responded by circulating the notice organisation-wide, along with guidance on returning the affected items to the Hub for onward return to the supplier.

	Key Findings	Risk & Impact	Agreed Management Action
4	**Limited Use of Equipment-Related Incident Data** A review of the minutes and papers for the Clinical Equipment Working Group (CEWG) identified occasional references to equipment-related incidents, typically as part of wider discussions on specific items. For example, a presentation was delivered to the group in response to an increase in Datix reports concerning failures of the Optical Airtraq device. However, Datix reports relating to equipment-related incidents are not routinely received or reviewed by the CEWG. This limits the group's ability to systematically monitor trends, identify recurring issues, and use incident data to inform decision-making around equipment management and procurement.	The absence of routine review of Datix equipment incidents by the CEWG may result in missed trends, delayed responses to recurring issues, and less informed decisions on equipment procurement and safety.	**Agreed Action:** • Ensure Datix reports related to equipment incidents are routinely submitted to and reviewed by the CEWG. • Add a standing agenda item to CEWG meeting agendas for reviewing equipment-related incidents. • To facilitate trend analysis and strategic planning, implement a dashboard/summary tracker of equipment related Datix reports highlighting frequency of incidents, types of equipment involved, severity and outcomes; and actions taken. **Expected Evidence of Implementation:** • CEWG meeting agendas, papers and associated actions/minutes. • Tracker of equipment-related Datix reports
		Medium Priority	**Officer:** Jonathan Wilson, Head of Clinical Logistics **Target Implementation Date:** 31 December 2025
	Theme: Quality, Safety & Patient Experience	Control Design	

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, Risk & Assurance 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 Service 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 Service 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]

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

Agenda Item No. 13

REPORT TITLE

Strategic Quality Plan 2025 - 2028 Quarterly Update

MEETING

Name of meeting	Quality, Patient Experience & Safety Committee
Date of meeting	3 February 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Liam Williams, Executive Director of Quality & 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. This paper provides a quarterly update on activity taken to date to deliver the objectives of the Strategic Quality Plan 2025-28. The update provides a review of progress, challenges and assurance status for the Quality, Patient Experience and Safety (QuESt) Committee.

2. The Plan's implementation is largely on track with 5% of tasks being completed and high priority tasks progressing well which provides assurance that the plans objectives are being actively pursued.

3. A small number of tasks have had their timelines deferred or extended, mainly due to capacity constraints, ongoing organisational changes or the need to consider alignment with new legislative requirements. Despite these delays all tasks remain within the overall strategic timeline and mitigating actions are in place.

4. The Trust has made notable strides in embedding cultural and leadership initiatives designed to address diversity, equity and compassionate care fostering a culture of continuous improvement and psychological safety.

5. The adoption of new Tools and Frameworks is supporting the development of quality management systems and the evaluation of improvement initiatives with the Quality Hub on Siren SharePoint, providing a centralised structure for resources and guidance to staff.

6. Challenges are identified particularly around the limitation of system-wide data sharing, particularly with external agencies and the impact this has on the achievement of several initiatives within the Strategic Plan.

7. Introduction and implementation of new statutory requirements such as the update Listening to People Regulations and the pending introduction of Health Impact Assessments creates a risk of inefficiency and misalignment of activity, particularly where Statutory Guidance is yet to be released.

8. Organisational Change Processes and limited team capacity have impacted the delivery of some tasks with timelines reviewed and updated.

9. Three areas are currently being reviewed for the ability to achieve the strategic vision and organisational priorities set out in the Strategic Quality Plan due to lack of capacity or insights.

   (i) Progress against Population Health & Value-Based Healthcare initiatives has not been as expected due to a lack of committed capacity, not securing a further Public Health Specialist Registrar and critically, the prioritisation of implementation of Welsh Government Ambulance Performance Framework requirements. The approach is evolving to focus on self-assessment, achievement of Health Impact Assessment Regulations and continuous improvement with a commitment to repeat the Population Health Needs Assessments and build organisational capability.

   (ii) Technical and procedural barriers limit the ability to identify care-experienced young people accessing our services and it is therefore difficult to develop improvement initiatives based on data and intelligence. However, initiative leads are exploring alternative approaches such as targeted outreach and proactive safeguarding to address these gaps.

10. Despite the challenges the Report provides assurance that the Strategic Quality Plan is being implemented with diligence and adaptability. Key risks are recognised and actively managed, and the Trust remains committed to its quality objectives, continuous improvement and stakeholder engagement. The assurance status is positive, with ongoing monitoring and responsive adjustments ensure delivery of the Plans aims.

11. Taking account of progress to date, known constraints and mitigating actions in place, there is reasonable assurance that the Strategic Quality Plan remains deliverable within its overall timeframe. This assurance is contingent on the resolution of key dependencies relating to data linkage, enabling capacity and the timely clarification of new statutory requirements, which will continue to be actively monitored and escalated through established governance routes.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

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

1. Take assurance on progress to date in delivering the Strategic Quality Plan 2025-28

2. Note the key risks, dependencies and capacity constraints impacting delivery, and the mitigating actions in place

3. Support continued quarterly assurance reporting, with a planned transition towards outcome-based assurance measures as delivery matures

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:

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

This report provides assurance against emerging risks relating to:

- Delivery of the Strategic Quality Plan within existing financial and workforce capacity
- System-wide data linkage limitations affecting outcome measurement and population-level insight
- Compliance risk associated with implementing new statutory requirements in advance of detailed national guidance.

These risks are monitored through Directorate and Corporate risk arrangements and escalated where thresholds are exceeded.

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
13 January 2026	Clinical & Quality Governance Group
21 January 2026	Senior Quality Leadership Team
3 February 2026	Quality, Patient Experience & Safety Committee

SITUATION

1. The Strategic Quality Plan 2025-2028 was endorsed by the Quality, Patient Experience and Safety Committee (QuESt) before onward approval by Trust Board in May 2025.

2. A detailed Implementation Plan has been produced to support the delivery of the Strategic Quality Plan 2025-28 which is monitored and updated by a Task & Finish Group of key internal stakeholders who meet monthly.

3. This paper provides an overview of progress made to date to deliver the objectives of the Strategic Quality Plan taking into consideration the impact and outcomes of the implementation activities as well as the challenges experienced in delivering the approved Strategic Plan.

BACKGROUND

4. The Strategic Quality Plan was developed through extensive stakeholder engagement and aligns with statutory and regulatory responsibilities, as well as the Trust's long-term Strategy.

5. The Plan recognises the valuable contributions of other Strategic Plans through a lens of delivering the quality agenda aligned with the Health & Social Care (Quality and Engagement) Wales Act 2020.

6. Audit Wales Quality Governance Follow Up Review 2024 recommends (R2 2024) ensuring that Progress Reports are included in the QuESt Cycle of Business.

7. The Strategic Quality Plan is designed to enhance quality outcomes for patients and communities whilst recognising the challenging financial and capacity constraints facing the NHS in Wales. As a result, a pragmatic approach was taken to prioritise improvements that are achievable within existing resources.

8. Due to engagement, with a broad range of stakeholders both internal and external, whilst shaping the Strategic Plan, it aims to be responsive to the real needs and expectations of patients, staff and communities. The Plan includes a strong emphasis on inclusivity, equity and compassionate, personalised care.

ASSESSMENT

9. The implementation of the Strategic Quality Plan is progressing in line with delivery timelines and as such is progressing broadly in line with agreed delivery timelines, with early focus on enabling and foundational activity. Overall delivery is currently assessed as on track, subject to the dependencies and constraints outlined in this paper. 5% of the implementation tasks are

completed with key actions aligned with Person Centred Care, Leadership & Governance and Technology & Innovation advancing and several priority and high priority task showing substantial progress.

10. Three tasks have reviewed and deferred timelines for delivery

    (i) Enhanced reporting on the impacts and outcomes of engagement activities is paused until the resolution of the Patient Engagement & Community Involvement Team Organisational Change Process but remains within the timeline of the overall Strategy.
    (ii) The timeline for delivering training associated with the corporate parenting agenda has been deferred to 2026/27 timelines whilst further work on this Strategy is undertaken.
    (iii) Developing processes to support 'double loop' learning to support innovation and transformation was aligned to the life cycle of the Strategic Quality Plan. As work is yet to progress in this area the start date has been deferred to 2026/27.

11. Five tasks have reviewed and extended timelines for delivery but remain within the timeline of the overall Strategy.

    (i) The development of revised QIA documentation and processes has extended from the end of Quarter 3 2025/26 to Quarter 4 of the same fiscal year to conclude collaborative work with Public Health Wales and consider implications of new legislation associated with Health Impact Assessments.

    (ii) Building capacity & conditions for our people to balance change management principles with QI methodology has also been extended from the end of Quarter 3 2025/26 to Quarter 4 of the same fiscal year due to the capacity of the teams to collaborate.

    (iii) The provision and support of Quality Improvement Training have been extended from the end of Quarter 3 2025/26 to Quarter 4 of the same fiscal year to ensure initial training courses have been completed and evaluated before reporting completion.

    (iv) The development of Quality Statements and Quality Assurance Self-Assessments across organisational Directorates and Departments have been extended by 3 months each. Significant progress has been made in this area and is reported and monitored through the Quality Management Group however further progress is required to meet the deliverable and more focus will now be provided on supporting teams to achieve deliverable outcomes.

(v) At this stage of implementation, assurance is primarily drawn from delivery of enabling infrastructure, governance and organisational capability. As initiatives mature, future assurance reporting will place increasing emphasis on outcome and impact measures, including decision-making quality, learning from improvement activity and patient experience indicators. A phased transition from activity-based to outcome-based assurance will be reflected in subsequent quarterly updates.

Highlights & Achievements

12. As part of the cultural journey within the Welsh Ambulance Services University NHS Trust (WAST) and linked to our People & Culture Plan and Strategic Equality Plan, the Strategic Quality Plan sets out to celebrate diversity and create fair opportunities for all our people. Part of the work in this area involved hosting the health zone within the national Mastering Diversity Event in September 2025. This activity is completed and WAST received positive feedback from external stakeholders at the event with plans to participate again next year.

13. Quality Governance activity is focussing on embedding the Duty of Quality and the Health & Care Quality Standards 2023 within our quality management systems. In line with this work and our Integrated Medium-Term Plan (IMTP) deliverables WAST has introduced a new WAST Improvement Network Platform powered by the Simply Do software package. The governance around the new WAST Improvement Network (WIN) Platform includes an evaluation matrix for improvement ideas which integrates the Health & Care Quality Standards with a particular focus on the Safe, Timely, Effective, Efficient, Equitable, Person Centred (STEEEP) Quality Domains. Through prioritisation processes this task was identified as a priority deliverable to effectively support continuous improvement activity and the enhancement and embedding of quality management systems across the organisation

14. The Quality Improvement structures are developing as part of the Strategic Quality Plan initiatives and in line with IMTP deliverables. This includes embedding assessment at every level of improvement and transformation. New Standard Operating Procedures for improvement activities within the organisation include processes designed for de-implementation. The intention to ensure that as an organisation we consider stopping or reducing ineffective, harmful or low-value practices to free up resources for alternative improvement initiatives and improve the quality of services provided to our population, patients and stakeholders.

15. The quality improvement and quality governance journey continues with a focus on ensuring that our quality improvement processes are aligned the

Improvement Cymru Framework aligned around the Institute for Healthcare Improvement (IHI) Principles. New Standard Operating Procedures and Frameworks developed for the Quality Hub and WIN Network are focused on these principles with a Memorandum of Understanding secured with Improvement Cymru to allow quality improvement leaders to roll out Improvement Cymru education materials to improvement champions across the organisation.

16. To demonstrate the impact of improvements aligned to these IHI Principles the Quality Hub has been launched on Siren SharePoint as a single point of contact for education, tools, resources and guidance to support quality improvement across the organisation. The tools and resources within the Quality Hub include access to the Simply Do Platform for collaborative improvement both through the WIN Network and through setting improvement challenges to key stakeholders where improvement solutions are required for identified problems. The introduction of LifeQI Software allows us to monitor and evaluate the impact of initiatives being tested through model for improvement PDSA cycles.

17. Patient Experience and Community involvement Teams continue to enhance outward facing resources to emphasise service user needs and communication preferences as part of the work to deliver compassionate communication across the organisation. Good progress has been made with refreshed WAST resources and platforms as well as the provision of easy read and pictorial information for those with learning disabilities. The Recite Me contract has been renewed to enable British Sign Language (BSL) and other languages to be available to convert information Trust websites. Development of a public engagement compact, which will formalise how the organisation communicates and engages with service users to ensure transparency and inclusivity, is progressing well.

18. Activity to embed compassionate leadership practices continues to progress in line with the People & Culture Plan intentions. Initiatives introduced to date include the introduction of essential conversations, Culture Change Workshops, Trade Union collaboration and the establishment of Culture Champions. The integration of quality into daily decision making for leaders continues to progress with dedicated sessions provided at leadership symposiums and WASTQ events. These efforts support the journey to foster psychological safety and learning culture within the organisation, empowering our people to uphold high standards of care. These leadership actions are critical path task which underpin the cultural transformation necessary for sustained quality delivery.

19. Clinical Model Transformation (CMT) Workstreams have provided assurance that transformative decisions are support by Quality Impact Assessments as

part of endeavours to enhance our quality planning functions within quality management systems. Quality Impact Assessments were completed for each of the CMT workstreams to help inform quality in decision making in line with the Duty of Quality. Balanced Scorecards have been approved for the CMT workstreams with an overall Scorecard currently in development and expected to be operational by the end of Quarter 4. Monitoring and Assurance measures have been developed to support these workstreams and work is now required to align the metrics with the adverse impact assessments within the QIA to support the monitoring and evaluation of the CMT initiatives based on impacts identified through assessments.

Challenges and Dependencies

20. Critical tasks within the implementation plan aligned with data linkage are facing risks to delivery due to limited system wide data sharing. Whilst internal progress is strong and confidence of internal data linkage between 999, 111 and ePCR platforms is high, external dependencies with Digital Health & Care Wales (DHCW) who are leading on the systemic changes required through legal mechanisms and reciprocal agreements are impeding delivery. This lack of comprehensive and systemic data linkage restricts are ability to measure ultimate patient outcomes and hiders system wide improvement. Delays in establishing systemic data linkage threatens the timely delivery of key metrics, compromises the accuracy of outcome reporting by limiting it to WAST touchpoints only, and may undermine the effectiveness of strategic decision making across the organisation. This risk is recognised and accepted at this stage, with mitigations focused on maximising internal data linkage, influencing national system partners, and ensuring strategic decisions remain proportionate to available intelligence.

21. The ability to formalise and strengthen the offer of listening discussions in line with the update Listening to People Regulations is challenged by the need to comply with the new statutory requirements by 1 April 2026 despite the absence of detailed guidance. Preparatory work progresses under uncertainty due to the lack of Statutory Guidance which increases the risk of misalignment with future regulatory expectations and has the potential to result in rework, inefficiency and associated compliance issues. However, expectations are that processes will mature over time and teams are prioritising work to delivery statutory requirements against the very tight timelines now set. Despite these uncertainties, there is assurance that statutory timescales are being actively managed, with flexibility retained to adapt processes as National Guidance is clarified.

22. The review and digitalisation of the QIA process to create a proportionate and user-friendly process to embed use at all levels of decision making has experienced timeline extensions. Initial lack of capacity within the Quality Assurance Team impacted the progress of initiatives in a timely manner however this was resolved during Quarter 1 of 2025/26 with the appointment of the Quality Assurance Lead and the Information and Intelligence Manager. The Quality Assurance Team are now working collaboratively with Public Health Wales teams to share improvement opportunities and to explore shared learning opportunities. However, the introduction of new regulations for Health Impact Assessments may impact next steps of implementation as the impacts of the new Regulations are considered. Quality Assurance Leads must consider the importance of demonstrating quality in decision making whilst understanding the impact of multiple Impact Assessments which are regulated, where Quality Impact Assessments are not specifically set out in Statutory Guidance. Impact Assessment Leads will meet in Quarter 4 to explore how the new Regulations as well as existing Impact Assessments can be achieved without labour intensive processes impacting timely decision making.

23. The expansion of the Community Network to ensure representation of diverse communities has been paused due to limited team capacity. While a review has been undertaken further promotion and engagement activities are currently on hold pending the resolution of an Organisational Change Process (OCP) following the impacts of the Service Review for the Patient Experience and Community Involvement Team. OCP processes have prevented recruitment into vacant posts significantly impacting on capacity to deliver on non-statutory responsibilities. Delays in network growth may reduce the organisation's ability to capture diverse perspectives, potentially impacting on the inclusivity and effectiveness of co-produced service design and delivery.

24. The integration of Change Management Principles with Quality Improvement Methodology has been delayed due to scheduling challenges, despite strong commitment from both teams. Delays in integration may slow the adoption of a unified approach to organisational improvement with the potential to reduce the effectiveness of change initiatives and quality outcomes.

Population Health & Value Based Healthcare

25. Whilst the Senior Quality Leadership Team remain committed to principles and values set out in the Strategic Quality Plan regarding Population Health & Value Based Healthcare, the team have not made the progress aspired to. In large part this has been due to organisational prioritisation of the Welsh Government Ambulance Performance Framework and associated Clinical Model Transformation changes.

26. The Trust has continued to work with Public Health Wales and has revised the placement opportunity for a Public Health Specialist Registrar to join WAST. It is hoped that by creating a joint placement between Public Health Wales or a Health Board and WAST, the opportunity might create greater interest in 2026 and subsequently offer specialist support to exploit the opportunities identified in the Baseline Report completed in 2025. A key area of focus for the Trust over the last year has been securing improvements in cardiac arrest outcomes and the Trust has been working closely with Save a Life Cymru to understand how a population health based approach can reduce the variation experienced across the country, specifically when considering Public Access Defibrillator placement and Automated External Defibrillation (AED)/Cardiopulmonary Resuscitation (COR) training availability.

27. In addition, the Trust has been responding to queries based on the assumption that rural service coverage and outcomes are worse than urban. Initial findings demonstrated that the relationship between rurality and service availability is far more nuanced, with some areas securing higher levels of provision than urban. This work is now evolving to secure the use of wider datasets that will enable a greater understanding of variation and the potential associations, based on healthcare evidence, beyond rural or urban location of incident, for example, deprivation and relative affluence, housing and ethnicity. Key to this work will be the availability of data services and analytical support which remains a key priority to secure.

28. The Trust has appointed a Commercial Development Lead and a Financial Sustainability Lead, both of whom will support the work required for the Trust to take a value-based healthcare approach. The Trust has also commissioned Edge Hill University and Swansea University to undertake an independent evaluation of the Clinical Model Transformation which includes a requirement to support a value-based assessment for the wider NHS system, as well as for WAST. In addition, a further request has been made to Swansea University to support the Trust consider the most appropriate methodology for an interim assessment of Ambulance Performance Framework Phase I that has been requested by Commissioners.

29. As a result, the approach has now evolved to align with new Health Impact Assessment Regulations, a commitment to ongoing self-assessment and continuous improvement in this area. Population health initiatives are linked to broader organisational strategies such as the delivery of data linkage and people's experience projects to maximise impact and avoid duplication. The team is committed to repeat the Population Health Needs Assessment in Quarter four of 2026/27 and will focus the coming period on building organisational capability for quality improvement, ensuring population health

remains a shared responsibility across teams. This revised approach reflects a proportionate and realistic response to current capacity constraints, maintaining strategic intent while reducing the risk of non-delivery.

Corporate Parenting

30. Initial efforts to deliver tasks aligned with corporate parenting objectives have faced technical and procedural challenges in identifying care experienced young people or those aligned to a social worker within current health and social care systems. The lack of integrated data, both within health bodies through data linkage and with the broader social care system, creates limitations of existing reporting systems. Whilst some parameters to identify these service users do exist there is currently no automated or scalable way to extract this information from current systems due to inconsistent data capture.

31. Achieving a unified, scalable system for identifying and tracking vulnerable children and young people across health and social care would require significant investment in data integration, system interoperability and cross-agency collaboration. Continued advocacy for national or regional data strategies is necessary to address these systemic barriers and enable long-term transformation, with clear articulation of information needs and intended outcomes essential to ensure future data collection and integration efforts are purposeful.

32. An alternative approach now being explored is to undertake outreach and engagement with defined community cohorts such as Foster Care Networks, Care Leaver Groups, etc to gather experiential insights and inform service improvements in the absence of robust data analytics. In addition, developing a proactive safeguarding approach, such as monitoring high-frequency or risky presentations and overlaying safeguarding data with deprivation index scores may produce additional insights for improvement opportunities.

33. These interim approaches provide assurance that the Trust continues to meet its safeguarding and corporate parenting responsibilities despite current systemic data limitations.

RECOMMENDATION

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

NEXT STEPS

35. Task & Finish Group will continue to meet and monitor the delivery of the Strategic Quality Plan.

36. Quarterly updates will continue to be provided to Committee to provide assurance on the activity taken to deliver the principles and aims of the Strategic Quality Plan.

37. A mid-point review of the Strategic Quality Plan will be completed during the 2026/27 fiscal year and an updated Plan produced where appropriate.

38. Future updates will increasingly articulate how implementation activity is translating into measurable improvements in quality, safety and experience, strengthening the Board's ability to take sustained assurance.

Agenda Item No.	14a

REPORT TITLE

Clinical Audit Plan 2026/27

MEETING

Name of meeting	Quality Patient Experience and Safety Committee (QuEST)
Date of meeting	February 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Andy Swinburn, Director of Paramedicine
Author of report	Vince Baglole, Head of Clinical Intelligence and Assurance

PURPOSE OF REPORT

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

REPORT SUMMARY:

1. Following an Audit Wales review of WAST's Quality Governance Arrangements undertaken in early part of 2024, one of the recommendations was for the Clinical Audit Plan to be submitted to Quality, Patient Experience and Safety Committee (QuEST) for scrutiny and approval ahead of each financial year, then monitored on a quarterly basis.
2. The plan is developed in consultation with the Clinical Intelligence & Assurance Team, Clinical Intelligence & Assurance Group, and senior clinical, and non-clinical managers within the Trust.
3. Consideration is given to linking audit topics to the IMTP, LDPs, and risk registers where possible.

RECOMMENDATION(S)

The QuEST is requested to:

1. Approve the Clinical Audit Plan 2026/27.

ADDITIONAL PAPER(S)

The QuEST is requested to receive the following:

1. The Clinical Audit Plan 2026/27 *(Annex 1)*

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 January 2026	Clinical Intelligence and Assurance Group (CIAG)
3 February 2026	Quality Patient Experience and Safety Committee (QuEST)

SITUATION

1. Following an Audit Wales review of WAST's Quality Government Arrangements in 2024, one of the recommendations was for the Clinical Audit Plan to be submitted to QuEST for scrutiny and approval ahead of each financial year and then monitored on a quarterly basis.

BACKGROUND

2. The development of this annual plan takes into consideration a number of aspects including the resources available both in terms of funding and skills. As is often the case in healthcare there are substantially more requests for clinical audits than there are resources available to manage them. For this reason, it has been necessary to tailor the plan so that it is realistic, achievable and that expectations are not overreached.

3. Care, treatment, and decision making should reflect best practice based on evidence to ensure that people receive the right care and support to meet their individual needs.

4. The Trust's Clinical Audit Plan allows the planning and prioritisation of clinical audits across the financial year. It is a dynamic document, and audits will be added during the reporting year as required.

5. Various groups and committees receive quarterly updates for the clinical audit plan to reflect those audits that are either planned, currently underway, or have been completed, and it is made available on the Trust's Intranet.

6. This plan, along with the associated action tracker for monitoring learning from each audit, is overseen by the Clinical Intelligence & Assurance Group. Updates are subsequently reported and noted at Clinical Directorate Business meetings.

ASSESSMENT

7. The plan is developed in consultation with the Clinical Intelligence & Assurance Team, Clinical Intelligence & Assurance Group, and senior clinical, and non-clinical managers within the Trust. Consideration is given to linking audit topics to the IMTP and LDPs, and risk registers where possible.

8. Many of the audits and re-audits can be undertaken solely by the Clinical Intelligence & Assurance Team. However, support is required for some topics where subject matter experts are needed as authors, and the support of sponsors to ensure completion of the audits and subsequent actions.

RECOMMENDATION

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

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

Welsh Ambulance Services University NHS Trust

Clinical Audit Plan

2026/2027

Final V1.0 Last Updated 12 January 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

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	June 2025					
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	To commence after ePCR changes implemented Indicative Q1	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	
TBC	1	Open Fracture (Co-amoxiclav)	Clinical Intelligence & Assurance Team	Assistant Director Clinical Delivery	Indicative Q2	N/A	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	Trauma in Older People Tool	Clinical Intelligence & Assurance Team	Assistant Director Clinical Delivery	Indicative Q2	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	Preparatory work undertaken. Meeting scheduled 29 05 25 Analysis commenced Awaiting clinical reviews prior to final analysis
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	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.

Ref	Clinical Audit Title	Rationale/Drivers	Clinical Audit Author	Clinical Audit Contact/Support	Audit Start Date	Comments
						Clarification of resuscitation definition and case selection required 07.06.25 by subject matter experts. Proposal to CQGG to also report on a "JRCALC subset". Further decisions made to align reporting with Warwick, Welsh Registry and Joint Commissioning Committee (JCC). In the interest of efficiency CIAG to determine if this should be undertaken together with JRCALC and CFR subset QA work. Technical spec updated and being reviewed by IDS. Unable to progress until ePCR updates implemented.
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

Ref	Clinical Audit Title	Rationale/Drivers	Clinical Audit Author	Clinical Audit Contact/Support	Audit Start Date	Comments
						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.
TBC	Open Fracture (Co-amoxiclav)	Compliment the audit relating to antimicrobial and Major Trauma reporting.	Clinical Intelligence & Assurance	Clinical Intelligence & Assurance Team.	Indicative Q2	
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	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	Indicative Q2	
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	

Ref	Clinical Audit Title	Rationale/Drivers	Clinical Audit Author	Clinical Audit Contact/Support	Audit Start Date	Comments
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	

Agenda Item No. 14b

REPORT TITLE

Clinical Audit Plan Q3 Update 2025-2026

MEETING

Name of meeting	Quality Patient Experience and Safety Committee (QuEST)
Date of meeting	3 February 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	Vince Baglole, Head of Clinical Intelligence and Assurance

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 2025/26 Clinical Audit Plan for Q3 (Oct – Dec).
2. The following audits have been completed:
    - 25_006 Clinical Frailty Scale Follow-up Audit 2025
3. The report also provides additional intelligence work undertaken by the Clinical Intelligence and Assurance Team.

RECOMMENDATIONS

The QuEST is requested to:

1. Note the required revision of 25_003 as above to the Clinical Audit Plan.
2. Note the additional intelligence work completed outside of the plan.
3. Note the update to the Q3 Clinical Audit Plan.

ADDITIONAL PAPERS

The QuEST is requested to receive the following:

1. Clinical Audit Plan Update Q3 2025/26 *(Annex 1)*

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
16th January 2026	CIAG
3rd February 2026	QuEST

SITUATION

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

BACKGROUND

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

    - 25_006 Clinical Frailty Scale Follow-up Audit 2025

5. Ongoing audits:

    - 25_003 Appropriate Use of Antimicrobials was commenced in Q2. There has been some delay in completing the clinical reviews due to operational demands and it is anticipated that the audit will be completed by no later than Q4.

    - 25_007 Magnesium Sulfate Administration - detailed preparatory work has commenced. The proposal and criteria table has been agreed, and the audit will be completed in Q4.

6. Not started:

    - The ePCR Clinical Data Assurance - Return of Spontaneous Circulation at Hospital Clinical Indicator Re-audit has not been progressed as anticipated. Reasons are multifactorial but include a potential UI change within the ePCR.

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

   - 13 clinical intelligence requests have been completed. 3 of these were requested under Freedom of Information Act. This figure does not include the rolling data requests that are being provided or those currently underway.

   - The Clinical Indicator (CI) script for older fallers discharged at scene has been completed. The CI will be included as part of a suite of CIs which sit within the ePCR Clinical Indicator Dashboard developed by Insight & Data Services.

   - Ongoing collaborative work has continued. Technical specifications have now been completed for the following EMERG category calls; Anaphylaxis and Convulsions.

   - CIAT conducted a focused analysis with the Regional Clinical Lead, in collaboration with C&V HB and BCUHB, to determine whether patients with confirmed stroke who self-presented to the emergency department had any prior contact with WAST. The resulting report will be submitted to the Clinical Advisory Group for approval in January before being presented to CIAG.

   - Publication of the 2nd edition of the Clinical Audit Newsletter (December 2025).

   - Following an Adult Practice Review (CTMSB03/2022 Adult W) an action held within the Safeguarding Team work plan was to conduct an audit of patients aged ≥16 years not conveyed to hospital, who lacked capacity, which was to be carried out by the subject matter experts.
     Initial Clinical Audit Prioritisation Tool (CAPT) score =16. Due to current capacity within the Safeguarding Team the audit has not started and will be transferred to 2026/27 Clinical Audit Plan until Safeguarding resource allows.

RECOMMENDATIONS

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

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

Welsh Ambulance Services University NHS Trust

Clinical Audit Plan

2025/2026
Quarter 3

Final V0.1 Last Updated 02 January 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

A number of new service delivery models are often required for a modern ambulance service. The robust evaluation of service development topics is essential and needs to be planned from their inception.

It is not always possible to predict at the start of a financial year all the topics that will require evaluation and therefore flexibility in setting a Clinical Audit Plan is required, resulting in the annual plan being a dynamic document, updated quarterly.

As part of the development and updating of this plan, the CIAT have streamlined and improved the process, forms and templates used. This approach has been further supported following an internal audit. When the CIAT receive topics for suggested audits, they are added to a spreadsheet, and a prioritisation tool is used to assist in identifying the order for inclusion on the plan.

The aim of this plan is to detail the clinical audits that are either planned, currently underway or have been completed during the financial year **(Table 1 & Table 2)**.

It is expected that all the topics identified in the plan will be initiated during the course of a financial year. Those initiated during Q3 or Q4 may not be fully completed and will need to be considered in the subsequent year's plan.

The completed clinical audit reports are available on the Clinical Audit page of the Trust's Intranet website. (https://nhswales365.sharepoint.com/sites/AMB-Intranet-Medical/SitePages/Clinical-Audit-Programme.aspx)

Head of Clinical Intelligence & Assurance

Table 1 – Summary (Full information in Table 2)

*	N/A = Not due to start	Not started/not progressing	Not started, decision made	**Progressing as planned	Completed
** A clinical audit is deemed as started once a clinical audit proposal and criterion table have been approved by the CIAT and the ePCRs and/or data supplied					
Clinical Audit Classification		Tier 1 = UK Ambulance Services or Trust wide		Tier 2 = Health Board/Locality/Team	

This section contains confirmed clinical audits
(This is a dynamic document, and topics will be added during the reporting year as required)

Ref	Tier	Clinical Audit Title	Clinical Audit Author	Clinical Audit Sponsor	Audit Start Date	Current Status (RAG)*				
						Q4 2024/ 2025	Q1	Q2	Q3	Q4
23_009	1	ePCR Clinical Data Assurance - STEMI Clinical Indicator Re-audit	Clinical Intelligence & Assurance Team	Head of Clinical Intelligence & Assurance	February 2025					
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	To commence after ePCR changes implemented	N/A	N/A	N/A	N/A	
24_005	1	Drug Administration Documentation in ePCR	Clinical Intelligence & Assurance Team	Head of Clinical Intelligence & Assurance	December 2024					
TBC	1	Recording of Failed Pathways in ePCR	TBC	Assistant Director of Clinical Development	TBC	N/A	N/A	N/A	N/A	N/A
25_001	1	ROLE Form Images in ePCR Re-Audit	Clinical Intelligence & Assurance Team	Head of Clinical Intelligence & Assurance	January 2025					
25_006	1	Clinical Frailty Scale Follow-up Audit 2025	Clinical Intelligence & Assurance Team	Head of Clinical Intelligence & Assurance	September 2025	N/A	N/A			

25_007	1	Magnesium Sulfate Administration	Clinical Intelligence & Assurance Team	Regional Clinical Lead SE	December 2025	N/A	N/A	N/A		
25_002	1	Inter-hospital Transfers: Clinical Indicator Care Bundle Compliance	Clinical Intelligence & Assurance Team	Head of Clinical Intelligence & Assurance	May 2025	N/A				
TBC	1	Non-medical Prescribing	Clinical Intelligence & Assurance Team	Head of Medicines Management	Not started/ decision made	N/A				
TBC	1	Trauma in Older People Tool	Clinical Intelligence & Assurance Team	TBC	Indicative Q4 2025/26	N/A	N/A	N/A	N/A	
25_003	1	Appropriate Use of Antimicrobials	Clinical Intelligence & Assurance Team	Head of Medicines Management	June 2025	N/A				
25_004	1	Appropriate Use of Ketamine	Clinical Intelligence & Assurance Team	Regional Clinical Lead – Consultant Paramedic	May 2025	N/A				
25_005	1	St Johns Data Breach – Missing Records (preparatory work for missing records)	Clinical Intelligence & Assurance Team	Head of Clinical Intelligence & Assurance	June 2025	N/A				

Table 2 – Full Information

Ref	Clinical Audit Title	Rationale/Drivers	Clinical Audit Author	Clinical Audit Contact/Support	Audit Start Date	Comments
23_009	ePCR Clinical Data Assurance - STEMI Clinical Indicator 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	February 2025	Update further delayed, and problems with consistent roll out @19/12, and whether all changes have been implemented. UI changes investigated, and SBAR presented to ePCR-CRG (28/3) to confirm outstanding issues. Following Autumn 24 UI release – the CI technical specification was updated and deployed by IDS. Start date of audit anticipated January 25. Audit completed presented to CIAG 08.05 2025
TBC	ePCR Clinical Data Assurance - Return of Spontaneous Circulation 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	To commence after ePCR changes implemented	Funding required for these specific changes. Autumn 2024 deployment. The 'Point of closure nudge tool' has been activated to improve outcome compliance. Technical spec updated and being reviewed by IDS.

Ref	Clinical Audit Title	Rationale/Drivers	Clinical Audit Author	Clinical Audit Contact/Support	Audit Start Date	Comments
						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. Clarification around resuscitation definitions and new JRCALC resuscitation guidelines, together with the reporting of CFR subset and JRCALC subset of ROSC necessitate further preparation and to avoid duplication of effort a potential ePCR UI change may also impact.

Ref	Clinical Audit Title	Rationale/Drivers	Clinical Audit Author	Clinical Audit Contact/Support	Audit Start Date	Comments
24_005	Drug Administration Documentation in ePCR	To ensure that drugs administered to the patient are documented within the ePCR drugs section in line with the relevant parts of section 10.0 of the Medicines Management Policy 4.0	Clinical Intelligence & Assurance Team	Clinical Intelligence & Assurance Team	December 2025	SQL developed. SBAR completed in preparedness for December 2024 CIAG. However, due to REAP4 paper shared for information via email. No comments received as of 02.01.25 suggesting changes required to criterion table. Approved. Audit completed, presented to CIAG 20 03 25
TBC	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.	TBC	Clinical Intelligence & Assurance Team	TBC	Required UI changes presented to ePCR CRG 29.05.24 CR0048, likely release Oct/Nov 2024 Revised date for UI changes Spring 2025 Sponsor has requested a clinical intelligence report be generated to inform the need for the audit. On hold as likely implementation is Dec 2025 with wider roll-out Jan 2026.
25_001	ROLE Form Images in ePCR Re-audit	To ascertain if improvements have resulted following completion of actions from the previous audit.	Clinical Intelligence & Assurance Team	Clinical Intelligence & Assurance Data Specialist	January 2025	SQL developed and data obtained. Audit undertaken.

Ref	Clinical Audit Title	Rationale/Drivers	Clinical Audit Author	Clinical Audit Contact/Support	Audit Start Date	Comments
						Completed audit presented to CIAG in April 2025.
25_006	Clinical Frailty Scale Follow-up Audit 2025	This is an action from an audit undertaken in 2023	Clinical Intelligence & Assurance Co-ordinator	Clinical Intelligence & Assurance Co-ordinator	September 2025	Commenced latter part of Sept 2025 Proposal presented to CIAT team meeting 26 09 25 SQL developed, data cleanse underway. Prepared for CIAG 19 12 25, meeting cancelled. Will be presented in January 2026
25_007	Magnesium Sulfate Administration	PGD being developed in 2025, potential need for audit when embedded into practice.	Clinical Intelligence & Assurance Co-ordinator	Clinical Intelligence & Assurance Team	December 2025	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 CL Audit proposal discussed and agreed 23 12 25
25_002	Inter-hospital Transfers: Clinical Indicator Care Bundle Compliance	CIAG approved change to global IHT metric encompassing many more cases which would have previously been included in a Clinical Indicator. CIAG requested an audit to provide assurance going forwards relating to	Clinical Intelligence & Assurance Co-ordinator	Clinical Intelligence & Assurance Team	May 2025	Audit commenced in Q1 as planned. Completed and findings presented in CIAG 12 09 25

Ref	Clinical Audit Title	Rationale/Drivers	Clinical Audit Author	Clinical Audit Contact/Support	Audit Start Date	Comments
		the care bundle in CI patients transported by WAST from smaller NHS premises to definitive care.				
TBC	Non-medical Prescribing	Policy 9.3: - Regular programmes of audit of compliance with information governance, records management standards and prescribing practice will be established. The Head of Medicines Management must include non-medical prescribing audits as part of the Trust's annual clinical audit plan, reporting these results through the Advanced Clinical Practice Delivery Group and Optimising Care Group and available for assurance.	Clinical Intelligence & Assurance Co-ordinator	Clinical Intelligence & Assurance Team	Not started/ decision made	Preparatory work being undertaken. Meetings scheduled 29 05 25, 24 06 25, 20 08 25. VB met with JL 26/9 Decision made to amend the current version of the policy. This will go to APSG and Policy Group for approval. Pharmacy Lead meeting with CIAT to formalise wording. Meeting scheduled 27 11 25 Completed
TBC	Trauma in Older People Tool	Trauma in Older People Tool is a rebranding and is due for re-launch Potential need for audit once embedded into practice.	Clinical Intelligence & Assurance Co-ordinator	Clinical Intelligence & Assurance Team	Indicative Q4 2025/26	
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	Preparatory work being undertaken. Meeting scheduled 29 05 25 Analysis commenced. Awaiting clinical reviews prior to analysis.
25_004	Appropriate Use of Ketamine	Action from CHARU working Group to ensure compliance to the Advanced Clinical Interventions SOP: Advanced	Clinical Intelligence & Assurance Lead	Regional Clinical Lead-Consultant Paramedic	May 2025	SQL developed Spreadsheet developed

Ref	Clinical Audit Title	Rationale/Drivers	Clinical Audit Author	Clinical Audit Contact/Support	Audit Start Date	Comments
		Analgaesia with Ketamine and PGD guidance.	Administrator / Co-ordinator			Audit commenced Presented to CIAG Oct 2025
25_005	St Johns Data Breach – Missing Records (preparatory work for missing records)	The audit will support a risk assessment undertaken (DATIX 20266) following the data breach and the results provided to Information Governance Steering Group (IGSG) by providing details of information the Trust holds in relation to incidents where there is a missing Patient Clinical Record completed by St Johns Falls Response.	Clinical Intelligence & Assurance Team	Clinical Intelligence & Assurance Team	June 2025	Chair's action request SBAR sent 21.05.25 This work will determine if there is a requirement to proceed to a full audit. Response received from KH (IG) on 10/09, in summary, group supported taking audit to CQGG for clinical sign off. Agreed that no further risk would be uncovered by reviewing all incidents.

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

Agenda Item No. 15

REPORT TITLE

Healthcare Inspectorate Wales: New NHS Wales Engagement Process

MEETING

Name of meeting	Quality, Patient Experience & Safety Committee
Date of meeting	3 February 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Liam Williams, Executive Director of Quality and Nursing
Author(s) of report	Penny Durrant, Deputy Director of Nursing, 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. This paper brings to the Quality, Patient Experience & Safety Committee (QuESt) the recent correspondence from Alun Jones, Chief Executive of Healthcare Inspectorate Wales (HIW), announcing the implementation of HIWs new NHS Wales Engagement Process from 6 October 2025. The transition represents more than a procedural change; it introduces a strengthened regulatory interface that places clear expectations on NHS bodies regarding transparency, responsiveness, and evidence of improvement. The accompanying guidance highlights shortcomings in the previous Relationship Manager Model, including inconsistent engagement, limited oversight of governance processes, and variable understanding of how organisations assure themselves of quality. The revised Model seeks to address these gaps through systematic, intelligence-led engagement, improved escalation clarity, and a heightened focus on continuous improvement.

2. For the Welsh Ambulance Services University NHS Trust (WAST), this development sits within a broader assurance context. Our Governance Framework, including QuESt, Board Sub-Committees, inspection response mechanisms and the evolving Quality Management System (QMS), provide a basis for alignment, although it is important to acknowledge that full compliance with the new Model will rely on continued strengthening in several areas. Insight from early dialogue between WAST leaders and HIWs Head of NHS Assurance was positive, reflecting a shared commitment to open intelligence exchange, scrutiny of emerging risk, and maturing assurance cultures. The discussion provided external validation of WASTs direction of travel, but it also offers QuESt an early signal that internal systems for evidence generation, triangulation of risk information, and demonstrable learning from inspection outcomes will increasingly be scrutinised by HIW.

3. Through the work of QuESt Committee, the Committee will use the Framework to test how well the Trust is positioned to meet expectations under the Duty of Quality, whether intelligence flows are sufficiently integrated, and where gaps may exist that require targeted action or investment. The new HIW approach to correspondence routing and designated recipients also provides an opportunity to examine whether internal inspection tracking, escalation and closure processes are sufficiently robust and whether Board and Committee reporting demonstrates effective incorporation of learning.

4. Accordingly, this paper recommends that QuESt not only notes the introduction of the new process but also recognises its relevance to the Trust's assurance maturity. Dissemination across the Executive Team has taken place, with Governance Leads reviewing the guidance in the context of existing systems. It is proposed that the QuESt Committee receives annual reflection on HIW engagement themes and inspection learning so that external insights are actively shaping improvement activity.

5. The HIW correspondence and guidance document are appended for reference so that Committee members can review the source material underpinning this assurance position.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

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

1. It is recommended that QuEST notes HIWs new engagement process, recognises its relevance to WASTs Assurance Framework, and supports continued dissemination across the Executive Team.

2. QuESt may also wish to receive an annual update on HIW engagement themes and inspection learning and endorse a brief mapping exercise to confirm alignment and identify any areas where assurance could be strengthened.

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: **Annex1**: Letter dated 7 January 2026: Healthcare Inspectorate Wales Review of Welsh Ambulance Services University NHS Trust **Annex 2**: Healthcare Inspectorate Wales NHS Wales Engagement Process. Guidance for Health Boards and NHS Trusts (English version) **Annex 3**: Healthcare Inspectorate Wales NHS Wales Engagement Process. Guidance for Health Boards and NHS Trusts (Welsh version)

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
13 January 2026	Clinical and Quality Governance Group
3 February 2026	Quality, Patient Experience & Safety Committee

OFFICIAL SENSITIVE

Direct Line: 03000 628163
E-mail: HIW-NHSassurance@gov.wales

Rachel Marsh
Chief Executive
Welsh Ambulance Services University NHS Trust
Via Email: Rachel.Marsh3@wales.nhs.uk

7 January 2026

Dear Rachel

Healthcare Inspectorate Wales Review of Welsh Ambulance Services University NHS Trust

As part of Healthcare Inspectorate Wales' (HIW) annual reviews programme for 2025-26, a commitment has been made to undertake a review within Welsh Ambulance Service University NHS Trust (the Trust). This forms a key element of our ongoing efforts to monitor and enhance the quality of healthcare services across Wales.

The focus of this review has been informed by several themes identified through the analysis of intelligence currently held by HIW. This includes strategic and oversight work, a review of quality, safety, and reported incidents within the Trust. Additionally, we have considered some of the key patient safety recommendations made in our previous two reviews of the Trust as outlined below.

As part of HIW's review follow-up process, a request has been included for an update on actions taken to date in response to some recommendations highlighted in our prior review reports. This is intended to establish the progress made and the sustainability of improvements implemented following these reviews. The previous review reports can be accessed as follows:

- Assessment of Patient Management Arrangements within Emergency Medical Service Clinical Contact Centres – published September 2020
- Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover – published October 2021

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CF48 1UZ
Tel / Ffôn 0300 062 8163
www.hiw.org.uk / www.agic.org.uk

In determining the focus areas of our current review, consideration has also been given to the strategic vision set out in the Trust's Integrated Medium-Term Plan for 2025-28. This includes the steps identified within the plan to further enhance and improve services delivered by the Trust.

The current review will focus on the following themes:

- Patient flow and handover process, including initiatives to release crews more quickly and consideration of alternative pathways, as well as standardising handover guidance and standard operating procedures (sops).
- Escalation processes, with a focus on clarity, consistency, and effectiveness
- Communication with patients, about delays
- Leadership and governance, including reporting, learning, and fostering a feedback culture
- Workforce planning & staffing levels, including staff wellbeing and support, staff training and development
- Data quality & accurate recording

To support our understanding of the identified themes and to enable us to assess how the Trust is managing each area, we kindly request your assistance in completing the enclosed self-assessment (Attachment 1).

The information you provide will be considered alongside the intelligence already held by HIW. We will review your response to identify any key areas warranting further exploration. In addition, we may consider launching a survey for the Trust's staff, to gather their views and experiences relating to specific themes, and we will also undertake interviews with some staff within the Trust.

Our work will take place remotely during January and February 2026. We kindly ask that you respond to this letter with the requested information and a completed self-assessment by no later than **23 January 2026**.

The review is scheduled to conclude in the Spring of 2026, culminating in the publication of a report. Please do not hesitate to contact me should you wish to discuss the contents of this letter further.

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www.hiw.org.uk / www.agic.org.uk

Yours sincerely

Helen Morgan
Senior Healthcare Inspector
Healthcare Inspectorate Wales

Cc.
Colin Dennis, Chair
Liam Williams, Director of Nursing
Andy Swinburn, Executive Director of Paramedicine

Llywodraeth Cymru / Welsh Government
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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.

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Proses Arolygiaeth Gofal Iechyd Cymru ar gyfer Ymgysylltu â GIG Cymru

Canllawiau i Fyrddau Iechyd ac Ymddiriedolaethau'r GIG

Cynnwys

Cyflwyniad

Mae Arolygiaeth Gofal Iechyd Cymru (AGIC) yn gyfrifol am arolygu, adolygu ac ymchwilio i wasanaethau GIG Cymru, er mwyn cael sicrwydd bod darparwyr gofal iechyd yn darparu gofal diogel o ansawdd i bobl. Rydym yn ystyried sut mae gwasanaethau yn cydymffurfio â rheoliadau a deddfwriaeth gofal iechyd, yn cyrraedd **Safonau Ansawdd Iechyd a Gofal 2023**, yn cydymffurfio â strategaethau, polisïau a deddfwriaeth Llywodraeth Cymru, ac yn gweithredu'n unol â'r safonau proffesiynol a'r canllawiau sy'n berthnasol i'w maes gofal.

Mae creu a chynnal cydberthnasau cynhyrchiol â Byrddau Iechyd ac Ymddiriedolaethau'r GIG yn hanfodol er mwyn darparu gofal diogel ac effeithiol. Yn unol â blaenoriaethau strategol AGIC, mae ein hymdrechion yn anelu at sicrhau bod gwasanaethau gofal iechyd ledled Cymru bob amser yn ddiogel ac yn effeithiol a'u bod yn ymateb i anghenion y boblogaeth. Mae ein hamcanion allweddol yn cynnwys cynnal pwyslais cadarn ar ansawdd gofal wrth i unigolion ddefnyddio gwasanaethau a throsglwyddo rhyngddynt, gan ddangos ystwythder wrth nodi ac ymdrin â risgiau sy'n dod i'r amlwg o ran diogelwch cleifion, a meithrin partneriaethau cydweithredol ym mhob rhan o'r system er mwyn hwyluso gwelliannau parhaus.

Yn unol â'r blaenoriaethau a'r amcanion a bennwyd gan AGIC, cynhaliwyd adolygiad o'r broses sicrwydd ar draws pob sector gofal iechyd yn 2024. O ganlyniad, gwnaed newidiadau sefydliadol, gan gynnwys sefydlu swyddi ar gyfer uwch-arweinwyr, fel Pennaeth Sicrwydd y GIG a Phennaeth Sicrwydd Gofal Iechyd Annibynnol. Yn sgil hyn, diwygiwyd y prosesau ar gyfer ymgysylltu â sefydliadau GIG Cymru, ac fel rhan o hynny datblygwyd model ymgysylltu newydd i ddisodli'r model Rheolwyr Cydberthnasau blaenorol. Caiff y Broses newydd ar gyfer Ymgysylltu â GIG Cymru ei chyflwyno ym mis Hydref 2025.

Y rhesymeg dros newid

Adolygiad o'r model ymgysylltu gan ddefnyddio rheolwyr cydberthnasau

Nododd ein hadolygiad o'r model ymgysylltu gan ddefnyddio rheolwyr cydberthnasau sawl maes i'w wella. Er bod pwynt cyswllt dynodedig ar gael i Fyrddau Iechyd ac Ymddiriedolaethau a oedd yn cydgysylltu ag AGIC, canfu'r dull ymgysylltu cyffredinol rai anghysondebau, gan gynnwys:

- Amlder cyfarfodydd
- Amrywiadau o ran cynnwys agendâu
- Trefniadau achlysurol ar gyfer adolygu papurau Pwyllgorau a Byrddau
- Lefelau amrywiol o ymgysylltu â rhanddeiliaid
- Amrywiadau yn y ffordd roedd rheolwyr cydberthnasau yn goruchwylio prosesau llywodraethu sefydliad
- Bylchau o ran deall sut mae sefydliadau'r GIG yn sicrhau eu hunain eu bod yn darparu gofal diogel ac effeithiol.

Er mwyn ymdrin â'r materion hyn, rydym wedi cyflwyno proses newydd ar gyfer ymgysylltu â GIG Cymru. Bydd y broses hon yn darparu dull ymgysylltu safonedig yn seiliedig ar dimau, wedi'i ategu gan wybodaeth a bydd yn hybu prosesau cyfathrebu clir drwy fodel integredig sy'n cyd-fynd â blaenoriaethau, amcanion a gwerthoedd AGIC.

Model yn seiliedig ar dimau ar gyfer ymgysylltu â'r GIG

Rydym wedi rhoi dull sy'n seiliedig ar dimau ar waith mewn perthynas â'r broses ar gyfer ymgysylltu â'r GIG ac mae hyn yn hanfodol er mwyn gwneud y canlynol:

- **Sicrhau cysondeb a pharhad**
  Darparu pwynt cyswllt dibynadwy a chyson rhwng Byrddau Iechyd, Ymddiriedolaethau'r GIG, ac AGIC. Mae hyn yn galluogi gwybodaeth amserol a chywir i lifo i'r tîm priodol, gan leihau dibyniaeth ar aelodau unigol o staff a sicrhau parhad pan fydd aelodau o staff yn newid.

- **Atgyfnerthu cydberthnasau cydweithredol**
  Meithrin partneriaethau dyfnach, mwy effeithiol â sefydliadau GIG Cymru. Mae dull sy'n seiliedig ar dimau yn sicrhau bod prosesau ymgysylltu ar draws GIG Cymru nid yn unig yn gyson, ond eu bod hefyd yn fwy ymatebol i anghenion a chyd-destunau unigryw pob sefydliad.

- **Datblygu gwybodaeth sefydliadol**
  Cynnal sail wybodaeth ganolog a chyfunol o fewn AGIC am bob un o sefydliadau GIG Cymru. Bydd y wybodaeth hon yn dod o amrywiaeth o ffynonellau, gan gynnwys:

- Gwaith ymgysylltu uniongyrchol â Byrddau Iechyd ac Ymddiriedolaethau
- Sylwadau a gwybodaeth gan randdeiliaid allanol
- Gwybodaeth gan Lywodraeth Cymru
- Setiau data a dangosyddion perfformiad cenedlaethol.

- **Galluogi gwaith sicrwydd a gwaith cynllunio rhagweithiol**
  Drwy waith systematig i ddadansoddi'r wybodaeth a gafwyd, bydd AGIC yn gwneud y canlynol:

  - Nodi tueddiadau a risgiau sy'n dod i'r amlwg
  - Ymateb yn gyflym i faterion y mae angen sylw arnynt ar unwaith
  - Llywio ac addasu prosesau cynllunio sicrwydd
  - Hwyluso prosesau deuffordd ar gyfer rhannu gwybodaeth gritigol â Llywodraeth Cymru a rhanddeiliaid eraill, gan felly wella tryloywder ac atebolrwydd.

Trosolwg o'r model newydd ar gyfer ymgysylltu â'r GIG

Fel rhan o'r model newydd ar gyfer ymgysylltu â'r GIG, caiff Pennaeth Sicrwydd y GIG ei gefnogi gan ddau dîm clinigol a thîm gwybodaeth AGIC. Gyda'i gilydd, maent yn arwain dull gweithredu cydgysylltiedig sydd nid yn unig yn rhoi blaenoriaeth i gasglu gwybodaeth, ond hefyd i'w dadansoddi mewn ffordd systematig. Mae hyn yn galluogi AGIC i nodi themâu, tueddiadau a risgiau posibl ym mhob rhan o'r system gofal iechyd yng Nghymru.

Caiff trafodaethau strategol eu cynnal yn rheolaidd ag arweinwyr clinigol a swyddogion gweithredol allweddol, gan sicrhau bob pynciau fel diogelwch cleifion, llywodraethu ac ansawdd bob amser yn cael sylw. Pan fydd pryderon, bydd y model yn pennu llwybrau uwchgyfeirio clir ac amserol er mwyn gallu ymdrin â materion yn gyflym ac mewn ffordd gydweithredol. Drwy gydol y broses, bydd pwyslais cryf ar dryloywder, partneriaeth a chyfathrebu dwy ffordd â rhanddeiliaid, gan sicrhau bod gweithgareddau sicrwydd yn rhagweithiol ac yn ymateb i anghenion datblygol GIG Cymru.

Disgwyliadau ar gyfer Byrddau Iechyd ac Ymddiriedolaethau'r GIG

Gwaith ymgysylltu strategol a chyffredinol

Mae gan AGIC ddisgwyliadau clir wrth ymgysylltu â sefydliadau GIG Cymru, boed hynny drwy ymweliadau wyneb yn wyneb neu drwy ryngweithio o bell.

Cyfarfodydd ar y cyd

Disgwylir i Fyrddau Iechyd ac Ymddiriedolaethau'r GIG ymgysylltu ag AGIC drwy gyfarfodydd strwythuredig fel y bo'n ofynnol. Bydd y cyfarfodydd hyn yn amrywio ar draws timau AGIC a byddant yn canolbwyntio ar y wybodaeth sydd gan AGIC am risgiau parhaus neu risgiau sy'n dod i'r amlwg, canfyddiadau a gwaith dilynol o weithgarwch sicrwydd AGIC, llywodraethu ac arweinyddiaeth, ansawdd gofal, breguster gwasanaethau a gwaith cynllunio strategol.

Tryloywder a rhannu tystiolaeth

Rhaid i Fyrddau Iechyd ac Ymddiriedolaethau'r GIG roi data amserol, cywir a chynhwysfawr i AGIC i gefnogi holl waith sicrwydd AGIC. Rhaid iddynt hefyd roi dogfennaeth berthnasol i AGIC pan ofynnir amdani ac o fewn unrhyw derfynau amser a bennir, ymateb i geisiadau sicrwydd am wybodaeth a thystiolaeth a chymryd rhan mewn trafodaethau thematig fel y bo'n ofynnol.

Y Ddyletswydd Ansawdd

Mae Deddf Iechyd a Gofal Cymdeithasol (Ansawdd ac Ymgysylltu) (Cymru) 2020 yn ehangu'r ddyletswydd ar gyrff y GIG mewn perthynas ag ansawdd. Mae'n ofynnol i Fyrddau Iechyd ac Ymddiriedolaethau'r GIG ymgysylltu ag Arolygiaeth Gofal Iechyd Cymru (AGIC) i ddangos y gwelliannau y maent yn eu gwneud o ran effeithiolrwydd, diogelwch a phrofiadau gofal. Wrth gyflawni eu cyfrifoldebau ansawdd, dylai cyrff y GIG ystyried Safonau Ansawdd Iechyd a Gofal 2023 wrth wneud penderfyniadau am wasanaethau gofal iechyd. Awgrymir hefyd y dylai sefydliadau gynnwys canfyddiadau AGIC yn eu hadroddiadau ansawdd ac y dylent sicrhau cysondeb â'r Safonau Ansawdd Iechyd a Gofal wrth wneud penderfyniadau ynghylch darparu gwasanaethau.

Gwella a dysgu'n barhaus

Dylai ymgysylltu ag AGIC feithrin diwylliant o welliant parhaus, gan gynnwys gweithredu'n unol â chanfyddiadau arolygiadau, rhannu'r gwersi a ddysgwyd ar draws y system, a dangos arweinyddiaeth ac atebolrwydd. Disgwylir i gyrff y GIG roi systemau rheoli ansawdd ar waith a defnyddio adborth i wella gwasanaethau. Dylai Byrddau Iechyd ac Ymddiriedolaethau'r GIG hefyd uwchgyfeirio pryderon drwy sianeli y cytunwyd arnynt a chyfrannu at brosesau datrys.

Cydgynhyrchu ag ymgysylltu â rhanddeiliaid

Mae AGIC yn disgwyl i Fyrddau Iechyd ac Ymddiriedolaethau'r GIG ddangos sut mae safbwyntiau rhanddeiliaid, gan gynnwys safbwyntiau cleifion a staff, yn llywio'r broses o ddylunio a gwella gwasanaethau. Mae'r dull cydgynhyrchu hwn yn cynnwys gwrando ar brofiadau bywyd ac adborth, sicrhau dulliau cyfathrebu cynhwysol a dwyieithog, a chanolbwyntio ar gydraddoldeb, amrywiaeth a chynhwysiant.

Yr awdurdod i gael mynediad ac i arolygu

Wrth gynnal gwaith sicrwydd, rhaid i sefydliadau GIG Cymru fod yn ymwybodol bod gan staff AGIC awdurdod i wneud y canlynol:

- Cael mynediad ac arolygu safle
- Cyfweld â phobl
- Archwilio dogfennau neu gofnodion, gwneud copïau ohonynt a mynd â nhw
- Cymryd mesuriadau, tynnu ffotograffau a gwneud recordiadau
- Cael mynediad i unrhyw gyfrifiadur a chyfarpar cysylltiedig
- Cymryd camau eraill, yn unol â'r ddeddfwriaeth ganlynol:
    - Deddf Iechyd a Gofal Cymdeithasol (Iechyd Cymunedol a Safonau) 2003
    - Deddf Safonau Gofal 2000
    - Deddf Iechyd a Diogelwch yn y Gwaith 1974.

Cyfarfodydd ymgysylltu wedi'u cynllunio ag AGIC

Mae'r isafswm ar gyfer y cyfarfodydd ymgysylltu gofynnol bob blwyddyn a'r cyfranogwyr allweddol wedi'u nodi yn **Nhabl 1** isod.

Tabl 1: Cyfarfodydd ymgysylltu wedi'u cynllunio – cyfranogwyr

Tîm AGIC	Staff y Bwrdd Iechyd neu'r Ymddiriedolaeth	Amlder
• Prif Weithredwr • Cyfarwyddwr Sicrwydd • Pennaeth Sicrwydd y GIG	✓ Prif Weithredwr ✓ Cadeirydd (cyfarfod ar y cyd)	Chwe mis
• Pennaeth Sicrwydd y GIG	✓ Prif Swyddog Gweithredol	Chwe mis
	✓ Aelodau Annibynnol Penodedig	Chwe mis
• Y Tîm Clinigol Acíwt	✓ Cyfarwyddwr Nyrsio ✓ Cyfarwyddwr Meddygol ✓ Cyfarwyddwr Perthynol i Iechyd a Therapïau (cyfarfod ar y cyd)	Pedwar mis
• Tîm Clinigol Iechyd Meddwl ac Anableddau Dysgu	✓ Cyfarwyddwyr Iechyd Meddwl ac Anableddau Dysgu ✓ Arweinwyr Clinigol Iechyd Meddwl ac Anableddau Dysgu ✓ Gweinyddwyr y Ddeddf Iechyd Meddwl (cyfarfod ar y cyd)	Pedwar mis

Caiff cyfarfodydd eu trefnu am o leiaf un awr, neu am gyfnod hirach os bydd angen.

Gall naill ai AGIC neu sefydliadau GIG Cymru ofyn am gyfarfodydd ychwanegol fel y bo'n briodol.

Caiff pob cyfarfod ymgysylltu ei strwythuro a'i ddogfennu, a bydd yr agendâu yn seiliedig ar wybodaeth ac yn cael eu rhannu ymlaen llaw.

Caiff canlyniadau cyfarfodydd eu cofnodi a'u rhannu â'r Bwrdd Iechyd perthnasol neu Ymddiriedolaeth berthnasol y GIG, ar draws timau AGIC, a gyda rhanddeiliaid perthnasol fel y bo'n briodol.

Gohebiaeth mewn perthynas ag arolygiadau neu adolygiadau

Mae AGIC wedi wynebu heriau wrth gydgysylltu'r unigolion a ddylai dderbyn gohebiaeth mewn perthynas ag arolygiadau, gan gynnwys adroddiadau a llythyrau, o fewn sefydliadau'r GIG. Ceir heriau pan fydd staff yn symud i rolau newydd neu pan fydd sefydliadau yn gwneud cais i gynnwys nifer o unigolion, nad yw o bosibl yn gydnaws â gweithdrefnau sefydledig AGIC. Gall sefyllfaoedd o'r fath arwain at restrau enwau cyswllt sydd wedi dyddio, amwysedd o ran pwy ddylai dderbyn gwybodaeth, a'r risg y bydd partïon heb awdurdod yn gallu gweld deunyddiau cyfrinachol. Gall y ffactorau hyn oedi'r broses gyfathrebu a chymhlethu camau gweithredu dilynol yn dilyn arolygiadau.

Er mwyn sicrhau cysondeb, bydd AGIC yn anfon gohebiaeth sicrwydd ysgrifenedig mewn perthynas ag arolygiadau ac adolygiadau at dderbynwyr dynodedig ym mhob un o sefydliadau'r GIG. Bydd y derbynwyr dynodedig yn gyfrifol am ledaenu'r wybodaeth i'w timau mewnol priodol. Mae hyn hefyd yn berthnasol i weithgareddau sicrwydd mewn practisau deintyddol a phractisau meddygon teulu. Rhestrir y derbynwyr dynodedig yn **Nhabl 2**.

Tabl 2: Derbynwyr gohebiaeth sicrwydd AGIC

- Prif weithredwr
- Cadeirydd
- Cyfarwyddwr Gweithredol Nyrsio
- Cyfarwyddwr Meddygol Gweithredol
- Cyfarwyddwr Gweithredol Therapïau a Pherthynol i Iechyd
- Blwch negeseuon e-bost enwebedig (fel Timau Llywodraethu / Diogelwch Cleifion)

Er eglurder, ni fydd AGIC yn anfon gohebiaeth sicrwydd (arolygiadau nac adolygiadau) at unigolion eraill, fel arweinwyr gofal sylfaenol a chymunedol ar gyfer arolygiadau o bractisau deintyddol neu bractisau meddygon teulu mwyach, ac ni fydd yr 'unigolion eraill' yn cael gwahoddiadau i borth rhannu diogel AGIC, Objective Connect. Bydd y derbynwyr uchod yn gyfrifol am rannu dogfennau perthnasol AGIC â thimau perthnasol yn y sefydliad, ac am lanlwytho ymatebion a thystiolaeth fel y bo'n briodol, i weithfan Objective Connect.

Mae'n bwysig nodi ar gyfer unrhyw ohebiaeth arall, fel pryderon neu ohebiaeth â Thimau Ymchwilio AGIC, a gohebiaeth arolygu ad hoc â thîm Cymorth Arolygu AGIC, y byddwn yn cyfathrebu ag unigolion perthnasol eraill fel y bo'n briodol.

Ymgysylltu parhaus ag AGIC

Bydd dulliau cyfathrebu â staff AGIC yn amrywio a byddant yn dibynnu ar thema'r cyfarfod neu'r pwnc i'w drafod. Bydd bob amser adegau lle bydd angen i aelodau allweddol o staff o fewn sefydliadau'r GIG gysylltu ag AGIC ac i'r gwrthwyneb. Gall hyn fod mewn perthynas ag ymholiadau cyffredinol, i drafod diogelwch cleifion, gofal neu faterion clinigol, a materion anghlinigol, fel newidiadau i wasanaethau neu newidiadau sefydliadol. Mae **Tabl 3** yn nodi pa dîm yn AGIC y dylid cysylltu ag ef i ddechrau, ond, lle y bo'n briodol, mae'n bosibl y caiff eich cyfeiriad e-bost ei roi i dîm gwahanol i ymdrin â'r mater. Ceir canllawiau ar sut i gysylltu ag AGIC yn Nhabl 3 isod.

Tabl 3: Canllawiau ar gysylltu - timau allweddol AGIC

Enghraifft o Ymholiad/ Hysbysiad:	Enghraifft o'r angen ymgysylltu:	Gyda phwy y dylid cysylltu:
Ymholiadau Cyffredinol.	Ansicrwydd o ran pwy y dylid cysylltu ag ef yn AGIC. Cael manylion cyswllt tîm. Ymholiad am brosesau AGIC. Cofnodi pryderon cyn eu huwchgyfeirio i'r Tîm Ymchwilio. Codi pryderon am AGIC.	**Pwynt Cyswllt Cyntaf AGIC** **E-bost:** AGIC@llyw.cymru **Ffôn:** 0300 062 8163 **Dolen i:** Cysylltwch â ni **Dolen i:** Y dudalen Dysgu a Dealltwriaeth
Ymholiadau am arolygiad arfaethedig neu'n dilyn arolygiad dirybudd.	Ymholiad am arolygiad y mae AGIC yn bwriadu ei gynnal. Ymholiad ar ôl cwblhau arolygiad. Ymholiad am ddefnyddio Gweithfan Objective Connect.	**Y Tîm Cymorth Arolygu** **E-bost:** AGIC.arolygu@llyw.cymru **Ffôn:** 0300 062 8163 **Dolen i:** Arolygu Gwasanaethau'r GIG
Y Gwasanaeth Adolygu ar gyfer Iechyd Meddwl.	Defnyddio'r Ddeddf Iechyd Meddwl a buddiannau'r bobl y caiff eu hawliau eu cyfyngu o dan y Ddeddf honno. Ceisiadau ar gyfer Gwasanaeth Meddyg a Benodwyd i Roi Ail Farn AGIC ac ymholiadau cysylltiedig.	**Y Gwasanaeth Meddyg a Benodwyd i Roi Ail Farn (SOAD)** **E-bost:** HIW.RSMH@gov.wales **Ffôn:** 0300 062 8163 **Dolen i:** Dogfennau SOAD

Trafod materion sy'n ymwneud ag ansawdd a diogelwch clinigol neu ansawdd a diogelwch cleifion.	Trafodaethau am ansawdd a diogelwch clinigol a/neu gleifion.	**Y Tîm Clinigol Acíwt** **E-bost:** HIW.AcuteClinical@gov.wales **Y Tîm Iechyd Meddwl ac Anableddau Dysgu** **E-bost** HIW.MentalHealth.Clinical@gov.wales **Ffôn:** 0300 062 8163
Materion anghlinigol. Materion yn ymwneud â'r gwasanaeth neu faterion sefydliadol allweddol. Canfyddiadau adroddiadau ymchwilio mewnol. Rhybudd cynnar am adroddiadau proffil uchel yn y cyfryngau.	Trafod materion gweithredol brys neu gynlluniedig, fel y materion hynny sy'n effeithio ar y gallu i ddarparu gwasanaethau. Hysbysiad brys am ddifrod/ materion yn ymwneud â'r ystad. Trafod canfyddiadau allweddol am ymchwiliadau neu adolygiadau mewnol, fel adolygiadau o ddiwylliant, ymddygiad a gwerthoedd. Mae digwyddiad wedi bod sy'n debygol o ddenu sylw yn y cyfryngau, felly rhoi rhybudd cynnar i AGIC.	**Pennaeth Sicrwydd y GIG** **E-bost:** HIW-NHSassurance@gov.wales **Ffôn:** 0300 062 8163
Y broses o gynnal adolygiad clinigol o Farwolaeth yn y Ddalfa.	Ymholiad am y broses o gynnal adolygiad clinigol o Farwolaeth yn y Ddalfa. Cyflwyno dogfennau allweddol mewn perthynas â Marwolaeth yn y Ddalfa, adroddiadau, cynlluniau gwella i gefnogi'r adolygiad. Ymholiad am adolygiad clinigol parhaus neu flaenorol o Farwolaeth yn y Ddalfa.	**Tîm Sicrwydd y GIG** **E-bost:** HIW-NHSassurance@gov.wales **Ffôn:** 0300 062 8163 **Dolen i:** Marwolaethau mewn Carchardai
Trafod achos newydd neu bresennol sy'n destun pryder i AGIC. Rhoi gwybod am ddigwyddiad yn ymwneud â'r Rheoliadau Ymbelydredd Ïoneiddio (Cysylltiad Meddygol).	Rhoi gwybod am bryder newydd. Holi am bryder parhaus sy'n effeithio ar glaf/ y cyhoedd. Pryder chwythu'r chwiban. Cyflwyno hysbysiad sy'n ymwneud â'r Rheoliadau Ymbelydredd Ïoneiddio (Cysylltiad Meddygol).	**Y Tîm Ymchwiliadau** **E-bost:** HIW.Concerns@gov.wales **Ffôn:** 0300 062 8163 **Dolen i:** Cwynion amdanon (AGIC) **Dolen i:** Chwythu'r chwiban **Dolen i:** Rhoi gwybod am Ddigwyddiadau yn ymwneud â'r Rheoliadau Ymbelydredd Ïoneiddio (Amlygiad Meddygol)

Trafod y broses uwchgyfeirio a gorfodi. Trafod y broses ar gyfer Gwasanaeth sy'n Peri Pryder. Trafod achos presennol/ gweithredol sy'n ymwneud â GIG Cymru sydd wedi'i uwchgyfeirio.	Holi am broses uwchgyfeirio a gorfodi AGIC. Gofyn am eglurder ynghylch proses AGIC ar gyfer Gwasanaeth sy'n Peri Pryder. Trafod dynodiad y sefydliad fel Gwasanaeth sydd Angen ei Wella'n Sylweddol. Cyflwyno gwybodaeth am broses AGIC ar gyfer Gwasanaeth sy'n Peri Pryder neu'n unol â'r gofynion fel Gwasanaeth sydd Angen ei Wella'n Sylweddol.	**Y Tîm Uwchgyfeirio a Gorfodi** **E-bost:** HIW.Enforcement@gov.wales **Ffôn:** 0300 062 8163 **Dolen i:** Y dudalen Uwchgyfeirio
Ymholiad am gofrestru gwasanaeth, fel practis deintyddol.	Ymholiad am statws cofrestru Practis Deintyddol o fewn ardal bwrdd iechyd	**Y Tîm Cofrestru** **E-bost:** AGIC.Cofrestru@llyw.cymru **Ffôn:** 0300 062 8163 **Dolen i:** Ymholiadau Cofrestru
Trafod prosesau AGIC ar gyfer cyfathrebu, cyhoeddi, y cyfryngau a'r cyfryngau cymdeithasol.	Trafod gwefan AGIC neu gynnwys AGIC ar y cyfryngau cymdeithasol Trefniadau ymgysylltu rhwng timau cyfathrebu yn sefydliadau GIG Cymru ac AGIC.	**Y Tîm Strategaeth a Chyfathrebu** **E-bost:** AGIC.cyfathrebu@llyw.cymru **Ffôn:** 0300 062 8163 **Dolen i:** Amserlen gyhoeddi **Dolen i:** Cael y newyddion diweddaraf (Bwletinau) **Dolen i:** Tudalen y cyfryngau cymdeithasol

Atodiadau

Atodiad 1: Newidiadau allweddol o'r model ymgysylltu gan ddefnyddio Rheolwyr Cydberthnasau

Gwnaed sawl newid allweddol wrth weithredu'r Model newydd ar gyfer Ymgysylltu â GIG Cymru, gan gynnwys:

- Diddymwyd rôl flaenorol Rheolwyr Cydberthnasau ac fe'i disodlwyd gan broses fanylach wedi'i chynllunio i atgyfnerthu trefniadau AGIC ar gyfer ymgysylltu â Byrddau Iechyd ac Ymddiriedolaethau'r GIG

- Diwygiwyd y rhestr ddosbarthu ar gyfer gohebiaeth sicrwydd AGIC yn sefydliadau GIG Cymru er mwyn hwyluso gwell cysondeb a lleihau gwallau

- Trosglwyddwyd y cyfrifoldeb dros oruchwylio'r Broses ar gyfer Ymgysylltu â'r GIG i Bennaeth Sicrwydd y GIG, wedi'i gefnogi gan ddau dîm clinigol a'r tîm gwybodaeth

- Bydd timau clinigol AGIC yn cynnal cyfarfodydd ymgysylltu rheolaidd ag arweinwyr gweithredol ac arweinwyr clinigol allweddol, gan ganolbwyntio ar themâu clinigol, diogelwch cleifion, llywodraethu, ac ansawdd

- Bydd Pennaeth Sicrwydd y GIG yn cynnal cyfarfodydd ymgysylltu anghlinigol wedi'u cynllunio â Phrif Swyddogion Gweithredu ac Aelodau Annibynnol y Bwrdd i drafod heriau gweithredol, a lle y bo'n briodol, ganfyddiadau allweddol priodol o arolygiadau

- Bydd y Tîm Partneriaethau yn cynnal cyfarfodydd ymgysylltu rheolaidd â rhanddeiliaid allanol, fel Llais, Archwilio Cymru, Archwilio Mewnol, Colegau Brenhinol, a chynrychiolwyr o Perfformiad a Gwella'r GIG

- Cafodd gweithdrefnau uwchgyfeirio yn AGIC eu hegluro ymhellach a chânt eu cydgysylltu ar ffurf ganolog.

Atodiad 2: Rhannu a defnyddio gwybodaeth

Mae gan AGIC lawer o gytundebau rhannu gwybodaeth â sefydliadau eraill rydym yn gweithio'n agos gyda nhw. Mae'r cytundebau hyn yn nodi'r rhesymeg dros rannu gwybodaeth er mwyn helpu'r sefydliadau i gyflawni eu hamcanion statudol cyffredin a chanolbwyntio ar eu priod weithgareddau. Maent yn helpu i ddatblygu rhaglenni gwaith sy'n ategu ei gilydd, gan sicrhau bod prosesau clir ar waith i rannu gwybodaeth, risgiau a phryderon.

Lle bydd risgiau posibl i ddiogelwch y cyhoedd, cleifion neu staff, bydd AGIC yn rhannu gwybodaeth ag awdurdodau/sefydliadau perthnasol fel yr heddlu, byrddau diogelu awdurdodau lleol a'r Awdurdod Gweithredol Iechyd a Diogelwch. Gallwch weld y cytundebau rhannu gwybodaeth ar ein gwefan: **Memoranda Cyd-ddealltwriaeth AGIC gyda Sefydliadau eraill**.

Caiff yr holl weithgareddau a chanlyniadau ymgysylltu eu storio'n ddiogel ar systemau electronig diogel AGIC (sef Pwls ac iShare). Defnyddir tystiolaeth a gwybodaeth i lywio penderfyniadau strategol, nodi risgiau a chefnogi gwelliannau parhaus ym mhob rhan o GIG Cymru a'r sector gofal iechyd annibynnol.

Rheoliad Cyffredinol ar Ddiogelu Data

Yn unol â'r Rheoliad Cyffredinol ar Ddiogelu Data, mae dyletswydd gyfreithiol arnom i ddiogelu unrhyw wybodaeth bersonol rydym yn ei chasglu gennych. Rydym yn defnyddio technolegau a meddalwedd amgryptio blaengar i ddiogelu eich data, ac yn cadw at safonau diogelwch caeth er mwyn atal unrhyw fynediad heb awdurdod atynt.

Mae rhagor o wybodaeth am ein **polisi preifatrwydd** ar gael ar ein gwefan.

Atodiad 3: Rôl timau AGIC wrth ymgysylltu â GIG Cymru

Mae'n bosibl na fydd rhai o dimau AGIC yn cymryd rhan uniongyrchol yn y Broses ar gyfer Ymgysylltu â GIG Cymru, ond byddant yn cefnogi timau perthnasol AGIC fel y bo'n briodol.

Y Gangen Partneriaeth, Gwybodaeth a Methodoleg

Mae'r Gangen Partneriaeth, Gwybodaeth a Methodoleg yn cynnwys tri thîm: Partneriaeth, Gwybodaeth a Methodoleg. Mae'r gangen yn helpu AGIC drwy gasglu gwybodaeth, asesu risgiau, datblygu methodolegau arolygu, a gweithio gyda phartneriaid i helpu i ysgogi gwelliannau ar draws gwasanaethau gofal iechyd. Mae'r gangen yn sicrhau bod arolygiadau wedi'u targedu a'u bod yn effeithiol, yn helpu i ymdrin â phryderon, ac yn llywio gwelliannau i'r system gyfan drwy waith dadansoddi a chydweithio strategol.

Y Tîm Partneriaethau

Mae'r Tîm Partneriaethau yn cynnal cydberthnasau ac yn ymgysylltu â rhanddeiliaid allanol ac yn rheoli Memoranda Cyd-ddealltwriaeth AGIC â sefydliadau eraill.

Mae'r tîm hefyd yn hwyluso'r Uwchgynhadledd Gofal Iechyd genedlaethol a gynhelir ddwywaith y flwyddyn, i rannu gwybodaeth am ansawdd a diogelwch gwasanaethau gofal iechyd a ddarperir gan GIG Cymru. Mae manylion ychwanegol am ddiben yr Uwchgynhadledd, a'r sefydliadau sy'n cymryd rhan, ar gael ar ein **gwefan**.

Mae rôl partneriaethau o fewn y Broses ar gyfer Ymgysylltu â'r GIG yn allweddol wrth greu a chynnal cydberthnasau strategol rhwng rhanddeiliaid er mwyn cael sicrwydd gan y GIG. Gan ddibynnu ar y rhanddeiliad, gall 'diben' ymgysylltu newid, gan amrywio o rannu gwybodaeth a sganio'r gorwel, i driongli safbwyntiau ar faterion sy'n allweddol i GIG Cymru, fel risgiau thematig neu risgiau o fewn lleoliadau unigol.

Mae'r tîm wedi datblygu map rhanddeiliaid er mwyn ymgysylltu'n rheolaidd, sy'n cynnwys sefydliadau, fel Archwilio Cymru, Llais, a Perfformiad a Gwella GIG Cymru. Yn ogystal, bydd y tîm yn mynychu cyfarfodydd allweddol ym mhob rhan o Lywodraeth Cymru, Arolygiaeth Gofal Cymru (AGC) ac Estyn, er mwyn casglu gwybodaeth ehangach. Bydd y wybodaeth a geir drwy'r cydberthnasau hyn a'r cyfleoedd ymgysylltu hyn yn bwydo i mewn i Grŵp Gwybodaeth Wythnosol AGIC ac yn helpu i lywio cynigion ar gyfer cynnal gwaith sicrwydd ar y cyd.

Y Tîm Gwybodaeth

Mae'r Tîm Gwybodaeth yn casglu ac yn dadansoddi data o arolygiadau, adolygiadau, adborth cyhoeddus a sawl ffynhonnell allanol i nodi risgiau a thueddiadau mewn gwasanaethau gofal iechyd. Defnyddir y wybodaeth i lywio Bwrdd Cynllunio Strategol a Phwyllgor Risg ac Uwchgyfeirio AGIC a'r Uwch-dîm Arwain, gan helpu i gynllunio neu

addasu blaenoriaethau arolygu ac ymateb i faterion sy'n dod i'r amlwg. Mae'r tîm yn cynnal dangosfyrddau ac yn llunio adroddiadau er mwyn helpu Uwch-dîm Arwain AGIC i fonitro perfformiad a nodi meysydd pryder.

Mae'r tîm hefyd yn rhoi gwybodaeth berthnasol i arolygwyr ac adolygwyr i lywio eu gwaith ac i sicrhau ei fod wedi'i dargedu ac yn effeithiol, ac mae'n datblygu, yn dadansoddi ac yn adrodd ar arolygon a ddefnyddir yn ystod arolygiadau ac adolygiadau. Yn ogystal, mae'r tîm yn annog tryloywder a gwelliant, drwy gefnogi proses AGIC ar gyfer Gwasanaethau sy'n Peri Pryder, gan alluogi camau gweithredu cyflym lle na fydd safonau gofal yn cael eu cyrraedd.

Defnyddir gwybodaeth i sicrhau bod rhaglen waith sicrwydd AGIC yn canolbwyntio ar leoliadau lle mae'r risg fwyaf na fydd cleifion yn cael y gofal gorau posibl. Mae'r tîm yn dehongli amrywiaeth eang o wybodaeth er mwyn gwneud penderfyniadau effeithiol a phriodol o ran sut y mae AGIC yn defnyddio adnoddau. Er mwyn cyflawni hyn, mae systemau a phrosesau ar waith i sicrhau bod penderfyniadau yn gyson ac yn seiliedig ar dystiolaeth.

Mae gwybodaeth allweddol yn bwydo i mewn i'r tîm gwybodaeth drwy amrywiaeth o ffynonellau (yn fewnol ac yn allanol), a chaiff hyn ei drafod yng Nghyfarfodydd Gwybodaeth Wythnosol AGIC. Caiff y wybodaeth a gesglir ei chyflwyno i dimau allweddol AGIC, ac i'r Bwrdd Cynllunio Strategol a'r Pwyllgor Risg ac Uwchgyfeirio, er mwyn llywio ac ailflaenoriaethu gwaith sicrwydd AGIC fel y bo'n briodol.

Mae'r tîm hefyd yn llunio papur briffio er mwyn helpu i lywio trafodaethau ymgysylltu ag arweinwyr clinigol Byrddau Iechyd ac Ymddiriedolaethau'r GIG. Gall y briff gynnwys canfyddiadau allweddol, fel manylion cyfarfodydd y Bwrdd, y Pwyllgor Ansawdd a Diogelwch neu'r Pwyllgor Deddfwriaeth Iechyd Meddwl, papurau cyfarfodydd y Tîm Gweithredol ar y Cyd, neu fanylion o Gynlluniau Tymor Canolig Integredig, a data a gafwyd gan Lywodraeth Cymru neu ar lefel genedlaethol.

Y Tîm Methodoleg

Mae'r Tîm Methodoleg yn sicrhau bod arolygiadau, adolygiadau neu ymchwiliadau AGIC yn cael eu cynnal mewn ffordd gyson, deg ac effeithiol, gan ddefnyddio dulliau cadarn yn seiliedig ar dystiolaeth, ac mae'n ystyried Safonau Ansawdd Iechyd a Gofal 2023 a rheoliadau a deddfwriaeth arall. Mae'r tîm yn dylunio ac yn cynnal methodolegau safonedig ar gyfer gwaith sicrwydd, gan sicrhau cysondeb a thryloywder ar draws holl weithgareddau AGIC. Caiff methodolegau hefyd eu haddasu ar gyfer gwahanol sectorau ac arbenigeddau gofal iechyd, gan ystyried risgiau a chyd-destunau gweithredol unigryw, a lle y bo'n berthnasol, cânt eu teilwra'n benodol at waith adolygu.

Mae'r tîm yn addasu i risgiau sy'n dod i'r amlwg ac yn mireinio methodolegau i ymateb i heriau newydd, sy'n golygu y gellir rhoi cyngor cyflym a chefnogol er mwyn gwella

gwasanaethau. Yn ogystal, mae'r tîm yn sicrhau bod y staff wedi'u hyfforddi i roi methodolegau ar waith yn gywir ac yn gyson, gan hybu gwelliant parhaus mewn arferion arolygu.

Er mwyn sicrhau tryloywder, mae'r methodolegau ar gael, ar gais, i wasanaethau gofal iechyd, ac mae'r tîm yn sicrhau eu bod ar gael i randdeiliaid, gan atgyfnerthu ymddiriedaeth y cyhoedd yng ngwaith AGIC.

Nid oes gan y Tîm Methodoleg ran uniongyrchol i'w chwarae yn y Broses ar gyfer Ymgysylltu â'r GIG ond mae'n bosibl y bydd yn cysylltu â sefydliadau os bydd angen.

Y Gangen Glinigol

Mae'r Gangen Glinigol yn cynnwys dau dîm: y Tîm Clinigol Acíwt a'r Tîm Iechyd Meddwl ac Anableddau Dysgu. Mae'r timau yn chwarae rhan allweddol wrth sicrhau bod gwasanaethau gofal iechyd ledled Cymru yn cyrraedd safonau uchel o ran diogelwch, effeithiolrwydd a gofal sy'n canolbwyntio ar yr unigolyn. Maent yn goruchwylio gwaith AGIC o safbwynt clinigol ac yn rhoi cyngor clinigol i arolygwyr ac i holl dimau AGIC lle y bo angen. Maent hefyd yn cyfrannu at farn AGIC, yn enwedig mewn perthynas â diogelwch cleifion, llywodraethu clinigol, ac ansawdd gofal. Yn ogystal, maent yn helpu i ddehongli'r Ddyletswydd Ansawdd a'i rhoi ar waith mewn lleoliadau go iawn.

Y Tîm Clinigol Acíwt

Mae'r Tîm Clinigol Acíwt yn canolbwyntio ar bob lleoliad clinigol sy'n rhan o GIG Cymru a'r sector gofal iechyd annibynnol, ond heb gynnwys Gwasanaethau Iechyd Meddwl ac Anableddau Dysgu, y mae'r Tîm Iechyd Meddwl ac Anableddau Dysgu yn gyfrifol amdanynt.

Y Tîm Iechyd Meddwl / Anableddau Dysgu

Mae cylch gwaith y Tîm Iechyd Meddwl ac Anableddau Dysgu yn cynnwys Gwasanaethau Iechyd Meddwl ac Anableddau Dysgu sy'n rhan o GIG Cymru a'r sector gofal iechyd annibynnol. Mae'r tîm yn canolbwyntio ar ddiogelwch clinigol, cydymffurfiaeth gyfreithiol â'r Ddeddf Iechyd Meddwl (1983) ac yn sicrhau y caiff gofal ei roi yn unol â **Chod Ymarfer Cymru (2016)**.

- **Cyfarfodydd ymgysylltu â'r GIG**
  Mae'r timau clinigol yn arwain y broses ymgysylltu ar y cyd ag arweinwyr neu reolwyr clinigol gweithredol a/neu uwch-arweinwyr neu reolwyr clinigol o fewn sefydliadau GIG Cymru. Mae hyn yn allweddol nid yn unig o ran cael sicrwydd am y ffordd y mae Byrddau Iechyd ac Ymddiriedolaethau'r GIG yn cael sicrwydd eu hunain, ond hefyd o ran rhannu gwybodaeth, sganio'r gorwel a chael sicrwydd

ynghylch risgiau a themâu sy'n dod i'r amlwg. Yn ystod cyfarfodydd ymgysylltu, bydd pwyslais hefyd ar ansawdd, rhannu gwybodaeth, rhybuddion cynnar ac uwchgyfeirio er mwyn nodi problemau posibl gan ddefnyddio ffrydiau gwybodaeth.

Bydd y cyfarfodydd ymgysylltu yn cynnig cyfle anffurfiol i rannu gwybodaeth feddal a chaled a byddant yn cynnig ffordd ddefnyddiol o driongli ac ategu gwybodaeth y mae AGIC yn ymwybodol ohoni, neu ddysgu gwybodaeth newydd a all fod yn berthnasol, a nodi meysydd risg newydd a gaiff eu hystyried fel rhan o weithgarwch sicrwydd AGIC. Bydd Tîm Gwybodaeth AGIC yn darparu papur briffio i'r timau clinigol cyn y cyfarfodydd ymgysylltu wedi'u cynllunio.

Tîm y Gwasanaeth Adolygu ar gyfer Iechyd Meddwl

Mae'r Tîm hwn yn rhan o rôl sicrwydd ehangach AGIC i fonitro cydymffurfiaeth â'r Ddeddf Iechyd Meddwl a sicrhau safonau gofal uchel.

Un o'r rolau hanfodol yn y tîm hwn yw'r gwasanaeth Meddygon a Benodir i Roi Ail Farn (SOAD). Mae'r tîm yn chwarae rhan ganolog wrth ddiogelu hawliau cleifion sy'n ddarostyngedig i Ddeddf Iechyd Meddwl 1983. Pan gaiff claf ei gadw neu os yw'n debygol y caiff claf ei gadw o dan y Ddeddf Iechyd Meddwl a'i fod yn gwrthod triniaeth (neu nad yw'n meddu ar y galluedd i gydsynio i driniaeth), penodir Meddyg a Benodir i Roi Ail Farn i ystyried a yw'r driniaeth arfaethedig yn briodol. Mae hyn yn sicrhau na chaiff y penderfyniadau o ran triniaeth eu gwneud gan y clinigydd sy'n trin y claf yn unig, gan ychwanegu haen oruchwylio annibynnol.

Mae'r broses Meddygon a Benodir i Roi Ail Farn yn anelu at amddiffyn unigolion agored i niwed drwy sicrhau bod y driniaeth a gânt yn gyfreithlon, yn foesegol ac y gellir ei chyfiawnhau o safbwynt clinigol. Felly, mae'n ofynnol i Feddygon a Benodir i Roi Ail Farn awdurdodi triniaethau penodol, fel meddyginiaeth y tu hwnt i dri mis neu Therapi Electrogynhyrfol (ECT), o dan adrannau 57, 58 a 62 o Ddeddf Iechyd Meddwl 1983.

Y Gangen Rheoleiddio ac Uwchgyfeirio

Mae'r Gangen Rheoleiddio ac Uwchgyfeirio yn cynnwys tri thîm: y Tîm Cofrestru, y Tîm Uwchgyfeirio a Gorfodi a'r Tîm Ymchwiliadau. Mae gan y gangen ran hanfodol i'w chwarae wrth sicrhau bod gwasanaethau gofal iechyd annibynnol yng Nghymru yn ddiogel, yn cydymffurfio ac yn cyrraedd y safonau rheoliadol. Mae hefyd yn rheoli **proses AGIC ar gyfer Gwasanaethau sy'n Peri Pryder i Gyrff y GIG yng Nghymru**.

Y Tîm Cofrestru

Mae AGIC yn gyfrifol am gofrestru darparwyr gofal iechyd a rheolwyr gwasanaethau gofal iechyd annibynnol yng Nghymru, o dan Ddeddf Safonau Gofal 2000 a rheoliadau

cysylltiedig. Mae hyn yn cynnwys Ysbytai Annibynnol, Clinigau ac Asiantaethau Meddygol, a Phractisau Deintyddol Preifat lle mae darparwyr yn cynnig gwasanaethau deintyddol preifat y tu allan i Fframwaith y GIG. Mae'r Tîm Cofrestru yn asesu a oes angen i wasanaeth gofrestru ac yn sicrhau bod darparwyr yn cyrraedd y Safonau Gofynnol Cenedlaethol cyn eu cofrestru.

Y Tîm Gorfodi ac Uwchgyfeirio

Mae'r Tîm Gorfodi ac Uwchgyfeirio yn arwain prosesau uwchgyfeirio ffurfiol, fel proses AGIC ar gyfer Gwasanaethau sy'n Peri Pryder i gyrff y GIG yng Nghymru. Yn ogystal, pan fydd gwasanaeth cofrestredig yn methu â chyflawni ei rwymedigaethau cyfreithiol a rheoliadol, mae AGIC yn gorfodi cydymffurfiaeth drwy brosesau strwythuredig sy'n briodol i'r sector Gofal Iechyd Annibynnol.

- **Uwchgyfeirio o fewn GIG Cymru**
  Mae AGIC yn rhoi blaenoriaeth i gymryd camau lle nad yw safonau yn cael eu cyrraedd. Er mwyn cynnal tryloywder a rhoi sicrwydd i'r cyhoedd ynghylch ansawdd a diogelwch gofal iechyd, mae AGIC yn defnyddio proses ar gyfer Gwasanaethau sy'n Peri Pryder i gyrff GIG Cymru pan fo'n nodi methiannau sylweddol o fewn gwasanaeth neu faterion systemig.

  Mae'r broses hon yn galluogi AGIC i nodi a thynnu sylw at 'Wasanaethau sydd Angen eu Gwella'n Sylweddol', gan felly wella tryloywder wrth gyflawni ei chyfrifoldebau. Mae'n sicrhau y caiff camau gweithredu amserol wedi'u targedu eu cymryd gan randdeiliaid perthnasol, gan gynnwys Byrddau Iechyd a Llywodraeth Cymru, i gynnal gofal diogel ac effeithiol. At hynny, mae'r dull hwn yn anelu at hwyluso gwelliannau a hybu cyfleoedd i ddysgu o fewn gwasanaethau sefydliad ac ym mhob rhan o GIG Cymru.

  Mae'r broses ar gyfer Gwasanaethau sy'n Peri Pryder a'r dynodiad ‘Gwasanaeth sydd Angen ei Wella'n Sylweddol’ dilynol yn annibynnol ac yn wahanol i Drefniadau Uwchgyfeirio ac Ymyrryd GIG Cymru. Fodd bynnag, bydd y broses hon yn llywio ein barn ac yn helpu ein cyfraniad at y trafodaethau ar statws cyffredinol cyrff y GIG yng Nghymru.

Y Tîm Ymchwiliadau

Mae'r tîm yn hanfodol wrth ddylanwadu ar ddiogelwch cleifion ac ansawdd gofal iechyd yng Nghymru a'u cefnogi. Mae'n rheoli chwythwyr chwiban a chwynion gan y cyhoedd, pryderon, a hysbysiadau statudol, gan ddefnyddio'r wybodaeth hon i nodi risgiau posibl i ddiogelwch cleifion neu broblemau â safonau gofal.

- **Rhannu gwybodaeth mewn ffordd ragweithiol**

Mae'r tîm yn helpu AGIC i nodi risgiau'n gynnar drwy gasglu gwybodaeth o gwynion, arolygiadau a hysbysiadau statudol.

- **Cefnogi prosesau uwchgyfeirio ac ymyrryd**
  Caiff gwybodaeth allweddol ei rhannu â Thîm Gorfodi ac Uwchgyfeirio AGIC yn unol â phroses AGIC ar gyfer Gwasanaethau sy'n Peri Pryder, ac â Chyfarwyddwr a Phennaeth Sicrwydd y GIG er mwyn helpu i lywio trafodaethau teirfforddd mewn perthynas â Threfniadau Uwchgyfeirio ac Ymyrryd y GIG.

- **Rhoi cylchoedd ymgysylltu ar waith**
  Caiff canfyddiadau ymchwiliadau eu hintegreiddio i waith ymgysylltu rheolaidd â chyrff y GIG, Llais, a rhanddeiliaid allweddol eraill. Mae hyn yn ategu'r cais i gyfranogi ac ymgynghori'n barhaus ym maes darparu gwasanaethau gofal iechyd.

- **Ysgogi gwelliant drwy ddealltwriaeth**
  Mae ymchwiliadau'r tîm yn llywio cynlluniau gwella strategol, gan helpu AGIC i gael sicrwydd bod sefydliadau'r GIG yn cyflawni'r Ddyletswydd Ansawdd, a'r Ddyletswydd Gonestrwydd o dan Ddeddf Iechyd a Gwasanaethau Cymdeithasol (Ansawdd ac Ymgysylltu) (Cymru) 2020.

- **Cydweithio**
  Mae'r tîm yn gweithio'n agos â Thimau Sicrwydd AGIC a'r timau Uwchgyfeirio a Gorfodi, Gwybodaeth, a Methodoleg, a gyda chyrff y GIG i sicrhau bod modd rhoi canfyddiadau ymchwiliadau ar waith a'u bod yn gydnaws â blaenoriaethau cenedlaethol.

  Bydd y Tîm Ymchwiliadau yn ymgysylltu'n uniongyrchol â sefydliadau GIG Cymru fel y bo'n ofynnol, a hynny'n ychwanegol at dderbynwyr gohebiaeth sicrwydd.

Y Gangen Strategaeth a Chyfathrebu

Mae'r Gangen Strategaeth a Chyfathrebu yn dîm traws-swyddogaeth sy'n gyfrifol am gynllunio strategol, dadansoddi polisïau, cyfathrebu, ac ymgysylltu. Mae'r gangen yn chwarae rhan ganolog wrth lywio cyfeiriad AGIC a sicrhau y caiff ei gwaith ei gyfleu a'i ddeall yn effeithiol.

- **Cyfrifoldebau strategol**
  Mae cynllunio strategol yn cynnwys datblygu cynlluniau strategol amlflwyddyn, cynlluniau gweithredol blynyddol, a chyhoeddiadau statudol fel yr adroddiad blynyddol. Mae'r gangen yn adolygu deddfwriaeth a pholisïau cenedlaethol perthnasol er mwyn asesu eu heffaith ar wasanaethau gofal iechyd yng Nghymru,

gan lunio nodiadau briffio mewnol i gefnogi gwaith cynllunio sefydliadol a gweithgarwch sicrwydd. Mae'r gwaith hwn yn gydnaws â blaenoriaethau cenedlaethol, gan gynnwys Deddf Llesiant Cenedlaethau'r Dyfodol (Cymru) a Cymru Iachach, ac mae'n ategu gallu AGIC i ymateb i risgiau a blaenoriaethau sy'n dod i'r amlwg.

- **Cyfrifoldebau cyfathrebu ac ymgysylltu**
  Mae'r gangen yn arwain gweithgarwch cyfathrebu ac ymgysylltu AGIC, gan sicrhau tryloywder yn y ffordd y caiff canfyddiadau, blaenoriaethau ac effaith eu rhannu â rhanddeiliaid, gan gynnwys y cyhoedd, cyrff y GIG, a darparwyr gofal iechyd annibynnol. Mae deunyddiau cyfathrebu yn hybu gwelliant drwy dynnu sylw at ymarfer da a'r gwersi a ddysgwyd o arolygiadau ac adolygiadau. Mae'r gangen hefyd yn rheoli gwefan AGIC, ei sianeli cyfryngau cymdeithasol a gweithgarwch sy'n gysylltiedig â'r wasg, gan sicrhau bod negeseuon yn glir ac yn hygyrch, a'u bod yn gydnaws ag amcanion strategol.

  Caiff gwaith ymgysylltu ei gydgysylltu drwy amrywiaeth o sianeli, gan gynnwys cylchlythyrau, ymgyrchoedd ymgynghori, a digwyddiadau, gyda'r Grŵp Cynghori Rhanddeiliaid yn chwarae rhan allweddol wrth lunio dulliau gweithredu cynhwysol a llywio gwaith AGIC.

- **Swyddogaethau trawsbynciol**
  Mae cydraddoldeb, amrywiaeth a chynhwysiant yn rhan annatod o bob agwedd ar waith y gangen, gan gynnwys rhoi Strategaeth Cydraddoldeb, Amrywiaeth a Chynhwysiant AGIC ar waith. Mae'r tîm hefyd yn rhoi cyngor a chymorth mewnol ar gydraddoldeb, amrywiaeth a chynhwysiant, ac mewn perthynas â datblygu'r gweithlu a llesiant, gan rymuso staff i gyflawni blaenoriaethau strategol yn y ffordd fwyaf effeithiol bosibl.

Y Gangen Gwasanaethau Rheoli Busnes, Digidol a Chorfforaethol

Mae'r Gangen Gwasanaethau Rheoli Busnes, Digidol a Chorfforaethol yn gyfrifol am sicrhau trefniadau cyflawni gweithredol effeithiol ym mhob rhan o AGIC. Mae'r cyfrifoldebau yn cynnwys cyllid, recriwtio, y gwasanaeth Pwyntiau Cyswllt Cyntaf, materion adnoddau dynol, llywodraethu, cwynion, busnes llywodraethol, gweinyddu'r rhaglen arolygiadau a phrynu a chynnal a chadw adnoddau a chyfarpar digidol AGIC.

Mae'r Tîm Cymorth Arolygu yn rhan o'r gangen hon. Mae'r tîm hwn yn darparu cymorth gweinyddol a logistaidd er mwyn sicrhau bod gweithgareddau arolygu a gweithgareddau rheoleiddiol AGIC yn mynd rhagddynt yn hwylus. Mae hyn yn cynnwys ymgysylltu ag adolygwyr cymheiriaid clinigol ac adolygwyr profiad y claf ar gyfer gwaith sicrwydd AGIC,

a gyda darparwyr gofal iechyd ar gyfer arolygiadau lle rhoddwyd rhybudd ac arolygiadau dirybudd dilynol. Mae'r tîm hefyd yn rheoli gweithfannau diogel Objective Connect er mwyn rhannu a derbyn dogfennau sensitif swyddogol.

Agenda Item No. 15

REPORT TITLE

Risk Management and Board Assurance Framework Report

MEETING

Name of meeting	Quality, Patient Experience & Safety Committee
Date of meeting	03 February 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. The more detailed description contained within the BAF (Annex 4) provides the Committee with an opportunity to review the controls in place against each principal risk and the assurance provided against those controls where applicable. This will assist Members in evaluating current risk ratings supported by the scoring matrix (Annex 2).

4. Members can take assurance that each of the principal risks have been reviewed during this reporting period in line with the agreed schedule detailed at Annex 3 with continual and dynamic focus on the highest rated risks scoring 15-25. Attention has been given to the risk ratings of each risk and the mitigating actions identified and taken to ensure that risks achieve their target score. This is in addition to the standard and regular review of all controls, assurances, and any gaps.

5. The Executive Leadership Team (ELT) approved the principal risk activity on 28 December 2025, and the review of each risk undertaken throughout the reporting period 2025 by Risk Owners.

6. The Trust's highest rated **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 strengthening internal control environment. These controls are 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.

7. Phase one and two of the Trust's Clinical Transformation Model have now gone live, with the new performance framework representing a significant milestone in delivering an enhanced clinical model aligned to patient acuity, workforce capability, and risk reduction. In parallel, early adoption of the 45 minute release (45MR) standard by some Health Boards represents a positive development, supporting more timely transfers of care and reducing avoidable harm.

8. Because of this progress, the Board is asked to note a reduction in the score for **Risk 223** from 25 (5x5) to 20 (4x5).

9. The ELT agreed that the score for **Risk 224** will remain at 25 (5x5) for this round. Data will be kept under review for the next quarter with a view to reduce the score once an analysis has been completed to determine whether the recent changes have delivered sustained or system-wide risk reduction. Internal controls cannot fully mitigate external system constraints, including Emergency Department capacity, patient flow and inconsistent delivery of national handover standards.

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

11. Strategic mitigation therefore remains focused on both internal transformation and system-wide influence. The Trust continues to engage with national and regional programmes - including the Six Goals for Urgent and Emergency Care - to support shared learning, alignment of expectations, and strengthened collective ownership of outcomes. The Audit Wales report (June 2025) into the effectiveness of unscheduled care arrangements across NHS Wales provides external insight into whole-system performance and identifies further levers to drive national consistency and accountability.

12. The introduction of 45MR from 1 October 2025 was a partially accepted MAG recommendation. NHS Wales Performance and Improvement (P&I) remain committed to this becoming the national standard, with Health Boards being required to adopt this by the end of January 2026. The progress already made by most Health Boards in the preceding months, represents a positive step toward reducing avoidable patient harm. A clinically led Handover-45 taskforce has been established, and workshops continue to support local improvement plans.

13. The risk data is presented by theme and category, supporting the identification of gaps and required escalations. A detailed operational action plan underpinning these risks is held at an operational level.

14. The risks continue to be reported to the Trust Board, with emphasis on actions within the Trust's control. These are reflected in the avoidable harm dashboard presented at each Board meeting. Further mitigations and transformational actions are also described in the Integrated Medium Term Plan (IMTP) and other regular reports, including the IMTP Assurance Report and the Monthly Integrated Quality & Performance Report to address these risks.

15. Most actions within the avoidable harm dashboard have been completed and several efficiencies and improvements have contributed to stabilised performance. However, the Trust cannot fully mitigate the scale of handover lost hours due to the wider system environment.

16. Whilst there have been no further material changes made during this period, the BAF includes a commentary for each risk for the Risk Owner to describe the rationale for each of the risk ratings which is particularly important where ratings have remained static.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

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

1. Consider contents of the report including:

    a. The controls in place against the risks.
    b. The actions described to further mitigate the risks.

ADDITIONAL PAPER(S)

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

The Finance & Performance Committee is requested to receive the following:

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
28 December 2025	Executive Leadership Team
3 February 2026	Quality Patient Experience and Safety Committee (QuEST)

Annex 1 – Corporate Risk Register Summary

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
223 QuEST	The Trust's inability to reach patients in the community causing patient harm and death	**IF** significant internal and external system pressures continue **THEN** there is a risk of an inability and/or a delay in ambulances reaching patients in the community **RESULTING IN** patient harm and death	Director of Operations	**20 (4x5)** ↓ **25 (5x5)**
224 QuEST	Significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service	**IF** patients are significantly delayed in ambulances outside A&E departments **THEN** there is a risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised **RESULTING IN** patients potentially coming to harm and a poor patient experience	Director of Quality & Nursing	**25 (5x5)** →

Annex 2 - Risk Scoring Matrix

Consequence:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Safety & Well-being - Patients/ Staff/Public	Minimal injury requiring no/minimal intervention or treatment. No time off work. Physical injury to self/others that requires no treatment or first aid. Minimum psychological impact requiring no support. Low vulnerability to abuse or exploitation - needs no intervention. Category 1 pressure ulcer.	Minor injury or illness, requiring minor intervention. Requires time off work for >3 days Increased hospital stay 1-3 days. Slight physical injury to self/others that may require first aid. Emotional distress requiring minimal intervention. Increased vulnerability to abuse or exploitation, low level intervention. Category 2 pressure ulcer.	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:**	**28/10/2025**	**TREND**	**OVERALL 20 (4x5)**
			Date of Next Review:	**28/11/2025**	⬇	

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

	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.

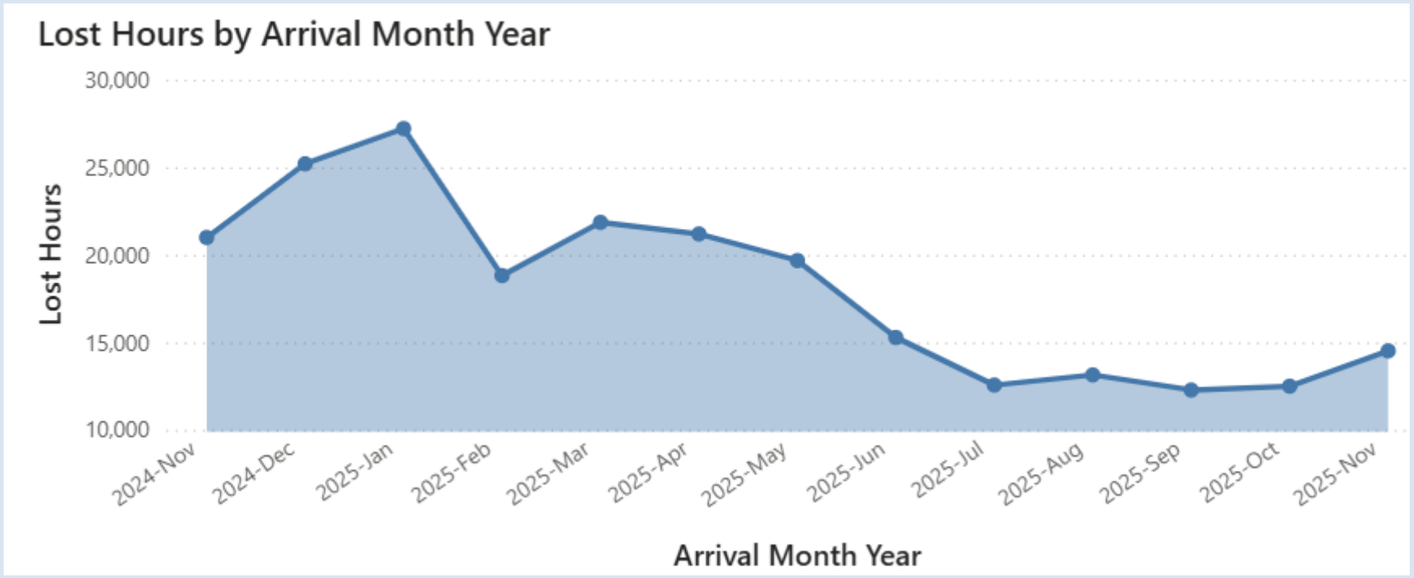
The next steps will include testing separate risk scores for internal and external mitigations, to support the demonstration of the impact of actions taken. This will not affect the overall score of 25 (5x5) which reflects the severity of patient harm and death.

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



Whilst the risk **score has reduced slightly from 25 (5x5) to 20 (4x5) it** still reflects the impact of ambulance handover delays at Emergency Departments and timely access to definitive care. The strategic implications for the Trust **remain** 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.

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	28/10/2025	TREND	OVERALL 20 (4x5)
		Date of Next Review:	28/11/2025	↓	

Phase one **and two** of the Trust's Clinical Transformation Model - specifically the new performance framework - have 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 (45MR)** standard by some Health Boards represents a positive step toward reducing avoidable patient harm by supporting more timely transfers of care and improving the overall experience for patients awaiting treatment. **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 **45MR from 1 October was a partially accepted MAG recommendation. There continues to be a determination from NHS P&I for this to be the standard, with Health Boards being required to adopt this by the end of January 2026 and replicate the best month of October, November or December 2025.** 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 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.**

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 **45MR** 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 effective. How will these impact the target risk score?***	Internal ***over the three lines of assurance. How do we know the assurances are effective*** ***Provide assurance on managing controls to ensure the Trust is doing everything in its capacity to reduce the impact of the risk***

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	28/10/2025	TREND	OVERALL 20 (4x5)
		Date of Next Review:	28/11/2025	↓	

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 set out by the Welsh Health Circular. Although national guidance exists, adherence is variable across sites and Health Boards, limiting WAST's ability to fully mitigate risk independently. These gaps are aligned and consistent with the gaps in Risk 224 of the Board Assurance Framework.	1. While Health Boards have developed handover improvement plans, there is currently no routine, structured mechanism for independent review or validation of their implementation, progress, or effectiveness. External Scrutiny is primarily limited to periodic updates through forums such as IQPD or JCC which may not provide consistent assurance of impact. These gaps are aligned and consistent with the gaps in Risk 224 of the Board Assurance Framework. The **45 MR** initiative, once embedded across all Health Boards, will help support to address this gap.

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	28/10/2025	TREND	OVERALL 20 (4x5)
		Date of Next Review:	28/11/2025	↓	

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. 6 weeks test of change Morriston	Sonia Thompson, Assistant Director of Operations	**COMPLETE**	OCT25 – Test of change now moved to BAU, discussions will be started within Swansea Bay to explore W45 options similar to Cardiff and Vale. July25 **-** Majority of test of change has remained, still seeing improvements in handover. Work ongoing with the Health Board looking at increase in front door attendance. Jun 25 – Currently in week 6 with average handovers remaining under 50 minutes. WAST qualitative and quantitative data has been shared with Health Boards to continue the trial.
2. Royal Glamorgan working to 45 minute handover	Sonia Thompson, Assistant Director of Operations	**COMPLETE**	OCT25 – No progressional update however the 2 CTM sites are still performing well in relation to Notification to Handover Performance. July25 - Ongoing progressing well, monitored locally, new measures put in place are being effective. Taking more of a risk at the front door and implemented a helicopter nurse Jun 25 – Handovers with average of 30 mins. Current ongoing discussion to rollout trial in other areas.
3. Clinical Model transformation (CMT) - 12 month pilot programme conducted to understand the full implications of the changes, identify issues and provide valuable insights into the effectiveness of the Clinical service model.	Pete Brown, Assistant Director of Operations, Integrated Care		**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

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	28/10/2025	TREND	OVERALL 20 (4x5)
		Date of Next Review:	28/11/2025	⬇	

			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.
4. Audit Wales investigation of Urgent and Emergency Care System: Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time?	Chief Executive Officer This will be assigned an operational colleague.	**COMPLETE**	**July25 –** Audit received and actions being worked through. Audit Wales are supportive of the actions taken by WAST and there is positivity received on what WAST are doing. Jun 25 – Awaiting report from Audit Wales May 25 – Awaiting report from Audit Wales which will come through Audit Committee.
5. Ongoing monitoring of the 45MR to continue through the winter to ensure consistent delivery	**Sonia Thompson, Assistant Director of Operations**		

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:	29/12/2025	TREND	OVERALL 25 (5x5)
		Date of Next Review:	29/01/2026	➡	

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.

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.

The way the data is being presented in themes and categories supports the identification of any gaps and escalations required. A more detailed action plan that supports these risks will be held at an operational level. This working draft is for discussion purposes and to highlight the direction of travel. There is still work to be done on this document.

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

This risk remains at the highest level despite early indications of improvement in some areas, performance remains variable across Wales and handover delays continue to present a high risk of patient deterioration, harm and poor experience, with 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. 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 and workforce capability.

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. Until sustained, evidenced system-wide improvement is demonstrated, the risk remains above target and appropriately sits on the Board Assurance Framework. The impact on staff wellbeing is recognised and is managed through the linked workforce risk (Risk 558).

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)** 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.	**External Monitoring / Assurance** • Oversight through Welsh Government, including Six Goals and Joint Commissioning arrangements. • Independent scrutiny via national audit and regulatory inspection.
2. **Six Goals for Urgent and Emergency Care Programme**	2. External performance assurance through Welsh Government oversight arrangements, including Six Goals and NHS Wales escalation frameworks.

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:	29/12/2025	TREND	OVERALL 25 (5x5)
		Date of Next Review:	29/01/2026		

• National system oversight of urgent and emergency care performance, including ambulance handover.			
3. **NHS Wales Performance Framework 2024-25** External monitoring of ambulance handover performance through national performance measures.	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.	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 to manage periods of sustained pressure.	Assurance through national operational oversight, escalation and review 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, Resource Escalation Action Plan (REAP) and Clinical Safety Plan (CSP). 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. 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 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 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. 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. This control strengthens organisational learning and assurance but does not, in isolation, reduce the overall risk score, which remains dependent on wider system performance.	**First Line of Assurance (Operational)** Identification and escalation of incidents, concerns and mortality cases through established patient safety processes.	**Second Line of Assurance (Internal Monitoring)** Review and oversight through clinical governance forums, including SCIF and CAG.	**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:	29/12/2025	TREND	OVERALL 25 (5x5)
		Date of Next Review:	29/01/2026		

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, decision-making and demand management. CMT provides an internal control to reduce avoidable conveyance, improve early clinical intervention 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
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.

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		Date of Next Review:	29/01/2026		

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.	17

REPORT TITLE

Audit Tracker 25-26 Q3 Reporting (Oct-Dec25) – QuEST 030226

MEETING

Name of meeting	Quality, Patient Experience and Safety Committee
Date of meeting	03 February 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 2025/26 Q3 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 3 of 2025/26. In an attempt to manage volume of papers, the tracker has been added to the Ibabs reading room filtered to the actions assigned to this committee for oversight. This digital reading room hosts documents for additional information, not essential for scrutiny or decision-making. Access to the reading room is through the documents/shared folder in Ibabs' main menu. Documents in the reading room will not be posted on the Trust's website with committee papers; however, copies can be provided to those without access to Ibabs upon request.

Internal Audit

4. During 2025/26 Quarter 3, there were a total of 21 **open internal audit recommendations** relevant to the Committee. Of these 21 open audit recommendations, eleven were due for closure in quarter, and the remaining ten were not yet due.

5. By the end of the quarter, six (55%) of the eleven audit actions **due for closure in quarter** were confirmed as completed:

   - two (40%) of the six met their original deadlines,
   - one (10%) following a single deadline revision,
   - one (10%) was completed after two deadline revisions, and
   - two (40%) both originally due by the end of April 2025 awaiting new dates.

6. The two actions closed in quarter that were awaiting new dates both relate to the 2024/25 Patient Experience and Community Involvement (PECI) internal audit. These actions (044-24/25 and 045-24/25) have been reviewed and deemed to be **no longer relevant**, with explanations provided by the Quality and Nursing Directorate reflected in the Audit Tracker Q3 updates.

Audit Ref.	Management Response	Summary of 2025/26 Q3 Update
044-24/25	PECI team to devise a proforma for directorates and quality improvement programmes / projects to request support and involvement to their scheme of work.	Under new PECI structure, future activity to be commissioned, and aligned to a small number of core IMTP priorities. When management response was drafted, the service change proposals were still in negotiation. Updated model means PECI will be part of a core team leading on Trust Quality Management System.
045-24/25	PECI team to develop a population health-based approach to analysing interventions and involvement across Wales, enhancing reporting to inform where variation occurs and linking with Clinical and Quality teams to confirm how/where PECI team can support increased improvements in outcomes.	Agreed action no longer feasible as, following the OCP, PECI will not have a dedicated resource to deliver a standalone programme. Instead, population-health analytics and principles will be embedded into the foundations of all our work, supported through QIAs, EqIAs and IMTP commissioning processes, rather than delivered as isolated, targeted projects.

7. **New revised deadlines** have been proposed for a total of five recommendations, all of which are first revisions:

Audit Year	Audit Title	No. Revised Dates	Status
2024/25	Start of Shift Procedure	3	1st revisions
2024/25	Emergency Communications Nurse System (ECNS) Implementation	1	1st revision
2024/25	Clinical Equipment	1	1st revision

8. The specific actions for which 1st revised dates have been applied in Q3 are listed below:

Trust Audit Ref. No.	Internal Audit	Directorate	Original Date	1st Revised Date
24/25-102	Start of Shift Procedure	Operations	31/10/2025	31/07/2026
24/25-103			31/10/2025	31/07/2026
24/25-105			31/12/2025	31/07/2026
24/25-080	Emergency Communications Nurse System (ECNS) Implementation	Operations	31/12/2025	30/06/2026
129	Clinical Equipment	Clinical	31/12/2025	31/03/2026

9. **At the end of quarter** there were a total of fifteen open audit recommendations remaining relevant to this committee. Of these

- six (40%) are due to be completed during Q4 (between January – March 2026)
- six (40%) are due for completion during 2025/27 Q1 (between April – June 2026), and
- three (20%) due for completion during Q2 (between July – September 2026)

External Audit

10. During 2025/26 Quarter 2, there were 33 **open external audit recommendations** relevant to the Committee: five relating to the 2023/24 Quality Governance Follow Up Review, and 28 actions resulting from the Welsh Risk Pool (WRP) Concerns Assessment undertaken in 2024.

11. Of the 33 open external audit recommendations, twelve were **due for closure** in quarter, seventeen not yet due, and four actions for which dates were to be advised.

12. By the end of the quarter, eight (67%) of the twelve audit recommendations due for closure were **confirmed as completed**, plus one further action which was not due for completion until the end of March 2026, making a total of nine.

13. In respect of the **four actions for which dates are still to be advised**, the Quality and Nursing Directorate has provided an updated (summarised below), outlining progress to-date why it is not yet possible to commit to a completion date:

    "A first iteration of the semantic environment was released before the festive period however this is caveated by the fact that it addresses only the feedback and incident modules and does not currently have all the filtering fields we would require to support effective Power BI development. The current semantic environment would not resolve these actions as they relate to claims case management, inquest and broader learning from events, which would not be supplied through the current arrangement.

    The Senior Quality Leadership Team met with the Digital Leadership Team in November 2025 to review the data requirements for the Quality and Nursing Directorate. The current prioritisation is to warehouse the Docworks data during this quarter [Quarter 4] before commencing the warehousing of broader Datix modules.

    We are able to create listing reports from the front end of Datix to load into the semantic environment to mitigate the lack of warehousing from the required modules; however, this would require manual workarounds by the teams involved, plus a re-work of the reporting string when data warehousing is available.

    Additionally, the Legal and Claims Team utilise a Civica module, as well as Datix for their work, and this is still on a timeline for confirmation of delivery dates.

    At the recent Always On Reporting meeting, it as agreed that Clinical Model Transformation (CMT) metrics needed to be prioritised over Datix delivery."

14. **New revised deadlines** have been applied for four (33%) open audit recommendations, all of which relate to the WRP Concerns Assessment 2024: three extended until the end of March 2026, and one extended until the end of September 2026. As these are all 2nd revised dates, the Director of Quality and Nursing has been invited to attend the Audit, Risk and Assurance Committee at its next meeting on 2nd March 2026, to provide the committee with an update and assurance on these deferred actions.

15. **At the end of quarter**, there were 24 remaining open actions:

    - nineteen (79%) due to be completed during Q4 (between January – March 2026),
    - one (4%) due to be completed during 2026/27 Q2 (between July – September 2026), and
    - four (17%) actions for which dates need to be set.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The Committee is requested to:

1. Receive assurance on the monitoring of management actions to address recommendations in the Tracker, noting any revised dates for actions.

2. Receive assurance regarding the open audit recommendations relating to the Welsh Risk Pool (WRP) Concerns Assessment 2024.

ADDITIONAL PAPER(S)

Annex 1 Audit Tracker 3.0 – 2526 Q3 Updates - Internal Audit (QuEST)
Annex 2 Audit Tracker 3.0 – 2526 Q3 Updates – External Audit (QuEST)

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 & 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
21 January 2026	Head of Compliance and Assurance
27 January 2026	Director of Corporate Governance/Board Secretary
03 February 2026	Quality, Patient Experience and Safety Committee

Welsh Ambulance Services University NHS Trust

Audit Tracker 3.0 - 2025/26 Quarter 3 (October - December 2025) Updates – QuEST (Internal Audit)

ID	Audit Tracker 2.0 Action Ref.	Year / Audit Plan	Audit Type	Committee Assigned	Public or Private Committee	Report Title	Assurance Rating	Responsible Officer	Director	Priority Level	Rec. No. in Audit Report	Recommendation	Action No. in Mngt Response	Management Response	Expected Evidence of Implementation	Agreed Deadline in Report	Status - met or not met agreed deadline in report	1st Revised Date	2nd Revised Date	3rd Revised Date	Action Status	*ACTION UPDATE	*LIST OF EVIDENCE SUPPLIED TO SUPPORT PROPOSED CLOSURE
21	668	23/24	Internal Audit	QuEST	Public	Serious Adverse Incidents - Joint Investigation Framework	Reasonable	Claire Appleton	Liam Williams	Medium	1.1	The Trust's 'Adverse Incident and Reporting Policy' should be reviewed and updated to reflect the requirements set out within the NHS Wales policy.	1.1	The Putting Things Right Team plan was to review relevant policies following the release of the new Putting Things Right Regulations by Welsh Government in May 2024. A recent update from Welsh Government has confirmed that the release will now be Autumn 2024. At which point the review will be undertaken. The Trust has approved policies in respect of incident reporting and management and a Putting Things Right Policy which are included on the intranet site (review dates are both April 2026). Staff also have access to User Guides on the intranet site for Datix Cymru. The All-Wales Patient Safety Policy (NHS Executive) (May 2023) is also due review in March 2024 and will be updated internally when released nationally.		30/11/2024	Not Met	31/12/2025			Closed in Quarter	25/26 Q3 - Update: **060126** (AK): **Proposed for closure.** This recommendation is being mitigated as the draft statutory national guidance states that every organisation must have a Listening to People Policy. This aligns with our already agreed internal proposal that the current Putting Things Right Policies will be superseded by a Listening to People Policy	n/a
22	681	23/24	Internal Audit	QuEST	Public	Electronic Patient Clinical Records: Clinical Compliance (ePCR)	Reasonable	Keith Dorrington	Jonny Sammut	Medium	1.1	To confirm accuracy of the self-certification compliance rate, management should consider capturing the method of training delivery on ESR.	1.1	For future training, the method of instruction will be captured as part of the ESR sign-off process (for example, classroom based, individual learning using the training materials, one to one instruction using the training zone in the application).		30/06/2024	Not Met	30/09/2024	31/03/2025	30/04/2026	Open		
23	683	23/24	Internal Audit	QuEST	Public	Electronic Patient Clinical Records: Clinical Compliance (ePCR)	Reasonable	Keith Dorrington	Jonny Sammut	Medium	1.3	Management should consider including a test in ESR to confirm competency before successfully self-certifying.	1.3	At the ePCR CRG WAST will discuss including a test to assess understanding at the completion of training.		30/06/2024	Not Met	30/09/2024	31/12/2024	30/04/2026	Open		
24	684	23/24	Internal Audit	QuEST	Public	Electronic Patient Clinical Records: Clinical Compliance (ePCR)	Reasonable	Keith Dorrington	Jonny Sammut	Medium	1.4	Whilst we acknowledge there are different methods of training delivery, management should review lower viewed training modules, to confirm that the completed ePCRs are compliant with expectations in this area.	1.4	"Through the ePCR Clinical Reference Group (CRG) we will review the lower viewed modules as set out in Appendix B of this report. This will build on knowledge discussed at the most recent ePCR CRG where a small audit has identified that the obstetric section is not being completed. However, we currently have only opened access to the Welsh GP Record (WGPR) for our cohort of Advanced and Senior Paramedics. The pathways section of the ePCR is not currently live and requires testing prior to going live, which explains the disparity reported in these sections of Appendix B."		30/09/2024	Not Met	31/12/2024	31/03/2025	30/04/2026	Open		
25	686	23/24	Internal Audit	QuEST	Public	Electronic Patient Clinical Records: Clinical Compliance (ePCR)	Reasonable	Keith Dorrington	Jonny Sammut	High	2.2	Management should ensure the tenant structure is developed to provide data at both a team and individual level to assist in identifying training needs and drive improvement in ePCR compliance.	2.2	"Reporting into CIAG, we will set up a Task and Finish Group to write the plan to deliver the dashboards against the Tenant Structure. This is a complex piece and requires input from multiple directorates. It is also dependent on the capacity within teams to deliver the dashboards, therefore the output of the T&F might be a business case jointly developed between the Digital and Clinical Directorates to outline the resources required and what this would cost to deliver."		30/09/2024	Not Met	31/03/2025	30/09/2025	30/04/2026	Open		
38	044-24/25	24/25	Internal Audit	QuEST	Public	Patient Experience & Community Involvement	Reasonable	Leanne Hawker	Liam Williams	Medium	3.1	The PECI team's work plan should be reviewed to better define and coordinate their activity.	3.1	PECI team to devise a proforma for directorates and quality improvement programmes/projects to request support and involvement to their scheme of work.	Copy of proforma developed for directorates and quality improvement programmes/projects to request support and involvement - Examples of completed proformas to demonstrate it is being utilised	30/04/2025	Not Set	TBA			Closed in Quarter	25/26 Q3 Update **060126** (AK): Under the new PECI structure, and in line with the Board approved Partnerships and Engagement approach, activity will now be commissioned through a defined organisation process and aligned to a small number of core IMTP priorities. This replaces the previous model where PECI independently created proforma and responses to ad-hoc directorate requests. Templates and processes will be agreed that maintain IMTP consistency and strategic alignment. When the original management response was drafted, the service change proposals were still in negotiation. The updated model means PECI will now form part of the core team leading on the Trust Quality Management System and delivery will involve PECI and other teams depending on the issue and geography. **Action No Longer Relevant**	Email from AK dated 18/12/2025 containing explanations for Audit Actions on lines 38 and 39
39	045-24/25	24/25	Internal Audit	QuEST	Public	Patient Experience & Community Involvement	Reasonable	Leanne Hawker	Liam Williams	Medium	3.1	The PECI team's work plan should be reviewed to better define and coordinate their activity.	3.1	PECI team to develop a population health-based approach to analysing interventions and involvement across Wales, enhancing reporting to inform where variation occurs and linking with Clinical and Quality teams to confirm how/where PECI team can support increased improvements in outcomes.	Copy of documentation evidencing adoption of a population health-based approach - Sample of enhanced reporting identifying variations - Evidence of engagement with Clinical Team re: variations - Evidence of engagement with Quality Team re: variations - Sample of PECI Team advice re: how it can support	31/08/2025	Not Set	TBA			Closed in Quarter	25/26 Q3 Update **060126**: (AK) The expectation that PECI would lead population-health engagement is no longer feasible or aligned with Board-endorsed shift towards targeted, system-wide engagement on IMTP priorities. The OCP introduces a role that will influence and support this agenda alongside the Quality Improvement and Clinical Directorates, but PECI will not have a dedicated resource to deliver a standalone programme. Instead, population-health analytics and principles will be embedded into the foundations of all our work, supported through QAs, EqIAs and IMTP commissioning processes, rather than delivered as isolated, targeted projects. While there may be opportunities to expand the scope of population-health activity in the future, the immediate priority is to shift toward an organisation-wide approach where population-health thinking is consistently applied across directorates, rather than led solely by PECI. **Action No Longer Relevant.** **25/26 Q3 Update:**	Email from AK dated 18/12/2025 containing explanations for Audit Actions on lines 38 and 39
40	048-24/25	24/25	Internal Audit	QuEST	Public	Patient Experience & Community Involvement	Reasonable	Leanne Hawker	Liam Williams	Medium	3.1	The Team should continue its work to increase survey responses to ensure there is significant level of response, to provide a level of assurance that responses reflect the views of the public.	3.1	Liaising with Fleet to explore use of QR Codes on vehicles to enable patients/families to access feedback surveys whilst waiting.	Copy of correspondence to/from Fleet to evidence liaison re: exploring use of QR codes for surveys in vehicles - Photos of QR codes for surveys displayed in vehicles"	31/03/2025	Not Met	31/07/2025	31/03/2026		Open		
44	059-24/25	24/25	Internal Audit	QuEST	Public	Roll-out of Penthrox	Reasonable	Judith Bryce	Andy Swinburn	Medium	1	"CFR Access to Replenish Penthrox Supply Not all CFRs have access to either the Omnicell cabinets or the Penthrox Safes to replenish stock levels after use. To replenish the CFR requires a senior Trust employee (usually a DOM) to meet them at an Omnicell Cabinet or Penthrox safe to gain access and replenish supply. Further, the Penthrox safes require Abloy keys to gain access. To date, only seven DOMs on the Abloy records have access."	1	"CFR leads are required to confirm the names and PIN of all current CFRs, to allow the Medicines Management team to check them against those CFRs already on the Omnicell system. North Wales Locality Managers to update the names and pay/ESR numbers of all DOMs that require access to the Penthrox safes. This will allow the Medicines Management team to check them against DOMs that already have the Penthrox access permission on their Abloy keys."	Omnicell system report for CFRs with registration and fingerprint enrolment numbers. Abloy key access registration report for North Wales Penthrox safes.	31/05/2025	Not Met	31/10/2025	31/12/2025		Closed in Quarter	25/26 Q3 Update **221225**: (LA) All active CFRs now successfully added to the Omnicell system. NW DOMs also added to access list for Penthrox safes. Penthrox supply is a continuing for volunteers but internal efforts will continue to explore solutions to make the process easier for volunteers in the long run. **Propose for closure.**	Correspondence email between Huw Jackson, Gareth Parry, and Judith Bryce regarding update to Omnicell for volunteers and list of NW DOMS.
52	077-24/25	24/25	Internal Audit	QuEST	Public	Risk Management & Board Assurance	Reasonable	Julie Boalch	Trish Mills	Medium	1	"The current documented guidance is sufficient to cover the existing approach to risk management across the Trust but in the light of the planned developments for the BAF, risk appetite, and the potential procurement of a digital solution, the procedures will need to be revised, updated and appropriately approved. Risk & Impact: The documented guidance may become out of date as procedures change, leading to risks not being managed as intended. "	1	"Once new ways of working are finalised and introduced the risk management documentation - Risk Management Policy; Risk Management Guidelines; and the Guidance on Interpreting the Board Assurance Framework will need to be updated and reapproved.	Updated suite of Risk Management documentation.	31/03/2026	Not Yet Due				Open		
53	080-24/25	24/25	Internal Audit	QuEST	Public	Emergency Communication Nurse System (ECNS) Implementation	Reasonable	Andrew Garner	Lee Brooks	Medium	3	"ECNS Audit Report Format Review of audit reports confirmed that they provided a mix of recognition of good practice alongside areas where corrective feedback was required. IAED performance standards notes that when providing feedback there should be focus on the exact performance that did not meet the standard. Our review of 30 audit reports noted that 13 did not reference the performance standard where an issue had been identified, and 17 did not indicate the categorisation of deviation. Currently audit reports are circulated via email to the clinician and line manager, however, there is no requirement for receipt or acknowledgement of content. Theme: Performance Monitoring Risk & Impact: Unclear and delayed feedback impact on the value and ability to influence practice of audits."	3	"Agreed Action: Quality Audit realigned to Operations Quality and bespoke job description being created to appoint into permanent Quality Audit (Clinical) posts. Operations Quality to have management and leadership oversight. Levelling to be undertaken to set out expectations for inclusion of all required information such as performance standards and deviation categories and a request to support levelling will be made to the International Academies of Emergency Dispatch (IAED). Consideration will be given more widely on how to ensure monitoring of receipt of feedback and respective managers/local management teams updated.	Quality assurance processes will be developed and refined internally, and the IAED Accredited Centre of Excellence (for which the Trust has for ECNS) sets out required standards which will be monitored closely in monthly compliance reports, submitted to the IAED and internally monitored by the Integrated Care Quality Meeting which reports onward into the Senior Operations Team (SOT).	31/12/2025	Not Met	30/06/2026			Open	25/26 Q3 Update **210126 (LT) 1st Revised Date of June 2026 applied** **060126** (TMN): Quality Audit colleagues recruited mid December - requesting extension on this to enable time to appropriately evidence closure of this item with documentation (6 months if possible)	
60	101-24/25	24/25	Internal Audit	QuEST	Public	Start of Shift Procedure	Limited	Sonia Thompson	Lee Brooks	Medium	1	"Awareness of SOP In February 2025, as part of the Quality & Support days, Ambulance Care focused on enhancing the operational efficiency and safety of ambulance services, particularly through the lens of Shift Start and Vehicle Security during shifts. Weaknesses were noted in relation to awareness of the SOP; as well as completion of expected forms (see Key Finding 3) and the time taken to be taken to complete the checks. As has been reported within the Operations Quarterly Sub-Report (Q4) such has highlighted a training need. Whilst it is appreciated these results are specific to Ambulance Care, consideration should also be given to understanding the current practices applied within EMS to confirm awareness of the SOP."	1	"Communications will be circulated to reinforce the SOP and its contents. The timing of this will coincide with the release of an updated SOP (as reflected in Key Finding 2).	Copy of the communications.	31/10/2025	Met				Closed in Quarter	25/26 Q3 Update **060126** (TMN): Evidence Submitted to **propose closure**	Evidence supplied 09/01/26 (via email from TMN): 2025-053 - EMSC Bulletin - Overrun Reduction 2025-051 - EMSC Bulletin - EMS Overrun Reductions
61	102-24/25	24/25	Internal Audit	QuEST	Public	Start of Shift Procedure	Limited	Benjamin Collins	Lee Brooks	Medium	2	"Update to SOP to reflect current practices As detailed within the SOP for Start of Shift arrangements: 'staff must complete their legal VDI checks (Appendix 1) to comply with the Road Traffic Act, prior to mobilising any call.' As reported from a recent Quality & Support day, only 50% of those in Ambulance Care are completing the forms alongside the acknowledgments included in the MDVIS; with the rest only using the MDVIS. However, there is no reference to MDVIS within the SOP which could raise confusion as to whether such is a supplement to, or replacement for, the VDI checks. Further, whilst the headings as per the MDVIS correlate with the primary checks as included in the VDI form, the latter provides more detail/guidance for the driver completing. It is also noted that, as a result of the recent Quality & Support Day, (see objective 5) there is a need to update the SOP to align with the needs of the NEPTS/Ambulance Care teams to 'ensure that all staff regardless of their specific roles are on the same page regarding shift commencement procedures.'"	2	"The Vehicle Accident Management Task & Finish Group are currently reviewing VDI processes within the Trust in line with the Vehicle Accident Management Internal Audit actions. Given the correlation with this audit, the scope of this group will be expanded to include Start of Shift SOP arrangements. On agreement of the new process from the Task & Finish Group, the SOP will be updated to reflect current practice. Senior Operations Team (SOT) will maintain oversight and responsibility of this audit action.	- AAA reports from the Task & Finish Group to confirm agreed process; - copy of updated SOP to reflect practice, and - copy of AAA to approve amended SOP.	31/10/2025	Not Met	31/07/2026			Open	25/26 Q3 Update **210126** (LT): **1st Revised Date of July 2026 applied.** **060126** (TMN): Requesting **extension to July 2026** - The report is being progressed however the T&F group have requested testing of the proposed VDI option prior to Pan Wales rollout. This extention will allow time for testing and then changes to SOP to occur	

62	103-24/25	24/25	Internal Audit	QuEST	Public	Start of Shift Procedure	Limited	Benjamin Collins	Lee Brooks	High	3	"Lack of evidence to demonstrate compliance of checks As has been identified through the recent Ambulance Care Quality & Support day, 50% of the staff involved (circa 162) completed the paper-based forms as per the SOP. It is not clear as to the completion rate for EMS as such was not the focus for their Quality & Support day; however, the site visits undertaken during the course of audit fieldwork noted that no forms were completed and retained post completion of the checks. Recognising the legal requirement for the completion of these checks, and wider compliance with the SOP, consideration should be given to the development of an electronic version of the VOI form, to be made available via the iPads. The receipt into a central mailbox / repository would allow for a date/time stamp to be actioned therefore providing an opportunity to understand the timeframe for completion amongst crews – the output of which can be reported and escalated as appropriate. Consideration could also be given to the inclusion of sign off for clinical and equipment checks noting there is no specified requirement, as per the SOP, for such to be documented (see objective 5)."	3	"The Vehicle Accident Management T&F Group are currently reviewing VOI processes within the Trust in line with the Vehicle Accident Management Internal Audit actions, this includes the process to demonstrate compliance and reporting of checks. Given the correlation with this audit, the scope of this group will be expanded to include Start of Shift SOP arrangements. SOT will maintain oversight and responsibility of this audit action.	- AAA reports from the Task & Finish Group to confirm discussions on the VOI process and reporting mechanisms, and - an updated version of the SOP	31/10/2025	Not Met	31/07/2026		Open	25/26 Q3 Update **060126** (TMN): Requesting **extension to July 2026** - The report is being progressed however the T&F group have requested testing of the proposed VOI option prior to Pan Wales rollout. This extention will allow time for testing and then changes to SOP to occur	
63	104-24/25	24/25	Internal Audit	QuEST	Public	Start of Shift Procedure	Limited	Sonia Thompson	Lee Brooks	Medium	4	"Review of Consumables There is a minimum list of expected consumables and equipment to be retained on EMS and Ambulance Care vehicles. Noting the lesser amount on the latter it is easier to maintain a regular stock check of the items. However, with EMS, there is the risk that crew members will pick up what they think is needed within the time period available to complete the check rather than there being a routine stock count completed, which will also pick up expiry dates for items. We appreciate that consumables review will be undertaken on behalf of the paramedics at MRDs; however consideration should be given to a regular scheduled review of consumables at the stations or through the MRD as part of the wider cleaning schedule to rationalise the consumables held and prevent wastage / excessive ordering."	4	"The Trust accepts this finding and recognises that whilst there is a list of minimal consumables in MRD this currently is not applied at ambulance stations. The Operations Directorate will share comms to staff on the minimal list of consumables required for Vehicles to reinforce the amount that needs to be held. The list will also be placed on all relevant vehicles. Consideration will also be given to incorporate a regular scheduled review of consumables.	- A copy of list of consumables that will be added to vehicles, _ a copy of the comms to reinforce the consumable amounts - AAA report from EMG (EMS Management Group) - AAA report from Ambulance Care Service Management Meeting to confirm discussions on scheduled review consideration.	31/10/2025	Met			**Closed in Quarter**	25/26 Q3 Update **060126** (TMN): Evidence Submitted to **Propose Closure**	Evidence supplied 08/01/26 (via email from TMN): 2026-001 - EMS Bulletin - Vehicle Consumables(EMS Vehicle Consumables Bulletin(Standardised Vehicle consumable and equipment lists for vehicles NB: Actions progressed outside of the business meetings therefore no AAA reports available. However, Operations Directorate is satisfied that the actions have all been completed.
64	105-24/25	24/25	Internal Audit	QuEST	Public	Start of Shift Procedure	Limited	Benjamin Collins	Lee Brooks	High	5	"Reporting There is no evidence of routine reporting being undertaken to measure compliance with the SOP, timeliness and accuracy of completion to permit escalation of concerns, should they be identified. Whilst the output of the Quality & Support day has been reported at Committee level, this related to an exercise completed in quarter 4 and was only in relation to Ambulance Care. The use of a central repository for completed forms (see Key Finding 3) would help facilitate reporting."	5	"EMG (EMS Management Group) will review the main key points of the SOP and potential compliance measurements and will complete a dip sample exercise based on the key components to review compliance and discuss next steps to include regular routine reporting. SOT will maintain oversight and responsibility of this audit action.	- AAA reports from EMG (EMS Management Group) into SOT (Senior Operations Team) to determine discussions on the SOP, and - the results of the dip sample / next steps discussions.	31/12/2025	Not Met	31/07/2026		Open	25/26 Q3 Update **060126** (TMN): Requesting **extension to July 2026** - The overruns group has been established and changes to the SOP are currently being undertaken, dip sampling will occur once changes finalised to reflect and dip sample the accurate processes.	
125	n/a	25/26	Internal Audit	QuEST	Public	Clinical Equipment	Reasonable	Jonathan Wilson	Andy Swinburn	Medium	1	A review of the Management of Medical Devices Policy identified a reference to an equipment 'standardisation policy'; however, it was confirmed that no such policy currently exists within the Trust. It was also noted that the policy does not specify which items of clinical equipment require regular maintenance. Additionally, the Disposal Procedure (see objective 6) is overdue for review, with its last scheduled update dated September 2023.	1	Update the Management of Medical Devices Policy to ensure it reflects current practice within the Trust, including: clarifying the scope, frequency and responsible parties for equipment maintenance by means of an appendix; and amending the reference to an equipment standardisation policy to clarify the standardisation process managed by clinical equipment working group. Conduct a formal review of the Disposal Procedure and update as necessary to ensure alignment with current operational and regulatory requirements.	•Management of Medical Devices Policy: Evidence of policy review and updated document for approval by Policy Group •Disposal Procedure: Evidence of procedure review and, if applicable, updated and approved document.	31/03/2026	Not Yet Due			Open		
126	n/a	25/26	Internal Audit	QuEST	Public	Clinical Equipment	Reasonable	Jonathan Wilson	Andy Swinburn	High	2	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. The last 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.	2	**Agreed Action 1:** •Reassess the suitability of RFID to assist in centralised asset management of clinical equipment; •Develop and maintain a Trust-wide centralised database for clinical equipment. Details to include equipment type and location, condition, maintenance schedule, expected lifecycle; and replacement planning. •Consolidate individual databases (Defibrillators, Mangar Cushion, LUCAS devices, suction units) into the centralised system.	**Expected Evidence of Implementation 1:** •Evaluation of suitability of RFID system against asset management criteria •Populated and active centralised database for all clinical equipment	31/01/2026	Not Yet Due			Open	25/26 Q3 Update **221225**: (JL) RFID configuration meeting taking place 22 Dec 2025 followed by a meeting to evaluate the system against the asset management requirements. As part of this work the individual databases of clinical equipment have been incorporated into the central system.	Meeting arrangements and centralisation of clinical equipment onto the system.[to be supplied]
127	n/a	25/26	Internal Audit	QuEST	Public	Clinical Equipment	Reasonable	Jonathan Wilson	Andy Swinburn	High	2	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. The last 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.	2	**Agreed Action 2:** •Implement an Asset Management Software system (such as eQuip) ahead of Scas for Safety Wales.	**Expected Evidence of Implementation 2:** •Evidence of an implemented Asset Management Software System.	30/06/2026	Not Yet Due			Open		
128	n/a	25/26	Internal Audit	QuEST	Public	Clinical Equipment	Reasonable	Jonathan Wilson	Andy Swinburn	Medium	3	Servicing of clinical equipment is carried out either in-house or via external contracts, with records maintained by both the Trust and suppliers—an improvement from previous audit findings. However, gaps remain: •Defibrillators: Serviced externally, with monthly reports listing only upcoming service dates. The August 2025 report showed 59 of 550 units (11%) overdue for servicing. The report lacks service history and age profiling, limiting oversight of lifecycle status. •Mangar Lifting Cushions: Serviced in-house on a rotational schedule. Records reviewed during the audit confirmed all items were within valid service dates. An age profile database is maintained to support replacement planning. •Lucas Devices: Serviced externally, with service history and upcoming dates recorded in a Trust-accessible database. All items were within valid service periods at the time of review. The current policy does not specify which equipment requires regular maintenance (see Key Finding 1), and 10 defibrillators were listed with 'unknown' locations, indicating potential loss or tracking issues.	3	•Improve maintenance records to ensure service reports include both historical and upcoming service dates. •Investigate the defibrillators overdue for servicing and ensure prompt scheduling •Include details of equipment age and expected lifecycle within the centralised database to support replacement planning (see key finding 2). •Clarify maintenance requirements to specify which items require regular servicing and by whom (see key finding 1). •Investigate missing equipment and strengthen location tracking controls (see key finding 2).	**Expected Evidence of Implementation:** •Updated service reports showing both historical and upcoming service dates. •Confirmation that overdue units have been serviced or scheduled, with supporting records. •Database entries showing equipment age and expected lifecycle details. •Revised Medical Devices Policy specifying maintenance requirements and responsible parties. •Updated inventory records resolving 'unknown' locations and documentation of tracking enhancements.	28/02/2026	Not Yet Due			Open		
129	n/a	25/26	Internal Audit	QuEST	Public	Clinical Equipment	Reasonable	Jonathan Wilson	Andy Swinburn	Medium	4	A review of the minutes and papers for the Clinical Equipment Working Group (CEWG) identified occasional references to equipment-related incidents, typically as part of wider discussions on specific items. For example, a presentation was delivered to the group in response to an increase in Datix reports concerning failures of the Optical Airtrag device. However, Datix reports relating to equipment-related incidents are not routinely received or reviewed by the CEWG. This limits the group's ability to systematically monitor trends, identify recurring issues, and use incident data to inform decisionmaking around equipment management and procurement.	4	•Ensure Datix reports related to equipment incidents are routinely submitted to and reviewed by the CEWG. •Add a standing agenda item to CEWG meeting agendas for reviewing equipment-related incidents. •To facilitate trend analysis and strategic planning, implement a dashboard/summary tracker of equipment related Datix reports highlighting frequency of incidents, types of equipment involved, severity and outcomes; and actions taken.	•EEWG meeting agendas, papers and associated actions/minutes. •Tracker of equipment-related Datix reports	31/12/2025	Met	31/03/2026		Open	25/26 Q3 Update **210126**: (LT) **1st revised date of March 2026** to afford sufficient time for appropriate evidence to be collated and submitted. **221225**: (JL) Individual Datix reports related to clinical equipment are now a standing agenda item at CEWG with the first review of these taking place in November 25. Future meetings will also show tracking of Datix reporting trends for clinical equipment-related incidents.	Partial evidence received 22/12/25:Agenda for CEWG

Welsh Ambulance Services University NHS Trust

Audit Tracker 3.0 - 2025/26 Quarter 3 (October - December 2025) Updates – QuEST (External Audit)

ID	Audit Tracker 2.0 Action Ref.	Year / Audit Plan	Audit Type	Committee Assigned	Public or Private Committee	Report Title	Assurance Rating	Responsible Officer	Director	Priority Level	Rec. No. in Audit Report	Recommendation	Action No. in Mngt Response	Management Response	Expected Evidence of Implementation	Agreed Deadline in Report	Status - met or not met agreed deadline in report	1st Revised Date	2nd Revised Date	3rd Revised Date	Action Status	*ACTION UPDATE	*LIST OF EVIDENCE SUPPLIED TO SUPPORT PROPOSED CLOSURE
27	155	23/24	External Audit	QuEST	Public	Quality Governance Follow Up Review	Not Rated	Kate Blackmore	Liam Williams	Not Set	2	"Quality Strategy Monitoring 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. "	2	"The approved Quality Plan will be supported by a robust implementation plan clearly articulating measurable actions and timescales for delivery against responsible and accountable owners. Updates will be provided via the governance structures to ensure regular updates are provided to QuEST via the cycle of business. The Assistant Director of Quality Governance will work with Corporate Governance leaders to ensure a clear cycle of updates and escalation is included within the implementation plan. The review of minutes from QuEST Committee which includes these progress reports, through four cycles of business, will close this action."		31/03/2026	Not Yet Due				Open		
28	156	23/24	External Audit	QuEST	Public	Quality Governance Follow Up Review	Not Rated	Vince Baglole	Liam Williams	Not Set	3	"Clinical Audit Plan 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."	3	"We will review the communication lines between CQGG, ELT and QuEST to provide clearer visibility on the key findings, outcomes and learning identified through Clinical Audit reports. Whilst amendments to approved clinical audit plans should not be delayed as a result of timescales associated with the cycle of business, quarterly updates will include more detail on the changes to the approved plan including the rationale. The review of minutes from QuEST committee which includes these findings, through four cycles of business will close this action."		31/03/2026	Met				Closed in Quarter	25/26 Q3 - Update: 171225 (LT): JC advised action completed. **Proposed for closure**	Copy of report 'Clinical Audit Plan Q2 2025/6' presented to QuEST Committee on 04 November 2025 outlining the refreshments made the clinical audit action tracking and reporting process.
29	159	23/24	External Audit	QuEST	Public	Quality Governance Follow Up Review	Not Rated	Claire Appleton	Liam Williams	Not Set	3.1	"Mortality Reviews 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. "	3.1	"The learning from deaths forum and associated sub groups Terms of Reference include the sharing of learning at a local level as well as contributing to learning on a national basis. This information is shared via the Alert, Advise, Assure (AAA) highlight report. The content of the highlight report will be reviewed through governance processes to ensure consistency of reporting aligned to the Agendas of these fora. Four highlight reports which include this consistency of data alongside QuEST committee minutes will close action 3.1"		31/12/2025	Met				Closed in Quarter	2025/26 Q3 Update: 151225 (AK) - Action completed. **Proposed for closure**	Learning from Deaths AAA Reports (x4) dated:7 January 2025, 18 March 2025, 24 June 2025, & 23 September 2025 Learning from Deaths (Mortality Reviews) Reports (x2) dated: - Quarters 3 and 4 - March 2024/25 - Quarters 1 and 2 - 2025/26 Minutes from QuEST Committee Meetings (x2) dated: 2025.05.09 and 2025.11.04
30	167	23/24	External Audit	QuEST	Public	Quality Governance Follow Up Review	Not Set	Hugh Bennett	Liam Williams	Not Set	8.3	"Quality Performance Reporting and Learning We found that the QuEST Committee is well served with quality information, but there are opportunities for improvement. The Trust should: 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."	8.3	"Whilst we remain limited by data accessibility we continue to pursue patient outcome data through ePCR as well as linking our critical systems to the Welsh Demographic Service allowing the first steps into linking remote clinical assessment with patient outcomes. The ability to achieve truly robust outcome measures without data linkage is limited, we continue to work with DHCW to resolve barriers to data sharing across NHS Wales. Three Alert, Advise, Assure (AAA) Highlight reports from Information Governance Steering Group will provide evidence of this ongoing work and will close both action 8.3 and 8.4"		30/09/2025	Not Met	31/12/2025			Closed in Quarter	25/26 Q3 Update: 070126 (HB): Agreed that AAAs from the IGSG will provide evidence of this on-going work with action to be closed. **Closure Proposed**	AAA reports from the IGSG (dated July 2025, Sept 2025 and Nov 2025)
31	168	23/24	External Audit	QuEST	Public	Quality Governance Follow Up Review	Not Set	Hugh Bennett	Liam Williams	Not Set	8.4	"Quality Performance Reporting and Learning We found that the QuEST Committee is well served with quality information, but there are opportunities for improvement. The Trust should: 8.4 develop patient outcome measures to support its existing quality measures"	8.4	"Whilst we remain limited by data accessibility we continue to pursue patient outcome data through ePCR as well as linking our critical systems to the Welsh Demographic Service allowing the first steps into linking remote clinical assessment with patient outcomes. The ability to achieve truly robust outcome measures without data linkage is limited, we continue to work with DHCW to resolve barriers to data sharing across NHS Wales. Three Alert, Advise, Assure (AAA) Highlight reports from Information Governance Steering Group will provide evidence of this ongoing work and will close both action 8.3 and 8.4"		30/09/2025	Not Met	31/12/2025			Closed in Quarter	25/26 Q3 Update: 070126 (HB): Agreed that AAAs from the IGSG will evidence this on-going work with action to be closed. **Closure Proposed**	IGSG AAAs x3 supplied 02/10/25 (dated Jul25, Sept25, and Nov25)
74	EA/2425-004	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	1	WAST should ensure that investigation outcomes for incidents are recorded accurately on Datix Cymru	01a	"Make additions to Adverse Incident SOP so that responsibilities for QA upon closure of incident records is clear. Self-assessment for each service area should be built into their Departmental Quality Performance Management Framework"		30/04/2025	Not Met	31/03/2026			Open		
75	EA/2425-005	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	1	WAST should ensure that investigation outcomes for incidents are recorded accurately on Datix Cymru	01b	"Work with the Once for Wales Central Team to design listing reports which can be cascaded to service areas identifying records which need to be reopened and adjusted or additional information provided"		30/04/2025	Not Met	30/09/2025	31/03/2026		Open		
76	EA/2425-006	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	1	WAST should ensure that investigation outcomes for incidents are recorded accurately on Datix Cymru	01c	"Develop and deploy Robotic Process Automation to identify incomplete/ inappropriately completed records and report this information by exception report to the Quality Management Group to monitor performance."			Not Set				Open	25/26 Q3 Update 060126 (AK) Update supplied which is reflected in the Q3 audit report	
77	EA/2425-007	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	2	WAST should introduce a KPI for incident reporting and regularly review and scrutinise cases to ensure that they are closed efficiently and do not remain open on the system longer than necessary	02a	Make additions to Adverse Incident SOP to ensure that timescales for reviewing new incidents, undertaking investigatory work and closing records is clear for all staff.		30/04/2025	Not Met	30/11/2025	31/03/2026		Open	25/26 Q3 Update 210126 (LT): **2nd / Final Revised Date of March 2026 applied.** Director to be invited to attend ARAC to provide update and assurance. 060126 (AK): **Proposed revised date of March 2026** due to staff sickness within the PTR Team	
78	EA/2425-008	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	2	WAST should introduce a KPI for incident reporting and regularly review and scrutinise cases to ensure that they are closed efficiently and do not remain open on the system longer than necessary	02b	"Heads of Service to develop Improvement trajectories for incident closures which will be monitored through service focus area Quality Management Group"		31/05/2025	Not Met	31/03/2026			Open		
79	EA/2425-010	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	4	The process for obtaining consent for the release of information arising from a concern should be reviewed and produced in a structured procedure, with arrangements for recording circumstances where consent is not required or appropriate.	04a	"SOP to be reviewed for current accuracy and then approved by Senior Quality Team"		30/04/2025	Not Met	31/12/2025			Closed in Quarter	25/26 Q3 Update 060126 (AK): **Proposed for Closure**	Putting Things Right Standard Operating Procedure, Data Verification and Assurance Process for Complaints
80	EA2425-011	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	4	The process for obtaining consent for the release of information arising from a concern should be reviewed and produced in a structured procedure, with arrangements for recording circumstances where consent is not required or appropriate.	04b	"Commence Quarterly Complaints Audit to provide assurance that SOP is being followed."		31/07/2025	Not Met	31/12/2025	31/03/2026		Open	25/26 Q3 Update 210126 (LT): **2nd / Final Revised Date of March 2026 applied.** Director to be invited to attend next ARAC to provide update and assurance. 060126 (AK): **Propose a revised date of March 2026** due to staff sickness within the PTR Team	
81	EA/2425-013	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	6	It is expected that both the Actions Module in Datix Cymru and the Yorkshire Contributory Framework is utilised and applied efficiently and correctly to ensure appropriate review of investigations in accordance with the All-Wales approach	6b	"Senior Quality Team to undertake options appraisal of digital action planning software to enhance organisational assurance in respect of action plan completion"		30/09/2025	Not Met	31/03/2026			Open		
82	EA/2425-014	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	6	It is expected that both the Actions Module in Datix Cymru and the Yorkshire Contributory Framework is utilised and applied efficiently and correctly to ensure appropriate review of investigations in accordance with the All-Wales approach	6c	"In order to set an achievable target within a continuous improvement journey, focus in the next year will be prioritised on how YCPF are being included in NRI completion. This will include reviewing organisational investigation templates and provision of training to the Corporate Patient Safety team, to then be cascaded to NRI investigators in service areas."		31/03/2025	Not Met	31/03/2026			Open		
83	EA/2425-015	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	6	It is expected that both the Actions Module in Datix Cymru and the Yorkshire Contributory Framework is utilised and applied efficiently and correctly to ensure appropriate review of investigations in accordance with the All-Wales approach	6c	"WAST to support workplan for OWCMS Incident Workstream to provide enhanced definitions and guidance for YCPF and ensure ambulance leaders can utilise it more confidently"		30/04/2025	Not Met	31/03/2026			Open		
84	EA/2425-016	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	9	WAST should ensure subject and sub-subject codes for all records in the Datix Cymru systems are completed consistently and comprehensively and are subject to validation checks	9	"This recommendation was addressed through the development of a Complaints Validation SOP. The SOP has taken time to embed due to OCP and recruitment across the PTR & Legal Services Department. Commence Quarterly Complaints Audit to provide assurance that SOP is being followed."		31/07/2025	Not Met	31/03/2026			Open		
85	EA/2425-017	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	10	WAST should ensure the description field is completed correctly on the Datix Cymru system and that these are subject to validation checks.	10	"This recommendation was addressed through the development of a Complaints Validation SOP. The SOP has taken time to embed due to OCP and recruitment across the PTR & Legal Services Department. Commence Quarterly Complaints Audit to provide assurance that SOP is being followed."		31/07/2025	Not Met	31/03/2026			Open		
86	EA/2425-018	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	1	WAST to ensure that inclusion of additional contacts, where appropriate, is undertaken in relevant complaint records. An audit process may provide assurance of this.	1	"Training on why and how to attach additional contacts was provided by Central OWWCMS team in November 2024 as part of a day-long training offer to all of the Patient and Family Relations team on the use of the Feedback module. Commence Quarterly Complaints Audit to provide assurance that training is being embedded in practice."		31/07/2025	Not Met	31/03/2026			Open		
87	EA/2425-019	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	2	WAST to undertake further training in relation to capturing reopened complaints in Datix Cymru.	2	"Training from the OWWCMS team included a section on how to manage Reopened complaints. Commence Quarterly Complaints Audit to provide assurance that training is being embedded in practice."		31/07/2025	Not Met	31/03/2026			Open		
88	EA/2425-020	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	3	WAST to consider noting a brief consideration of value on Datix Cymru at the outset of every stage of a complaint or claim.	3	"Develop a guidance flowchart to assess whether cases will breach the Redress threshold"		30/09/2025	Not Met	31/03/2026			Open		
89	EA/2425-021	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	4	WAST to review the current exclusion from relevant complaint letters of standard paragraphs for Breach of Duty and Qualifying Liability	4	"WAST recognises the potential for changes to the approach around how legal information is provided to complainants as part of the revised PTR Guidance and Concerns Regulations. WAST will review the information it provides on Breach of Duty and Qualifying Liability within its complaints responses. A review paper will drafted for the Executive Team due to the statutory requirement for this information to be provided. "		30/04/2025	Not Met	31/10/2025			Closed in Quarter	25/26 Q3 Update 060126 (AK): **Propose for closure**	Executive Summary: Welsh Risk Pool Concerns Assessment Recommendations 2024 Email dated 11.12.25 from Liam Williams, Executive Director of Quality & Nursing

90	EA/2425-024	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	7	WAST should ensure the Management of Compensation Claims Policy is updated and subject to periodic reviews	7	"WAST recognises the potential for changes as part of the revised PTR Guidance and Concerns Regulations. Policy has been drafted but needs to be placed into appropriate template, track changes, consultation with TU and rescheduled for Policy Group."	31/12/2025	Met			Closed in Quarter	25/26 Q3 Update 060126 (AK): **Proposed for closure.** This recommendation is being mitigated as the draft statutory national guidance states that every organisation must have a Listening to People Policy. This aligns with our already agreed internal proposal that the current Management of Compensation Claims Policy will be superseded by a Listening to People Policy	Email from Lisa Trounce dated 5 September 2025 following a meeting with Claire Appleton, Assistant Director of Putting Things Right - confirming agreed approach.
91	EA/2425-025	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	8	WAST to continue to increase its use of the Datix Cymru system for the management of matters utilising the current stage and claim details fields as much as possible	8	"Designate the fields that require completion to provide clarity to staff. "	28/02/2025	Not Met	31/01/2026		Open		
92	EA/2425-026	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	8	WAST to continue to increase its use of the Datix Cymru system for the management of matters utilising the current stage and claim details fields as much as possible	8b	"Development of QA dashboard in Datix to monitor field completion."	30/04/2025	Not Met	31/03/2026		Open		
93	EA/2425-027	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	8	WAST to continue to increase its use of the Datix Cymru system for the management of matters utilising the current stage and claim details fields as much as possible	8c	"Development of regular BI report to provide assurance "		Not Set			Open	25/26 Q3 Update 060126 (AK): Update supplied reflected within the Q3 audit report.	
94	EA/2425-028	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	9	WAST to update the flowchart for the management of inquests and police information requests	9	"Inquest Management SOP to be developed to supersede flowchart (Police information requests are now managed by Records)"	31/05/2025	Not Met	31/12/2025	30/09/2026	Open	25/26 Q3 Update 210126 (LT): **2nd / Final Revised Date of September 2026 applied.** Director to be invited to attend next ARAC to provide update and assurance. 070126 (AK): This action cannot be completed owing to changes within Legal Services Team structure. The current SLA comes to an end on 05/02/2026 and it is possible that inquest management will be transferred external to the Trust. We are unable to complete a SOP for this until status of legal provision within/to the Trust is confirmed. This may not be for several months therefore action c/f to 2026/27. **Proposed revised date of September 2026**	
95	EA/2425-029	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	10	WAST to continue to increase its use of the Datix Cymru system with regards to inquest matters to include the fields for both current stage and statements.	10a	"Designate the fields that require completion to provide clarity to staff."	31/03/2025	Not Met	31/10/2025		Closed in Quarter	25/26 Q3 Update 060126 (AK): **Proposed for closure.**	Screenshot x 3 of Welsh Risk Pool Inquest Dashboard (the fields on which the Dashboard are built are included in the Dashboard title) Excel spreadsheet 'Stage History Datix Cymru' (spreadsheet provides the range of coding options available to the team under those fields)
96	EA/2425-030	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	10	WAST to continue to increase its use of the Datix Cymru system with regards to inquest matters to include the fields for both current stage and statements.	10b	"Development of QA dashboard in Datix to monitor field completion"	30/04/2025	Not Met	31/10/2025		Closed in Quarter	25/26 Q3 Update 060126 (AK): **Proposed for closure**	Screenshots of Welsh Risk Pool Inquest Dashboard
97	EA/2425-031	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	10	WAST to continue to increase its use of the Datix Cymru system with regards to inquest matters to include the fields for both current stage and statements.	10c	"Development of regular BI report to provide assurance "		Not Set			Open	25/26 Q3 Update 060126 (AK): Update supplied reflected within the Q3 audit report.	
98	EA/2425-032	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	11	WAST to update the Learning from Event Report Standard Operating Procedure to reflect the new process that is being implemented.	11	"Management of LFERs has transferred from Legal Services to Patient Safety team under OCP arrangements. It is anticipated that this will bring significant benefits in terms of more timely and comprehensive completion, although 'legacy' cases may still present some challenges during the transition period. A SOP is under development as part of the new arrangements. SOP to be finalised & approved by SQF"	30/04/2025	Not Set	31/10/2025	31/03/2026	Open	25/26 Q3 Update 210126 (LT): 2nd / Final Revised Date of March 2026 applied. Director to be invited to attend next ARAC to provide update and assurance. 060126 (AK): Proposed revised date of March 2026	
99	EA/2425-033	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	12	WAST to fully utilise the Datix Cymru System for the tracking of both Learning from Event Reports and Case Management Report submission deadlines and the introduction of an assurance and tracking process to offer visibility to this.	12a	"Designate the fields that require completion to provide clarity to staff. "	31/03/2025	Not Met	31/01/2026		Open		
100	EA/2425-034	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	12	WAST to fully utilise the Datix Cymru System for the tracking of both Learning from Event Reports and Case Management Report submission deadlines and the introduction of an assurance and tracking process to offer visibility to this.	12b	"Development of QA dashboard in Datix to monitor completion "	30/04/2025	Not Met	31/03/2026		Open		
101	EA/2425-035	24/25	External Audit	QuEST	Public	WRP Concerns Assessment 2024	Limited	Claire Appleton	Liam Williams	Not Set	12	WAST to fully utilise the Datix Cymru System for the tracking of both Learning from Event Reports and Case Management Report submission deadlines and the introduction of an assurance and tracking process to offer visibility to this.	12c	"Development of regular BI report to provide assurance "		Not Set			Open	25/26 Q3 Update 060126 (AK): Update supplied reflected within the Q3 audit report.	

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

Agenda Item No.	18

REPORT TITLE

2025/26 Quality Governance Reviews:
Committee Annual Report 2025/26 and Cycle of Business 2026/27

MEETING

Name of meeting	Quality, Patient Experience and Safety Committee
Date of meeting	3 February 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	Trish Mills, Director of Corporate Governance/Board Secretary Alex Payne, Corporate Governance 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 committee received a full report on the 2025/26 quality and governance review outcomes at its meeting on the 4 November 2025. At this meeting the revised terms of reference for the committee for 2026/7 were endorsed. It was acknowledged at that meeting that the committee's annual report and cycle of business would be brought back for approval prior to year-end.

2. The full package of documents from the 2025/26 committee effectiveness reviews will be taken to the Audit, Risk and Assurance Committee at its meeting on the 2 March 2026. This includes the Quality, Patient Safety and Experience Committee's 2025/26 annual report The AAA from this meeting of the committee will be included within the annual report with the others once it is completed.

3. The committee is asked to discuss and approve its annual report for 2025/26 and its cycle of business for 2026/27, which has been updated in line with the terms of reference changes. The primary adjustment is the inclusion of reporting on the delivery of core aims in relation to delivering value and the development of value based healthcare in an out of hospital setting.

4. During 2025/26 the committee met six times and met quorum on each occasion. The qualitative feedback received from this year's effectiveness review will inform changes to the meetings going forward. This year's review has reinforced that the committee is considered to be effective, with high engagement, robust agendas and strong scrutiny and Charing. Many thanks to all committee members for their engagement.

5. The committee may wish to consider focusing on two priorities for 2026/27 including but not limited to value based healthcare assurance reporting that was added to its terms of reference, and the effectiveness of the Trust's quality management system, which was raised in the quality and governance reviews in November.

6. The committee is asked to review and approve its cycle of business for 2026/27. There are some areas of the cycle which are to be agreed which have been highlighted in yellow. The substantive adjustment to the cycle is the inclusion of the value-based health care assurance reporting. Other areas for discussion include the format of future reporting for infection, prevention and control matters, and the mental health/dementia standards reporting.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The Committee is requested to:

(a) Approve the draft Annual Report at annex 1.
(b) Approve the draft Cycle of Business for 2026/27 at annex 2.

ADDITIONAL PAPER(S)

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

Annex 1 QuEST Committee 2025/26 Annual Report
Annex 2 QuEST Committee Cycle of Business 2026/27

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
3 February 2026	Quality Patient Experience and Safety Committee (QuEST)

QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE (QUEST) ANNUAL REPORT 2025/26

INTRODUCTION

1. The Trust's Standing Orders and Committee Terms of Reference require that Board Committees evaluate their effectiveness annually and present an annual report to the Trust Board.

2. As the factors underpinning effective governance can change, for example as people leave, organisations restructure, or strategy shifts, regular reviews of Board Committees ensure governance remains fit for purpose.

3. Standing Orders, committee terms of reference, and codes of governance provide that boards should routinely assess the effectiveness of their governance arrangements, of which the board's committees form an integral part.

4. The committee met on the 4 November 2025 and 3 February 2026, and through a facilitated discussion reviewed its effectiveness, its terms of reference, and its operating arrangements. This Annual Report reflects on the effectiveness of the committee in 2025/26 and proposes changes to terms of reference.

5. The trust board has commissioned an external effectiveness review which will be undertaken in early 2026 by the Good Governance Institute (GGI). The GGI will be reviewing the board committee framework within quarter four 2025/26 and quarter one of 2026/27 which may necessitate further changes throughout 2026/27. Although at this stage it is not anticipated that there will be material changes to this committee.

PURPOSE OF THE COMMITTEE

6. The committee is established to scrutinise improvements in outcomes in quality, patient experience, effectiveness, and safety to reduce incidences of avoidable harm. It provides oversight of and seeks assurance on statutory and regulatory compliance, including but not limited to the Duty of Quality and the Duty of Candour as set out in the Health and Social Care (Quality and Engagement) (Wales) Act 2020.

MEMBERSHIP AND ATTENDANCE

7. The committee met six times in 2025/26 and was quorate on each occasion. Of the six meetings this year two were extraordinary (13 June and 10 October) and were convened to transact urgent matters of business related to the Clinical Model Transformation Programme.

8. The committee is supported by the Chair and two Non-Executive Directors as members, and a number of prescribed attendees. The chart below illustrates attendance of members and attendees as listed in the terms of reference for 2025/26. The committee welcomed non prescribed attendees at various meetings as well as external guests.

COMMITTEE ATTENDANCE						
NAME	9 MAY 2025	13 JUN 2025[1]	5 AUG 2025	10 OCT 2025[2]	4 NOV 2025	3 FEB 2026
Bethan Evans (Chair)						
Ceri Jackson						
Rhiannon Beaumont-Wood						
Liam Williams						
Andy Swinburn			Jonathan Chippendale			
Lee Brooks	Peter Brown				Mark Harris	
Rachel Marsh			Hugh Bennett		Hugh Bennett	
Jonny Sammut	Keith Williams					
Trish Mills		Julie Boalch		Julie Boalch		
Mark Marsden						
Hugh Parry					From item 6.1	
Henry Garrard						

	Attended
	Deputy attended
	Apologies received
	No longer member

9. As can be seen above attendance is excellent. No changes to membership are proposed at this stage, noting however that may change following the outputs from GGI.

COMMITTEE'S VIEWS ON EFFECTIVENESS

Feedback from membership

10. The committee undertook a light effectiveness review on 4 November 2025, as agreed with the Audit, Risk and Assurance Committee (ARAC). This was due to the comprehensive review undertaken in 2024/25 involving a detailed examination of the terms of reference and the assurance arrangements for each delegated responsibility.

11. For 2025/26 a survey of the members was carried out to gather feedback on the proposed changes to the terms of references and to identify what is working well, and where improvements could be made. The questions asked were:

    - Are there any changes you wish to see to the terms of reference?
    - Are there any changes you would like to see to the committee's membership?
    - What works well in this committee?
    - What improvements would you recommend?

12. The feedback from the committee included that there was broad agreement that the committee's membership is appropriate and diverse, and whilst concerns were raised about the number of attendees, with some questioning the value added by non-contributing participants, wide attendance is encouraged and welcomed by the committee in open session.

13. The committee is seen as effective with high engagement, robust agendas, and strong scrutiny and chairing. However, there is a desire for more focus on the effectiveness of the Quality Management System as a whole, including quality planning, control, and improvement; not just assurance.

14. The terms of reference are viewed as suitable and were endorsed by the committee on 4 November, subject to changes which transfer responsibility for value based healthcare from the Finance and Performance Committee. These matters are reflected in the cycle of business for the committee for 2026/27.

Management of the committee's work programme

15. The committee has a cycle of business that is aligned to its terms of reference. All matters scheduled for oversight and review have been brought to the committee and in this respect, it has discharged its responsibilities in providing assurance to the Board. The revised cycle of business for the committee was reviewed at the meeting on the 3 February 2026.

16. The committee prepares its agenda aligned to the cycle of business in order to ensure it discharges its delegated responsibilities in a systemic way. Any deviation from the cycle is reported to the committee.

17. The board is kept informed of the committee's oversight of a range of issues by way of an 'Alert', 'Assure' and 'Advise' (AAA) report to the Board after each meeting. Any issues of concern are escalated to the board in the 'Alert' section, and the chair of this committee presents that report at each board meeting.

18. Rather than set out in this report the substantial detail of the work of the committee in 2025/26, the AAA reports for all six meetings are linked below.

    18.1. AAA: 9 May 2025
    18.2. AAA: 13 June 2025 (extraordinary meeting)
    18.3. AAA: 5 August 2025
    18.4. AAA: 10 October 2025 (extraordinary meeting)
    18.5. AAA: 4 November 2025
    18.6. AAA: 3 February 2026

19. The committee is not currently serviced by any sub-committees.

20. The private business received in year included receipt of closed risk management discussions,

PROPOSED CHANGES TO THE TERMS OF REFERENCE

21. There is only one material change to the terms of reference and that is the inclusion of the 'receipt of assurance on the delivery of core aims in relation to delivering value and development of value based healthcare in an out of hospital setting', transferred from the Finance and Performance Committee. This was endorsed by the committee on 4 November and will be approved by the board on 29 January.

22. Proposed changes to operating arrangements for this committee set out below were agreed on 4 November:

    22.1. Committee to consider how to focus business in relation to quality management systems, given the existing provision of the terms of reference (3.6). It was agreed to be for the Executive Director of Quality and Nursing to take account of this for future committee reporting.

    22.2. Continue with agenda setting meetings and encourage themes for meetings to aid in the flow and triangulation. Members are encouraged to review the agenda both when it is commissioned and closer to the meeting and alert the secretariat if insufficient time has been allocated. Likewise, presenters should ensure they are cognisant of the time allocated which includes time to present and for discussion.

    22.3. To encourage the use of dashboard reporting where possible, and for the use of presentations to be proportionate. The recently published report and presentation guidance will support this approach.

    22.4. To encourage a focus on outcomes and achievement of deliverables, where organisational plans are agreed.

    22.5. To hold discussions in 2026/27 on the committee specific metrics following the revision of the MIQPR and consider the onward committee reporting.

COMMITTEE PRIORITIES

Priorities for 2025/26

23. The committee received an update on progress against its priorities at each meeting. The 2025/6 priorities were:

Priority	Progress
• Continued monitoring and reporting on performance against the Duty of Quality and Duty of Candour	• The committee receives the PTR report at each meeting with focused discussion on the metrics that demonstrate how the Trust meets it statutory duties. At the August and November 2025 and February 2026 meetings, the Putting Things Right (PTR) recovery plan was reviewed. This plan is aimed to increase the Trust's compliance against PTR regulations. An update on the recovery plan, with the quarterly PTR report, is scheduled for the February 2026 meeting. The committee has escalated issues related to PTR and the recovery plan to the board. • Future updates on the implementation of the Duty of Candour and Duty of Quality will be programmed as required, informed by the prompts on the Cyle of Business. • The Duty of Quality Annual Report 2024/25 was received by the Committee at its meeting on 13 June 2025 and was approved by the Trust Board on 26 June 2025 for publication.
• Prioritising the implementation of the new Strategic Quality Plan to ensure tangible outcomes	• The committee will receive the Strategic Quality Plan 2025-28 Quarterly Update at the meeting on 3 February 2026, where they will be assured on progress to date in delivering the Strategic Quality Plan 2025/28. Members will be asked to note the key risks, dependencies and capacity constraints impacting delivery, and the mitigating actions in place. The Committee will be asked to support continued quarterly assurance reporting, with a planned transition towards outcome-based assurance measures as delivery matures. • The committee received a progress update against the delivery of the Strategic Quality Plan 2025/28 at the November 2025 meeting. • This followed the receipt of the Strategic Quality Plan 2025-2028 by the Committee at its meeting on 09 May 2025, which was approved by the Trust Board approved the plan on 29 May 2025.

• Focus on the Clinical Model Transformation, ensuring robust quality assurance and patient experience improvements	• The committee held an extraordinary meeting in October 2025 to review and endorse the Quality Impact Assessment and Equality Impact Assessment for the phase two go-live of the revised Ambulance Performance Framework (APF), ahead of the extraordinary Trust Board meeting to approve the go-live of phase two APF • The committee continues to monitor progress through regular updates and highlight reports; scrutiny of evaluation findings and interim reports; and assurance that the transformation aligns with statutory duties and strategic goals. • Verbal updates on the Ministerial Advisory Group Wait-45 Taskforce and Revised Performance Framework were provided at the August 2025 and February 2026 meetings. This activity is not a part of the Clinical Model Transformation; however, it is often discussed in relation to this organisational change.

Priorities for 2026/27

24. It is good practice for committees to set priorities for the forthcoming year when they review their effectiveness. The committee will do so at its February 2026 meeting, and these will be provided to the board at its May meeting.

25. Progress on priorities will be reported to the committee quarterly and to the Board through its highlight report.

PAPER	PRE C'EE FORUM	FREQUENCY	Q1	Q2	Q3	Q4	LEAD	PURPOSE	COMMENT/COMPLIANCE
QUEST COMMITTEE - CYCLE OF BUSINESS 2026/27									
TERMS OF REFERENCE NOTED IN RED TEXT									
STRATEGY DEVELOPMENT AND DELIVERY									
3.1 Oversee and contribute to the development of the Trust's strategies and plans for the delivery of high quality and safe services, consistent with the Board's overall strategic direction and any requirements and standards set for NHS bodies in Wales.									
3.2 Consider the implications for quality, safety and equitable care in strategies and aligned plans.									
3.3 Receive assurance on the implementation of strategies and plans within the remit of the Committee, with a particular focus on the impact of desired outcomes in those strategies and plans									
Quality Plan aligned to Delivering Excellence 2030	CQGG/TB	Initial and cyclical review					EDQN	Approval	
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
SAFE, EQUITABLE									
3.4 Receive assurance on compliance with the Duty of Quality and Duty of Candour as set out in the Health and Social Care (Quality and Engagement) (Wales) Act 2020 to improve the quality of healthcare provided by the Trust and to support the delivery of an open and honest reporting and continuous learning culture - See Note 2 (see also QIAs below)									
3.14 Review and recommend to the board the Trust's annual Duty of Candor and Quality Report(s) and quality improvement priorities for the coming year, monitoring progress against these priorities and their impact on patient safety.									
3.5 Receive assurance that the Health and Care Quality Standards 2030 are embedded Trust wide with actions taken in relation to any identified non-compliance.									
3.6 Receive assurance that there is a quality management system in place that ensures compliance with relevant standards and regulations, facilitates continuous improvements and processes, and enhances patient safety and patient experience.									
3.12 Review the impact of professional standards and staffing issues on patient care, noting the People and Culture Committee has oversight of the selection, training, registration and revalidation for staff									
3.7 Receive assurance that there is a process in place for quality impact assessments, and consider the implications for quality and safety and equitable care arising from the development of the Trust's corporate strategies and plans, or those of its stakeholders and partners, including those arising from any Committees of the Board									
Duty of Quality Report (to include Duty of Candour)	CQGG/TB	Annually					EDQN	Endorsement	
Meds management report	CQGG	Annually					EDP	Assurance	Standalone report in Q1 on meds management (& medical devises by exception) & exception report - see Note 10
3.8 Receive reports on significant concerns or adverse findings highlighted by external bodies in relation to clinical quality safety, effectiveness and patient experience and seek assurance of the actions being taken by management to address these									
External reports	CQGG	Ad Hoc					EDQN/DP	Assurance	
3.9 Receive assurance that the Trust is compliant with the Dementia Standards, Mental Health Act 1983, Code of Practice, and the Mental Capacity Act 2005.									
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
3.10 Review the annual infection prevention and control plan and receive assurance on its implementation and the systems in place to ensure compliance with statutory and regulatory requirements for infection prevention and control									
Annual IPC report	CQGG	Annually					EDQN	Assurance	TBC re receipt of this for 2026/27; to have discussion with QSPE on this assurance reporting and adjustments from 2025/26
3.11 Receive assurance that the Trust is meeting its obligations with respect to safeguarding of children and vulnerable adults									
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
3.13 Ensure that robust arrangements are in place for the review of patient safety incidents (to include near misses) to identify similarities or trends and areas for focused or organisation-wide learning									
MIQPR report	ELT	Quarterly					EDSPP	Assurance	Includes balanced scorecard of all Board level metrics
Putting Things Right Report	CQGG	Quarterly					EDQN/DP	Assurance	See Notes
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
3.15 Review policies in its remit and endorse policies for board approval that relate to complaints and incidents in line with Putting Things Right.									
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									
3.16 Receive assurance that the care planned and provided across the breadth of the organisation's functions is evidence-based, clinically effective and quality driven. and where this falls beneath expected standards, the impact is reviewed to support continuous improvement.									
3.17 Approve the annual clinical audit plan that meets the standards set for the NHS in Wales; review the outcomes of clinical audits in line with the clinical audit plan and provide assurance to the Audit, Risk and Assurance Committee in this respect									
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)
3.18. Advise the board on a set of key indicators for quality, patient experience and clinical safety, and monitor performance against those indicators.									
MIQPR annual review of QUEST metrics	ELT	Annually					EDSPP	Approval	To review and agree Board level metrics for coming year
PTR report annual review of metrics	CQGG	Annually					EDQN	Approval	To review and agree the Committee level metrics for the coming year (over and above MIQPR metrics - if any) currently contained in PTR report
3.19 Receive assurance that there is an ethos of continual quality improvement and regular methods of updating the workforce in the skills needed to demonstrate quality improvement throughout the organisation									
Mortality Report	CQGG	Bi-annually					EDQN	Assurance	See Note 12
3.2 1.1.Receive assurance on delivery of core aims in relation to delivering value and development of value based healthcare in an out of hospital setting.									
Value-based healthcare report	CQGG						EDQN	Assurance	The inclusion of this is subject to the approval to the terms of reference for 2026/27. Frequency of reporting to be decided
PATIENT CENTRED									
3.20 Oversight of patient experience feedback, including themes, trends and learning, and approve the Patient Experience Plan on behalf of the Board									
3.21 Receive assurance that the organisation has a patient centred approach, putting patients, patient safety, quality of care and safeguarding above all other considerations.									
3.22 Receive assurance that the Patient Experience & Community Involvement (PECI) continuous engagement model is taken into account in the design and delivery of services, ensuring the full implementation of lessons learnt									
3.23 Receive assurance that lessons are learned from patient experience information and patient safety and workforce related incidents, complaints and claims, and that learning from reports and incidents is embedded in the Trust's practices, policies and procedures									
3.24 Receive assurance that there is good collaborative team and partnership working to provide the best possible outcomes for its citizens									
3.25 Ensure any matters raised by the Executive Director of Quality & Nursing (including in their role as Caldicott Guardian),Executive Director of Paramedicine, or other Directors in relation to patient safety and clinical risk are considered and addressed promptly and fully									
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									
3.26 Oversee the effective management of strategic and principal risks, as set out within the Board Assurance Framework (BAF), as appropriate to the purpose of the committee									
3.27 Seek assurance that governance arrangements are appropriately designed and operating effectively to ensure the provision of high quality, safe healthcare and services across the whole of the Trust's activities, and that these are compliant with relevant legislation									
3.28 Receive and gain assurance from internal and external audits in their remit. It will receive assurance that management actions to address recommendations are in place via the audit tracker receive appropriate reporting as agreed by the Audit, Risk and Assurance Committee. This committee will, where appropriate, scrutinise the impact of actions in response to audit recommendations									
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	
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

Cycled for each meeting
Ad hoc item - prompt for agenda setting
Reporting developing

Agenda Item No.	19

REPORT TITLE

Committee Priorities and Cycle of Business Monitoring Report 2025/26

MEETING

Name of meeting	Quality Patient Experience and Safety Committee
Date of meeting	03 February 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]

Cycle of Business Monitoring

1. This report updates the Committee on progress against the priorities it set for 2025/26 and progress against the agreed its cycle of business (CoB). The Committee's CoB was approved by the Committee in May 2025. Each meeting agenda is set by referencing the cycle, together with the forward planner, action log and highest rated principal risks. There are no matters to escalate to the committee on the monitoring report.

2025/26 Committee Priorities

2. During the effectiveness reviews, it was agreed that it is good practice for Committees to set priorities for the forthcoming year. The priorities, which are set out below, were agreed by the Trust Board in May 2025 and will be tracked quarterly in the monitoring report.

3. 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.

4. The 'post-agenda setting' key indicates that items in blue were either on the agenda as scheduled or was an *ad hoc* item which was discussed in agenda setting and scheduled. The orange indicates where an item was programmed for receipt but has been deferred to a future meeting. The Committee's priorities and progress against them is as follows:

Priority	Progress
• Continued monitoring and reporting on performance against the Duty of Quality and Duty of Candour	• The committee receives the PTR report at each meeting with focused discussion on the metrics that demonstrate how the Trust meets it statutory duties. At the August and November 2025 and February 2026 meetings, the Putting Things Right (PTR) recovery plan was reviewed. This plan is aimed to increase the Trust's compliance against PTR regulations. An update on the recovery plan, with the quarterly PTR report, is scheduled for the February 2026 meeting. The committee has escalated issues related to PTR and the recovery plan to the board. • Future updates on the implementation of the Duty of Candour and Duty of Quality will be programmed as required, informed by the prompts on the Cyle of Business.

	• The Duty of Quality Annual Report 2024/25 was received by the Committee at its meeting on 13 June 2025 and was approved by the Trust Board on 26 June 2025 for publication. <u>2024/25 Progress</u> *<u>(included as this priority was carried over into 2025/26)</u>* • An update on the Duty of Quality Implementation Plan was received in February 2025. Included within the report, an update was provided on the progress on developing self-assessments against the Health and Care Quality Standards.
• Prioritising the implementation of the new Strategic Quality Plan to ensure tangible outcomes	• The committee will receive the Strategic Quality Plan 2025-28 Quarterly Update at the meeting on 3 February 2026, where they will be assured on progress to date in delivering the Strategic Quality Plan 2025/28. Members will be asked to note the key risks, dependencies and capacity constraints impacting delivery, and the mitigating actions in place. The Committee will be asked to support continued quarterly assurance reporting, with a planned transition towards outcome-based assurance measures as delivery matures. • The committee received a progress update against the delivery of the Strategic Quality Plan 2025/28 at the November 2025 meeting. • This followed the receipt of the Strategic Quality Plan 2025-2028 by the Committee at its meeting on 09 May 2025, which was approved by the Trust Board approved the plan on 29 May 2025.
• Focus on the Clinical Model Transformation, ensuring robust quality assurance and patient experience improvements	• The committee held an extraordinary meeting in October 2025 to review and endorse the Quality Impact Assessment and Equality Impact Assessment for the phase two go-live of the revised Ambulance Performance Framework (APF), ahead of the extraordinary Trust Board meeting to approve the go-live of phase two APF • The committee continues to monitor progress through regular updates and highlight reports; scrutiny of

	evaluation findings and interim reports; and assurance that the transformation aligns with statutory duties and strategic goals. • Verbal updates on the Ministerial Advisory Group Wait-45 Taskforce and Revised Performance Framework were provided at the August 2025 and February 2026 meetings. . This activity is not a part of the Clinical Model Transformation; however, it is often discussed in relation to this organisational change.

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 the:

1. Quality, Patient Experience and Safety Committee Cycle of Business Monitoring Report - January 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
03 February 2026	Quality, Patient Experience and Safety Committee

PAPER	PRE C'EE FORUM	FREQUENCY	Q1	Q2	Q3	Q4	LEAD	PURPOSE	COMMENT/COMPLIANCE
QUEST COMMITTEE - CYCLE OF BUSINESS 2025/26									
TERMS OF REFERENCE NOTED IN RED TEXT									
Quality Plan aligned to Delivering Excellence 2030	CQGG/TB	Initial and cyclical review					EDQN	Approval	Plan for approval in 2025/26 (including QIA and EqIA) Q3 Included in Quality Plan Progress Update. The population/public health detail will be incorporated into the update report in Q3 regarding the Quality Plan deliverables.
Clinical Plan aligned to Delivering Excellence 2030	CQGG/TB	Initial and cyclical review					EDP	Approval	Plan for approval in 2025/26 (including QIA and EqIA) Q2 Included in Clinical Plan Progress Update
Quality Impact Assessments	CQGG	Ad Hoc					EDQN/DP	Assurance	See Notes
TBC assurance reporting on 'what good looks like' for QUEST remit	STB	TBC					EDQN/DP	Assurance	Reporting developing in 2025/26
Duty of Quality Report (to include Duty of Candour)	CQGG/TB	Annually	→				EDQN	Endorsement	Q1: this was taken to the Extraordinary meeting on 13 June 2025.
Meds management report	CQGG	Annually					EDP	Assurance	Standalone report in Q1 on meds management (& medical devises by exception) & exception report - see Note 10
External reports	CQGG	Ad Hoc					EDQN/DP	Assurance	
Dementia Standards Report	CQGG	Annually					EDQN	Assurance	See Notes. Mental health encompasses a broad range of specialisms , including **dementia**, learning disabilities, substance misuse, neurodiversity, child and adolescent mental health (CAMHS), older people's mental health, post-natal mental health, and adult mental health. Mental health as an umbrella term for all of these.
Annual Mental Health Report	CQGG	Annually					EDQN	Assurance	See Notes re legislative compliance reporting requirement. Regular KPIs being developed 2025/26
Annual IPC report	CQGG	Annually		→	→		EDQN	Assurance	Metrics also included in MIQPR. Q2 report deferred to Q3. Q3 receipt deferred to Q4. Will be brought back in Q4 with the IPC Standards Self-Assessment (report title to be confirmed).
Annual safeguarding reports	CQGG/TB	Annually					EDQN	Assurance	Annual safeguarding report (All Wales and WAST). Quarterly metric in MIQPR on risk report data and referrals
MIQPR report	ELT	Quarterly					EDSPP	Assurance	Includes balanced scorecard of all Board level metrics
Putting Things Right Report	CQGG	Quarterly					EDQN/DP	Assurance	*See Notes*
Policies for review and approval	Policy Group	Ad Hoc					BS	Approval	Board to approve PTR policy (SoRD). Note AW recommendations on PTR and Adverse Incident Policies in the 2024 quality governance review follow up. Q3 Prevent Policy for Committee approval. Q4 Alternatives to Conveyance Policy for approval.
Clinical audit plan	CQGG/AC	Annually					EDP	Approval	QUEST report to Audit Committee that plan endorsed. See Note 9. Q4 to be incorporated within the monitoring report and action tracker.
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). Q4 included on agenda as an Update on Clinical Indicators within Red Category (to include Maternity responses within WAST)
MIQPR annual review of QUEST metrics	ELT	Annually					EDSPP	Approval	To review and agree Board level metrics for coming year
PTR report annual review of metrics	CQGG	Annually					EDQN	Approval	To review and agree the Committee level metrics for the coming year (over and above MIQPR metrics - if any) currently contained in PTR report
Near Miss and Low Harm Intelligence Report	TBC	Annually					EDQN	Assurance	Onward assurance is provided to the ARAC regarding these arrangements (added in 08072025); for Q2 this was included in the PTR Report. Report issued to ARAC on 020925.
Mortality Report	CQGG	Bi-annually					EDQN	Assurance	See Note 12
PECI report	TBC	Bi-annually					EDQN	Assurance	See note 11
Patient Experience	N/A	Quarterly					EDQN	Assurance	Following Q4 ASM, now known as Patient Experience.
Patient Experience updates	N/A	Quarterly					EDQN	Assurance	Following Q4 ASM, now known as Patient Experience.
Audit recommendation tracker	ELT	Quarterly					BS	Assurance	
Audits within purview of Committee	Audit	Ad Hoc					Relevant Director	Assurance	
Board Assurance Framework	ELT	Quarterly					BS	Assurance	
Corporate Risk Register	ELT	Quarterly					BS	Assurance	
SUB-GROUPS									
Where applicable	N/A	Ad Hoc					N/A	N/A	No sub-committees - however may set up task and finish groups from time to time
GOVERNANCE									
Committee effectiveness review annual report	Audit/Board	Annually					BS	Approval	
Review of Terms of Reference	Audit/Board	Annually					BS	Approval	
Committee Cycle of Business annual refresh	N/A	Annually					BS	Approval	Q1: Dealt with via chair's action in April.
Committee Cycle of Business monthly review	N/A	Quarterly					BS	Review	Review against cycle progress at each meeting
Committee Review of Annual Priorities	N/A	Quarterly					BS	Review	
PROMPTS									
Operations Report	SLT	QUarterly					EDO	Information	

EDQN = Executive Director of Quality and Nursing
EDO = Executive Director of Operations
EDP = Executive Director of Paramedicine
EDSPP = Executive Director Strategy, Planning and Performance
BS = Board Secretary

Key: Pre-agenda setting
- Cycled for each meeting
- Ad hoc item - prompt for agenda setting
- Reporting developing

Key: Post-agenda setting
- Presented as cycled
- Ah hoc / item considered - not programmed
- → Item deferred
- Reporting developing

1	**Putting Things Right Report**	Note in February 2024 Quest PTR report that future reports will move to aggregated thematic reviews to determine patters and trends corporately and at Health Board levels. Audit Wales Quality Governance Review 2022 made recommendations related to quality information. The 2024 Qualty Governance Follow Up Review (October 2024) re-opened previously closed recommendations as follows: - 8.1 Develop a system to triangulate learning themes across its quality assurance reports. This should ensure clarity about what improvement actions have been taken as a result and how learning has been disseminated across the organisation. This has been re-opened - 8.2 Enhance Covid-19 reporting in the integrated quality and performance report by including information about the harm caused to patients by ongoing service pressures caused by the virus. This can remain closed and is superseded given the risk posed by C19 now. - 8.3 Work with health bodies so that there are systems to determine the outcomes for patients who have received emergency ambulance services. This should particularly seek to understand the consequence and harm resulting from service failures such as long ambulance waits. This has been re-opened - 8.4 Develop patient outcome measures to support its existing quality measures. This has been re-opened. Report says: We found the Trust continues to face challenges in reporting patient outcomes due to differing patient systems in place across organisations. However, there is more the Trust can and should do to triangulate and identify themes and learning. The Putting Things Right report summarises some of the key themes from joint investigations and incidents, but not others such as concerns or mortality reviews. However, neither report [PTR and MIQPR] provides triangulation with other information to identify broader key themes and there is limited information on what is being done to address challenges and identify and implement learning. 05 November 2024 meeting: Discussion re reporting of low and no harm events (in relation to the near-miss report). Need to consider how best to receive / frequency.
2	**Duty of Quality and Duty of Care**	The 2024 Qualty Governance Follow Up Review recommendations as follow: R4 - The Trust should take steps to increase compliance rates for duty of quality and duty of candour training to ensure staff have a good understanding of their responsibilities under the requirements
3	**Annual Quality Report**	H&C (Q&E) Act will have a requirement to publish an annual report setting out the steps taken to secure improvements in the quality of health services. WG is also required to publish an annual report on the steps they have taken to comply with the duty of quality also. Introduced for end of 23/24 The 2024 Qualty Governance Follow Up Review recommendations as follow: R4 - The Trust should take steps to increase compliance rates for duty of quality and duty of candour training to ensure staff have a good understanding of their responsibilities under the requirements
4	**Annual Duty of Candour Report**	H&C(Q&E) Act s.7; publish report after the end of the reporting year (s.8(1)). Duty of Candour Regulations will be developed 23/24. Introduced for end of 23/24. The DoC Annual report will not be a standalone annual report, Details will be presented in the Annual PTR report to prevent duplication. The 2024 Qualty Governance Follow Up Review recommendations as follow: R4 - The Trust should take steps to increase compliance rates for duty of quality and duty of candour training to ensure staff have a good understanding of their responsibilities under the requirements
5	**Dementia Standards**	Funding requests made annually to WG for dementia programme. The All Wales Dementia Care Pathway of Standards published in 2021. WG national steering group with WAST representation. Reporting on compliance against the 20 dementia care pathway standards being developed in 23/24 (see Nov 22 QUEST paper for link to standards).
6	**QIA**	The QIA *process* was endorsed by QUEST. Thereafter CQGG reviews all QIAs and the Chairs of CQGG will escalate those in their professional judgment should be reviewed by QUEST. QUEST paper 110523 - CQGG will: (a) Be assured that there is an appropriate QIA process undertaken for all new and existing Trust wide service redesign/transformation, projects and cost improvements; (b) Receive oversight reports on new and existing Trust wide schemes/projects that have undergone a full QIA to ensure risk planning is robust and the impact on quality and performance is being thoroughly assessed and negative impact mitigated (c) Have oversight of the framework and central repository for all QIA's; initial screening and full QIA. (d) have oversight of onward report to the Executive Management Team; Quality, Patient Experience and Safety (QuEST) Committee and; Trust Board, as appropriate. Reports to QuEST will identify QIAs completed and explicitly identify those that have required EMT review and authorisation.
7	**Clinical Audit**	Clinical audit is an important way of providing assurance about the quality and safety of services. The Trust's Clinical Audit Team provides training and support to clinical team leaders such as senior paramedics. The type of support provided by the team includes developing audit proposals, preparing and collating data (for example patient clinical records) and writing audit reports. The Trust does not have a clinical audit policy but follows an internal audit recommendation has developed a clinical audit guide and audit proposal template to support staff. QUEST to assure Audit Committee that clinical audit plan in place via AAA from Chair of QUEST. Clinical Audit Internal Audit done in 2023/24 - see recommendations Audit Wales Quality Governance Review Update 2024 made recommendations related to clinical audit: R3 - There are opportunities to further enhance reports on the Trust's Clinical Audit function, by: - 3.1 More clearly highlighting any changes made to the approved Clinical Audit Plan; and - 3.2 Capturing key findings, outcomes and learning from completed audits Report notes that whilst more recent clinical audit progress reports have provided a better summary of progress, there remains scope for reports on clinical audit to provide stronger assurance to the QuESt on its activity. The accompanying clinical audit tracker provides members with an update on recommendations arising from clinical audits, however, our review found it can be difficult to understand the key issues raised from looking only at the recommendations and progress reports do not currently highlight any findings from clinical audits. The Internal Audit review found that actions to address recommendations are monitored via relevant internal groups However, it remains difficult for QuESt members to be assured about the outcomes of clinical audit activity, and whether learning from clinical audits is becoming embedded to improve the Trust's performance without the inclusion of further narrative within progress reports
8	**Meds Management and Medical Devices**	Meds management sits in the Ambulance Practice Steering Group that feeds into CQGG. It reviews compliance with controlled drugs; patient group directives (directives for registrants for prescription only drugs e.g. flu vaccine etc) which are regularly reviewed; JRCALC guidelines; meds management and controlled drugs policy; audit of controlled drugs. Standalone report will be presented to QUEST in Q4 setting this out and proposing assurance reporting. Any exception reporting on meds management or medical devices to Quest by exception. MM audit compliance in Q1 New Meds Management Policy August 23 says at 16.6 To support the principles of antimicrobial stewardship, an annual audit of antimicrobial use by APs will be conducted and the findings reported to the Trust Ambulance Practice Steering Group, appropriate Trust Committees and where appropriate, National Antimicrobial Stewardship Forum
9	**Mortality reviews**	In August 2021 the Delivery Unit issued the All Wales Learning from Mortality Review Framework. The Framework is a significant shift from the Trust's previous method of undertaking Mortality Reviews. The Framework document sets out that NHS organisations in Wales should undertake Mortality Reviews in relation to requests for information from the newly formed Medical Examiners Service (MES) in Wales. Mortality review meetings provide a systematic approach for the peer review of patient deaths to reflect, learn and improve patient care. Mortality reviews are conducted when a patient dies whilst in the Trust's care, including whilst waiting for an ambulance to arrive. To aid learning the Trust also reviews cardiac arrests where patients have survived. A Serious Case Incident Forum scrutinises issues identified through mortality reviews Identification of cases is via several sources including ME referral, incident reporting (internal and from system partners), HM Coroner, internal clinical reviews, clinical audit processes and horizon scanning. See Mortality Reviews Framework (QUEST 110523) with reporting to Quest at 7.1 and proposed to come via the Patient Safety Report with numbers of reviews, learning and actions. Oversight of the mortality review process is by CQGG at least six monthly. Audit Wales Quality Governance Review 2022 made recommendations related to mortality reviews. The 2024 Qualty Governance Follow Up Review (October 2024) re-opened previously closed recommendations as follows: R3 The QuESt Committee does not receive adequate assurances on mortality reviews. The Trust should ensure the QuESt Committee receives quarterly update reports to include: - 3.1 The number of reviews undertaken, and the numbers of reviews required but not yet complete. **This has been re-opened.** - 3.2 Any significant concerns, lessons learned and what changes have been made as a result. **This has been re-opened.** - 3.3 Updates on actions to address the mortality review backlog. **This has been re-opened.** - 3.4 Updates on progress implementing the all-Wales Learning from Mortality Reviews Framework. **This can remain closed.** R4 The Trust has a significant backlog of mortality reviews. The Trust should develop an action plan to reduce the backlog, reporting progress at each QuESt meeting. **This has been re-opened.** Report writers shoudl refer to the 2024 follow up report which noted that whilst the Trust has implemented the new framework for mortality reviews, there is fluctuating performance relating to delivering timely mortality reviews and there is scope for more consistent reporting of mortality review activity, outcomes and learning. See Learning From Deaths report to QUEST 13 August 2024 for background detail.
10	**Mental Health**	Reporting to include compliance Mental Health Act 1983, Code of Practice, and the Mental Capacity Act 2005, DoLS etc See consent to examination and treatment policy endorsed at ELT 130224 with monitoring through clinical audit plan and responsibilities listed. Mental health KPIs to be developed in 2025/26
11	**Quality Plan**	Audit Wales Quality Governance Review Follow Up 2024 recommendations: Quality Strategy R1 - As the Trust develops a new Quality Plan in 2024, it should ensure that delivery is achievable within the resources available. The plan should clearly detail the funding required, the risks of under-delivery (due to capacity and resource constraints) and be underpinned with an implementation plan. Quality Strategy monitoring R2 - There is scope to strengthen quality strategy implementation plan delivery reporting. To enhance clarity, the Trust should, in its progress reports: - 2.1 Provide timescales for the expected delivery of each action; - 2.2 Differentiate between the progress of individual actions and strategic outputs; and - 2.3 Ensure that progress reports are reported regularly and are included in the QuESt cycle of business [note the report indicates quarterly from August 2024]