

# Bundle Quality, Patient Experience and Safety Committee 7 May 2026

## Agenda attachments

### 00 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 3 February 2026  
Item 03 2026-02-03 unconfirmed QUEST Public Minutes
- 4.1 Action log & matters arising  
Item 04.1 Action Log  
Item 04.1 QuEST Action 02-06.26
- 4.2 Committee AAA highlight report 3 February 2026  
Item 04.2 Quest Committee Highlight Report February 2026
- 4.3 FOR APPROVAL, ASSURANCE AND DISCUSSION
- 5 09:35 – Staff experience: Mike Senior – Community First Responder (CFR)  
*Use of Live Video Technology – Community First Responder Experience*  
*A Community First Responder (CFR) experience highlights the positive impact of live video technology in supporting clinical decision-making and reassurance for patients, families, and responders.*  
*On 15 November 2025, CFR Mike Senior (Fairbourne Team) attended an incident in Tywyn, Gwynedd, involving a 17-month-old patient. During consultation with the Clinical Support Desk (CSD), a paramedic initiated a live video link to Mike's mobile phone to visually assess the patient. Mr Senior reported that the use of video significantly enhanced reassurance for both the parents and him, supporting confidence in the clinical assessment and next steps. He was previously unaware that this capability was available within the Trust and described it as a sensible and effective approach, particularly in paediatric cases.*  
*Following the incident, Mr Senior submitted a formal compliment praising the professionalism and support provided by the CSD paramedic. This was logged through the PECL process and subsequently captured via the online video booth to support organisational learning and assurance.*  
*Live video functionality is currently operational within CSD, NHS 111, and is expected to extend to RICS, with increasing uptake reported. This feedback provides further evidence of the value of digital technology in enhancing remote clinical support and patient experience.*
- 5.1 Patient experience updates: Roy Davies  
Item 05.1 Patient Experience Update Roy Davies
- 6 10:05 – Operations Directorate quarterly report Q4 2025/26  
Item 06 Operations Quarterly Report Q4 2025-2026
- 7.1 10:25 – Putting Things Right report Q4 2025/26  
Item 07.1 Putting Things Right Report, Quarter 4, 2025-2026 (January 2026 – March 2026)  
Item 07.1 Annex 1 Putting Things Right Report, Quarter 4, 2025-2026 (January 2026 – March 2026)
- 7.2 Putting Things Right / Concerns Management Programme progress report April 2026  
Item 07.2 Putting Things Right Concerns Management Programme Progress Report
- 8 10:55 – Monthly integrated quality performance report [MIQPR]  
Item 08 MIQPR  
Item 08 Annex 1 MIQPR
- 9 11:05 – Spotlight on clinical indicators: Out of hospital cardiac arrest (OOHCA) – Return of spontaneous circulation from cardiac arrest (ROSC)  
Item 09 Spotlight on Clinical Indicators – OoHCA

Item 09 Annex 1 Focus on OHCA V2 QUEST

- 9.1 11:25 – COMFORT BREAK
- 10 11:40 – Internal audit report: Cymru High Acuity Response Unit (CHARU)  
Item 10 Internal Audit Report Feedback from ARAC to QuEST CHARU  
Item 10 Annex 1 CHARU Final Internal Audit Report
- 11 11:50 – Duty of quality annual report 2025/26  
Item 11 Duty of Quality Annual Report 2025–26  
Item 11 Annex 1 Duty of Quality Annual Report 2025–2026  
Item 11 Annex 2 Duty of Quality Annual Report 2025–2026
- 12 12:05 – Strategic quality plan 2025/28 implementation plan progress update  
Item 12 Strategic Quality Plan 2025–2028 Quarterly Update (Quarter 4 2025–26)
- 13 12:15 – Respiratory protective equipment (RPE) report (overview and update)  
Item 13 Respiratory Protective Equipment (RPE) Report Overview and Update
- 14 12:20 – Patient experience and community involvement (PECI) Bi–annual report (October 2025–  
March 2026)  
Item 14 Patient Experience and Community Involvement Bi–Annual Report (PECI) (Oct 2025 –  
March 2026)  
Item 14 Annex 1 Peci Bi–Annual Report October 2025 – March 2026
- 15 12:30 – Mortality intelligence report  
Item 15 Learning from Deaths (Mortality Reviews) Report, Quarters 3 and 4 2025–2026, October  
2025 – March 2026
- 16 12:40 – Medicines management assurance report  
Item 16 Medicines Management Assurance Report 2026  
Item 16 Annex 1 Medicines Management Assurance Report Annual Summary 2025–26  
Item 16 Annex 2 WAST Antimicrobial Report 2025
- 17 12:50 – Risk management and board assurance framework  
*\* Risk 223 The Trust's inability to reach patients in the community causing patient harm and death*  
*\* Risk 224 Significant handover delays outside A&E departments impacts on access to definitive care  
being delayed and affects the trust's ability to provide a safe and effective service*  
Item 17 Risk Management Report
- 18 13:00 – Audit tracker Q4 2025/26  
Item 18 Audit Tracker 25–26 Q4 (Jan–Mar26)
- 18.1 CONSENT ITEMS
- 19 Committee cycle of business monitoring report Q1 2026/27  
Item 19 Cycle Monitoring Report May 2026  
Item 19 Annex 1 CoB Monitoring Report  
Item 19 Annex 2 CoB Notes
- 19.1 13:10 – CLOSING ITEMS
- 20 Reflections
- 21 Any other business
- 22 Date & time of the next meeting: 6 August 2026

Length of Meeting: 03:45		Agreed [OPEN] QUEST COMMITTEE - 7 May 2026					Deadline for Papers: 28 April 2026		Last good practice Exec Review: 22 April 2026		Notes	
Time	Mins allotted	Agendum	Title	Format	Item for	Item requested by	Paper prepared by	Item presented by	Colleagues to cc	Scheduled at ELT	Further approval route (if app.)	Notes
<b>OPENING ITEMS</b>												
		1	Chair's welcome, apologies and quorum	Verbal	Information	Standing	n/a	Chair	n/a			
		2	Declarations of interest	Verbal	To State Conflicts	Standing	n/a	Chair	n/a			
09:30	00:05	3	Minutes of the open meeting 3 February 2026	Paper	Approval	Standing	n/a	Chair	n/a			
		4	4.1 Action log and matters arising 4.2 Committee AAA highlight report 3 February 2026	Paper	Discussion	Standing	n/a	Chair	n/a			
<b>FOR APPROVAL, ASSURANCE AND DISCUSSION</b>												
09:35	00:30	5	Staff experience: Mike Senior - Community First Responder (CFR)	Video	Discussion	CoB	Quality	Penny Durrant	Leanne Hawker, Alison Kelly			
		5.1	Patient experience updates (Roy Davies)	Verbal	Assurance	CoB	Quality	Penny Durrant	Leanne Hawker, Alison Kelly			
10:05	00:20	6	Operations Directorate quarterly report Q4 2025/26	Paper	Assurance	CoB	Operations	Lee Brooks	Judith Bryce Toni-Marie Norman			
10:25	00:30	7	7.1 Putting Things Right report Q4 2025/26 7.2 Putting Things Right / Concerns Management Programme progress report April 2026	Paper	Assurance	CoB	Quality	Penny Durrant	Wendy Herbert, Alison Kelly			
10:55	00:10	8	Monthly integrated quality performance report (MIQPR)	Paper	Assurance	CoB	SPP	Rachel Marsh	Hugh Bennett, Mark Thomas Mel O'Connor			
11:05	00:20	9	Spotlight on clinical indicators: Out of hospital cardiac arrest (OOHCA) - Return of spontaneous circulation from cardiac arrest (ROSC)	Paper	Assurance	CoB	Clinical	Andy Swinburn	Andy Swinburn			
11:25	00:15	<b>COMFORT BREAK</b>										
11:40	00:10	10	Internal audit report: Cymru High Acuity Response Unit (CHARU)	Paper	Assurance	CoB	Gov	Andy Swinburn	Gregory Lloyd (Lisa Trounce)			
11:50	00:15	11	Duty of quality annual report 2025/26	Paper	Endorsement	CoB	Quality	Penny Durrant (Kate Blackmore)	Kate Blackmore			
12:05	00:10	12	Strategic quality plan 2025/28 implementation plan progress update	Paper	Assurance	CoB	Quality	Penny Durrant (Kate Blackmore)	Kate Blackmore			
12:15	00:05	13	Respiratory protective equipment (RPE) report (overview and update)	Paper	Assurance	Forward Planner	Quality	Penny Durrant	Sarah Morgan, Alison Kelly			
12:20	00:10	14	Patient experience and community involvement (PECI) Bi-annual report (October 2025 - March 2026)	Paper	Assurance	CoB	Quality	Penny Durrant	Leanne Hawker, Alison Kelly			
12:30	00:10	15	Learning from Deaths (Mortality Reviews) Report Quarters 3 & 4 (October 2025 - March 2026)	Paper	Assurance	CoB	Quality	Penny Durrant	Alison Kelly			
12:40	00:10	16	20/04/2026 Medicines management assurance report	Paper	Assurance	CoB	Clinical	Andy Swinburn (Huw Jackson)	Huw Jackson			
12:50	00:10	17	Risk management and board assurance framework * Risk 223 The Trust's inability to reach patients in the community causing patient harm and death * Risk 224 Significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service	Paper	Assurance	CoB	Gov	Julie Boalch	n/a			
13:00	00:10	18	Audit tracker Q4 2025/26	Paper	Assurance	CoB	Gov	Trish Mills	Lisa Trounce			
<b>CONSENT ITEMS</b> The items that follow are for information only. Should a member wish to discuss any of these items they are requested to notify the Chair so that time may be allocated to do so.												
13:10	00:00	19	Committee cycle of business monitoring report Q1 2026/27	Paper	Approval	CoB	Gov	Trish Mills	Sarah Harland			
<b>CLOSING ITEMS</b>												
		20	Reflections	Verbal	Discussion	Standing	n/a	Chair	n/a			
13:10	00:05	21	Any other business	Verbal	Discussion	Standing	n/a	Chair	n/a			
		22	Date & time of the next meeting: 6 August 2026	Verbal	Information	Standing	n/a	Chair	n/a			
13:15	03:45	<b>CLOSE</b>										

**LEAD PRESENTERS**

Name	Position
Julie Boalch	Assistant Director of Corporate Governance and Risk
Lee Brooks	Executive Director of Operations
Penny Durrant	Deputy Director of Nursing, Quality and Governance
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

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Left Trust
BEAUMONT-WOOD, Rhiannon	<b>Non-Executive Director</b> * Member of the Remuneration Committee * Member of the the Audit, Risk and Assurance Committee * Member of the Quality, Patient Experience and Safety Committee	Dorset Integrated Care Board (NHS Dorset), Non-Executive Director	Financial Interest	May 2023		08-Feb-26
		Nursing and Midwifery Council (NMC), Designated Council Member for Wales	Financial Interest	June 2024		
		RBW Executive and Professional Coaching Ltd, Company Director (Company No 14938585) and Shareholder	Financial Interest	June 2023		
		Currently on coaching framework with Health Education and Improvement Wales	Financial Interest	June 2024		
		Registered Nurse (NMC)	Non-Financial Professional	January 1985		
		Registered Specialist Community Public Health Nurse	Non-Financial Professional	September 1996		
BEESLEE, Jayne	<b>Non-Executive Director</b> * Chair of the Finance and Performance Committee * Member of the Remuneration Committee * Member of the Academic Partnership Committee	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	<b>Executive Director of Operations</b>	Partner employed by Welsh Ambulance Services NHS Trust	Any Other Interest	July 2019		
		Member of the Order of St John	Any Other Interest	01 March 2023		
		Volunteer – St John's Ambulance Cymru	Any Other Interest	06 April 2023		
		Council Member – St John's Ambulance Cymru Gwent Council	Any Other Interest	06 April 2023		
		Trustee of Action for Children [1097940]	Position in Charity or Voluntary Organisation	01 February 2021		
CURRAN, Peter	<b>Non-Executive Director</b> * Chair of the Audit, Risk and Assurance Committee * Chair of the Charity Committee * Member of the Finance and Performance Committee * Member of the Remuneration Committee	Company Director - Action for Children [04764232]	Directorships	01 February 2021		
		Company Director - Action for Children (Wales) Ltd [10011497]	Directorships	05 April 2022		
		Trustee of National Youth Arts Wales [1170643]	Position in Charity or Voluntary Organisation	06 May 2021		
		Company Director - National Youth Arts Wales [10449512]	Directorships	06 May 2021		
		Non-Executive Director for Taff Housing	Position in Charity or Voluntary Organisation	01 May 2022	17 July 2025	
		Chair - Taff Housing Association	Any Other Interest	17 July 2025		
		Company Director - Team Police Ltd [12518812]	Directorships	01 January 2022	31 October 2024	
		Independent Board Member of the Project Board - National Contemporary Art Gallery for Wales	Any Other Interest	01 January 2024	30 September 2025	
		Interim Finance Director for Torfaen Leisure Trust	Directorships	01 September 2023	29 February 2024	
		Member of Governing Body / Independent Member – Kaplan International Colleges UK Ltd [05268303]	Directorships	01 March 2024		
		Independent Member - Kaplan Open Learning (inc member of the Audit & Risk Committee)	Directorships	21 March 2024		
DENNIS, Colin	<b>Chair of Trust Board and Non-Executive Director</b> * Chair of Remuneration Committee	Chair - Citizen Housing [Charity] (previously WM Housing Group)	Position in Charity or Voluntary Organisation	01 January 2015	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	<b>Non-Executive Director</b> * Chair of Quality, Patient Experience & Safety Committee * Member of Finance & Performance Committee * Member of People & Culture Committee * Member of Remuneration Committee	Chief Executive Officer (Employed) at My Choice Healthcare Limited.	Any Other Interest	01 June 2019		
		Non-Executive Board Member at Beacon Housing (Social Housing Organisation - Community Benefit Society)	Position in Charity or Voluntary Organisation	01 November 2019		
		Company Director - My Choice Healthcare South Wales Limited	Directorships	11 March 2020		
		Company Director - Moorlands Rehabilitation (Staffordshire) Limited.	Directorships	20 December 2019		
		Company Director - Moorlands Property Ltd	Directorships	16 August 2022		
		Company Director - Springfield (Bargoed) Limited.	Directorships	12 March 2020		
		Company Director - Springfield Property Lettings Ltd	Directorships	16 August 2022		
		Company Director - Homes of Excellence Limited	Directorships	19 March 2021		
		Company Director - Victoria House Care Property Limited	Directorships	05 March 2020		
		Company Director - My Choice Healthcare (Four) Limited	Directorships	27 April 2022		
		Company Director - Luk Ros Property Limited	Directorships	12 March 2020		
		[Previously called Homes of Excellence Healthcare Limited, Company name changed 12.08.2022 - #12513139]	Directorships	12 March 2020		

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Left Trust
<b>EVANS, Bethan</b> [continued]	<b>Non-Executive Director</b> * Chair of Quality, Patient Experience & Safety Committee * Member of Finance & Performance Committee * Member of People & Culture Committee * Member of Remuneration Committee	Company Director - Hawthorn Court Property Limited	Directorships	27 April 2022		
		[Previously called My Choice Healthcare (Three) Limited, Company name changed 12.08.2022 - #13371375]	Directorships	27 April 2022		
		Company Director - Ocean Living Property Limited	Directorships	22 July 2022		
		Company Director - Hawthorn Court Care Limited	Directorships	22 July 2022		
		Company Director - Glynconel Property Limited	Directorships	01 July 2022		
		Company Director - My Choice Healthcare (Two) Limited	Directorships	01 July 2022		
		Company Director - Carmarthen Care Limited	Directorships	02 January 2024		
		Company Director - Towy Castle Property Limited	Directorships	01 September 2023		
		Company Director - Glamorgan Care Ltd	Directorships	25 October 2024		
		Company Director - The Mountains Care Ltd	Directorships	09 December 2024		
		Company Director - Alexandra House Care Ltd	Directorships	24 June 2024		
		Company Director - Alexandra House Property Ltd	Directorships	24 June 2024		
		Company Director - My Choice Healthcare Seven Ltd	Directorships	22 October 2024		
		Company Director - Danygraig Property Ltd	Directorships	10 December 2024		
		Company Director - The Mountains Property Ltd	Directorships	09 December 2024		
<b>HITCHON, Estelle</b>	<b>Director of Partnerships and Engagement</b>	Member of Academi Wales Expert Panel	Position in Charity or Voluntary Organisation	15 July 2024		
		Independent Governor (Non-Executive Director), Coleg Sir Gar/Coleg Ceredigion	Non-Financial Personal	01 January 2025		
<b>HUTCHINGS, Hayley</b>	<b>Non-Executive Director</b> * Member of the Remuneration Committee * Member of the Academic Partnership Committee * Member of the People and Culture Committee	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	
		Consultant Advisor to the FASAR Trial, Nottingham Trent University	Financial Interest	25 March 2026		
<b>JACKSON, Ceri</b>	<b>Non-Executive Director &amp; Vice Chair of the Trust Board</b> * Chair of the People and Culture Committee * Member of the Charity Committee * Member of Audit Committee * Member of Quality, Patient Experience & Safety Committee * Member of Remuneration Committee	Management Consultant primarily working in third sector	Interest in Companies and Securities	01 May 2019		
		Associate Director of SamKat Consulting Ltd in my capacity as self-employed management consultant	Directorships	01 June 2021		
		Charity Trustee - Stroke Association Trustee, Chair Wales Advisory Group.	Position in Charity or Voluntary Organisation	08 October 2020		
		Charitable Company - Stroke Association - Company Director	Directorships	08 October 2020		
<b>KNEESHAW, Carl</b>	<b>Director of People</b>	Chartered Fellow of Chartered Institute of Personnel and Development	Personal or Departmental Sponsorship	April 2020		
		Fellow of Institute of Leadership	Personal or Departmental Sponsorship	October 2020		
		Safeguarding Lead for local outreach charity, Brunstad Christian Church – Huntworth, Bridgwater, Somerset	Position in Charity or Voluntary Organisation	September 2018		
<b>LEWIS, Angela</b>	<b>Director of Culture Change</b>	Nil Declaration				
<b>MARSH, Rachel</b>	<b>Executive Director of Strategy, Planning and Performance</b>	Nil Declaration				
<b>MILLS, Patricia (Trish)</b>	<b>Director of Corporate Governance/ Board Secretary</b>	Nil Declaration				
<b>PARRY, Hugh</b>	<b>Trade Union Partner</b>	Nil Declaration				
<b>ROBERTS, Edward</b>	<b>Interim Finance Director (from 09 September 2025)</b>	Nil Declaration				
<b>ROWAN, Hannah</b>	<b>Non-Executive Director</b> * Chair of Academic Partnership Committee * Member of Charity Committee * Member of People & Culture Committee * Member of Remuneration Committee	Director, St Martin's Associates (Business consulting and coaching)	Directorships	04 April 2022		
		Non -Executive Director Qualifications Wales ( regulator for all non degree qualifications in Wales)	Any Other Interest	01 April 2021		
		Trustee MAE Cymru (Christian charity which champions gender equality in church of Wales)	Position in Charity or Voluntary Organisation	13 November 2021	November 2023	
		Elected member, The governing body of the church in Wales (Parliament of church in Wales - voting member)	Any Other Interest	01 April 2021		
		Relative (Parent) is a Non-Executive Director for Social Care Wales	Any Other Interest	01 April 2017	31 March 2025	
<b>SAMMUT, Jonathan (Jonny)</b>	<b>Director of Digital Services [appointed 26.09.2023]</b>	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	
		Strategic Advisor to College of Paramedics	Any Other Interest	01 January 2020		
<b>SWINBURN, Andrew (Andy)</b>	<b>Executive Director of Paramedicine</b>					
<b>TURLEY, Christopher</b>	<b>Executive Director of Finance and Corporate Resources</b>	Treasurer of Royal Gwent Hospital League of Friends.	Position in Charity or Voluntary Organisation	01 February 2022	05 November 2024	
<b>TURNER, Damon</b>	<b>Trade Union Partner</b>	Nil Declaration				

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Date Left Trust
<b>WILLIAMS, Liam</b>	<b>Executive Director of Quality and Nursing (from 01 August 2022)</b>	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		
<b>WOOD, Emma</b>	<b>Chief Executive (from 01 October 2025)</b>	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	21 January 2026	
		Member of Yoga Professional Alliance	Non-Financial Personal	July 2025		
		Part-time Yoga Teacher at Burnham Swim and Sports Academy Leisure Centre	Financial Interest	July 2025		
		Sub/Relief Yoga Teacher at Omni Studio, Worle, Norh Somerset	Financial Interest	04 April 2026		



GIG  
CYMRU  
NHS  
WALES

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

**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 3 FEBRUARY 2026 VIA TEAMS**

**Meeting started at 09:30**

**PRESENT:**

Bethan Evans	Non-Executive Director and Chair
Ceri Jackson	Non-Executive Director and Vice Chair of the Board
Rhiannon Beaumont-Wood	Non-Executive Director
Lee Brooks	Executive Director of Operations
Henry Garrard	Trade Union Partner ( <i>joined at Item 5</i> )
Rachel Marsh	Executive Director of Strategy, Planning & Performance
Mark Marsden	Trade Union Partner
Trish Mills	Director of Corporate Governance/Board Secretary
Hugh Parry	Trade Union Partner ( <i>left during item 11</i> )
Liam Williams	Executive Director of Quality and Nursing
Andy Swinburn	Executive Director of Paramedicine

**IN ATTENDANCE:**

Claire Appleton	Head of Putting Things Right ( <i>left after Item 8</i> )
Kate Blackmore	Assistant Director of Quality Governance
Jonathan Chippendale	Assistant Director of Clinical Development
Penny Durrant	Deputy Director of Nursing, Quality and Governance ( <i>left during item 11</i> )
Sarah Harland	Corporate Governance Officer
Leanne Hawker	Head of Patient Experience & Community Involvement
Alison Kelly	Business and Quality manager
Wendy Herbert	Assistant Director of Quality and Nursing
Osian Lloyd	Head of Internal Audit, NWSSP
Alex Payne	Corporate Governance Manager

**APOLOGIES:**

Jonny Sammut	Director of Digital Services
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**OBSERVING:**

Janice Smith	Good Governance Institute
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## OPENING ITEMS

### 1. CHAIR'S WELCOME, APOLOGIES AND QUORUM

1.1 Janice Smith was welcomed from the Good Governance Institute. Apologies from Jonny Sammut were noted. It was also noted that Trade Union representatives were in attendance. Quorum was confirmed.

### 2. DECLARATIONS OF INTEREST

2.1 There were no other declarations recorded.

### 3. MINUTES OF PREVIOUS MEETING 4 NOVEMBER 2025

3.1 The minutes of the open meeting of the Quality Patient Experience and Safety Committee held on 4 November 2025 were received and approved.

### 4. ACTION LOG AND MATTERS ARISING

4.1 The action log was received and the following actions were closed:

**06.4 -11/25 Patient Story**. Action closed.

**09-08/25 Ministerial Advisory Group WAIT 45 Taskforce**

The Finance and Performance Committee considered the action and received a paper on NEPTS Capacity Management Plan at its January meeting. Within this context, the committee's discussion on NEPTS capacity confirmed that the service continues to operate within significant limitations, with demand regularly exceeding available and funded capacity. In 2025, NEPTS completed 552,602 journeys. 184,901 journeys were cancelled. 7.6% of total demand was cancelled by health boards. 5.1% was cancelled by service users themselves. CMP cancellations amounted to 3.9%.

Members noted the impact of reduced volunteer availability, longer journey distances, and increasingly complex patient requirements, all of which contribute to cancellations, delays, and poor patient experience. These issues directly align with the concerns raised through PTR and the Quest action regarding unmet need and potential patient harm.



The committee reviewed internal actions already underway, including roster optimisation, efficiency improvements, and closer monitoring of activity patterns. While these measures were recognised as necessary and appropriate, the committee emphasised that they will not fully bridge the gap between capacity and rising demand. As a result, the committee concluded that system level engagement, particularly with health boards and commissioners, remains essential. Ongoing discussions through the JCC were highlighted as key to exploring eligibility criteria, funding arrangements, and wider opportunities for service redesign.

Non-Executive Director triangulation confirmed that these points align with their own experiences, providing further assurance that the constraints and risks are well understood and that the actions being taken are proportionate. In addressing the QUEST action directly, the committee confirmed that the organisation is taking reasonable and responsible steps to mitigate patient harm and improve the service. However, the committee acknowledged that, given current demand and capacity pressures, some level of poor patient experience is likely to continue.

## ITEMS FOR ASSURANCE, DISCUSSION OR APPROVAL

### 5. PATIENT EXPERIENCE – ROY DAVIES

- 5.1 The committee received an account from Roy Davies of a prolonged ambulance delay during a cardiac emergency, which resulted in his neighbour transporting him to hospital. Members heard that Roy felt there was a lack of empathy from call handlers, highlighting the challenge of balancing speed and compassion under operational pressure and the necessity for accurate information gathering. The categorisation of Roy's call as amber, led to discussion about the specificity of the prioritisation process and the public's understanding of call categorisation. Operational context was provided, noting high call volumes for chest pain and the difficulty in identifying those, like Roy requiring an immediate response, as well as the significant impact of hospital handover delays on response times. It was noted that chest pain is an Orange Now in the new Ambulance Performance Framework. Roy's feedback is being used to inform quality monitoring, service improvements, and the development of more empathetic complaint responses, with a commitment to continued learning and system-wide collaboration.

**The Committee: Noted Roy Davies' experience and thanked him for sharing it with the committee.**



## 5.1 PATIENT EXPERIENCE UPDATES – ALISON CLARKE

5.1 Leanne Hawker provided an update on actions following the previously presented patient experience from Alison Clarke. Leanne confirmed further discussions have taken place and additional actions are being developed. Commissioners have been engaged to address underlying issues, and the capacity management plan has been discussed at relevant internal groups. Mark Harris and the local service area manager are scheduled to meet with Alison in the coming weeks to keep her informed of progress. The Chair noted the positive use of patient stories to drive change and the action that had been taken by the Finance and Performance Committee to review performance in more detail.

## 6. MINISTERIAL ADVISORY GROUP WAIT 45 TASKFORCE UPDATE

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

6.1 The Ministerial Advisory Group Wait 45 Taskforce has continued its work to reduce handover delays through clinically led, multi-agency collaboration. This has included a series of design events and focused improvement sprints. There were some concerns about how widely the output from the events were shared. While some early gains were achieved, sustaining progress has remained difficult, particularly given the scale and complexity of system pressures. Challenges within NEPTS also persist however roster reviews and commissioner engagement are under way to support an increase in patient journeys, although these actions alone are unlikely to fully resolve the wider operational constraints. Social care involvement remains critical, as health services cannot address handover delays in isolation. Work is progressing to strengthen integration with local authority and community services. However, there are still gaps in community based options for frail and elderly patients, which often leads to avoidable conveyance to emergency departments.

6.2 Concerns were raised about whether recommendations can be fully delivered at Health Board level, particularly if accountability shifts from central oversight to local implementation. The committee agreed that regular updates on taskforce progress will be essential, since this work underpins its core agenda and supports ongoing system improvements.

6.3 Liam Williams clarified that the position had shifted since the paper was written and reported that although performance had improved during the autumn, it had since deteriorated again due to increasing winter pressures, a trend not explicitly reflected in the written report. Liam stated that Health Boards had not achieved the expected recovery to their October position by



the end of January, offering a level of candour beyond the report, which outlined expectations but did not acknowledge their non-achievement. Liam also described the commencement of a system “reset”, explaining that Health Boards were now entering their second sprint cycle to improve inpatient flow, providing real time context not captured in the formal document.

- 6.4 In addition, Liam clarified that Welsh Government had not set a specific date for achieving improvements in under-45-minute handovers and that no sanctions would be applied for not meeting the new trajectories, offering transparency that softened the urgency implied by the report. Liam further provided operational insight into the challenges, including the practical impact of handover delays, the lack of sustained improvement from earlier actions, and the reasons the system continues to struggle despite extensive intervention.
- 6.5 Rhiannon Beaumont-Wood raised concerns about the limited involvement of social care in improving patient flow. Liam advised that social care is a consistent theme in design discussions and noted a new Chief Medical Officer led programme aimed at integrating adult social care into community response. Lee Brooks reported ongoing efficiency work, including roster reviews, but expressed concern that the handover 45 initiative may lose momentum at health board level due to the shift from central to local responsibility.
- 6.3 Ceri Jackson sought clarity on how the report’s recommendations will be implemented. Liam confirmed that organisational and local clinical leads are progressing early clinical decision making and pathway work. Andy Swinburn added that limited community options for complex patients make effective hospital discharge planning essential for improving flow.

**The Committee: received and noted papers setting out progress of the National Handover Ministerial Advisory Group Wait 45 Taskforce and the approach taken by the NHS Wales Leadership Board to sustainable improvement in handover delays being achieved in Wales.**

## **7. OPERATIONS DIRECTORATE QUARTERLY REPORT Q3 2025/26**

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

- 7.1 Key highlights from the report were identified as follows: Phase 2 of the Ambulance Performance Framework (APF) has been implemented, and operational pressures remain high; handover delays persist, the longest exceeded 18 hours; rural and urban equity issues were discussed, with initiatives underway to improve resource allocation; alternative dispatch



framework is under review, with focus on patient safety and staff wellbeing; and incident reporting backlog (Datix) is being addressed, however real-time learning other than of critical incidents remains a challenge.

- 7.2 Ceri Jackson enquired whether increasing resources in rural areas such as Powys would improve patient experience there, or if those resources would still be diverted to busier urban areas during handover delays. Lee Brooks reported that while the issue is complex, efforts such as rotational models and smart tethering are being implemented to address this, with current data showing that urban patients are currently waiting longer than rural ones.
- 7.3 Rhiannon Beaumont-Wood asked two main questions regarding the Operations report. First, how the patient safety aspects of the alternative dispatch arrangement framework, particularly where non-clinicians are involved, will be closely monitored, not just through complaints and incidents but as close to real time as possible. Rhiannon's second question was, given the ongoing backlog in responding to Datix reports, whether immediate learning can be drawn from these reports rather than waiting until all reviews are completed, to ensure more timely learning during the transformation process.
- 7.4 Kate Blackmore assured Rhiannon that the Quality Management Group regularly monitors Datix, using a dashboard to track both backlog and new intelligence. They review thematic coding and trends in each cycle, look for new or concerning themes, and discuss findings with subject matter experts. This monitoring and learning is reported through CQGG as part of their highlight reporting. Claire Appleton provided partial assurance, noting that while there are processes for rapid review of high-harm incidents and triaging complaints or external sources, the backlog and delays in full investigations mean there is a risk of not fully capturing timely learning, especially for near-miss incidents.

### **The Committee: received the Operations Directorate Quarterly Report Q3 2025/26.**

## **8. PUTTING THINGS RIGHT REPORT Q3**

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

- 8.1 Liam Williams presented the Q3 Putting Things Right (PTR) report and noted that despite additional resources, improvement has not been achieved, and performance has deteriorated for some indicators. The Board received some of these metrics in the MIQPR at the board meeting on 29 January and acknowledged that changes to the clinical model had increased complexity for some investigations.



- 8.2 The PTR and Legal Services Performance Organisational Recovery Plan was not available for this meeting. Liam advised that that the Putting Things Right (PTR) Recovery Plan is comprehensive but lacks a formal trajectory, with efforts focused on resolving this and prioritising changes for the upcoming Listening to People regulations. The Chair responded that it is disappointing not to have the Recovery Plan at the meeting, and requested it be shared with committee members after Executive Leadership Team (ELT) review on 18 February. The Chair also emphasised ongoing concern about the lack of improvement. Liam agreed to circulate the PTR Recovery Plan to committee members after it has been reviewed by ELT, rather than waiting until the next meeting. A briefing to members was also offered on receipt of the plan.
- 8.3 Claire Appleton summarised that the PTR report shows some improvement in National Reportable Incidents (NRI) closures and fewer joint investigations, but there is an upward trend in complaints received this winter, adding pressure to business as usual and recovering backlogs.
- 8.4 The committee discussed the upcoming implementation of new Listening to People Regulations, which will require an offer of face-to-face meetings for complainants and provision of bereavement support. There is concern about the feasibility of meeting these requirements given the absence of final guidance from Welsh Government and current resource constraints. The lack of clarity on timing and operational details is creating uncertainty for planning and impact assessment. The Committee will receive feedback after ELT discussion on preparedness for new regulations and resource implications.
- 8.5 Andy Swinburn expressed concern that new regulations will significantly increase the burden on clinical teams, making compliance extremely challenging without additional resources. Lee Brooks highlighted executive anxiety about implementing new regulations without finalised guidance or resources, warning that the organisation cannot be assured of readiness.
- 8.6 Rhiannon Beaumont-Wood asked about the status and impact of a digital solution for manual data extraction, and about preparedness for the new Listening to People regulations, including workforce modelling and capacity. Liam Williams advised that digital progress is underway with a nearly complete semantic environment, but the team is prioritising building for the new regulations. Liam explained that while draft regulations are available, final guidance is pending, so full preparedness cannot yet be assured. Resource allocation for implementation is being actively considered, but final decisions are still in progress.



- 8.7 Members expressed concern over the significant uncertainty and operational impact associated with this and it was agreed that ELT would further consider organisational preparedness and associated resource implications. The committee will receive feedback on the organisation's readiness and planned implementation approach once ELT has concluded its review.
- 8.8 The significant levels of absence in the PTR team was recognised which has a knock on effect to performance. The committee highlighted the importance of supporting staff wellbeing, particularly in light of high absence rates and the impact of stress and moral injury associated with current workloads and operational pressures. Ongoing work with People Services and Occupational Health was noted.
- 8.9 Ceri observed that patient, family and staff experiences are not where they should be, highlighting the idea of a deep dive into moral injury, and asked about the organisation's ability to learn quickly and apply learning, especially with the new APF. Liam reported that stress and moral injury are being reviewed through health and safety and people services, and that early joint screening of incidents and complaints now enables faster organisational learning and proportionate investigations under the new ambulance performance framework.
- 8.10 The Chair emphasised that, given the current performance and the upcoming regulatory changes, there is a clear risk. The committee was assured that, for complaints and incidents that are investigated and closed, the work is being done well, learning is being applied, and improvements are being made in areas such as functional neurological disorder and pregnancy-related issues. Members also noted that there had been a further increase in new complaints and incidents resulting from increased delays in responding. However, the committee was not assured regarding performance timelines, overall PTR performance, and the ability to meet new regulatory requirements for the Listening to People Regulations, due to the absence of the Recovery Plan, ongoing underperformance and resource constraints.

**The Committee received the report on activity within the Putting Things Right and Legal Services portfolio.**



## **9. MONTHLY INTEGRATED QUALITY PERFORMANCE REPORT (MIQPR) NOVEMBER/DECEMBER 2025**

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

- 9.1 The Monthly Integrated Performance Report (MIQPR) was received, setting out the metrics for November and December 2025. January handover hours rose sharply (19,000), reversing recent improvements. The Clinical Model Transformation (CMT) programme is developing a benefits realisation workstream, a dedicated programme of work is now being established to "drill down into the data" associated with the new clinical processes introduced under CMT, with the intention of ensuring that the organisation fully understands how the model is operating in practice and where improvements can be made to maximise its impact. The committee will see this as part of its Cycle of Business in 2026/27.
- 9.2 Members noted the need for further metrics for Orange and Amber categories, while receiving assurance that call to door times for stroke and STEMI are being monitored and that additional indicators are under review.
- 9.3 The committee also considered how delays affect access to specialist services such as thrombectomy for stroke, agreeing to progress a joint quality improvement programme with Health Board partners. Differences in Purple and Red response times were explored, with call volume and travel time identified as key drivers. The committee agreed to continue monitoring the impact of Phase two of the CMT, with the expectation that performance indicators will demonstrate improvement over time.
- 9.4 Rhiannon asked about the decline in 111 performance, the need for metrics for Orange and Amber categories, and how clinician feedback is used to improve safety. Rachel confirmed that ongoing work is being undertaken to review and strengthen the metrics included within the MIQPR, noting that while 111 clinical callback timeliness had deteriorated due to clinicians increasingly supporting higher-priority 999 activity. The service is delivering important improvements, particularly through clinicians providing enhanced support to 111 call handlers, reviewing emergency department dispositions, and preventing unnecessary emergency department attendances, benefits that are not fully visible within current performance indicators.
- 9.5 Ceri asked about differences in Purple and Red response times and stroke pathway delays. Andy and Rachel explained that delays are mainly due to resource availability and pathway challenges. Lee Brooks added volume and travel time as key factors affecting response time differences.



- 9.6 The Chair acknowledged that the current call-to-door times for patients are still too long and emphasised the connection between these delays and ongoing handover issues. The Chair expressed that it will be important to monitor how the implementation of phase two of the CMT affects performance indicators and whether it leads to improvements in response times.

## 10. INFECTION PREVENTION AND CONTROL REPORT 2024/25 AND IMPROVEMENT PLAN

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

- 10.1 Liam Williams presented the Infection Prevention and Control (IPC) report 2024/25 and IPC Improvement Plan, summarising recent progress, ongoing work in personal protective equipment (PPE) provision, policy review and current priorities in training and fleet cleanliness.

- 10.2 The Chair commented that similar issues had been discussed in previous years and emphasised the importance of seeing a tangible impact following the appointment of the Head of Infection Prevention and Control (Sarah Morgan). The committee requested that the Head of IPC provides an update at the next meeting setting out progress against the 2026/27 IPC work plan; implementation of national All-Wales cleaning standards; and any identified resource or operational risk requiring escalation.

Liam Williams explained that the team has transitioned from having committed but non-specialist staff to now having specialists in IPC, which he believes positions them better for future progress. Liam clarified that the current report bridges the previous situation and the new direction, and expressed greater confidence in the team's expertise and the forthcoming application of new national cleaning standards.

- 10.3 Rhiannon Beaumont-Wood noted the significant work undertaken to strengthen PPE provision, including improvements to respiratory protective equipment (RPE) availability and associated training. Rhiannon sought to understand the Trust's PPE preparedness, particularly noting the Covid Inquiry is ongoing. Liam advised that the Head of IPC is implementing a systematic audit cycle for IPC, improving data presentation, and that the organisation is now better equipped with PPE for all emergency vehicles. Liam also noted ongoing work to review guidance for highly contagious infectious diseases. Rhiannon sought to have comparative data included in future reports.



- 10.4 Trish Mills suggested that, given that the Public Health Wales Board Assurance Framework is not yet in place, and the focus on PPE in the forthcoming Module 3 Covid Inquiry report, it would be helpful to bring forward a discrete update on PPE preparedness before the full framework is available. Liam Williams agreed, and the Head of IPC will include in the next update the current PPE assurance position; progress on implementation of the revised PPE and RPE processes; and outstanding risks or gaps requiring escalation at the next meeting. The Chair supported this, noting it would be helpful, especially since the hand hygiene action plan showed a 75% non-submission rate, which she described as exceptionally high and unacceptable.
- 10.5 Liam advised that IPC assurance will be included in the Trust's Annual Duty of Quality report, and that once the Public Health Wales IPC Board Assurance Framework is published a baseline and compliance update will be brought to QuEST. Liam added that the team has benchmarked against the English version and will present the Welsh iteration when available.
- 10.6 The Chair asked about the confidence of executives regarding delivery of the IPC Service Improvement Plan, noting previous challenges and the need for assurance that actions will be delivered this time, even with ongoing resource pressures. Liam Williams advised that there has been a step change in collaboration and escalation between IPC, Fleet, Estates and Operations, and that the current plan is being prioritised through the IMTP process.
- 10.7 Liam stated that not all actions are feasible, but the Head of IPC is prioritising what can be achieved, and a further iteration of the plan with confidence intervals will be brought back to the committee. Liam emphasised strengthened implementation and ownership over the past year. Members agreed that further assurance will be provided through the future Trust Annual Quality Report and a future update once national guidance and assurance frameworks are issued. The Chair specifically requested clear evidence that the organisation is now seeing the impact of actions that have been recognised as necessary for some time.

**The Committee:**

- 1. Reviewed content of this report;**
- 2. Recognised the significant changes made to the team and their work since the start of the 2024 financial year;**
- 3. Acknowledged that the refreshed IP&C approach is in its initial phase and will require extensive partnership and coordinated action moving forward; and**



**4. Noted the escalation and governance arrangements in place to address non-compliance with IP&C Audits, including the role of operational ownership, executive oversight and IPC Board Assurance Framework alignment.**

**11. EMERG CLINICAL INDICATORS**

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

- 11.1 Members received an update on the development and refinement of the EMERG clinical indicators used to measure the effectiveness of care within this new category of the APF. The indicators are designed to provide both generic and condition specific insight, supporting assessment of overall clinical effectiveness while also tracking outcomes for high priority conditions including sepsis, maternal emergencies, neonatal care, anaphylaxis and convulsions. The indicators now provide automated, quality-assured insight into both overall clinical effectiveness and outcomes for key conditions such, sepsis, maternal and neonatal emergencies, anaphylaxis and convulsions.
- 11.2 The Committee noted the inclusion of nationally adopted measures, as well as work to align stroke data with the Sentinel Stroke National Audit Programme which would form part of the Orange Now Category. While recognising that wider system constraints continue to affect some indicators, the committee was assured by the progress made and agreed that the enhanced indicator suite will meaningfully support ongoing improvement within the CMT Programme.
- 11.3 Jonathan Chippendale delivered a EMERG clinical indicators presentation, which represents the current progress towards the initial agreed "EMERG" clinical indicators. Rhiannon sought assurance on the development, accuracy and applicability of the new emerge clinical indicators, including data quality, clinician engagement, and the need to measure remote clinical care. Jonathan confirmed the indicators show positive early results, clarified the coding approach, and outlined plans to extend metrics into remote and triage pathways.
- 11.3 Members discussed the need to set aspirations for the new indicators, integrate them into operational practice, prioritise improving call-to-door times, and develop future measures, particularly for remote clinical care. Members recognised technical limitations, data-capture challenges and the importance of aligning improvement work across clinical and operational teams. It is agreed it would be helpful to make future presentation easier to understand.



**The Committee:**

- 1. Noted progress and success of current publication status of EMERG indicators;**
- 2. Discussed and supported actions to improve repeat-measure recording (pain, SpO<sub>2</sub> and NEWS2) to increase reportable coverage; and**
- 3. Noted dependencies for remaining indicators and the planned next steps (including automated anaphylaxis reporting from Jan 2026).**

**12. INTERNAL AUDIT REPORT: CLINICAL EQUIPMENT**

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

12.1 The committee received the Clinical Equipment Internal Audit Report, with reasonable assurance. The report highlighted significant improvements since the 2019 review and identified the need for an inventory management system to track key equipment and maintenance, with work ongoing to address this outstanding issue.

12.2 Rhiannon Beaumont-Wood asked about arrangements for evaluating equipment effectiveness and future audit inclusion. Andy Swindburn confirmed oversight by the Equipment Working Group and ongoing reviews. Osian Lloyd highlighted the need for improved incident reporting and noted future audit consideration.

**The Committee: Received and took assurance from the Clinical Equipment Internal Audit and noted the discussion at the meeting of the Audit, Risk and Assurance Committee on 2 December 2025.**

**13. STRATEGIC QUALITY PLAN 2025/28 IMPLEMENTATION PLAN PROGRESS**

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

13.1 Kate Blackmore introduced the Strategic Quality Plan, noting capacity constraints affecting several workstreams and the need to adjust timelines while maintaining focus on priority delivery. The areas which require recalibration include the population health and value-based healthcare ambitions, and work relating to care-experienced young people, where technical and data limitations persist. The Chair welcomed the update but expressed concern that delays could lead to an unmanageable final phase and stressed the importance of ensuring the organisation can realistically deliver the plan within available resources.



- 13.2 Kate Blackmore stressed that the organisation is exploring different delivery approaches rather than stepping back from commitments, shifting focus toward self-assessment, readiness for Health Impact Assessment regulations (effective from April 2027), and ongoing continuous improvement work linked to population health needs assessments. She also noted technical and procedural barriers to identifying care experienced young people and indicated the team is adapting by drawing on experiential feedback instead of relying on unavailable measurable data.
- 13.3 Liam acknowledged the capacity issues and explained the plan had been refocused to reflect the demands of the CMT and APF, with greater confidence under the new Chief Executive's emphasis on quality. Rachel Marsh reinforced the need for a tighter, more realistic set of actions aligned to IMTP principles. The Chair agreed, supporting a prioritised approach to ensure the plan remains deliverable within available capacity.
- 13.4 Rhiannon emphasised the need for quality improvement to be embedded in day-to-day practice. Rhiannon also highlighted links with the new clinical indicators, especially for vulnerable groups, and noted concerns about relying too heavily on Siren for engagement.
- 13.5 Kate clarified that while some timelines have been extended, many tasks have progressed and the extensions reflect a need for proper assurance rather than lack of delivery. Kate emphasised that work is being integrated with wider programmes such as the CMT, that communication goes beyond Siren, and that a planned mid-point review will ensure the strategy remains realistic and focused on what can be achieved with available capacity.

#### **The Committee:**

- 1. Received the report, noting progress to date in delivering the Strategic Quality Plan 2025-28 as well as the key risks, dependencies and capacity constraints impacting delivery, and the mitigating actions in place;**
- 2. Supported continued quarterly assurance reporting, with a planned transition towards outcome-based assurance measures as delivery matures.**



## 14. CLINICAL AUDIT PLAN 2026/27 ACTION TRACKER Q3 (UPDATE) 2025/26

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

- 14.1 Jonathan Chippendale provided the Clinical Audit Plan for 2026/27 for discussion and approval, noting which audits would roll forward, which were in progress and recent developments. The update included audits on magnesium sulphate, antimicrobial use and the new older fallers care bundle. The update also highlighted the increasing focus on broader clinical intelligence alongside traditional audit activity.
- 14.2 Ceri asked for clarification on the age threshold for the 'trauma in older people' audit and whether the end-of-life care audit would include children as well as adults. Jonathan confirmed the trauma audit is expected to use 65+ as the threshold (subject to confirmation with the clinical lead) and agreed to check with the palliative care lead whether the end-of-life care audit could appropriately include children. Andy Swinburn added that future audit work will increasingly focus on clinical intelligence to drive practice change, while still maintaining capacity to undertake traditional audits.
- 14.3 Rhiannon Beaumont-Wood asked whether audit findings, particularly in areas of palliative care are shared with health boards, noting the importance of system-wide learning and pathway alignment. Jonathan confirmed that audit findings are shared with health boards once they have completed the internal assurance process, noting recent examples of joint work with Cardiff and Vale and Betsi Cadwaladr University health board on stroke pathways.

### **The Committee:**

- 1. Approved the 2026/27 Clinical Audit Plan;**
- 2. Noted the revisions to audit timelines and the increasing emphasis on clinical intelligence, and received the Q3 update, including progress on ongoing audits and confirmation that completed audits will continue to be shared with health board partners following internal assurance.**

## 15. HEALTHCARE INSPECTORATE WALES (HIW) NEW NHS WALES ENGAGEMENT PROCESS

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

- 15.1 Liam Williams introduced the new Healthcare Inspectorate Wales (HIW) engagement process, noting that WAST had submitted its self-assessment and supporting evidence for the forthcoming desktop review. The Chair welcomed the update and expressed support for the revised approach.



- 15.2 Rhiannon asked whether HIW's reference to communication about delays related to wider public messaging or communication during incidents. Liam confirmed it covered both but was primarily focused on improving how the service informs patients during emergencies. Rhiannon further highlighted the need for clearer proactive explanation to the public, Liam agreed this was important and noted it remained a recognised area for improvement.
- 15.3 The Committee noted the introduction of the new HIW NHS Wales Engagement Process and its implications for organisational quality governance. Members requested Liam provide an update outlining (1) how the organisation will implement the new engagement requirements (2) any anticipated changes to reporting or assurance processes and (3) any associated risks requiring escalation to the Trust Board.

**The Committee: Confirmed they wish to receive an annual update on HIW engagement themes and inspection learning and endorsed a brief mapping exercise to confirm alignment and identify any areas where assurance could be strengthened.**

## **16. RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK**

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

- 16.1 Trish Mills presented an overview of the Risk Management and Board Assurance Framework, noting that the two highest rated risks, Risk 223 *the Trust's inability to reach patients in the community causing patient harm and death* and Risk 224 *significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service* are reviewed monthly. A recent reduction in Risk 223 from a longstanding score of 25 to 20 reflected improved handover performance, though sustainability remains uncertain.
- 16.2 Trish highlighted that many mitigations discussed throughout the meeting directly support these risks and confirmed that a PTR related risk is also being developed. Rhiannon Beaumont-Wood asked about the confidence in sustaining reduced handover delays and whether the new regulatory requirements should also feature as a corporate level risk. Trish agreed the handover risk may need to increase again if performance deteriorates and confirmed that emerging regulatory pressures, including Listening to People Regulations, may require the addition of a further risk.

**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.**



## 17. AUDIT TRACKER Q3 2025/26

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

17.1 Trish Mills presented the Q3 Audit Tracker, noting steady progress across actions and highlighting that most outstanding items are on their first revision and remain on track. Trish confirmed that two Patient Experience and Community Involvement (PECI) actions proposed for closure will remain open pending further assurance discussions. Work is ongoing with Welsh Risk Pool (WRP) recommendations, several of which require updated timelines aligned to the Datix system changes. Trish also advised that alignment with WRP annual assessment will continue to avoid duplication, and acknowledged the strong compliance and oversight maintained by the Quality Patient Experience and Safety teams.

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

## 18. COMMITTEE ANNUAL REPORT 2025/26 AND CYCLE OF BUSINESS 2026/27

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

18.1 The committee received the draft Committee Annual Report for 2025/26, presented by Trish Mills, which outlined the committee's activities, assurance work and key areas of focus over the reporting period. The committee reviewed the content and confirmed that it accurately reflected its work during the year.

18.2 The committee considered and approved the proposed Cycle of Business for 2026/27, noting that it had been updated to reflect organisational priorities and external regulatory requirements. During discussion, the committee agreed the priority areas for the forthcoming year, including:

- oversight of value-based healthcare and quality improvement;
- delivery of the PTR Recovery Plan and preparedness for the Listening to People regulations;
- strengthened Infection Prevention and Control (IPC) assurance,
- monitoring delivery of the Strategic Quality Plan; and
- structured oversight of Clinical Model Transformation (CMT) benefits realisation, including a formal evaluation framework.

18.3 The Committee emphasised the importance of maintaining clear sight of transformation outcomes and supported the inclusion of a CMT evaluation report as a recurring item within the 2026/27 work programme.



GIG  
CYMRU  
NHS  
WALES

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

- 18.4 Rhiannon Beaumont-Wood suggested that findings from the public accountability process may generate further quality related priorities, and Trish agreed this would be considered once the outcomes are known, noting that any resulting actions would be directed to the appropriate committee.
- 18.5 Rachel Marsh considered whether benefits realisation from the CMT should be reflected in future committee work, Trish agreed this would be incorporated appropriately. The committee requested that a formal evaluation framework for the CMT programme be developed and reported to the committee. This evaluation should provide clarity on expected benefits, measurable outcomes, delivery risks and the approach for monitoring impact across the year. The committee agreed that oversight of CMT benefits realisation must be embedded within the 2026/27 Cycle of Business.

**The Committee:**

- 1. Approved the draft Annual Report at annex 1; and**
- 2. Approved the draft Cycle of Business for 2026/27 at annex 2.**

## CONSENT ITEMS

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

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

**The Committee noted the Committee Cycle of Business Monitoring Report and progress against the 2025/26 Priorities.**

## CLOSING ITEMS

**20. KEY MESSAGES FOR THE BOARD**

20.1 These were summarised by the Chair and reflected in the AAA.



## **21. REFLECTIONS**

- 21.1 Members reflected positively on the quality and candour of discussions, noting that the meeting provided valuable shared insight into the significant operational and strategic challenges facing the organisation. The patient story was highlighted as a powerful reminder of the real-world impact of system pressures and the importance of ongoing improvement. Members expressed appreciation for the openness of contributors and the strength of scrutiny applied throughout.
- 21.2 Ceri Jackson expressed concern regarding staff wellbeing and the impact of moral injury across clinical and corporate teams. In response to this, members requested that Liam Williams provide an update summarising (1) current organisational work on stress and moral injury, (2) how this links to the People & Culture Committee's ongoing work, and (3) how learning will be integrated into service improvement and staff support programmes.
- 21.3 The committee also recorded thanks to Rhiannon Beaumont-Wood for her contribution as she attended her final committee meeting before leaving the board.

## **22. ANY OTHER BUSINESS**

- 22.1 The Chair offered warm thanks to Rhiannon Beaumont-Wood for her valued contribution to the committee, expressing appreciation for Rhiannon's consistent scrutiny, challenge and support. The Chair also thanked Rhiannon for her engagement and support outside formal meetings, recognising the positive impact she has had on the organisation. Rhiannon will be missed both within QuEST and at Trust Board as she moves on to her new role at Powys Teaching Health Board

## **23. DATE AND TIME OF THE NEXT MEETING**

- 23.1 7 May 2026 at 9:30.

**MEETING CLOSE: 15:09**

**ACTION LOG - UPDATE  
QUEST COMMITTEE**

Minute Ref	Date	Agenda Item	Action Note	Responsible	Due Date	Progress/Comment	Status
06-02/26	3 February 2026	<b>Ministerial Advisory Group WAIT 45 Taskforce</b>	<b>Update on Ministerial Advisory Group Wait 45 Taskforce</b> The committee noted that performance developments and national expectations relating to the Wait 45 Taskforce have changed since the paper was written. The Committee therefore requests that the Executive Lead provide regular updates on progress of the Ministerial Advisory Group's work, Health Board recovery trajectories, and any implications for WAST's operational delivery. Updates should include emerging risks, system-wide engagement and changes to national direction.	Liam Williams	7 May 2026	<b>Update 23 April 2026</b> Memorandum received from Lee Brooks provided to deal with this action.  <b>Update 3 March 2026</b> Following the Agenda Setting Meeting on 26 February, it was agreed that Lee Brooks will draw out an update on the Wait 45 roll-out, release to respond, within the Operations Report at the May meeting [to include staff impact for PCC and the impact across the organisation where it aligns to performance, quality/patient safety/experience and our people]. Email sent to LB on 3 March 2026 requested this. Once received, committee to decide the outcome of the action going forward.	Complete
08-02/26	3 February 2026	<b>Putting Things Right Report Q3</b>	<b>Putting Things Right Recovery Plan</b> Liam Williams agreed to circulate the PTR Recovery Plan to committee members after it has been reviewed by the Executive Leadership Team, rather than waiting until the next meeting.	Liam Williams	7 May 2026	<b>Update 29 April 2026</b> Now referred to at the Concerns Management Plan, to be included within the papers	Open
08-02/26	3 February 2026	<b>Putting Things Right Report Q3</b>	<b>Feedback on the organisation's readiness and planned implementation</b> The committee noted the significant uncertainty and operational impact associated with the forthcoming <i>Listening to People</i> regulations, including the absence of final national guidance and the organisation's current capacity constraints. It was agreed that the Executive Leadership Team would further consider organisational preparedness and associated resource implications. The committee will receive feedback on the organisation's readiness and planned implementation approach at a future meeting, once the Executive Leadership Team has concluded its review.	Liam Williams, Claire Appleton	7 May 2026	<b>Verbal update to be provided at meeting</b>	Open
10-02/26	3 February 2026	<b>Infection Prevention and Control</b>	<b>IPC Progress update</b> The committee noted ongoing work to strengthen IPC governance, including the development of a formal audit cycle, updated training requirements, and improved fleet cleanliness arrangements. The committee requests that the Head of Infection Prevention and Control provide an update at the next meeting, setting out (1) progress against the 2026/27 IPC work plan, (2) implementation of national All-Wales Cleaning Standards, and (3) any identified resource or operational risks requiring escalation.	Liam Williams	6 August 2026	<b>Update following the Agenda Setting Meeting on 26 February 2026 for May meeting</b> Deferred to the August meeting - see forward planner.	Not due
10-02/26	3 February 2026	<b>Infection Prevention and Control</b>	<b>PPE Assurance and Preparedness</b> The Committee noted the significant work undertaken to strengthen PPE provision, including improvements to respiratory protective equipment (RPE) availability and associated training. To provide ongoing assurance, the Committee requests that the Head of Infection Prevention and Control submit an update outlining (1) the current PPE assurance position, (2) progress on implementation of the revised PPE and RPE processes, and (3) any outstanding risks or gaps requiring escalation.	Liam Williams	7 May 2026	<b>Update from Julie Boalch 23/04/2026</b> The Quality Team have prepared a report for the meeting on 7 May 2026, to address the areas outlined in the action.  <b>Update following the Agenda Setting Meeting on 26 February 2026 for May meeting</b> Included in agenda for May 2026 meeting [append to the action log if it for assurance only]	Complete
15-02/26	3 February 2026	<b>Healthcare Inspectorate Wales (HIW) New NHS Wales Engagement Process</b>	<b>New NHS Wales Engagement Process</b> The Committee noted the introduction of the new HIW NHS Wales Engagement Process and its implications for organisational quality governance. Members requested that the Executive Lead for Quality & Patient Safety provide an update outlining (1) how the organisation will implement the new engagement requirements, (2) any anticipated changes to reporting or assurance processes, and (3) any associated risks requiring escalation to the Trust Board.	Liam Williams	7 May 2026	<b>Update following the Agenda Setting Meeting on 26 February 2026</b> Deferred to the August meeting - see forward planner.	Not due
18-02/26	3 February 2026	<b>Committee Annual Report 2025/26 and Cycle of business 2026/27</b>	<b>Clinical Model Transformation Evaluation</b> As part of reviewing the Committee Annual Report 2025/26 and agreeing priorities for 2026/27, the committee requested that a formal evaluation framework for the Clinical Model Transformation (CMT) Programme be developed and reported to QuEST. This evaluation should provide clarity on expected benefits, measurable outcomes, delivery risks, and the approach for monitoring impact across the year. The committee agreed that oversight of CMT benefits realisation must be embedded within the 2026/27 Cycle of Business.	Rachel Marsh	6 August 2026	<b>Update following the Agenda Setting Meeting on 26 February 2026</b> Deferred to the August meeting - see forward planner.	Not due
21-02/26	3 February 2026	<b>Reflections</b>	<b>Staff Wellbeing and Moral Injury Insight</b> In response to concerns raised by Ceri Jackson regarding staff wellbeing and the impact of moral injury across clinical and corporate teams, the committee requested that Liam Williams provide an update summarising (1) current organisational work on stress and moral injury, (2) how this links to the People & Culture Committee's ongoing work, and (3) how learning will be integrated into service improvement and staff support programmes.	Liam Williams	7 May 2026	<b>Update 29 April 2026</b> When complete, will be going to PCC.  <b>Update 3 March 2026</b> Email sent to Chair of People and Culture Committee (including Exec Leads and LW) to highlight action to PCC and that it has been included within their Action Log.	Open
14.2/02022025	2 March 2026	<b>Assurance to ARAC on Near Miss and Low Harm Intelligence Framework</b>	<b>ACTION REQUEST FROM AUDIT RISK AND ASSURANCE COMMITTEE ACTION LOG PTR Paper and Recovery Plan</b> QuEST committee would be specifically requested to consider the near miss reporting issue as part of its review of the PTR Paper and Recovery Plan at the meeting on 7 May to provide interim assurance to the committee.	Liam Williams	7 May 2026		Open



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## MEMORANDUM

**DATE:** 22 April 2026  
**TO:** QuEST Committee  
**FROM:** Lee Brooks, Executive Director of Operations  
**SUBJECT:** Response to Action 06-02/2026

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This memo is provided to deal to Action 06-02/26.

Data impacts of handover delays are not repeated here, as these are contained in the regular reporting provided to Trust Board in the dedicated paper, and in the risk reporting. Data is also available in the MIQPR.

Following publication of the independent Ministerial Advisory Group on NHS Wales Performance and Productivity review in April 2025, Recommendation 15 called for health boards to ensure that no ambulance handover exceeds 45 minutes, while maintaining the overall ambition of achieving handover within 15 minutes wherever possible. The Welsh Government response accepted this recommendation in part, confirming that the 15-minute expectation remained established through the NHS planning framework for 2025/26 and that a national ambulance patient handover improvement delivery group would develop a plan in the first quarter of 2025/26 to assess readiness to implement a maximum 45-minute handover time within six months. [\[MAG Report - English | PDF\]](#), [\[WG response to MAG | PDF\]](#)

In support of this direction, WAST prepared a revision to the all-Wales ambulance release protocol to incorporate a 45-minute Release to Respond threshold. The Trust's position remains that ambulance handover performance is inconsistent across Wales and that, despite preparatory work undertaken across the system, Release to Respond has not yet been implemented. The Trust's analysis is that voluntary improvement alone has not yet delivered the consistency or pace of change required, and that clearer system direction, together with resolution of practical enablers such as governance and equipment arrangements, remains necessary to support implementation.

This is significant because the principal safety risk for the Trust remains upstream in the community. Risk 223 – "The Trust's inability to reach patients in the community causing patient harm and death" remains one of the Board's principal risks. Although that risk reduced from 25 to 20 during 2025 following lower handover delays, the Board has previously understood that a sustained period of improvement is required for that position to be maintained. In light of recent deterioration in handover performance, the Board should be concerned that current arrangements do not yet provide sufficient assurance that this risk will reduce at the pace required and that it is in fact likely that at the next review, the Operations Senior Leadership Team may raise the risk score.

The Trust will continue to work constructively with health boards, Welsh Government and NHS Performance & Improvement to support an agreed and implementable national approach. However, given the direct relationship between prolonged handover delays, ambulance availability and risk to

patients waiting in the community, this remains a matter of significant concern for the Trust and an area where sustained system focus is still required.

**Lee Brooks**  
**Executive Director of Operations**



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

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

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

<b>Trust Board Meeting Date</b>	26 March 2026
<b>Committee Meeting Date</b>	3 February 2026
<b>Chair</b>	Bethan Evans

### KEY ESCALATION AND DISCUSSION POINTS

#### ALERT

(Alert the Board to areas of attention)

1. The **Q3 Putting Things Right (PTR)** report was received at this meeting noting that despite significant additional resources, improvement has not been achieved, and performance has deteriorated for some indicators. The board received some of these metrics in the MIQPR at the board meeting on 29 January and acknowledged that changes to the clinical model had increased complexity for some investigations. The significant levels of absence in the PTR team was recognised which has a knock on effect to performance. The committee highlighted the importance of supporting staff wellbeing, particularly in light of high absence rates and the impact of stress and moral injury associated with current workloads and operational pressures. Ongoing work with People Services and Occupational Health was noted.
2. Members expressed disappointment that the **PTR and Legal Services Performance Organisational Recovery Plan** was not available for review and were not assured that formal trajectories for improvement have been identified. The committee requested that, once the plan is reviewed by the Executive Leadership Team (ELT) on 18 February, that the recovery plan be circulated to members, rather than waiting for the next scheduled meeting.
3. Notwithstanding the limited assurance the committee received on PTR recovery, they did acknowledge that where concerns were investigated and closed that learning was being applied and that the team's support for families affected was very much evident. Members also noted that there had been a further increase in new complaints and incidents resulting from increased delays in responding. Members thanked the teams for continuing to do this in difficult circumstances.
4. The committee discussed the upcoming implementation of new **Listening to People Regulations**, which will require an offer of face-to-face meetings for complainants and provision of bereavement support. There is concern about the feasibility of meeting these requirements given the absence of



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final guidance from Welsh Government and current resource constraints. The lack of clarity on timing and operational details is creating uncertainty for planning and impact assessment. The Committee will receive feedback after ELT discussion on preparedness for new regulations and resource implications.

## ADVISE

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

5. The committee received an account from **Roy Davies** of a prolonged ambulance delay during a cardiac emergency, which resulted in his neighbour transporting him to hospital. Members heard that Roy felt there was a lack of empathy from call handlers, highlighting the challenge of balancing speed and compassion under operational pressure and the necessity for accurate information gathering. The categorisation of Roy's call as amber, led to discussion about the specificity of the prioritisation process and the public's understanding of call categorisation. Operational context was provided, noting high call volumes for chest pain and the difficulty in identifying those, like Roy requiring an immediate response, as well as the significant impact of hospital handover delays on response times. It was noted that chest pain is an Orange Now in the new Ambulance Performance Framework. Roy's feedback is being used to inform quality monitoring, service improvements, and the development of more empathetic complaint responses, with a commitment to continued learning and system-wide collaboration.
6. Members welcomed the new **Healthcare Inspectorate Wales (HIW)** engagement process, noted the upcoming local review by HIW, and the completion of a self-assessment and evidence request. The committee will receive an update on the review as it progresses.
7. **The Ministerial Advisory Group Wait 45 Taskforce** has continued its work to reduce handover delays through clinically led, multi-agency collaboration. This has included a series of design events and focused improvement sprints. There were some concerns about how widely the output from the events were shared. While some early gains were achieved, sustaining progress has remained difficult, particularly given the scale and complexity of system pressures. Challenges within NEPTS also persist however roster reviews and commissioner engagement are under way to support an increase in patient journeys, although these actions alone are unlikely to fully resolve the wider operational constraints. Social care involvement remains critical, as health services cannot address handover delays in isolation. Work is progressing to strengthen integration with local authority and community services. However, there are still gaps in community based options for frail and elderly patients, which often leads to avoidable conveyance to emergency departments. Concerns were raised about whether Release to Respond will be fully delivered at Health Board level, particularly if accountability shifts from central oversight to local implementation. The committee agreed that regular updates on taskforce progress will be essential, since this work underpins its core agenda and supports ongoing system improvements.
8. The Committee received the **Operational Update for Q3 2025/26**, and members discussed:
  - Phase 2 of the ambulance performance framework has been implemented, and operational pressures remain high.
  - Handover delays persist, and to provide context at the time of the meeting the longest exceeded 18 hours.
  - Rural and urban equity issues were discussed, with initiatives underway to improve resource allocation.



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- Alternative dispatch framework is under review, with focus on patient safety and staff wellbeing.
  - Incident reporting backlog (Datix) is being addressed, however real-time learning other than of critical incidents remains a challenge.
9. Members **reflected** positively on the quality and candour of discussions, noting that the meeting provided valuable shared insight into the significant operational and strategic challenges facing the organisation. The patient story was highlighted as a powerful reminder of the real world impact of system pressures and the importance of ongoing improvement. Members expressed appreciation for the openness of contributors and the strength of scrutiny applied throughout. Members also expressed appreciation for the openness of contributors and the strength of scrutiny applied throughout. The committee recorded thanks to Rhiannon Beaumont-Wood for her contribution as she attended her final committee meeting before leaving the board.
10. The committee **met briefly in private** to receive a confidential risk report with nothing to escalate to the board at this stage.

## ASSURE

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

11. Members received an update on the development and refinement of the **EMERG clinical indicators used to measure the effectiveness of care** within this new category of the ambulance performance framework. The indicators are designed to provide both generic and condition-specific insight, supporting assessment of overall clinical effectiveness while also tracking outcomes for high-priority conditions including sepsis, maternal emergencies, neonatal care, anaphylaxis and convulsions. The indicators now provide automated, quality-assured insight into both overall clinical effectiveness and outcomes for key conditions such, sepsis, maternal and neonatal emergencies, anaphylaxis and convulsions. The committee also noted the inclusion of nationally adopted measures, as well as work to align stroke data with the Sentinel Stroke National Audit Programme which would form part of the Orange Now Category. While recognising that wider system constraints continue to affect some indicators, the committee was assured by the progress made and agreed that the enhanced indicator suite will meaningfully support ongoing improvement within the Clinical Model Transformation Programme.
12. The **Monthly Integrated Performance Report (MIQPR)** was received, setting out the metrics for November and December 2025. January handover hours rose sharply (19,000), reversing recent improvements. The clinical model transformation programme is developing a benefits realisation workstream to analyse emerging process data and identify opportunities to improve end to end patient times for key groups, including stroke, STEMI and fallers. The committee will see this as part of its cycle of business in 2026/27. Members noted the need for further metrics for orange and amber categories, while receiving assurance that call to door times for stroke and STEMI are being monitored and that additional indicators are under review. The committee also considered how delays affect access to specialist services such as thrombectomy for stroke, agreeing to progress a joint quality improvement programme with Health Board partners. Differences in purple and red response times were explored, with call volume and travel time identified as key drivers. The committee agreed to continue monitoring the impact of phase two of the clinical model transformation, with the expectation that performance indicators will demonstrate improvement over time.



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13. Partial assurance was provided on the **Strategic Quality Plan Implementation Update**, with concerns expressed on deferring activity toward the latter stages of the plan and the delivery risk that poses. Areas being reassessed for approach and delivery include population health, care experienced young people, and value-based healthcare objectives. Challenges with implementation were attributed to ongoing capability and capacity issues resulting from the significant clinical model changes adopted across the organisation over the last year. 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. Positively, the plan highlighted progress on a range of indicators and it was noted is now being reshaped to embed quality and improvement within core business, with a midpoint review scheduled to confirm deliverability. Engagement activity continues through multiple channels, with Siren now acting as the central access point for resources. The committee endorsed continued quarterly assurance reporting and welcomed a move toward outcome based measures as the plan matures.
14. The committee received the **Infection Prevention and Control (IPC) Annual Report 2024/25** as well as an update outlining recent progress and future plans. This including the move to a specialist IPC team and improved collaboration across IPC, fleet, estates and operations, which was welcomed. Key work continues on strengthening training, revising cleaning standards, and ensuring all emergency vehicles are equipped with appropriate PPE and respiratory protective equipment. The committee requested clearer comparative data in future reports, including audit coverage and fleet context, and sought assurance on preparedness for future infectious disease outbreaks. It was confirmed that guidance reviews are under way and that all vehicles are now fully equipped for IPC requirements. The committee raised concern about the high level of non-submission of hand hygiene action plans and asked for strengthened escalation and governance arrangements. Members agreed that further assurance will be provided through the annual quality report and a future update once national guidance and assurance frameworks are issued. The Chair noted specifically that she is looking for clear evidence that the organisation is now seeing the impact of actions that have been recognised as necessary for some time.
15. The **Clinical Audit Plan 2026/27** was approved, and the tracker update for Q3 2025/26 was received with no escalations.
16. The **Clinical Equipment Internal Audit** was received. This was a reasonable assurance rated audit that had been scrutinised by the Audit, Risk and Assurance Committee in December. Members will continue to track progress of actions to mitigate risks identified in the audit.
17. The committee approved its **Annual Report and cycle of business** aligned to refreshed terms of reference for 2026/27, noting that assurance reporting for value based healthcare, IPC, mental health and dementia is to be determined.
18. An update was received on the **Audit tracker (internal audit, external audit/reports)**. Whilst there were actions that has revised dates, there was good closure of both internal and external audit risks. The committee will continue to monitor progress, particularly on the Welsh Risk Pool Concerns Assessment actions.



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## RISKS

### Risks Discussed:

This committee has oversight of two of the Trust's high scoring risks – those being **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.

The board discussed these risks at its meeting the week before this committee meeting, and in particular the rationale for risk 223 reducing to a score of 20 but not risk 224. Members at board noted, as did committee members, that the reduction in handover delays – albeit not consistent across the country – has a fairly immediate effect on risk 223, whereas the patient safety knock-on effect of risk 224 will take more time to take effect and for the Trust to see any resulting reduction in patient harm. Notwithstanding this, both risks are reviewed monthly and further changes will continue to be reviewed closely by this committee and the board.

### New Risks Identified:

- Staff capacity and immense pressures directly affecting the ability to deliver on some key areas of this committee's remit ran through much of this meeting.
- A risk related to PTR is in development, with the committee discussing the incorporation of compliance with regulations to that or to a separate risk.

### COMMITTEE AGENDA FOR MEETING

Patient experience	Ministerial Advisory Group W45 Taskforce update	Operations directorate Q3 report
PTR report Q3 and Recovery Plan update	MIQPR	IPC report 2024/25 and improvement plan
EMERG Clinical Indicators	Clinical equipment internal audit	Strategic Quality Plan implementation plan progress
Clinical audit plan 2026/27 and Q3 tracker	HIW new NHS Wales engagement process	Risk management and BAF
Audit tracker Q3	Committee annual report and cycle of business 2026/27	Cycle of business and monitoring report

### COMMITTEE ATTENDANCE

NAME	9 MAY 2025	13 JUN 2025 <sup>1</sup>	5 AUG 2025	10 OCT 2025 <sup>2</sup>	4 NOV 2025	3 FEB 2026
Bethan Evans (Chair)						
Ceri Jackson						
Rhiannon Beaumont-Wood						
Liam Williams						
Andy Swinburn			Jonathan Chippendale			

<sup>1</sup> Extraordinary meeting

<sup>2</sup> Extraordinary meeting



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COMMITTEE ATTENDANCE						
NAME	9 MAY 2025	13 JUN 2025 <sup>1</sup>	5 AUG 2025	10 OCT 2025 <sup>2</sup>	4 NOV 2025	3 FEB 2026
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



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# QUEST Update briefing 7th May 2026

## Patient Story: Roy Davies – Emergency Response to Suspected MI

**Updated: 5 March 2026**

[peci.team@Wales.nhs.uk](mailto:peci.team@Wales.nhs.uk)



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## Summary of Patient Experience Story

Roy Davies (recorded October 2025) -

<https://youtu.be/QfyJMc9gkIM?si=xlpB12IV9lc1Im-k>

On 23 February 2025, Roy Davies experienced chest pain at home. A 999-call made at 22:49 advised a 6–8 hour wait for an ambulance, despite symptoms indicative of myocardial infarction. The call was categorised Amber 1.

A repeat call at 23:00 resulted in the same advice, with no escalation and repeated scripted questioning. Due to the delay, Roy was taken to Prince Charles Hospital by his neighbour. He was subsequently transferred to University Hospital of Wales, where he received an emergency stent.

Roy was later informed by the treating surgeon that he would not have survived had he waited for an ambulance.

## Key Risks and Issues Identified

- Patient safety risk from prolonged ambulance response times for suspected MI in the community.
- Operational pressure arising from hospital handover delays and system-wide demand.
- Call handling experience perceived as lacking empathy and flexibility, with over reliance on scripted responses.
- Inefficient repeat questioning during multiple emergency calls.
- Poor patient experience of the PTR response, lacking clarity on learning, action, and improvement.
- Discrepancy between public-facing messaging (website/emergency response information) and lived experience.



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Roy Davies

## Impact

- High risk clinical harm narrowly avoided.
- Significant anxiety and distress for patient and family.
- Reduced public confidence in emergency ambulance response.
- Reputational risk to the Trust.

## Themes for Assurance

- Clinical Risk – Effectiveness and timeliness of emergency response for chest pain / MI.
- Quality of Communication – Empathy, personalised responses, and clear explanations to patients.
- Learning from Complaints – Demonstrable learning, feedback, and service improvement through PTR.
- Public Transparency – Accuracy and realism in public messaging regarding demand and response categories.

## Actions Taken / In Progress

- Patient story shared at QMG (Nov 2025) and QuEST Committee (Feb 2026).
- Early collaborative work with NHS Performance & Improvement to review patient experiences of STEMI and CVA pathways.
- Ongoing review of public feedback to understand community experiences of emergency services.
- Targeted engagement activity led by PEI and Partnerships & Engagement teams.
- Preparatory work aligned to new “Listening to Patients” regulations (effective 1 April 2026), strengthening person centred communication.



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Roy Davies

## Required Areas of Continued Focus

- Review and improvement of clinical assessment and escalation processes for chest pain/MI calls.
- Strengthening empathy and flexibility in call handling, particularly during repeat calls.
- Improving PTR responses to clearly articulate:
  - What went wrong
  - What has been learned
  - What has changed as a result
- Refreshing public messaging to ensure alignment with operational realities.

## Intended Outcomes

- Reduced harm to patients awaiting emergency response in the community.
- Improved patient and public trust through honest, compassionate communication.
- Evidence of systemic learning and measurable service improvement.
- Stronger alignment with Trust values and regulatory expectations.
- Support prioritisation of high impact improvements for patients experiencing time critical conditions such as MI.



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## OPERATIONS DIRECTORATE QUARTERLY REPORT FOR COMMITTEES 2025-26 Q4 (January – March 2026)

The Committees are informed this report is now structured according to the new Operations Directorate Assistant Director of Operations portfolios. This has resulted in five portfolios reducing to four to support the creation of the new Deputy Director of Operations role. An appointment to this position has been made following the recruiter supported process and a start date will be confirmed shortly. Paul Underwood has accepted an offer and is to join WAST from Aneurin Bevan University Health Board where he has been the General Manager, Urgent Care for the last six years. Paul has extensive experience across health (including ambulance) as well as in the private and third sectors.

The structure of this report shall be reviewed following Paul's induction to the organisation and Directorate.

### National Operations & Support

#### General Update

##### **Putting Things Right Recovery Plan**

As part of the broader Trust wide PTR recovery plan, Operations Quality has met the trajectory set for overdue complaints at the end of March, ensuring complaint responses are proportionate to enable timely completion within required timeframes/targets. The department closed the recovery plan on trajectory with only 4 complaints overdue the PTR Tier 1 target, down from 88 in October 2026.

##### **Accredited Centre of Excellence (ACE) for MPDS**

Work has commenced on the 20 points of accreditation for re-accreditation as an ACE for MPDS, due in December 2026. Operations Quality is working closely with the International Academies of Emergency Dispatch (IAED) on re-accreditation activities. The Trust has been an ACE for MPDS since 2017. ACE not only provides assurance that the Trust provides high quality 999 call taking to internal and external stakeholders but also provides several other benefits including call handler certification and recertification costs, access to IAED college courses, software versions and updates, and client support. To achieve ACE, the Trust needs

to meet the required standard of 999 call compliance from random audit (approximately 350 calls a month) including achieving under 7% non-compliant calls. Random call compliance is well within the IAED set criteria and has been for the past 12-months, putting the Trust in a strong position for re-accreditation.

### **Resource Department Culture Review**

A programme of work is underway focussed on the culture in the Resource department. A listening exercise and poll was undertaken in December 2025 and in March 2026, we brought all Resource teams together for the first time as a follow up exercise to review the themes (attached at Appendix A), commence the development of a team charter and agree next steps. Feedback from the day was positive and we will continue to work with the OD team to develop an action plan and next steps.

## **Coordination & Integrated Care**

### **Challenges**

#### **Abstractions**

Sickness related abstractions within EMSC continue to present challenges. Work is underway with People Services and Service Managers to develop a formal action plan, alongside a coordinated programme led by Locality Managers to ensure a consistent approach across all sites.

EMSC coordination continues to maintain a safe and effective service, with mitigation measures in place to manage abstraction levels.

#### **111 Clinical Performance**

Clinical performance within the 111 service continues to experience pressures. A comprehensive deep-dive review is currently underway, led collaboratively by the Operational Delivery Unit data analysis team, the Head of Service, Integrated Care and Integrated Care Operational colleagues. This review aims to fully understand the underlying drivers of performance challenges and to identify opportunities for improvement across clinical processes, workforce deployment, and service efficiency. Findings and recommended actions will be shared once the analysis is complete.

### **IMTP**

## **Clinical Navigator TEAMS® Video Functionality**

This enhancement to Remote Clinical Support went live on 10 March 2026, strengthening clinical decision-making, patient safety and access to appropriate pathways and outcomes.

The service is available to WAST responders on scene, enabling real-time visual review of the patient's clinical presentation and context by senior clinical colleagues within the EMS Co-ordination Centres. Subject to patient consent, this is delivered via one-way video, complementing existing telephone-based clinical navigator support and enhancing remote clinical assessment when advice is requested.

## **Integrated Care First Line Organisational Change Process (OCP)**

The Organisational Change Process (OCP) has now been fully completed, with interviews for the newly established positions concluding in early February 2026. Successful candidates have been identified, and preparatory work is well underway to support the transition into the new structure.

Work continues on the development of Standard Operating Procedures (SOPs), associated training materials, and updated rosters to ensure clarity of roles, consistency of practice, and operational readiness across all impacted functions.

Targeted engagement is ongoing with affected staff, including secondees returning to their substantive posts, to ensure they receive the necessary information, guidance, and support required for a smooth transition into the revised arrangements. To safeguard service continuity and minimise disruption, the transition will be delivered using a phased, tiered implementation approach. This will allow teams to embed new processes gradually and ensure any emerging issues can be addressed promptly.

### **111 Roster Review**

Roadshows to support survey engagement were held across Wales from 12 to 15 January. Survey closed on 8 February with an approximate 65% response rate, representing staff across call handlers, clinicians and varying contract lengths. The suite of rosters has been agreed between, staff, Trade Union Partners and the project team. Briefing Sessions for manager to carry out detailed 1-to-1's with all staff to share the roster lines and to agree choices will be carried out in the coming weeks. The allocation rule set has been agreed in partnership so that in the event of over-subscription to an individual line then a fair and equitable process will be followed. It is anticipated that rosters will be placed onto GRS in the coming weeks with a phased implementation to commence on 1<sup>st</sup> June 2026.

## General Update

### LifeX C3 Interface

The LifeX–C3 interface went live on 7 January 2026, enabling Response Coordinators to manage radio operations directly within C3 CAD, reducing the need to use a separate system and supporting more efficient crew and call management.

Key benefits:

- Radio integrated in C3, reducing system switching.
- Simplified radio traffic handling to improve operational efficiency.
- Clearer prioritisation of Priority Request to Speak via on-screen indicators.
- Improved Shift Manager oversight for monitoring and call clearing.
- Quicker group calls to a callsign (no directory search/scrolling).
- Visible identification of monitored talk groups.

### Section 136 Patients

A new call process and AQM questionnaire were introduced to record section 136 requests from police for transporting mental health patients. This process will improve data on the volume of these calls and provide evidence to support the 'Right Care Right Person' agenda with police forces.

### C3 Pre-Alert Functionality Update

Pre-alerts for RCS0 (ineffective breathing) calls will no longer appear immediately on the Clinical Navigators queue. Instead, these calls will only show up once fully coded and confirmed as RCS0. This change boosts accuracy, which allows Clinical Navigators to concentrate on relevant incidents, and increases clinician capacity by ensuring urgent cases get immediate responses. It also improves efficiency in allocating clinical resources for appropriate calls.

### Paramount Pro QA Upgrade

The International Academies of Emergency Dispatch (IAED) mandates that each user or service routinely updates the Medical Priority Dispatch System (MPDS) (the 999-call prioritisation system used by WAST) to the latest version, typically on a biannual basis. This

ensures adherence to best practice and consistency. Additionally, agencies certified as Accredited Centres of Excellence (ACE), including WAST, are required to implement the most recent MPDS version within one year of its release.

These upgrades are clinically imperative to maintain compatibility with other UK Ambulance Trusts, particularly when exchanging calls electronically across services. Accurate matching and translation of clinical dispatch codes, whether MPDS or Pathways, is vital to safeguard patient safety.

We can report that an upgrade was carried out on 10 February 2026. During the Clinical Model Transformation, the Trust experienced delays deploying updates as focus shifted to support key operational changes. Alert to the potential for risk the Operations Quality Team, EMSC, and other stakeholders collaborated to ensure all necessary updates were given priority attention in early 2026. Consequently, the Trust is now nationally aligned.

The upgrade also provided an opportunity to review the CHARU and CFR Code Set. The upgrade also provided an opportunity to review the CHARU and CFR Code Set.

Comprehensive training was delivered to all EMSC staff in advance of this upgrade.

## **CAD Upgrade**

Several improvements were made following the CAD upgrades to the following areas:

- MAIT (Multiagency Incident Transfer)
- Escalation Functionality within CAD
- Changes to CFR / CWR Allocation Process
- Call Escalation via LowCode
- P1–P4 Back-Up Requests – CAD System Change

## **Staff Relocation to Matrix**

Thanet House served as the work base for more than 150 staff, in addition to varying numbers of bank staff and GP Hub personnel. Following assessment, the aging facility at Thanet House was deemed no longer fit for purpose, prompting the decision to move services to a modern, more suitable environment that supports the Trust's long-term operational needs.

Colleagues previously based at Thanet House have now been successfully relocated to the Matrix site in Swansea, in line with the Trust's strategic aspirations for future service delivery.

Building works at the Matrix site completed at the end of January 2026, enabling relocation activity to begin on 4 February 2026. All staff have now transitioned to the new site, ensuring continuity of service and improved facilities for teams supporting patient care.

## **Falls Desk Trial**

To best utilise the funding provided by Welsh Government there was a short term expansion of the Falls Desk service to offer improved support at night. Stronger daytime coverage and new night-time services offered greater clinical assistance and more consistent decision-making throughout extended hours. During the night period (Dec-March), the desk managed 673 patients, with only 322 requiring ambulance conveyance. (48%). From February 2 to March 31, 2026, a pilot program tested the APPNAV intervention for Falls and Frailty patients who were at risk of worsening conditions or repeat visits. The funding allocations for 2026/27 does not support continuation of night shift cover, but this will be continually evaluated. Beyond these calls, APPNAVs performed standard APPNAV tasks, concentrating on falls and frailty, and coordinated community and urgent care to prevent unneeded ED escalation.

A pilot from 2 February to 31 March 2026 tested the APPNAV intervention for Falls and Frailty patients at risk of deterioration or repeat attendance. Beyond these calls, FAPPNAVs performed standard APPNAV tasks, concentrating on falls and frailty, and coordinated community and urgent care to prevent unneeded ED escalation.

In its first three months, the Falls Desk handled 2,370 incidents and provided early clinical advice in nearly 2,000 cases. Through new remote guidance, 415 patients (18%) were safely helped up, and over 70% were assisted off the floor within two hours, lowering risks associated with long periods of immobility. Patients who received remote assistance had balanced clinical outcomes: 31% were safely managed via Consult and Close pathways, while the rest were almost evenly divided between those transported and those not transported. This shows that early clinical assessment can safely reduce unnecessary transport without increasing risk in a group that needed intervention.

Falls Responder utilisation rose from 52% to 62.5%. Daytime usage is still higher than overnight, mainly due to resource availability.

Following our evaluation of 2025/26 funding has been confirmed to continue the Falls Desk via Welsh Government for 2026/27. However, there is no line of sight to direct funding beyond this financial year so we will need to develop a plan in-year.

## **Respiratory Desk Trial**

An Integrated Care Respiratory Desk was trialed from 4 to 18 February 2026 to test a focussed respiratory assessment point within Integrated Care, enabling earlier identification of patients suitable for management through community respiratory pathways, SPoA services, or other non-ambulance options. This approach aimed to support more effective use of WAST resources and strengthen collaboration with community teams increasingly able to manage higher-risk respiratory patients at home when appropriate.

Clinicians involved in the trial received additional respiratory-specific training and were supported throughout by the Specialist Respiratory Lead to ensure a consistent, high-quality assessment approach. During the trial, the Respiratory Desk clinician primarily triaged MPDS code 06D02 (difficulty speaking between breaths) directly from the Clinical Support Desk queue and operated between 06:30 and 18:30, Monday to Sunday.

The trial is currently being evaluated, with results expected by the end of the quarter.

## **Single Clinician Queue**

Technical development of the Single Clinical CAD Module is progressing well, with the module now installed in the Training system and currently undergoing configuration to ensure operational readiness. Training packages are being developed in parallel, with delivery sessions scheduled from late March to mid-April. Engagement sessions will begin in early March, followed by dedicated Q&A opportunities to support staff understanding and preparedness. Work also continues with Health Boards to confirm Remote Worker access arrangements.

Alongside this, development of Standard Operating Procedures and associated processes is underway, including detailed plans to maintain business continuity in the event of any service interruptions. Overall, all workstreams remain on track and aligned with the planned Go-Live date of 21 April.

## **Emergency Operations**

### **Challenges**

## **TOIL Allocation**

A pilot scheme was agreed in Partnership which saw a monitored approach to TOIL allocation with an overwhelming 'can do' approach to allowing staff to utilise TOIL. The

benefits of this will see the Trust TOIL balance reduce appropriately and importantly improve staff wellbeing by enabling time off when needed to rest and recuperate.

Throughout the months of December, January & February a TOIL approval rate of over 80% has been observed. During regular TOIL project meetings, the reasons for decline have been scrutinised and the overwhelming reason for declined TOIL requests was due to low UHP and therefore to protect safe levels of local resource availability.

March sees the last month of the pilot, and a final meeting is scheduled at which there will be a determination as to how we adopt the process as BAU, and importantly how we monitor the figures going forward. A final pilot meeting will take place at the beginning of May which will review the whole period and moving forward a monthly Toil scrutiny meeting will be held, working in partnership with TUs and chaired by Emergency Operations Head of Service.

### **SORT Uplift**

Preparations for the SORT uplift training are progressing well, with proactive collaboration from EMS teams to optimise staff abstraction while safeguarding UHP. Communication around cross-charge arrangements are ongoing to support the FSP framework. We are currently at 222 SORT members with a recruitment plan in place to deliver 290 by end of September 2026; no training will be undertaken through the 6-week school summer holidays due to high abstractions. SORT staff on duty between 0600-0200 are being recorded and reported on the daily risk huddles with a mechanism being developed to provide assurance and identify themes and trends.

### **Specialist Operations Vehicles**

The fleet department advised they were on course to deliver enhanced operational capability, with the planned acquisition of five additional SORT crew carriers and five replacement HART vehicles scheduled for completion by the end of the financial year. Conversations are ongoing with fleet to identify delivery dates.

### **Continuity 2 Rollout**

The Continuity 2 training programme continues to advance, with the majority of Trust-wide departments either having completed training or confirming dates. A minor delay is anticipated, with six departments outstanding, the EPRR team is actively pursuing engagement and will escalate through SOT channels should timely cooperation not be forthcoming.

## IMTP

### **APP Roster Review**

The APP Roster review deliverable is progressing well with all Health Boards providing OMDA with key local information. OMDA are interpreting this information and applying into their algorithms and methodology to use Optima Predict to provide vital APP demand data. The output from OMDA will include recommended rotas including all local APP rotations (i.e., Primary Care, APP Navigator etc). Based upon this information local APP roster design will take place in partnership and full APP involvement.

### **Increasing Capacity in Rural Areas**

The actions of the Task & Finish Group have progressed and made some local impacts in supporting local individuals in preparing for readiness to apply for EMT roles. As an IMTP deliverable this subject has now demonstrated assurance, so it has formally been closed. However, this workstream is seen as requiring constant focus to have maintain operational capacity, so the Task & Finish Group members have agreed to terminate T&F Group but re-establish itself as an ongoing working group have a constant overview of the rural position. The recommendation that the working group will continue to liaise closely with the workforce team and work through a series of long, medium and short term actions to improve and sustain rural capacity.

## General Update

### **Mandatory In-Service Training (MIST)**

Mandatory In-Service Training (MIST) compliance continues to show positive progress across EMS. In 2025/26, EMS is closing the year at 93.66% compliance, with the remaining gaps largely understood and managed. Processes are underway regarding a small number of colleagues who did not complete their training as expected. All other outstanding cases relate to staff who do not currently require assessment, such as those on long-term sickness or maternity leave, and these will be addressed through return-to-work arrangements. For 2026/27, early engagement has been strong, with 69% of EMS staff and 68% of ACA staff booked onto MIST as at 8 April, following the introduction of self-booking. Managers are now allocating sessions where required, with the expectation that all staff will be booked by the end of May. The first MIST session commenced on 14 April, marking the formal start of delivery for the new year. It is expected this revised and trade union approach to planning will reduce the number of mop-up/additional training requirements placed on our training colleagues.

## Ambulance Care

### Challenges

#### Financial Saving Plan

The organisation faces a significant operational and financial challenge arising from the discontinuation of last year's additional funding that heavily supported Discharge & Transfer capacity, winter resilience, and delivery against key performance targets. This temporary funding has been critical in reducing cancellations, stabilising flow, and maintaining service performance during peak pressure periods.

While discussions with Commissioners are continuing, we do not yet have confirmed agreement for next year's plans or funding arrangements. This creates some uncertainty for operational planning, particularly as the additional discharge and transfer capacity, and the Capacity Management Plan (CMP) support that has helped reduce cancellations, are currently due to conclude on 31 March.

Without continued investment, our ability to meet forecast demand, sustain patient flow, and protect performance, especially through high-pressure periods, will be significantly constrained. The loss of this capacity will also place increased strain on core services, with likely implications for handover delays, staff workload, and overall system resilience. This year our IMTP includes the NEPTS Improvement Programme which will ensure we are maximising our approach to capacity.

### IMTP

#### NEPTS Roster Review

The roster review process is progressing as planned. Working Party 3 has now been completed, and there will be a six-week period before Working Party 4 convenes. The six-week gap between Working Parties provides sufficient time for teams to make any final adjustments to their submissions ahead of the final review. During this interval, staff groups have been tasked with refining and finalising two roster options for consideration. These two options will be formally presented at Working Party 4, which will mark the final stage of the design phase.

A two-week voting period will then take place, led and overseen by union representatives to ensure transparency, fairness, and independence in the selection process. Staff will vote for their preferred roster, and the option receiving the majority support will become the final agreed roster.

Subject to completion of the voting process and any subsequent implementation planning, the new rosters are expected to go live in Q2.

## General Update

### Cleric Patient Application

The development of the new Cleric patient app is progressing well and is now approaching final completion. This application is designed to significantly improve the patient experience by allowing users to:

- Receive real-time vehicle location and journey status updates
- Mark themselves as ready for collection
- Book, manage, or cancel journeys directly through the app

Implementation timeline has been impacted by extended governance requirements. Specifically, the approval of the Data Protection Impact Assessment (DPIA) which has taken longer than anticipated.

The implementation timeline has been delayed due to a requirement to complete a wider WAST DPIA related to the MDVS tracking on all current vehicles which is linked with an out of date WAST privacy policy . An amended version of the app, without the real time vehicle location, is being developed with CLERIC with a phased implementation date targeted for June.

### Culture Review

Following the completion of the externally led Culture Review earlier this year, the NEPTS management team has continued to progress the next phase of work. The findings and recommendations were shared with staff, and since then we have met with the Culture Team and local management groups to develop a structured action plan directly aligned to the review's recommendations.

A number of improvements are already underway, including:

- Standardisation of the three-week induction programme for all new JCC staff, ensuring a consistent and supportive introduction to the service.
- Targeted ad-hoc training, including focused support on making difficult calls, handling cancellations, and other challenging communication scenarios.
- Additional recommendations from the review have been incorporated into a wider improvement plan, which teams are now actively working through.

This work will continue throughout the year, with regular updates to staff as actions are completed and further improvements are implemented.

## **Discharge and Transfer**

The Discharge and Transfer process is now fully embedded into business as usual, with booking behaviours consistently aligning to the expectations set by Welsh Government. Sites are demonstrating much stronger discipline around advance bookings, resulting in smoother planning, fewer late changes and a more reliable approach to managing demand. This has strengthened operational predictability and improved the overall flow of patients through the system.

We have now also implemented a live Discharge and Transfer Dashboard, providing site leads and operational teams with real-time visibility of their bookings. This has already streamlined late activity and enabled quicker intervention when issues arise. The dashboard is now used daily at the national 11:00hrs Health Board huddle, where it has been extremely well received, offering a clear picture that supports patient flow across the system.

## **Fleet Replacement**

A total of 65 new large Peugeot Boxer vehicles are scheduled for fleet deployment by the end of Quarter 4, accompanied by an additional 13 smaller NEPTS multi-use replacement vehicles to further enhance operational capacity and readiness

## **Pan Directorate Updates**

### **Financial Savings**

The Operations Directorate has developed a Financial Savings Plan for 2026/27 to deliver £4.337 of savings, representing 1.8% of its overall budget. The plan builds on a strong track record of delivering required savings and sets out a combination of schemes already identified through Senior Leadership Team planning, alongside further workstreams being developed through the Operations Financial Savings Group (OFSG). The majority of schemes are intended to be recurrent, supporting longer-term financial sustainability.

Governance arrangements have been established through the OFSG to provide oversight, scrutiny and assurance of delivery. Each savings scheme has clear ownership, delivery actions and phasing assumptions, with performance monitored at scheme level. Monthly monitoring will align with end-of-month finance reporting, enabling early identification of under- or over-delivery and timely mitigation where required.

While there is confidence in the overall direction of travel, a small residual delivery and phasing risk remains. This will continue to be actively managed through ongoing scrutiny, identification of alternative schemes where necessary, and a strong focus on maximising

recurrent savings. Regular assurance updates will be provided to senior leadership and executive leadership to maintain visibility of progress, risks and mitigating actions throughout the financial year.

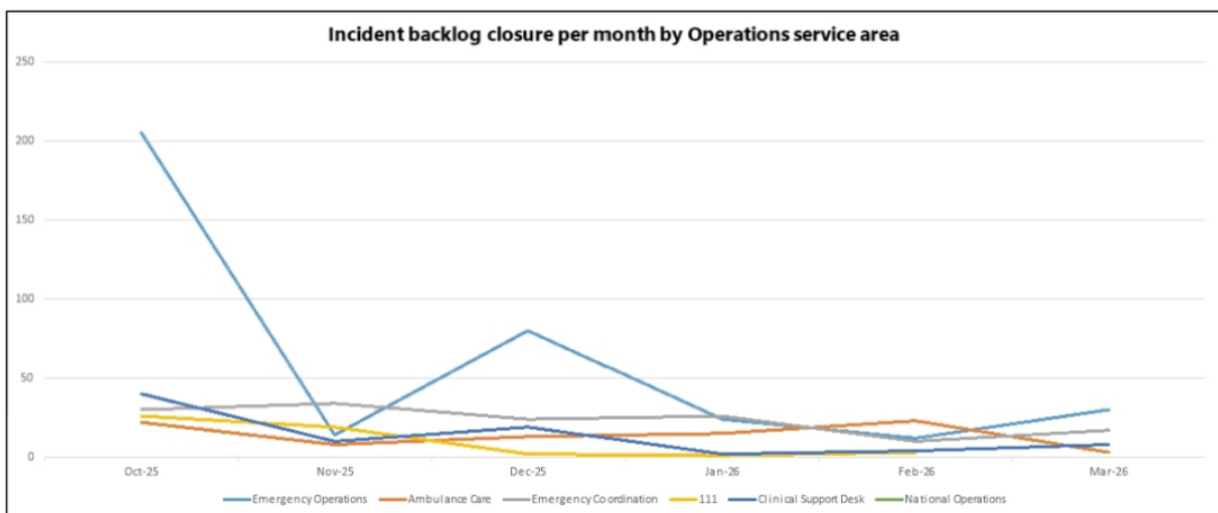
## Datix Backlog

Progress against the Datix Backlog Action Plan continues to be positive, with 41 actions currently identified across all Operations service areas and Quality, Safety and Patient Experience Directorate. Of these, 15 actions have been completed and 18 are actively progressing.

Since backlog recovery work commenced in September 2025, a total of 1,389 historic incidents have been closed, representing a 43% reduction from the original 3,205 cases, some of which dated back to 2021/22. Variances identified within the current reporting data are being reviewed with the Trust Datix Lead to confirm the accurate position.

From September 2025, services have reported 2,416 new incidents and closed 1,408 of them, achieving a 58% closure rate. Notably, 69% of these new incidents closed, were closed within 30 days, indicating encouraging improvements in compliance and timeliness.

**Incident closure period: 01 September 25 – 29 March 26**



## Quality and Support Days

Quality and Support Days were delivered across Operations throughout January and February on the following dates:

- Integrated Care: 14 January and 11 February
- EMS Operations, EMS Coordination and Ambulance Care: 15 January and 12 February

Across both months, a total of 969 MS Forms were completed. Feedback themes were as follows:

January – Christmas and New Year Period:

Feedback focused on operational and staff-experience matters relating to the festive period, including:

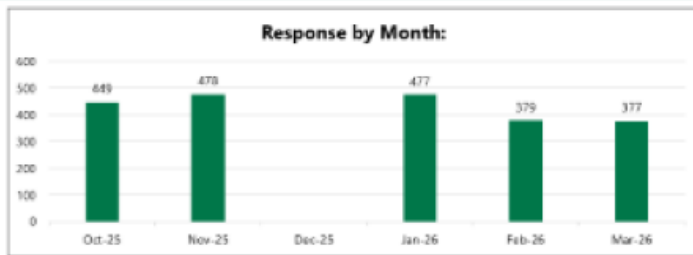
- Christmas period cover
- Christmas dinners
- Voucher scheme
- Self-rostering

February:

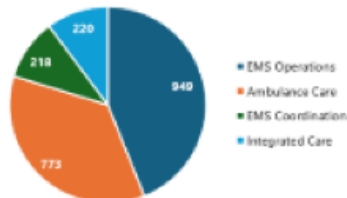
Feedback centred on key workforce and compliance topics:

- Sexual harassment
- CPD training and compliance
- E-Learning (EMS Coordination only)

Operations Managers are currently engaging with local teams who have expressed interest in implementing self-rostering for the upcoming festive period. February results will also be reviewed by local management teams during March.



**Response by Operations Service Area:**



**Staff wellbeing prioritised during a significant period of change via CMT programme while addressing both Trust-wide themes and local service priorities. Key areas of focus included:**

- Emotional wellbeing status
- NHS Wales Staff Survey
- CMT Programme
- Infection Prevention and Control
- Overruns and Shift Start and Finish SOP
- Statutory and Mandatory Training including MIST
- Compliance
- Communication
- Ambulance Care Capacity Management Plan and
- Performance Standards
- Christmas Planning
- Sexual Safety
- Continuous Professional Development
- Work environment and support
- Wellbeing impact and resources

**Feedback gathered during these sessions is actively shaping local action plans and informing national programmes:**

- 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.
- Christmas dinners and voucher scheme (funded via the Welsh Ambulance Charity).
- Team based self roster during the festive period.
- Training needs around sexual harassment reporting.
- CPD opportunities and development
- Staff resilience and wellbeing support

Additional priorities included strengthening awareness of key guidance and legal requirements, such as seatbelt use and the Shift Start and Finish SOP.


**Continuous feedback regarding impact of communication challenges, particularly difficulties navigating Siren to find essential information and documents.**

**\* Feedback from February and March relating to CPD and staff wellbeing support is currently under review with relevant corporate teams.**


**Key Outcomes:**

- **50 follow-up conversations held with staff requesting additional support.**
- **18 staff without a completed PADR have now either completed one or have a date scheduled**
- **Over 80% of EMS response staff engaged in November reported that the current MIST training programme is beneficial to their role and support replacing CPD hours with dedicated rostered training days for MIST and pre-planned CPD.**
- **64% of EMS response staff engaged in November reported an improvement in overruns over the past 12 months and indicated that the Start & Finish SOP is effective in improving end-of-shift finishes and reducing overruns.**
- **92% of staff working core Christmas shifts reported sufficient management support to escalate issues when required.**
- **72% staff whose teams implemented Christmas self-rostering reported that it worked 'Extremely/Very Well'.**
- **93% of staff who opted in to answer questions relating to sexual harassment in February indicated being very confident/confident in identifying and understanding sexual harassment in the workplace (14/379 staff opted out of answering questions).**
- **93% of staff in March reported they feel supported by their team and line manager**

## APPENDIX A – Resource Department Culture Themes



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### Resourcing Team Listening Exercise Theme Summary

**How we treat and interact with each other**

- Teamwork, humour and pride in the service are clear strengths.
- Cultural experiences differ, some colleagues feel excluded or unable to speak up.
- Everyone can help build a more inclusive culture by noticing who's left out and encouraging positive behaviours.



**How we experience leadership and management**

- Many people experience their managers as supportive valuing regular check-ins and team meetings.
- Leadership can feel inconsistent across sites, with unclear decisions, formal or fragmented communication and avoided difficult conversations.
- Everyone can strengthen the culture by communicating clearly, giving constructive feedback and supporting one another, regardless of role.



**How we communicate and feel heard**

- People generally feel comfortable sharing ideas and staying connected through natural, informal communication.
- Feedback doesn't always lead to visible action, leaving some unsure whether their voice matters and sometimes creating tension.
- Everyone can support better communication by checking understanding, sharing information and raising ideas constructively.



**How our workload, systems and pressures affect us**

- There is a strong can-do attitude, with teams pulling together under pressure and committed to delivering quality work.
- However, uneven workloads, duplicated systems and deprioritised meetings create frustration and leave little time for improvement.
- Teams can help by raising issues early, sharing ideas, supporting one another and collaborating on small, achievable improvements.



**How trust and fairness feel in our hybrid ways of working**

- Employees value flexible hybrid work, in-person collaboration and the trust to manage their own time.
- Challenges arise from inconsistent hybrid experiences, perceptions of monitoring or autonomy and assumptions about productivity, creating tension and mistrust.
- Focusing on contributions rather than work location and challenging unhelpful assumptions can improve trust and collaboration.



**How supported, included and able to grow we feel**

- Peer support and care within the team are strong, especially during busy or pressured times.
- Challenges include inconsistent access to wellbeing support, uneven development opportunities and managers needing more guidance on complex people issues, affecting morale and retention.
- Fostering an inclusive environment, offering support, mentoring, and creative development opportunities can improve confidence, growth and team wellbeing.



**Thank you for your honesty, engagement and commitment - let's continue improving together.....**



**OUR WAST WAY**  
HOW WE LEAD TO BE OUR BEST





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Agenda Item No.

07.1

## REPORT TITLE

Putting Things Right Report Quarter 4 (January - March 2026)

## MEETING

Name of meeting	Quality, Patient Experience & Safety Committee
Date of meeting	7 May 2026
Public or Private	Public
If private - <a href="#">rationale</a>	n/a

## REPORT SPONSOR

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

## PURPOSE OF REPORT

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

## REPORT SUMMARY

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

1. This report provides assurance to the Quality, Patient Experience and Safety Committee on the Trust's performance, compliance and risk position within the Putting Things Right (PTR) and Legal Services portfolio for Quarter 4, 2025/26. It confirms that core statutory and regulatory responsibilities have improved during a period of sustained operational pressure, while recovery actions continue to strengthen assurance and sustainability.



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2. External assurance remains stable. One Public Services Ombudsman for Wales Report was received during the quarter, and all Regulation 28 Prevention of Future Death responses were submitted within required timescales. While the Welsh Risk Pool Annual Assessment is ongoing, an NHS Wales Performance Review identified specific risk themes relating to Nationally Reportable Incidents (NRIs). A proportionate organisational response is in development, with further assurance to be provided to the Committee in the next reporting cycle.
3. The Concerns Management Improvement Programme has delivered demonstrable improvements, and this is captured in a separate paper.
4. Overall, the report provides assurance that risks are understood, mitigation is in place, and recovery actions are delivering measurable improvement, while clearly setting out the areas requiring continued Committee oversight to support long-term sustainability and organisational learning.

## 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; and
2. Receive assurance regarding current compliance and recovery progress and note areas requiring continued Committee oversight to support sustainable improvement and statutory assurance.

## 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 4, 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](#)]

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

## RISK(S) THIS REPORT MITIGATES

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

Risk ID: Currently as Directorate Risk - *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

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

Quality Enablers

<input checked="" type="checkbox"/> Leadership	<input checked="" type="checkbox"/> Workforce	<input checked="" type="checkbox"/> Culture
<input checked="" type="checkbox"/> Information	<input checked="" type="checkbox"/> Learning Improvement & Research	<input checked="" type="checkbox"/> Whole Systems Approach

## WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

<input type="checkbox"/> A socially responsible and inclusive employer	<input type="checkbox"/> An innovative and sustainable organisation	<input checked="" type="checkbox"/> A pro-active, accessible and equitable care provider
<input checked="" type="checkbox"/> n/a	<input checked="" type="checkbox"/> n/a	<input type="checkbox"/> n/a

## IMPACT ASSESSMENTS FOR CONSIDERATION

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

Does this paper require an impact assessment	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
--	--

## APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
29 April 2026	Executive Leadership Team



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NHS  
WALES

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Welsh Ambulance Services  
University NHS Trust

## SITUATION

1. This Putting Things Right Report covers the period from 1 Jan – 31<sup>st</sup> March 2026. This report covers the PTR functions which broadly include:
  - Patient Safety (proactive & reactive), including Low harm and near-miss reporting
  - Complaints management and resolution
  - Ombudsman relationships, information sharing, reports, and responses
  - Coroner relationships, information sharing, reports, and responses
  - Redress management
  - Claims management, including clinical negligence, personal injury, road traffic accident and damage to property
  - Organisational learning (including Learning from Events and Welsh Risk Pool submissions)
  - The PTR and Legal Services Team also lead the learning from mortality agenda. This is covered in detail within the separate twice-yearly Learning from Mortality Report to this Committee.

## BACKGROUND

2. The Report consists of 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

#### (i) External Assurance

During the last quarter:

3. The Trust has had 7 cases opened by the Public Services Ombudsman for Wales (PSOW) (compared to 13 last quarter). Eleven cases have been closed without investigation and one case resulted in a final Section 27 Report (non-public interest) with the main element of the concern not upheld. This demonstrates positive external assurance regarding the quality of investigations and responses in the majority of compliant cases.
4. The Trust has received two Regulation 28 Prevention of Future Death Reports in the last quarter. The content and learning from these Reports are presented in the Learning from Death paper. Both Reports were responded to by the Trust within the 56-day timescale.
5. The Welsh Risk Pool (WRP) Annual Assessment remains ongoing with evidence gathering still underway.
6. As part of routine monitoring a focussed Assessment Report was shared with the Trust that had been completed by NHS Wales Performance and Improvement (P&I) Quality and Safety Team. The Assessment reviewed NRI Outcome Forms which were coded Delay in Treatment (control room). There is a follow up meeting with NHS P&I early May to discuss the content of their findings.
7. An Assurance Report will then be provided to the Trust's Executive Leadership Team (ELT) for endorsement. Quality, Patient Experience & Safety Committee members will be duly appraised in next quarter's report.



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## (ii) **Internal Assurance**

### **Concerns Management Improvement Programme**

8. A Concerns Management Improvement Programme Proposal was developed and endorsed by the ELT in response to sustained operational changes and pressure that had negatively impacted the Trust's ability to meet statutory and regulatory requirements under the Putting Things Right (Concerns) Regulations, including complaints handling and patient safety investigations. This work is addressed in a separate report.
9. The ongoing operational management of the concerns management function has now transferred back to business-as-usual governance and operational structures, including the Quality Management Group and the Clinical and Quality Governance Group.

### **Compliance**

10. Performance against the 5 working day Welsh Government target to register and acknowledge complaints has improved back to 100% and sustained over a 2-month period. This provides the complainant with assurance that their concern has been received and is being addressed.
11. Monthly compliance figures for providing concerns responses within 30 working days are recovering but as a lagging metric, will likely demonstrate the impact of recovery improvement over the coming quarter. This has resulted in more complainants receiving a response in a more timely manner.
12. The Trust's Patient Safety Team have provided Duty of Candour written notification letters within 5 working days of contact for every case where successful contact was made.
13. The Trust has only one overdue Learning from Events Report requiring submission. This will be addressed in the coming month. Patient safety and clinical negligence learning evidence is largely been approved on first submission, with a small number of Amber deferred cases. The Trust is still developing its maturity with personal injury learning submissions and the



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number of deferred cases in this area is being closely monitored by the (Acting) Head of Health and Safety.

14. The number of overdue Inquest Statements has been monitored as an adjunct to the main PTR Recovery Task and Finish Group, as shown below. Whilst there has been a 50% reduction in overdue statements, continued improvement has stagnated. Service Leads report having to reallocate resources to focus on recovery efforts and having less available capacity to sustain improvements. This capacity-driven limitation will need to be addressed through Phase 3 of the Concerns Management Improvement Programme.

### **Assurance profile**

15. The number of incidents being finalised and closed on the Datix system continues to be an area of concern and challenge, with teams reporting the same necessity to deprioritise this work to complete complaint and NRI investigations.
16. The volumes of complaints received demonstrates a significant upwards shift since last year. Complaint volumes in 2025/26 were 50% higher than in 2023/24 when the last investment was made into the PTR and Legal Department. This figure does not include the volume of non-patient specific enquiries to the Trust, largely on safety grounds (144 cases during 2025/26 compared to 26 during 2023/24), an area of work that is also growing.
17. Following the departure of the Trust's Solicitor/Claims Manager, the Trust has begun utilising the services of NHS Wales Shared Services Partnership's Legal and Risk Team. The transition period is being managed carefully and has been an intense period for staff in the Legal Services Team in transferring case records and familiarising themselves with Referral Pathways.
18. Staff across the Trust involved in claims and inquest work have felt the loss of having dedicated and bespoke legal support with a clear understanding of the Welsh Ambulance Services Nhs Trust's unique service delivery processes and organisational memory. To provide assurance to the Committee that the Legal Team are engaging with Welsh Legal and Risk Service as appropriate.



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19. Absence across the PTR and Legal Services has remained high during the final quarter of the year but the increasing organisational focus on this area of work has been helpful in improving morale and, alongside natural recovery from periods of sickness.
20. Attendance is anticipated to improve during Quarter 1, 2026/27, although sustained monitoring will continue.

## **LEARNING AND IMPROVEMENT**

21. The Trust's Serious Case Incident Forum has noted a theme of near-miss incidents relating to property access and an opportunity to improve inter-agency partnership working to ensure efficient use of resources and a timely response for patients in need. There has been clarification and learning in relation to access and inter-agency roles for these types of incidents.
22. From 1 April 2026 a trial arrangement is in place whereby Fire and Rescue Service are the primary agency for gaining entry to properties. Police attendance is reserved for situations where a crime scene is suspected or where there is a clear risk or threat to staff safety. In addition, a police contractor will be responsible for securing properties once entry has been gained, which any service can contact to organise.
23. This development is linked to the 'Right Care, Right Person' initiative and aims to provide clearer role delineation and reduce delays and uncertainty around access, particularly for non-mental health presentations. Learning has centred on ensuring early identification of the most appropriate partner agency, improved escalation via control and Duty Managers, and reinforcing that ambulance services do not hold powers of entry.

### **National Reportable Incidents**

24. The incidents that have been reported as NRIs this quarter related to:
  - Non-clinical call management - Insufficient efforts to obtain patient contact details, incorrect MPDS protocol selection and call categorisation



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- Remote clinical care - inadequate remote clinical assessment (poor exploration of low O2 sats and cyanosis, poor exploration of ABC status), non-compliant to call categorisation protocols
- Clinical care - incorrect route medication (adrenaline given IV instead of IM); delay in requesting the Police to attend to assist with entry to property

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

25. In parallel to the PTR Recovery Workstream, the Listening to People Workstream delivered the core requirements to enable the Trust to successfully implement the legislation from 1 April 2026. This included documentation updates, targeted training delivery, digital readiness through Datix Cymru configuration, and stakeholder communications.
26. While the Trust was broadly ready for implementation, several elements, particularly relating to Policy development and wider roll of training, were unable to be fully completed due to the late issue of National Guidance and have therefore been carried into Phase Two.
27. Until National Key Performance Indicators are confirmed, the Trust's ability to provide standard performance reporting and comparative assurance under the new regulations remain limited. Interim local monitoring arrangements are therefore in place to maintain oversight pending the national performance metrics being approved and released.

### **RECOMMENDATION**

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

### **NEXT STEPS**

29. Operation of the Concerns Management Improvement Programme Board and subsequent assurance and escalation to ELT and Strategic Transformation Board remain in place to provide greater transparency with regards to oversight of delivery against Programme objectives.

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# PTR & Legal Services – Quarterly data



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PTR & Legal Services – Quarterly data  
Q4 2025-26

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by Claire Appleton  
Assistant Director of Concerns, Patient Safety and  
Legal Services

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

## **Assurance Profile**

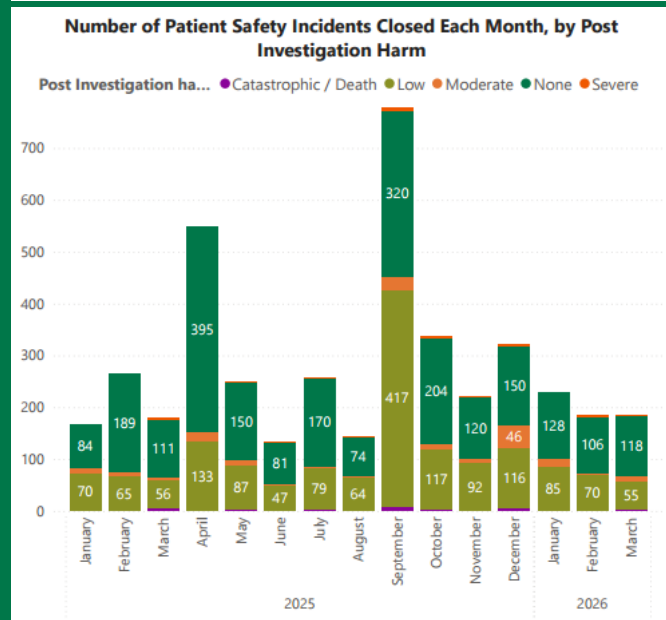
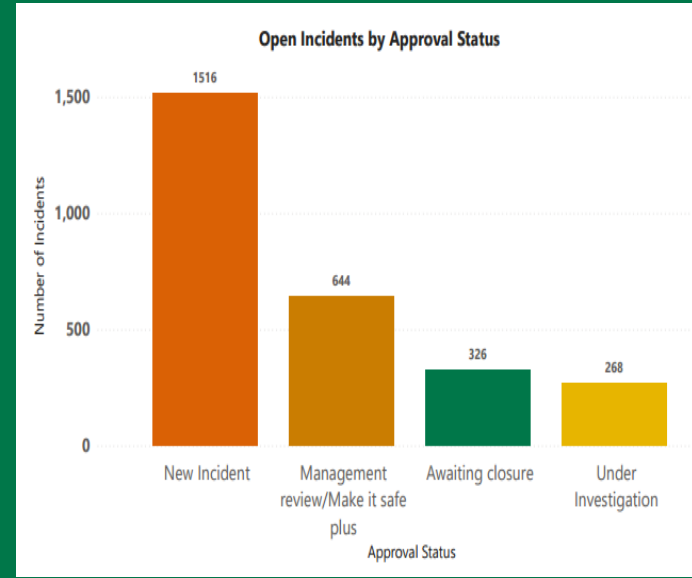
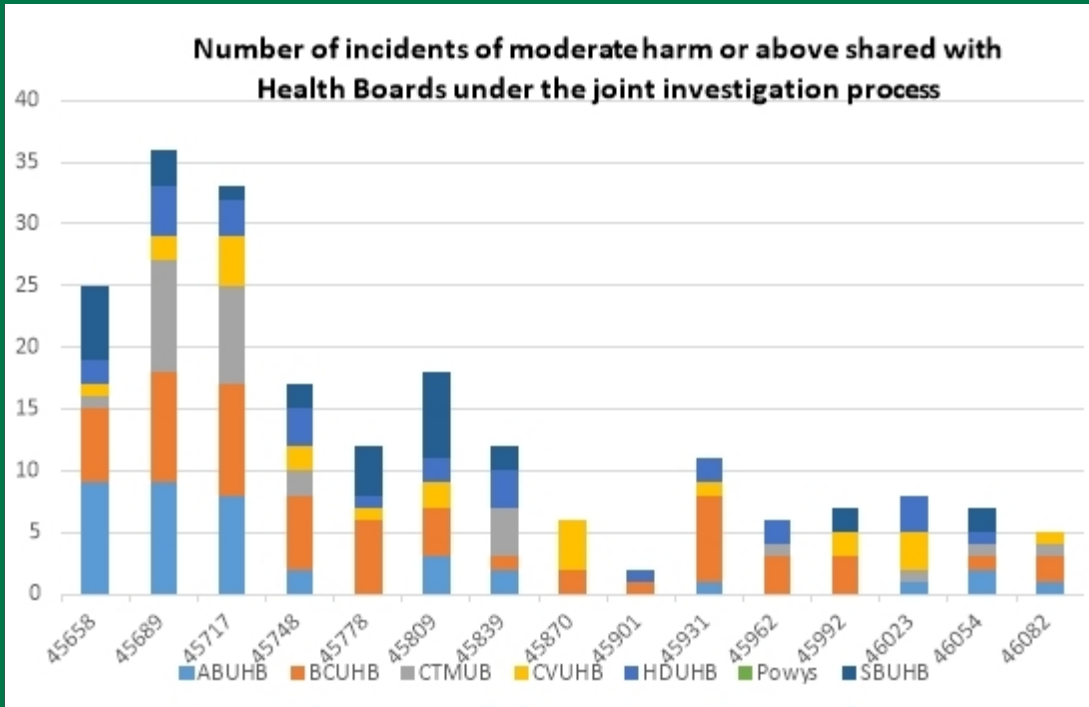
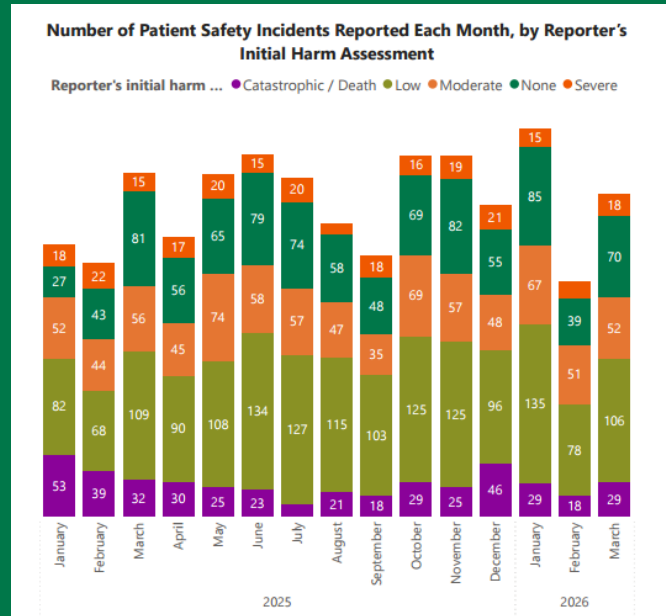
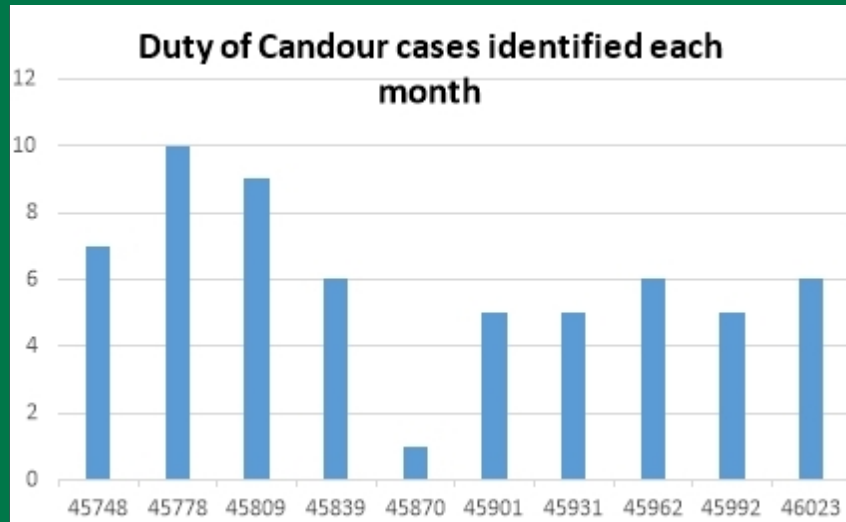
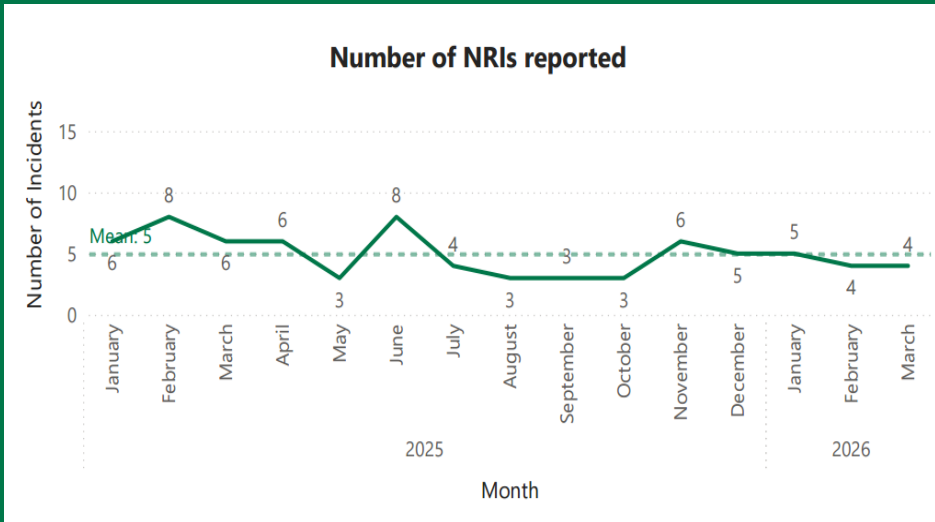
- *what does our PTR & Legal Services data tell us about quality and safety in the Trust?*
- *how effectively are we managing the Putting Things Right & Legal Services functions?*

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.

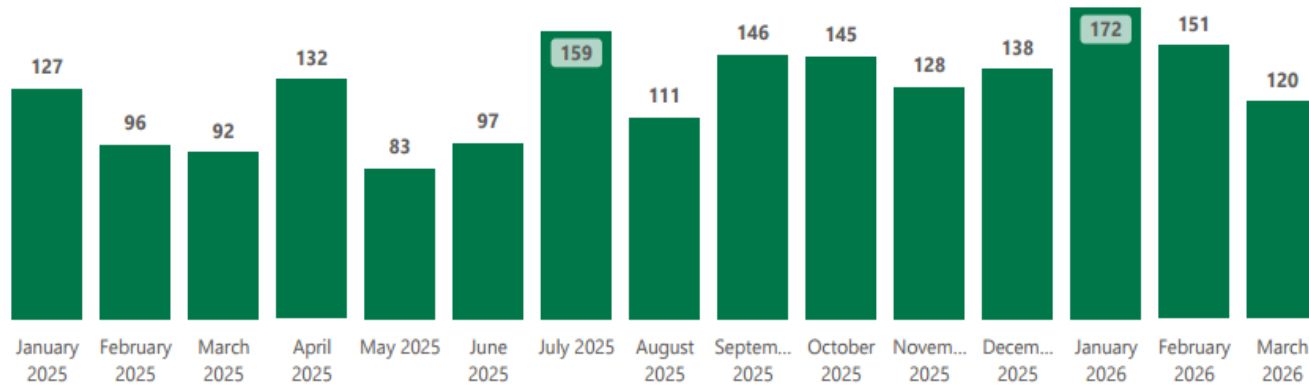


# Assurance Profile – Incidents & Duty of Candour

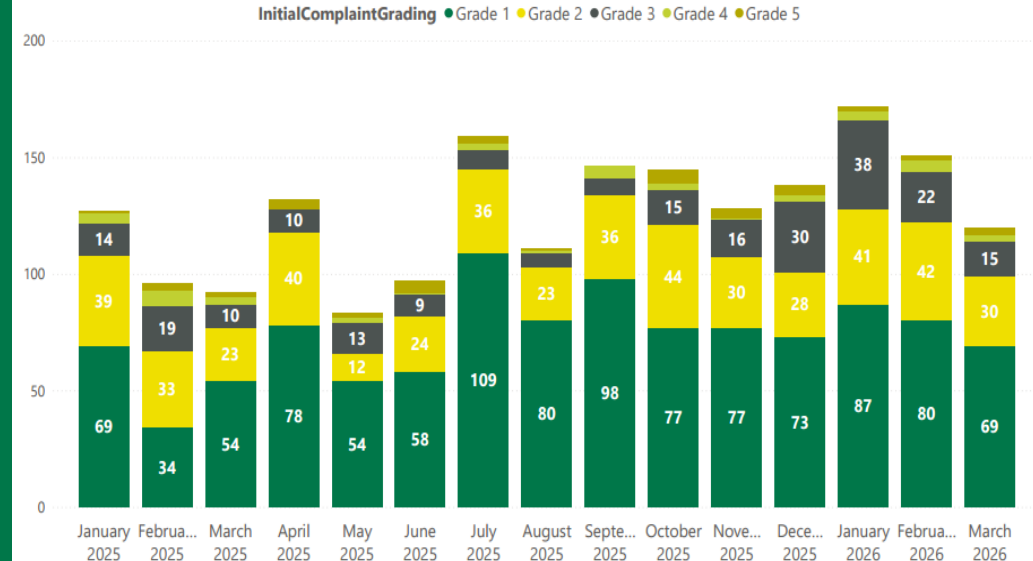


# Assurance Profile – Complaints

Number of Complaints Received (Including Early Resolution)

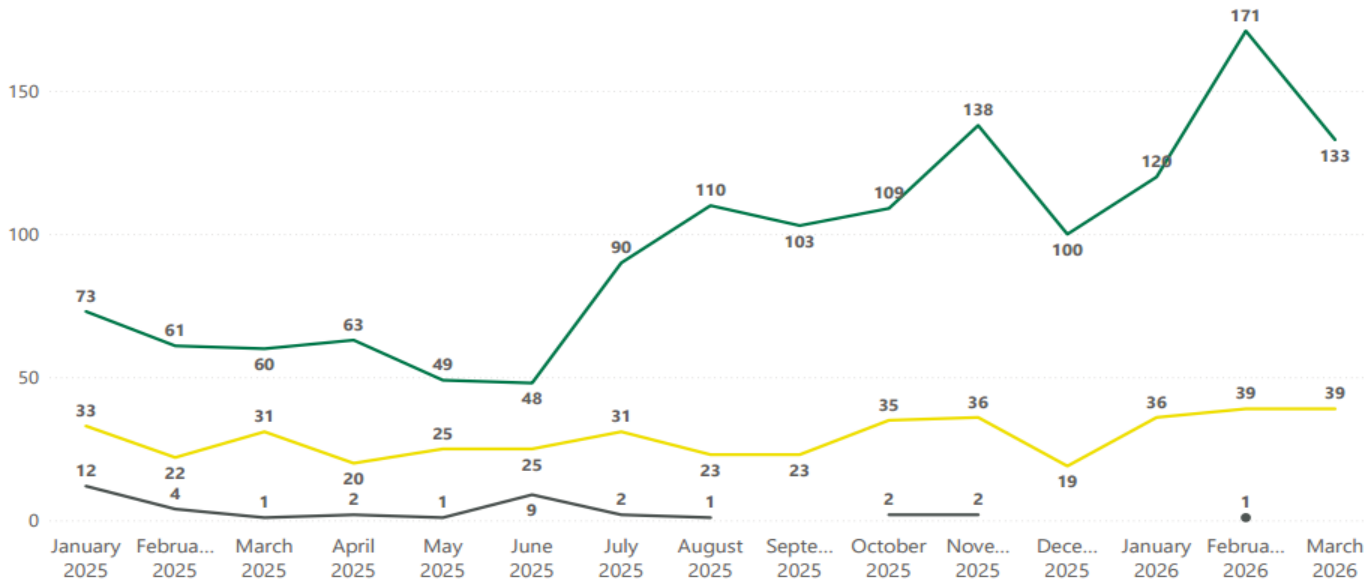


Number of Complaints Received (incl re-opened ),by initial complaint grading.

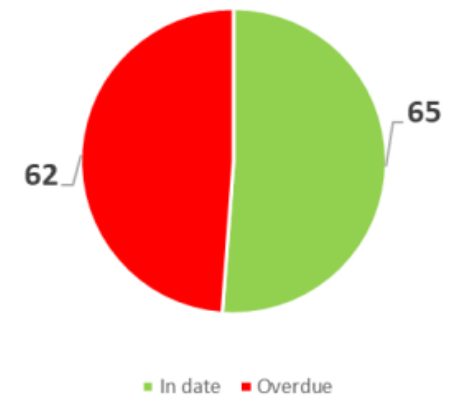


Number of complaints closed by final outcome.

Outcome ● Not upheld ● Upheld ● Withdrawn



Open Complaints profile

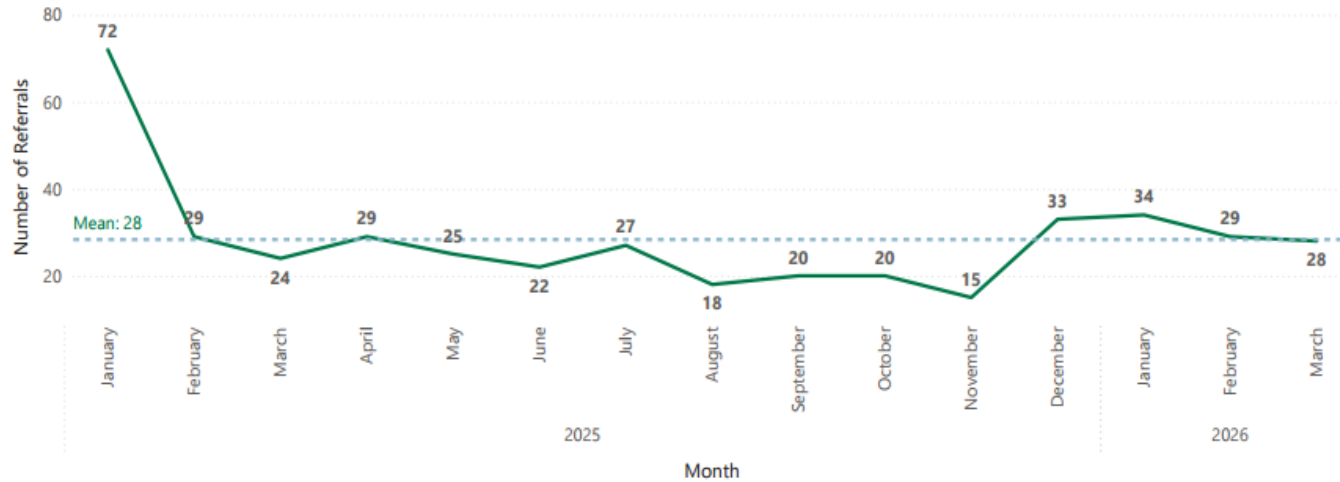


# Assurance Profile –Legal Services

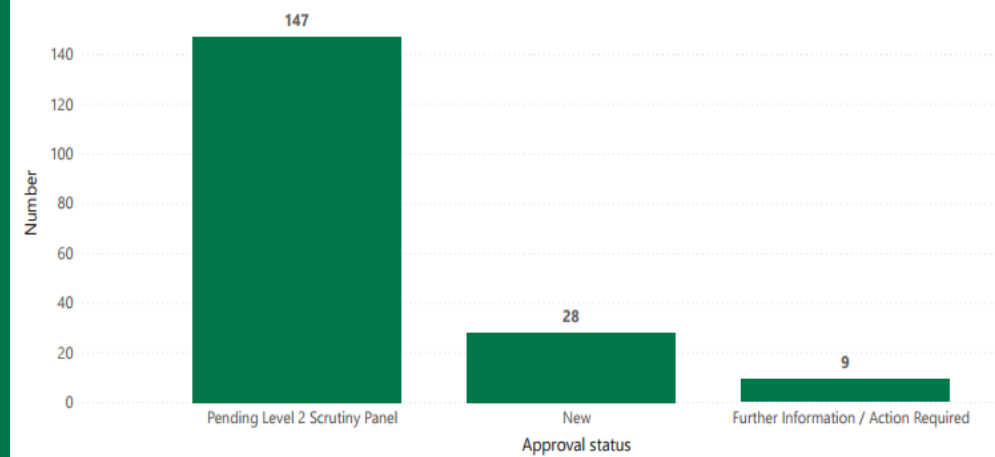
		Jan-25	Feb-25	Mar-25	Apr-25	May-25	June25	July-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec -25	Jan - 26	Feb -26	Mar- 26
Claims opened	Personal Injury (PI)	4	2	2	5	1	3	2	0	0	0	1	0	0	0	1
	PI Road Traffic Accident	2	0	1	1	0	0	1	0	0	1	0	0	0	0	4
	Clinical Negligence	1	4	3	5	4	4	5	4	6	3	1	1	1	4	6
	Road Traffic Accident	23	11	19	21	17	28	22	19	10	15	14	13	15	15	18
	Damage to property	3	3	3	7	6	2	4	4	8	9	13	5	5	2	2
Claims closed	Personal Injury (PI)	9	2	0	--	30	9	3	2	8	1	0	1	0	0	4
	PI Road Traffic Accident	8	0	0	--	9	1	0	0	6	1	0	1	0	1	3
	Clinical Negligence	1	1	10	6	3	3	1	2	29	1	1	1	0	9	10
	Road Traffic Accident	12	27	11	--	39	58	51	12	22	26	21	15	8	5	52
	Damage to property	2	5	5	--	6	11	8	2	9	10	6	7	6	5	5
Claims open at the end of the month	Personal Injury (PI)	73	73	75	88	50	60	62	60	50	50	51	50	50	50	45
	PI Road Traffic Accident	45	45	46	46	37	44	46	46	39	42	41	40	40	39	33
	Clinical Negligence	186	189	178	174	176	177	181	183	161	161	161	160	161	156	152
	Road Traffic Accident	227	217	225	240	205	196	175	184	175	162	156	155	169	177	125
	Damage to property	15	18	16	19	13	10	9	12	11	9	17	14	12	10	9
		<b>546</b>	<b>542</b>	<b>540</b>	<b>567</b>	<b>486</b>	<b>487</b>	<b>473</b>	<b>485</b>	<b>436</b>	<b>424</b>	<b>426</b>	<b>419</b>	<b>432</b>	<b>432</b>	<b>366</b>

# Assurance Profile – Mortality Governance

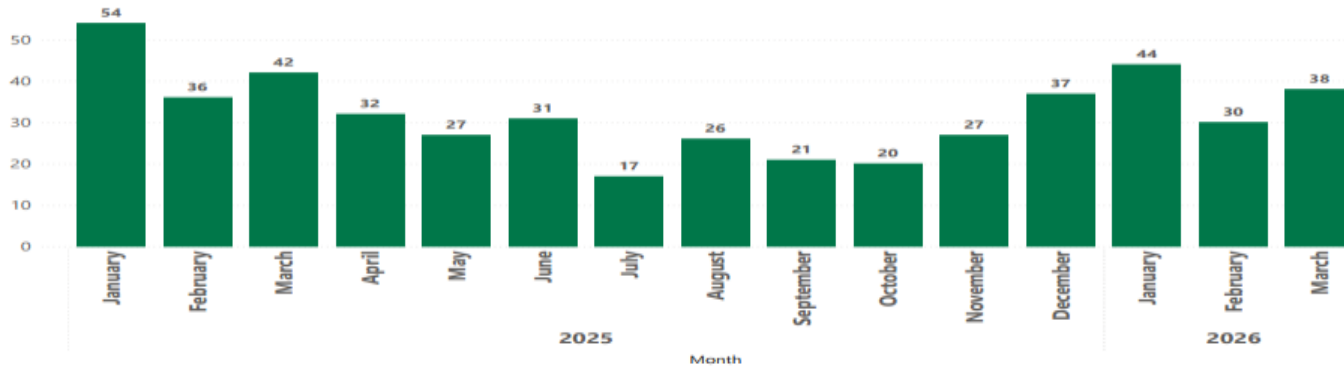
Number of Medical Examiner referrals by the Date of ME Scrutiny Summary



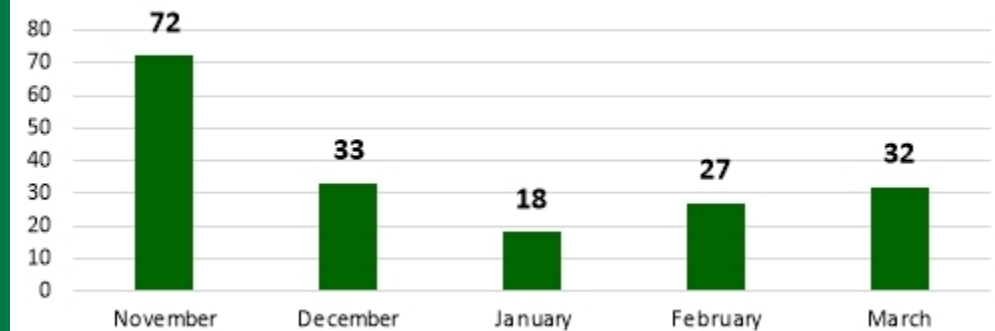
Medical Examiner referrals by Approval Status



Number of Coroner Approaches by Month



Overdue Coronial statements



## Key priority areas

- Reduce Level 2 Scrutiny Panel backlog (147 pending)
- Reduce overdue coronial statements
- Increase ME scrutiny throughput and close action items



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Agenda Item No. 07.2

## REPORT TITLE

Putting Things Right / Concerns Management Programme Progress Report April 2026

## MEETING

Name of meeting	Quality, Patient Experience and Safety Committee
Date of meeting	07 May 2026
Public or Private	Public
If private - <a href="#">rationale</a>	n/a

## REPORT SPONSOR

Executive sponsor	Penny Durrant, Deputy Director of Nursing, Quality & Governance
Author(s) of report	Julie Boalch, Assistant Director of Corporate Governance & Risk Penny Durrant, Deputy Director of Nursing, Quality & Governance

## PURPOSE OF REPORT

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



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## REPORT SUMMARY:

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

### **Programme progress and governance oversight**

1. The Strategic Transformation Board (STB) considered the Putting Things Right / Concerns Management programme update at its meeting on 28 April 2026. Whilst progress has been made during the recovery period, including backlog reduction and strengthened oversight, the programme remains under close executive scrutiny. Oversight has now transitioned to a more structured assurance approach, with STB providing primary governance of delivery, risk and sustainability.

### **Phase 1 (Recovery) closure**

2. Notwithstanding this progress, STB confirmed that assurance cannot yet be provided across several key areas. Proposed closure of Phase 1 (Recovery) was not supported, with five of seven indicators remaining off target, including measures with zero tolerance. Members were clear that improvement in trajectory alone is insufficient, and that phase closure must be based on demonstrable delivery against agreed outcomes.
3. Digital readiness was also not accepted as complete. Whilst elements of implementation have progressed, ongoing system dependencies, data limitations and further process redesign are required. This indicates that digital and operational readiness for the Listening to People regulations remains in development rather than fully assured.

### **Absence of trajectories and forward look**

4. The STB was not assured by the absence of a clear trajectory noting that current graphs and commentary do not show how off-track indicators will improve, over what timescale, and when delivery against target is expected to be achieved.
5. A clear trajectory and forward-looking analysis has been requested to support assurance regarding recovery, sustainability and expected timelines for delivery.

### **Sustainability, capacity and governance expectations**

6. The STB identified a lack of assurance in relation to sustainability following the cessation of overtime and additional recovery capacity, particularly in understanding the impact on performance and the associated risks to sustaining improvement.



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7. Assurance is dependent on data being internally validated and robust. Where this cannot be demonstrated, reporting timelines to QuEST and Board may require adjustment to ensure the integrity of assurance provided.
8. Since commencement of the recovery programme, good progress has been made across backlog reduction and wider programme delivery, including improvements in complaint handling performance, strengthened governance oversight and increased executive scrutiny. This has enhanced organisational visibility and control and provides a stronger platform for ongoing improvement. As the programme matures, it has also highlighted the importance of ensuring that these gains are supported by sustainable arrangements, particularly in the context of increasing complaint volumes, legal pressures and expanded statutory responsibilities, which require the operating model to continue to evolve.
9. The remaining open actions therefore relate less to recovery activity and more to assurance of sustainability. These include delivery of full digital functionality, strengthened management intelligence, clearer performance trajectories, and assurance that existing capacity, resource and governance arrangements remain sufficient to safely manage current and projected demand. Executive oversight is therefore focused not simply on returning metrics to target, but on ensuring the Trust is operating with a model that is sustainable, defensible and capable of meeting future regulatory expectations under the new Listening to People framework.
10. Phase 3 of the Concerns Management Programme will focus on providing longer-term assurance, shifting from recovery activity to confidence in a sustainable operating model. This will include review of service design, capacity assumptions, digital maturity, governance ownership and organisational learning to ensure improvements are sustained rather than reliant on temporary measures such as overtime or short-term support. The key assurance question is therefore no longer solely whether backlog recovery can be achieved, but whether the concerns management model is fit for purpose and capable of meeting future regulatory expectations.
11. At the point of reporting, executive oversight recognises that progress has been made across Phase 1 delivery, with a number of actions completed and improved governance and control arrangements established. A smaller number of priority areas remain in progress, particularly in relation to digital maturity, trajectory planning, sustainable capacity and regulatory readiness, and these continue to receive focused oversight.
12. The programme is moving in a positive direction; however, further evidence is required to demonstrate that improvements are consistently delivered and sustained over time. Phase 1 closure will therefore be determined by achievement of agreed outcomes, rather than improvement in trend alone.



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## Reporting approach and next steps

13. Future reporting will provide clearer trajectories and forward-looking analysis, setting out how and when performance is expected to return to target. This will include reassessment of Phase 1 closure against agreed outcomes, clarification of digital readiness, and confirmation that deliverables are only closed once intended outcomes are achieved, supporting a more robust basis for assurance.

## RECOMMENDATION(S)

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

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

1. Note the current position of the PTR / Concerns Management programme;
2. Receive assurance regarding progress made during the recovery period;
3. Note that further evidence is required to demonstrate sustained delivery, particularly in relation to digital maturity, sustainability and trajectory planning; and
4. Support continued executive oversight of the programme until improvements are demonstrated as embedded and sustained.

## ADDITIONAL PAPER(S)

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

n/a



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

## STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

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

## RISK(S) THIS REPORT MITIGATES

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

PTR recovery risk  
Listening to People regulations risk

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

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

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

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

<input checked="" type="checkbox"/> Leadership	<input checked="" type="checkbox"/> Workforce	<input checked="" type="checkbox"/> Culture
<input checked="" type="checkbox"/> Information	<input checked="" type="checkbox"/> Learning Improvement & Research	<input checked="" type="checkbox"/> Whole Systems Approach

## WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

<input checked="" type="checkbox"/> A socially responsible and inclusive employer	<input checked="" type="checkbox"/> An innovative and sustainable organisation	<input type="checkbox"/> A pro-active, accessible and equitable care provider
<input type="checkbox"/> n/a	<input type="checkbox"/> n/a	<input type="checkbox"/> n/a

## IMPACT ASSESSMENTS FOR CONSIDERATION

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

Does this paper require an impact assessment  No  Yes

If yes, what impact assessment is attached

## APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
28 April 2026	Strategic Transformation Board
29 April 2026	Executive Leadership Team



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Agenda Item No.

08

## REPORT TITLE

Monthly Integrated Quality Performance Report – March 2026

## MEETING

Name of meeting	Quality, Patient Experience and Safety Committee
Date of meeting	7 May 2026
Public or Private	Public
If private - <a href="#">rationale</a>	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

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



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## REPORT SUMMARY:

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

1. The purpose of this report is to provide senior decision makers in the Trust with an integrated dashboard (Our Patients, Our People, Value and Partnerships/System Contribution) focused on the "vital few" key metrics. This report is for March 2026.
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 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 were implemented as scheduled on 1 July 2025. Early performance data indicates that the Arrest category is operating within the expected target range; however, Emergency performance remains outside the desired thresholds. On 2 December, the second phase of the New Ambulance Performance Framework went live. This phase removed the previous Amber and Green categories and introduced three new classifications: Orange (Now), Yellow (Soon), and Green (Planned). Analysis of the first two months following implementation shows that Orange (Now) median response times, including call-to-door intervals, are currently longer than expected and not meeting performance ambitions.
4. The Trust saw 16,469 hours lost to hospital handover during March 2026, compared to 21,852 lost hours in March 2024. This follows on from variations seen since June 2025 pan-Wales. Whilst reductions have been very welcome, they are 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.



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## RECOMMENDATION(S)

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

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

1. Consider the March 2026 Integrated Quality and Performance Report and actions being taken and determine whether:
  - a. The report provides sufficient assurance;
  - b. Whether further information, scrutiny or assurance are required; or
  - c. Further remedial actions are to be undertaken through Executives.

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

## RISK(S) THIS REPORT MITIGATES

Where relevant note the local, directorate, corporate or BAF risk number
<b>223</b> The Trust's inability to reach patients in the community causing patient harm and death
<b>224</b> 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
<b>100</b> 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) [ <a href="#">link to standards</a> ]		
<input checked="" type="checkbox"/> Safe	<input checked="" type="checkbox"/> Timely	<input checked="" type="checkbox"/> Effective
<input checked="" type="checkbox"/> Efficient	<input checked="" type="checkbox"/> Equitable	<input checked="" type="checkbox"/> Person Centred
Quality Enablers (select all that apply) [ <a href="#">link to standards</a> ]		
<input checked="" type="checkbox"/> Leadership	<input checked="" type="checkbox"/> Workforce	<input checked="" type="checkbox"/> Culture
<input checked="" type="checkbox"/> Information	<input checked="" type="checkbox"/> Learning Improvement and Research	<input checked="" type="checkbox"/> Whole Systems Approach

## WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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



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## IMPACT ASSESSMENTS FOR CONSIDERATION

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

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

## APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
29 April 2026	Hugh Bennett – Assistant Director Commissioning & Performance



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## SITUATION

1. The purpose of this report is to provide senior decision-makers within the Trust with an integrated dashboard (Our Patients, Our People, Value and Partnerships/System Contribution) focused on the "vital few" key metrics. This report is for March 2026.

## 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.
3. December's Board Development received a presentation on options for the MIQPR, based on feedback received from NEDs and Executives. The following actions were agreed:
  - a) To review the current set of KPIs against the Trust's strategic objectives, with a view to reducing the number of KPIs (the Trust will undertake the usual review against the IMTP and other changes in the health care system in Wales);
  - b) Disaggregate the MQIPR into committee specific KPIs, but retain the overall scorecard for each committee in order to avoid silo working and maintain an overall awareness of the Trust's operating context across its balanced scorecard;
  - c) Report by exception, so for the committee specific KPIs, only that that are off target will receive a narrative detailing what is causing the KPI to be off target and what is being done about it. For KPIs that are on target, graphs will be provided in an appendix with no supporting narrative;
  - d) Retain the balanced scorecard as a way of achieving strategic alignment in a quantitative form;
  - e) Seek to add a more predictive element to the reporting (this will take a period of time to achieve, but the Trust has a strong track record of forecasting & modelling);



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- f) Remove the use of upward/downward trend as a target and replace with agreed benchmarks/targets; and
  - g) A greater use of statistical process control charts, but agreement to empower the Trusts' analysts to determine the best way of visualising the data.
4. These changes will take place over a number of months, with full go live in Q1 + Q2, once the 2026-29 IMTP has been agreed and once the Trust is in a new financial year. Trust Board will also receive a report to its March meeting on a revised scorecard (set of metrics) and revised ambitions (benchmarks and ranges). This will then go live from 1 April 2026, with further work required with each committee during Q1 on their committee specific metrics. As a first step, the F&P report focuses on the KPIs for which it is the lead committee.

## ASSESSMENT

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

5. **Ambulance Response** (safety / patient experience): on 1 July 2025, the Trust's New Ambulance Performance Framework 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 March 2026, there were 934 purple calls to the ambulance service, around 2.65% of all calls, and 4,780 (Emerg) red calls, around 13.55% of all calls. The main measure for Purple Arrest calls is the Return to Spontaneous Circulation (ROSC) rate which was 22.5% in March 2026 compared to 19.8% in March 2025 with an underlying upward trend. Consideration is currently being given to what ambition should be set for this important metric, as part of Trust Board scorecard discussions.
6. The median response times for purple and red calls were 7 minutes 37 seconds and 9 minutes 25 seconds respectively, with the required range being 6- 8 minutes. Operations SLT received a report that identified two issues: 1) the deflection rate from RCS0 to Integrated Care is not behaving in the way the Trust anticipated and 2) the impact of handover lost hours on the Trust's capacity to respond. For 1) the Trust is reviewing whether some Emerg incidents in the RCS0 cohort should go straight to dispatch, therefore reducing the RCS0 demand, comparing old Red volumes with new Arrest/Emerg and consideration of whether further Clinical Navigator capacity is required to reduce the number of time outs. For 2) W45 is key. No issues of clinical or operational practice were identified.



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7. On 2 December, the second phase of the New Ambulance Performance Framework went live. Amber and Green categories were removed, and new Orange (Now), Yellow (Soon) and Green (Planned) categories were introduced for those patients needing a face-to-face response. The changes are designed to improve patient safety and patient outcomes by better stratifying patient demand. The March 2026 median response times for Now (Orange) was 1 hour 23 minutes and 53 seconds, which is higher than the Trust would want (there is no Welsh Government target for the median currently).
8. Traditionally, the main factors which affect response times are demand and capacity (recruitment and lost hours). EMS production has been good but has decreased slightly to 93% in March, and handover lost hours remained stable; 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.
9. As above, the level of lost hours to **handover outside Emergency Departments** remains a critical component of long waiting times and patient safety incidents. 16,469 hours were lost during March 2026; a 24.6% reduction compared to March 2025 and is the ninth lowest monthly figure since December 2021. Whilst this reduction is very welcome, there is variation across Wales, with Betsi Cadwaladr health board remaining high, with 7,054 hours being lost within the health board during February 2026. 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.



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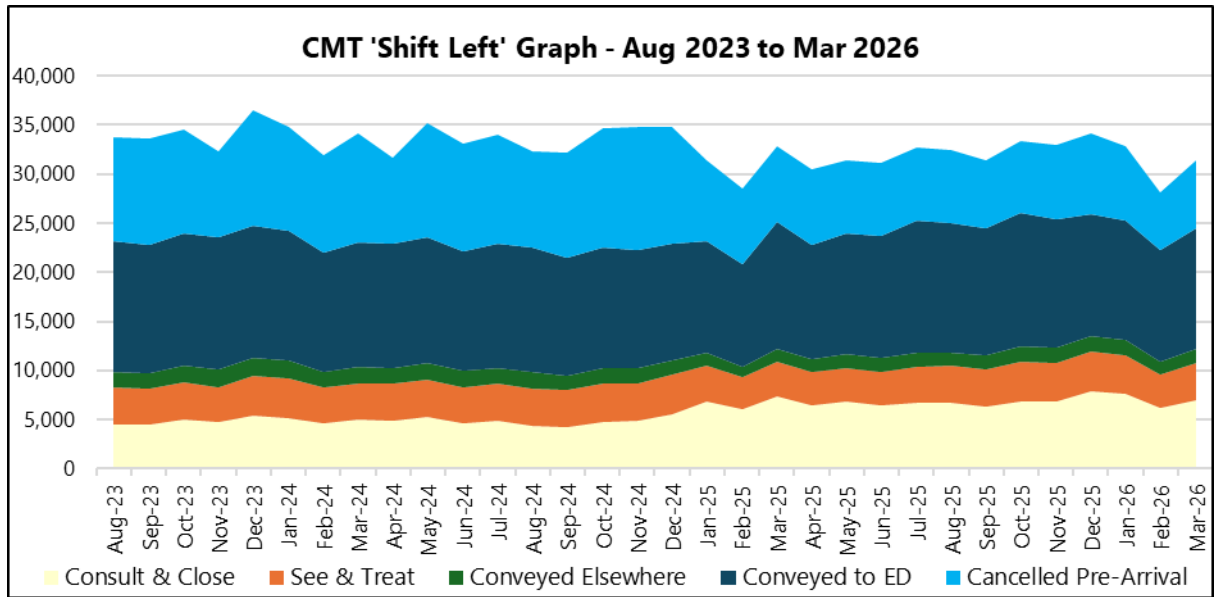
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10. **National Reportable Incidents (NRIs) / Concerns Response:** the Trust reported four NRIs to NHS Wales Performance & Improvement in March 2026, remaining stable with the previous month, and five serious patient safety incidents were referred to health boards under the Joint Investigation Framework. In March 2026 complaint response times improved to 70%, compared to the 57% recorded in March 2025, however, is 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.
11. **Clinical outcomes:** The percentage of suspected stroke patients who are documented as receiving an appropriate stroke care bundle was 89.7% in March 2026, slightly decreasing from March 2025 (91.6%), 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.
12. For March 2026, the Trust saw call to hospital door times of two hours and 15 minutes for stroke patients and two hours and thirty-seven 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.
13. In March 2026, 5,771 patients **cancelled** their ambulance (this figure excludes patients who refused treatment), which is a considerable reduction on previous levels and significantly compared to March 2025 (6,433). 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

14.



The graph focuses on the Trust’s ambition to allow more patients to be dealt with remotely, either without the need for a physical response or the need to convey. It highlights an improvement in both Consult & Close and See & Treat rates as well as a decline in the number of patient cancellations, thus reducing the unmet demand.

### RECOMMENDATION(s)

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

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# Monthly Integrated Quality & Performance Report

March 2026

Annex 1 – Top Indicator Dashboard



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Annex 1 – Top Indicator Dashboard  
Version 1.0  
April 2026

by Commissioning & Performance Team

# Section 1: Monthly Indicators / Top Indicator Dashboard



Top Monthly Indicators	Target 2025/26	Jan-26	Feb-26	Mar-26	2 Year Average	RAG	Top Monthly Indicators	Target 2025/26	Jan-26	Feb-26	Mar-26	2 Year Average	RAG
<b>Our Patients</b>							<b>Capacity</b>						
<b>Timeliness Indicators</b>							Hours Produced for Emergency Ambulances	95-100%	97%	96%	93%	93%	A
NHS111 Call Handling Abandonment Rates	<5%	14.0%	13.1%	15.2%	11.7%	R	Sickness Absence ( <i>all staff</i> )	<6%	8.72%	8.25%	7.47%	7.88%	R
111 Clinical Triage Call Back Time (P1)	>90%	87.3%	90.3%	92.4%	96.1%	G	Staff Turnover Rate	<10%	7.74%	7.78%	7.75%	8.18%	G
999 Call Answer Times 95th Percentile	00:06	00:06	00:12	00:03	00:21	G	Statutory & Mandatory Training	>85%	87.98%	88.73%	89.19%	86.02%	G
Arrest (Purple) Median	6-8 Minutes	07:08	06:49	07:37	N/A	G	PADR/Medical Appraisal	>85%	75.11%	73.52%	76.65%	74.33%	R
Emerg. (Red) Median	6-8 Minutes	09:33	08:54	09:25	N/A	R	Number of Shift OVERRUNS	<2,800	3,777	3,342	3,507	3,713	R
Now (Orange) Median	<30 Minutes	01:52	01:14	01:24	N/A	R	<b>Value</b>						
Oncology Journeys arriving within 45 mins and up to 15 minutes after appointment time	>70%	76.8%	78.9%	79.5%	76.6%	G	Financial balance - annual expenditure YTD as % of budget expenditure YTD	100%	100.00%	100.00%	N/A	100%	G
Advanced Discharge & Transfer journeys collected less than 60 minutes after booked time (NEPTS)	>90%	78.9%	74.4%	77.6%	78.7%	R	EMS Utilisation Metric (CHARU)	30%	30.5%	28.1%	29.2%	28%	A
<b>Clinical Outcomes / Quality Indicators</b>							Average Jobs per Shift (All Vehicles)	2.73	2.68	2.71	2.75	2.52	A
Return of Spontaneous Circulation (ROSC)	>25%	23.4%	21.4%	22.5%	21.1%	A	NEPTS on the Day Cancellations		15.6%	14.8%	14.7%	14%	
Stroke Patients with Appropriate Care	>95%	89.5%	87.7%	89.7%	88.5%	A	<b>Partnerships / System Contribution</b>						
Stroke Call to Hospital Door Times	Under Review	02:56	02:21	02:15	02:26		<b>CMT</b>						
ST-Elevation Myocardial Infarction (STEMI) with Appropriate Care	>95%	76.6%	73.2%	78.2%	68.9%	R	Successful Consult & Close Outcome	>22%	20.8%	19.6%	20.0%	17.5%	R
National Reportable Incidents reports (NRI)		5	4	4	4		No of Handovers over 45 mins	Zero	5,549	4,564	4,791	5,880	R
Can't Send & Cancelled by Patient Volumes	<6000	6,352	4,806	5,771	7,387	G	Number of Handover Lost Hours	<7500	19,243	14,957	16,469	18,717	R
Concerns Response within 30 Days	>75%	60%	59%	70%	62%	R							
Enactment of the Duty of Candour Total		6	6	5	5								

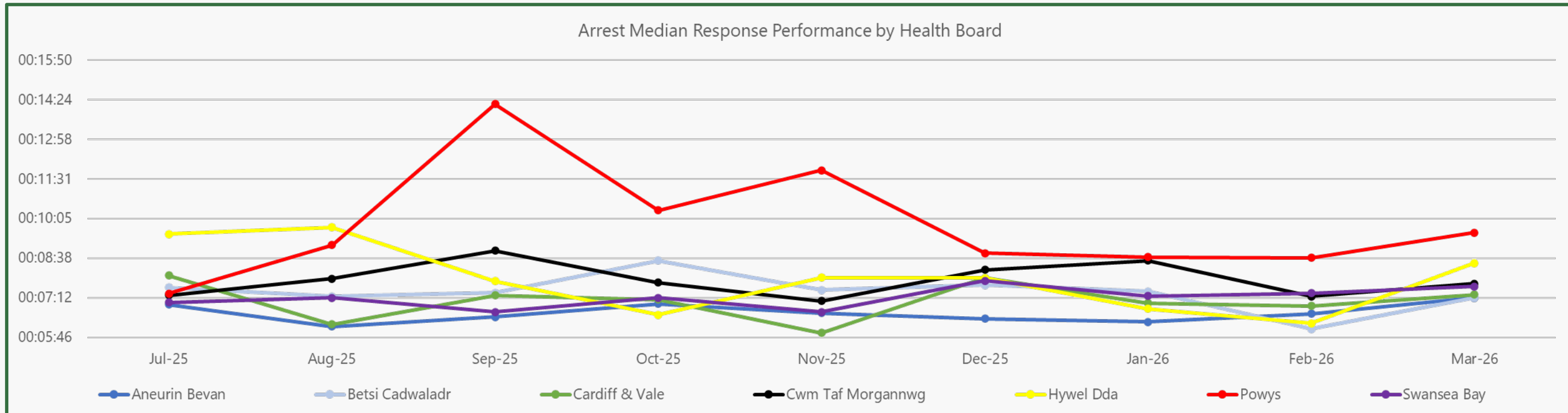
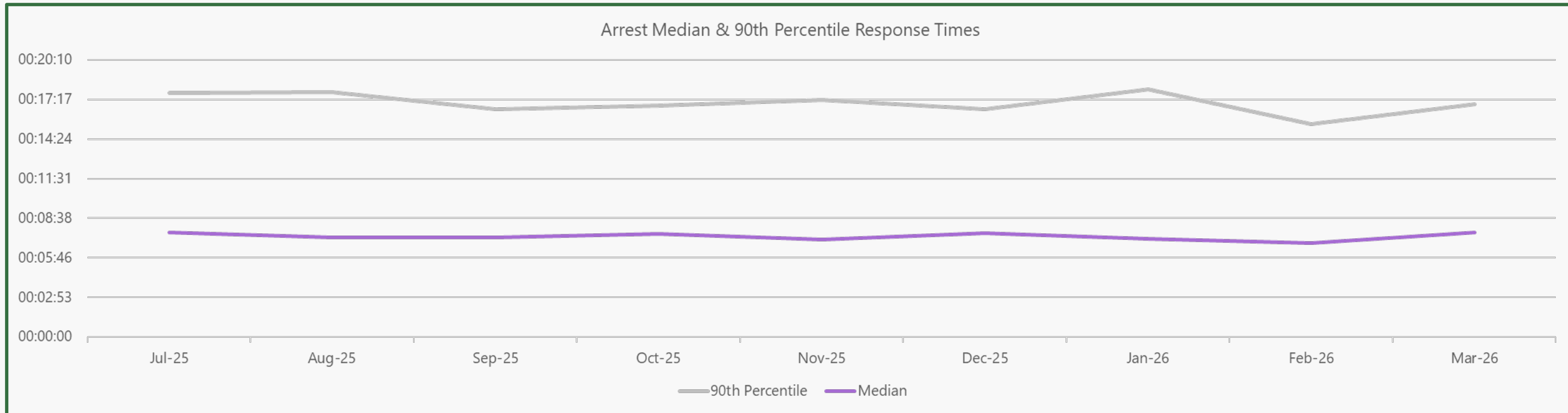
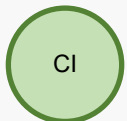
**In-Month RAG Indicates = TBD: Status cannot be calculated (To Be Determined)**  
**Green: Performance is at or has exceeded the target (Indicates no action is required)**  
**Amber: Performance is at or within 10% of target (Indicates some issues/risks to performance (monitoring is required))**  
**Red: 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

Influencing Factors – Demand, Hours Produced and Hours Lost

(Responsible Officer: Lee Brooks)

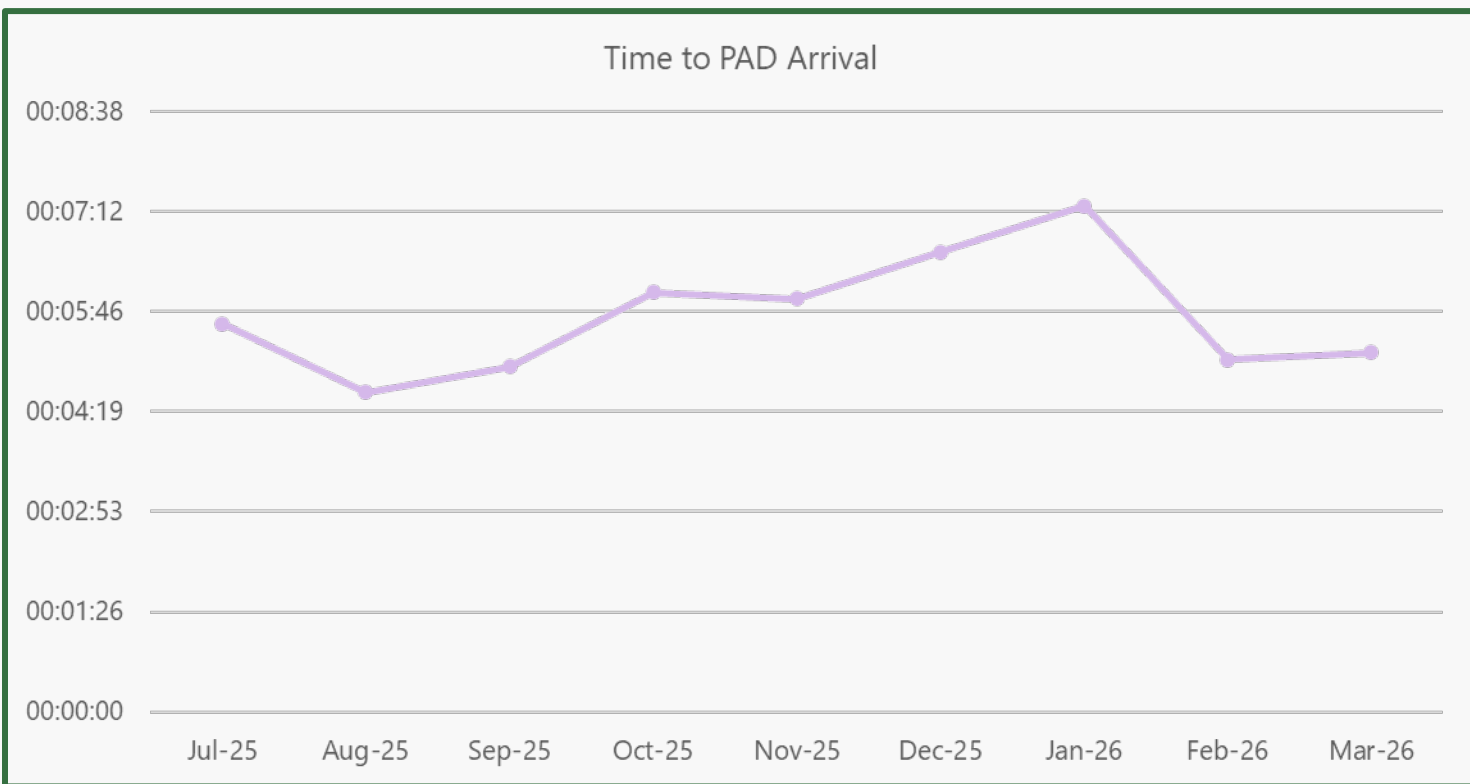
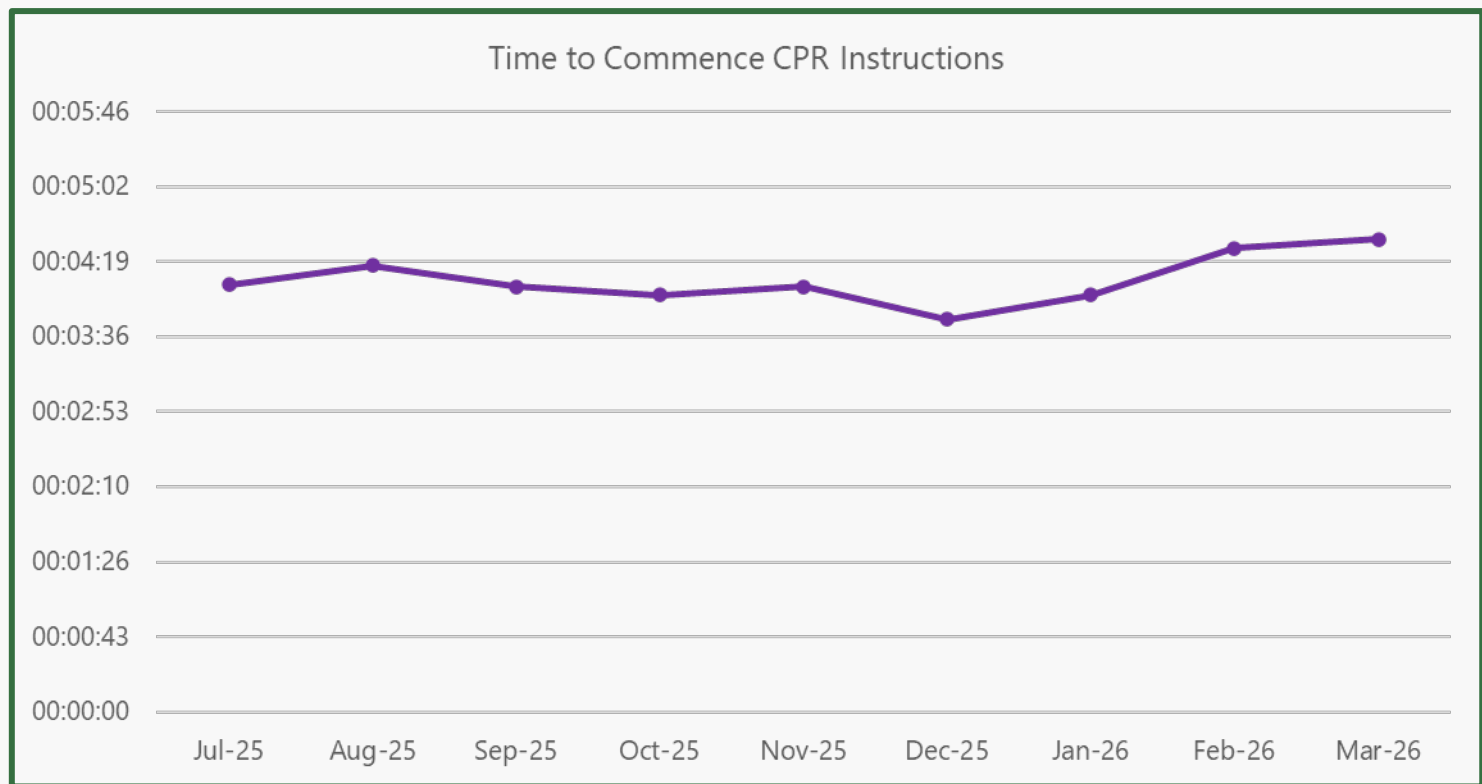
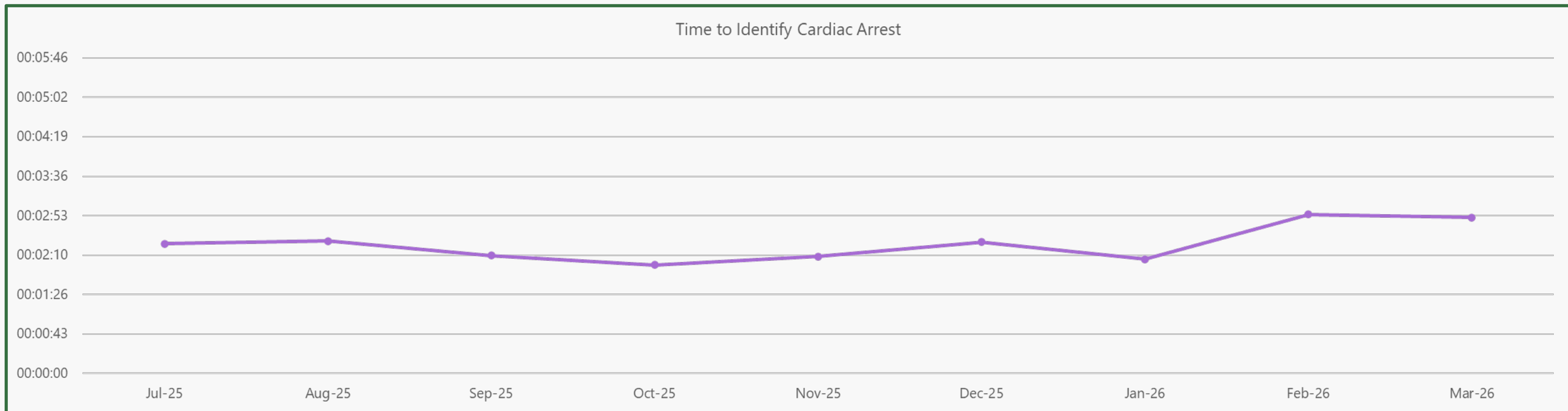
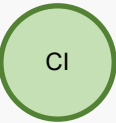


# Our Patients: Quality, Safety & Patient Experience

## Arrest Purple Performance Indicators

Influencing Factors – Demand, Hours Produced and Hours Lost

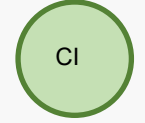
(Responsible Officer: Lee Brooks)



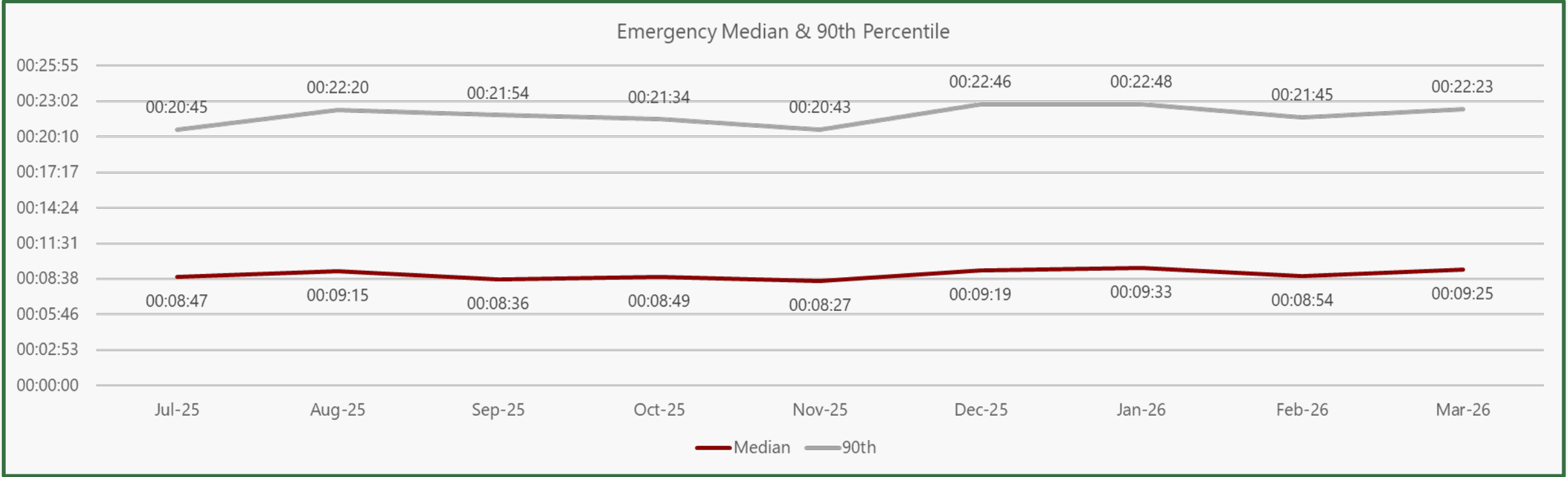
# Our Patients: Quality, Safety & Patient Experience

## RED EMERG Performance Indicators

(Responsible Officer: Lee Brooks)



Influencing Factors – Demand, Hours Produced and Hours Lost



### Analysis

In March 2026 there were 4,780 Emerg (Red) calls, around 13.55% of all calls.

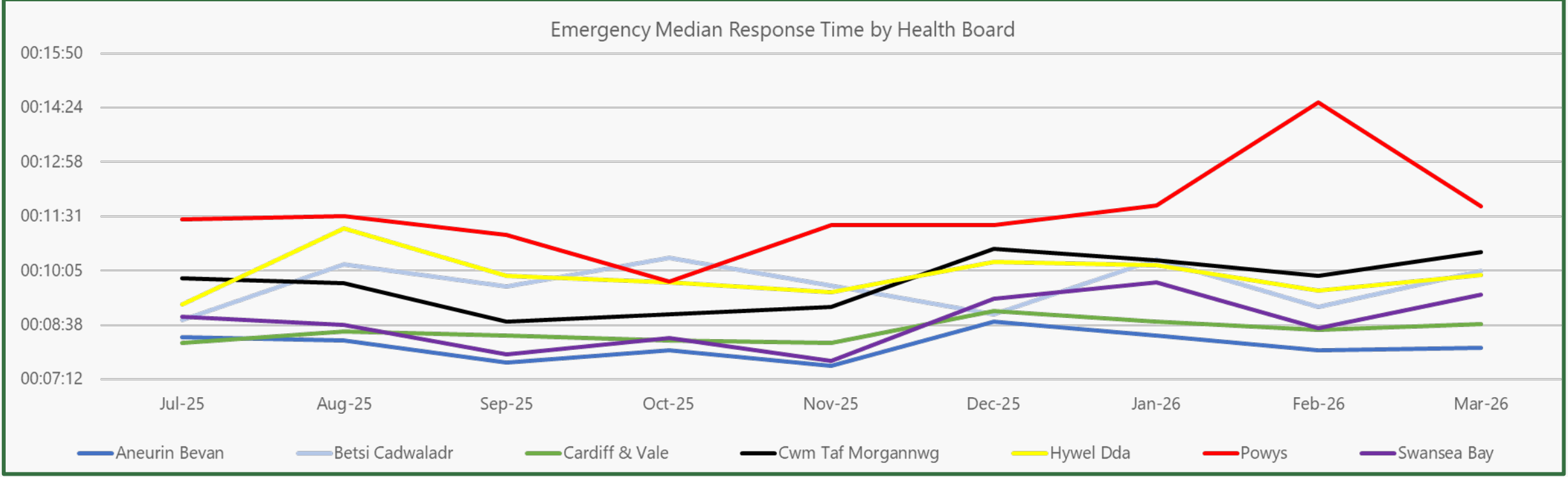
The median response time in March 2026 for Emerg incidents was 9 minutes 25 seconds. Aneurin Bevan health board had the lowest median time of 8 minutes and 2 seconds, and Powys had the highest at 11 minutes and 47 seconds.

For Emerg calls, the 90th percentile response time was 22 minutes 23 seconds. Aneurin Bevan had the lowest time of 17 minutes and 34 seconds, and Powys had the highest at 32 minutes and 45 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

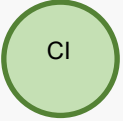
Arrest is performing better than the Trust modelled, but Emergency performance is performing worse than the Trust modelled. Although analysis was carried out on this discrepancy along with several workshops no definitive reason was established. There is a view that the difference in volumes between Arrest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



# Our Patients: Quality, Safety & Patient Experience

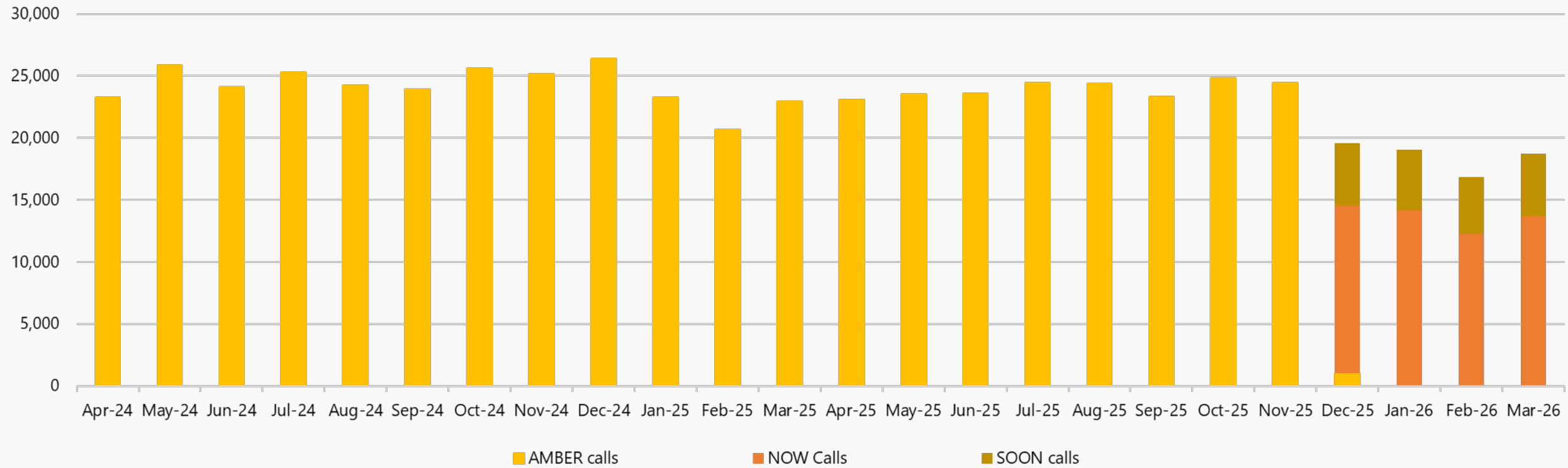
## Amber Performance Indicators

(Responsible Officer: Lee Brooks)



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

Old Amber, Now & Soon Demand



#### 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. In March 2026 there were 13,705 Now (Orange) calls, around 38.85% of all calls.

The median response time in March 2026 for Orange Now incidents was 1 hour and 24 minutes. Powys health board had the lowest median time of 55 minutes and 11 seconds, and Swansea Bay had the highest at 2 hours, 29 minutes. For Orange Now calls, the 90th percentile response time was 5 hours and 33 minutes. Powys had the lowest time of 3 hours and 50 minutes, and Swansea Bay had the highest at 8 hours and 21 minutes.

The median response time in March 2026 for Yellow Soon incidents was 1 hour and 46 minutes. Hywel Dda health board had the lowest median time of 1 hour and 17 seconds, and Swansea Bay had the highest at 2 hours 31 minutes.

For Yellow Soon, the 90th percentile response time was 11 hours and 47 minutes. Powys had the lowest time of 7 hours and 23 minutes, and Cwm Taf Morgannwg had the highest at 13 hours and 29 minutes.

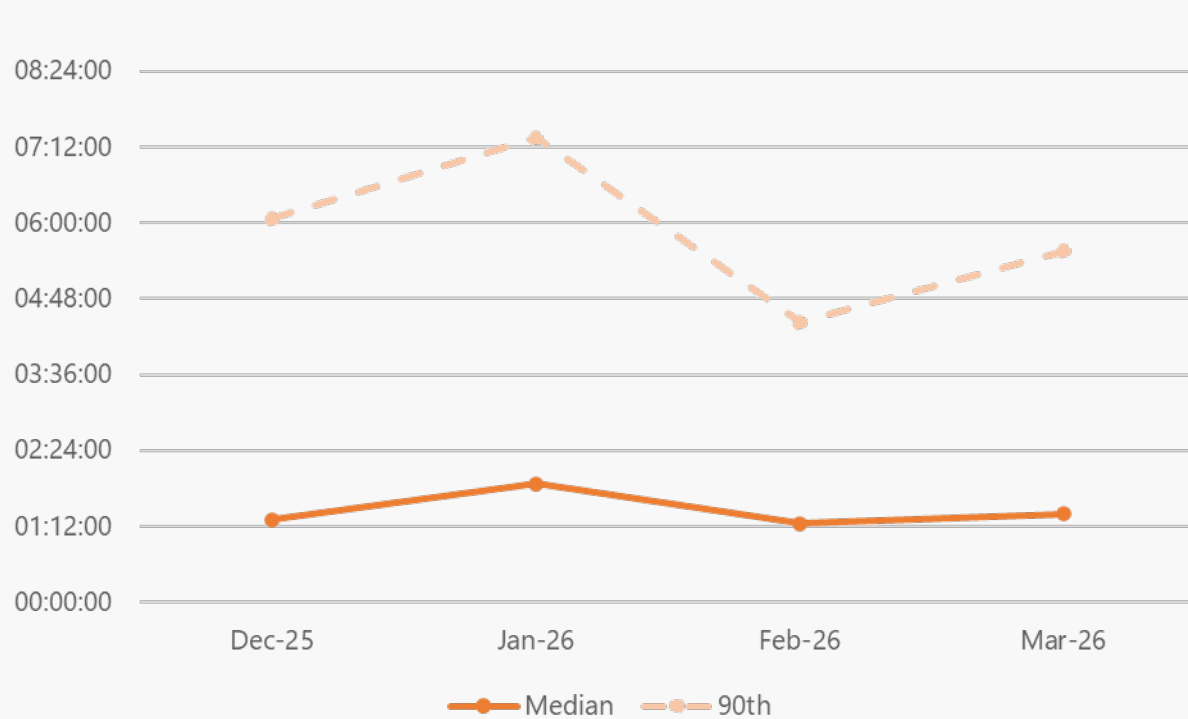
#### Remedial Plans and Actions

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

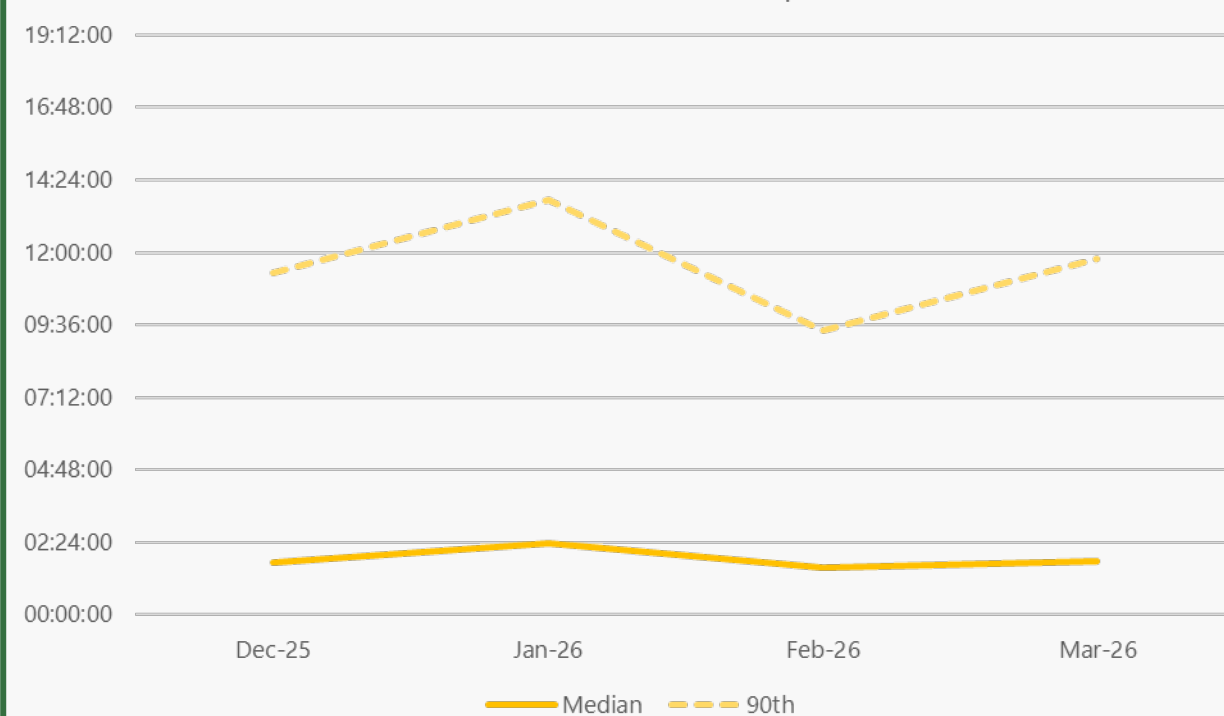
#### Expected Performance Trajectory

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.

Orange Now Median and 90th Response Times



Soon Yellow Median and 90th Response Times



# 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.

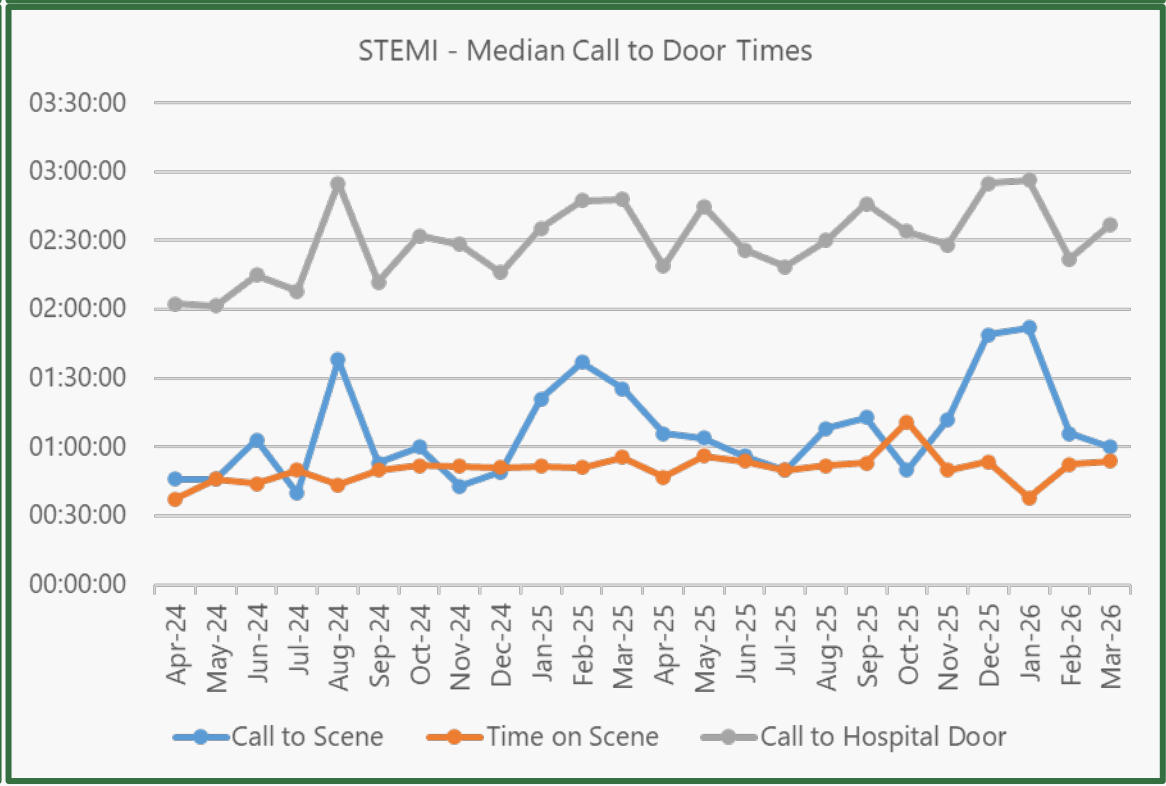
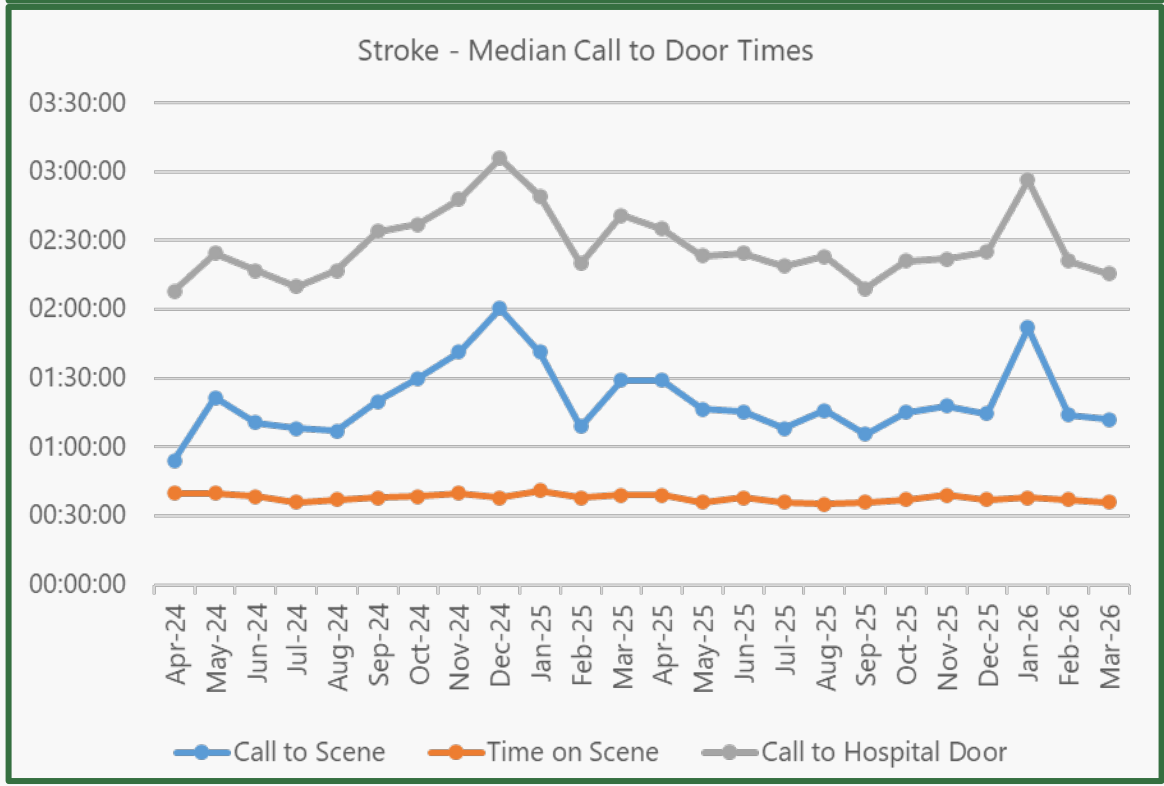
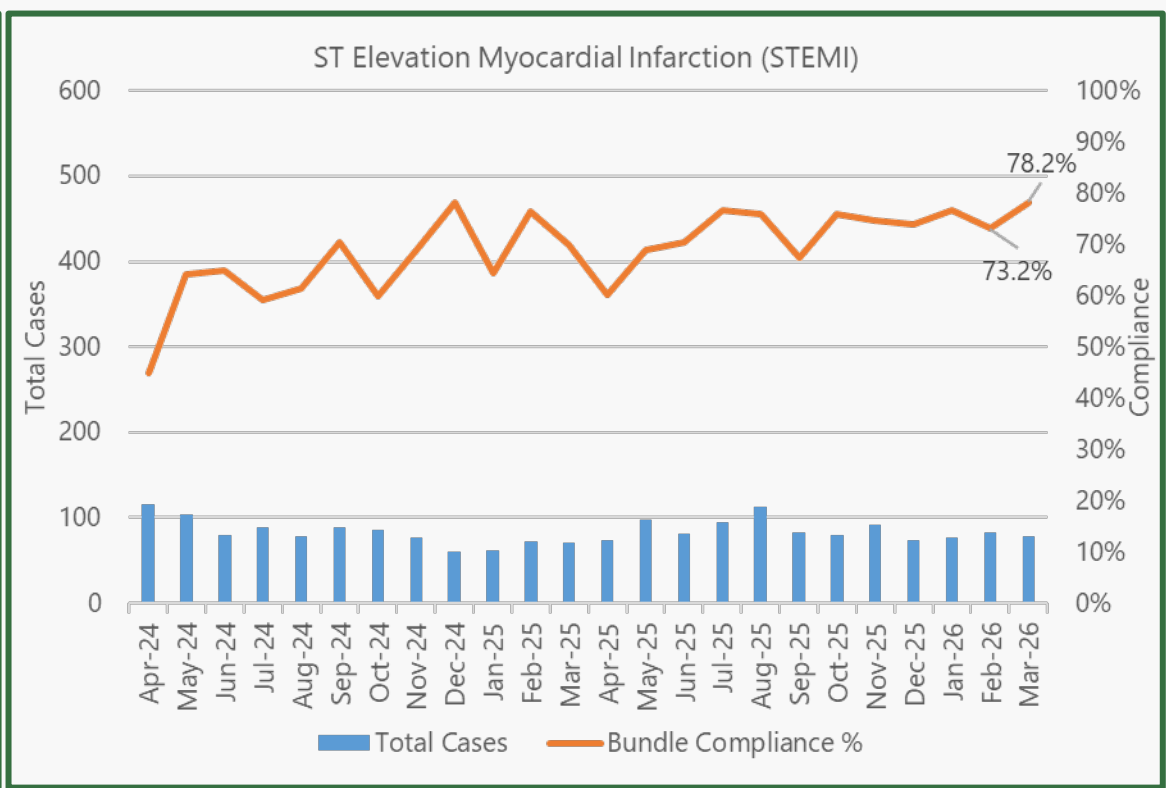
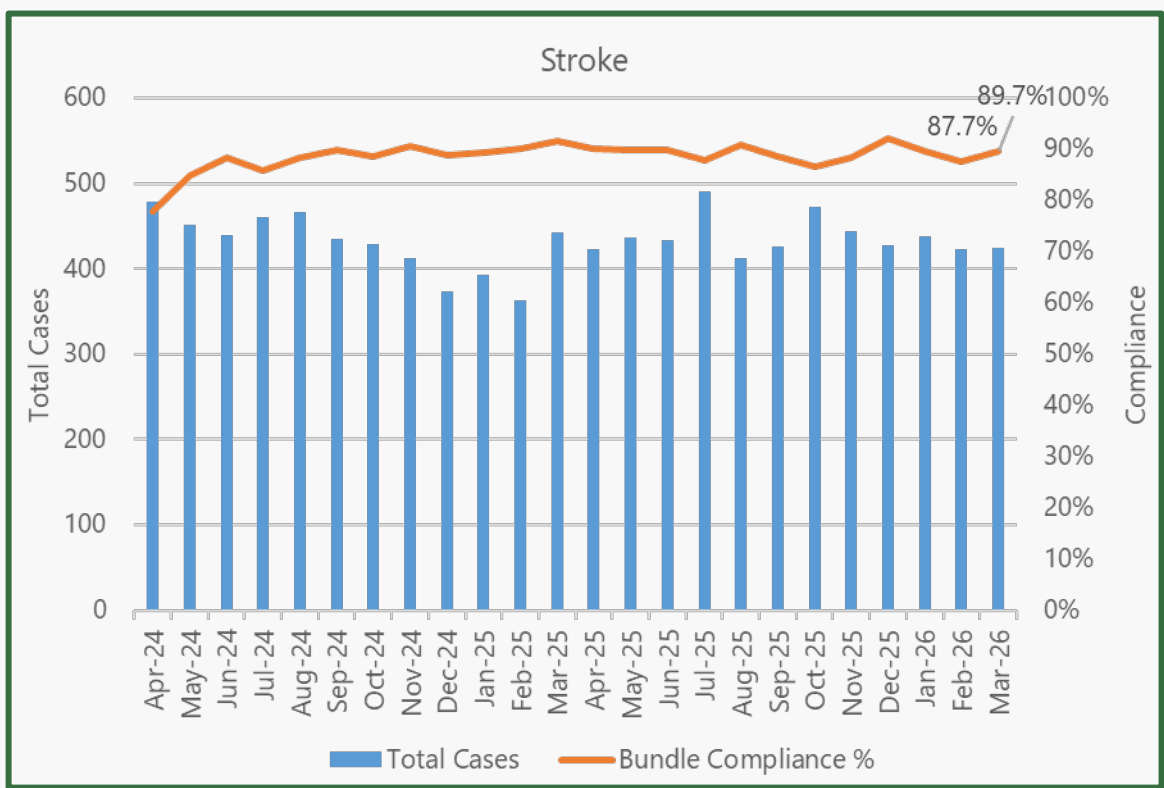
Stroke  
**A**

Stroke Call to Door

STEMI  
**R**

Self-Assessment:  
Strength of Internal Control: Moderate

(Responsible Officer: Andy Swinburn)



**Analysis:**  
The percentage of patients documented as receiving appropriate care bundles during March 2026 was:

**Stroke – 89.7% a slight increase month on month- 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) – 78.2%,** an improvement month on month. There has been good compliance across most of the care bundle elements. The number of cases remained low (78) 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 has been as of Jan 2025 to prevent guideline-driven practice reducing the reported bundle score.

**Call to door times for Stroke** – call to door times decreased marginally for stroke in March. 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. However, call to scene time has reduced.

**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.

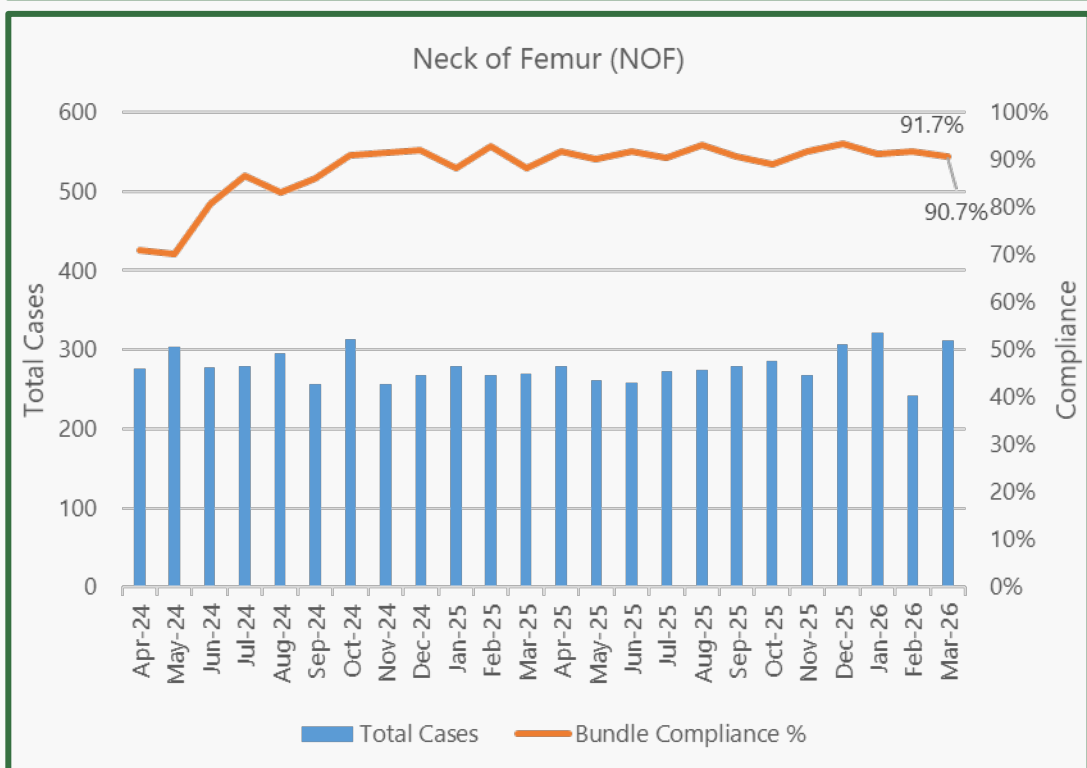
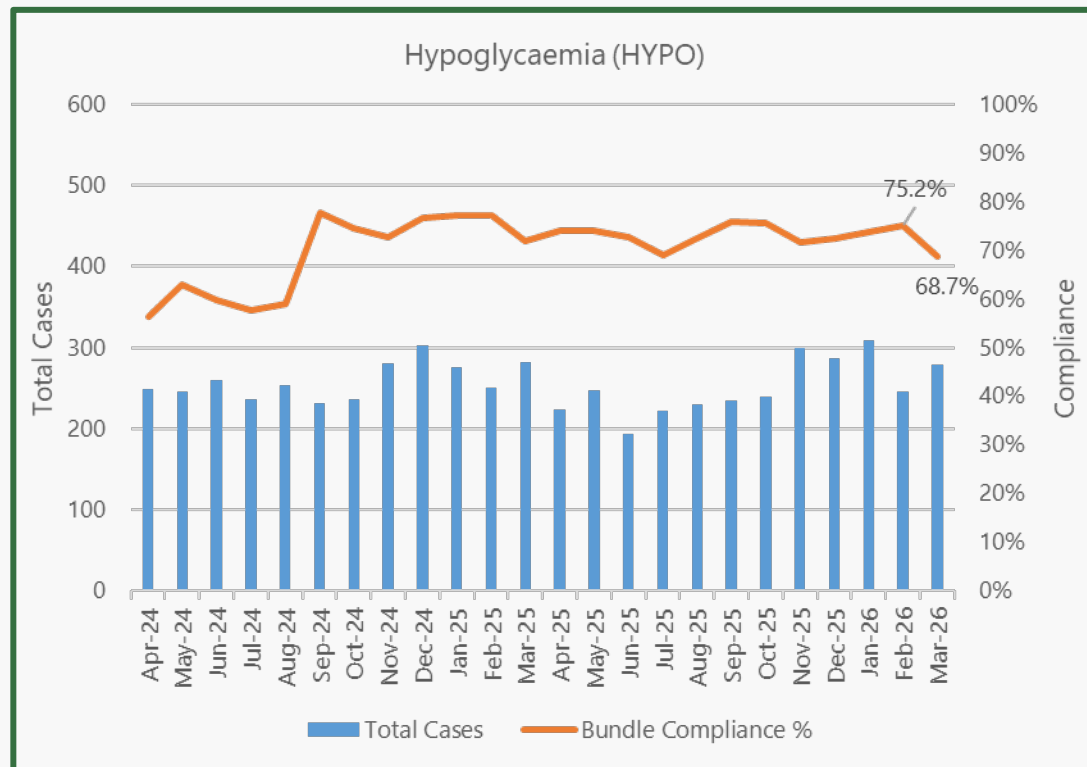
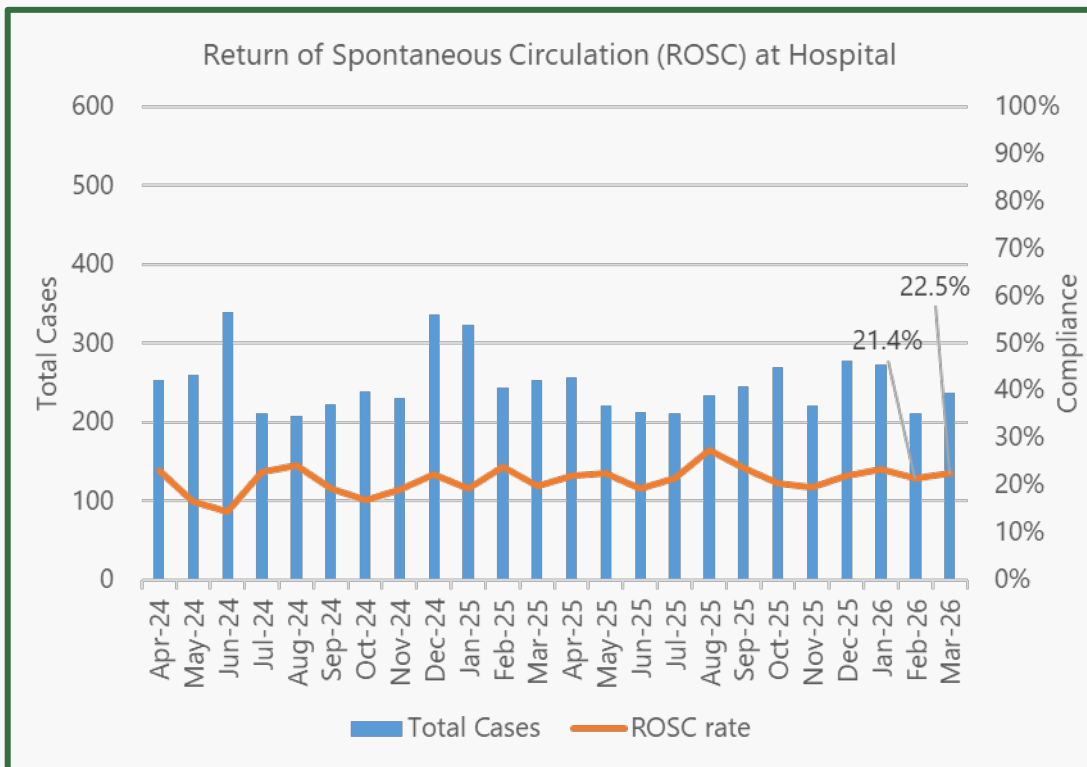
**Expected Performance Trajectory:**  
As a result of the work from the CI Recovery Group T&F group and the ongoing improvement interventions, a continued increase in compliance rates is expected and will be monitored by the Clinical Intelligence & Assurance Group.

# 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)



#NOF Call 2 Door in development

**Analysis:**

The percentage of patients documented as receiving appropriate care bundles in March 2026 was:

**Hypoglycaemia (diabetic patients with low blood glucose) – 68.7%, a decrease since last month.** Compliance has remained consistently around 73% compliance across the bundle, but has seen a drop to 68.7% in March

**Fractured Neck of Femur (hip fracture) – 90.68%, a decrease in performance from last month (91.77%).** A slight decrease in compliance which is evident across the care bundle.

**Return of Spontaneous Circulation at hospital (from cardiac arrest) – 22.5%, an increase from 21.43% in March.** 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

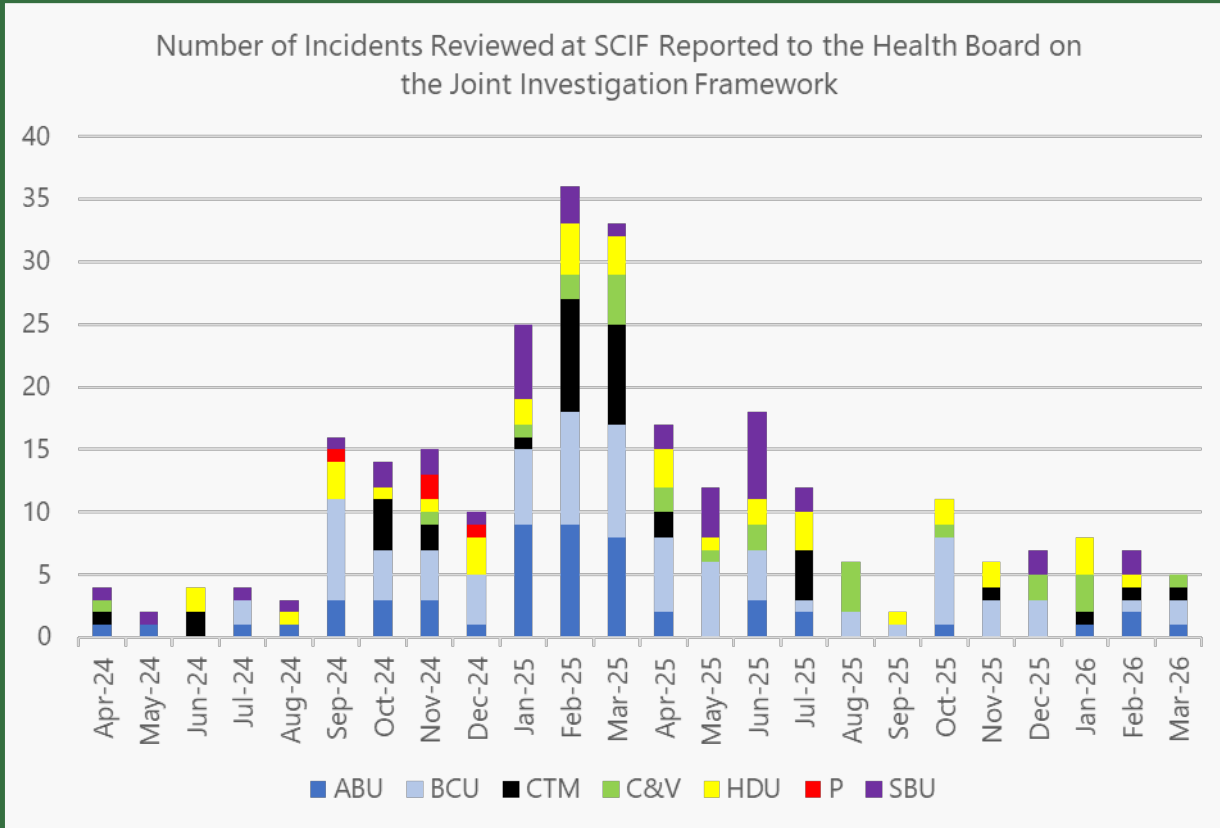
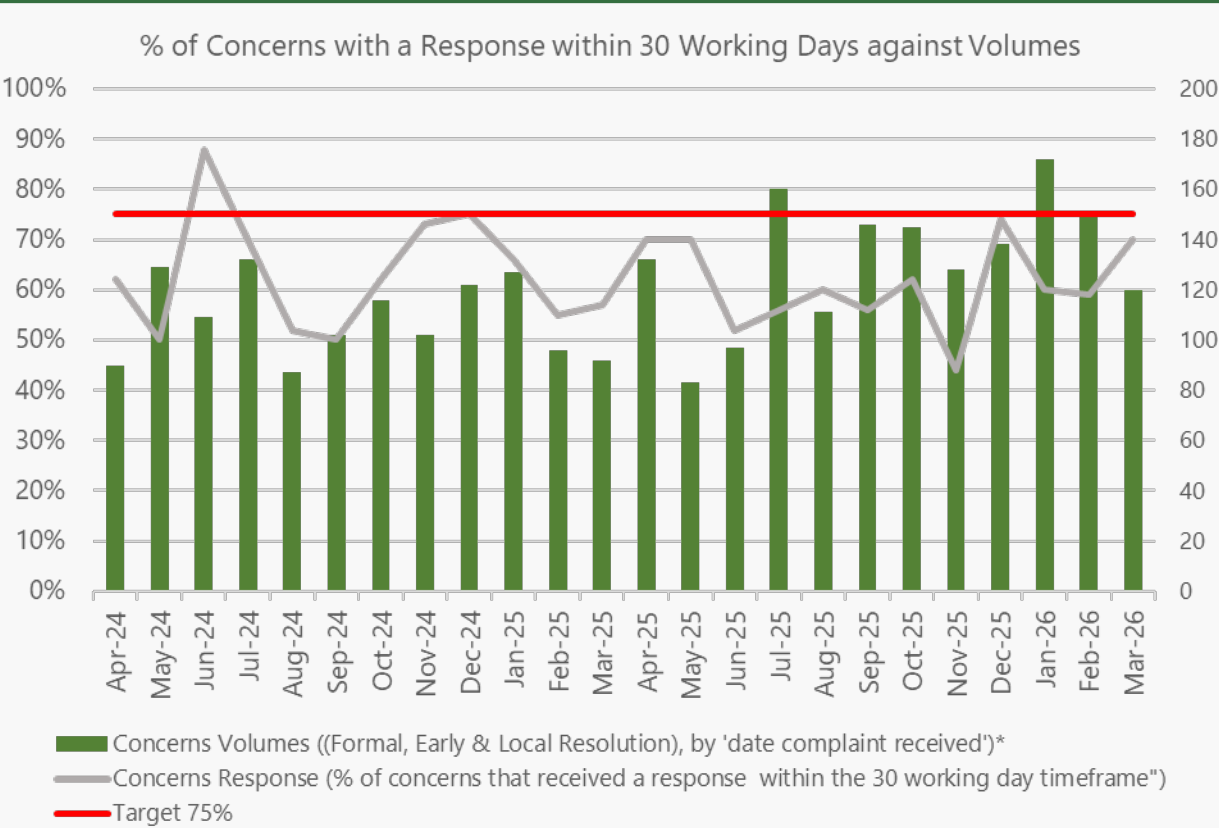
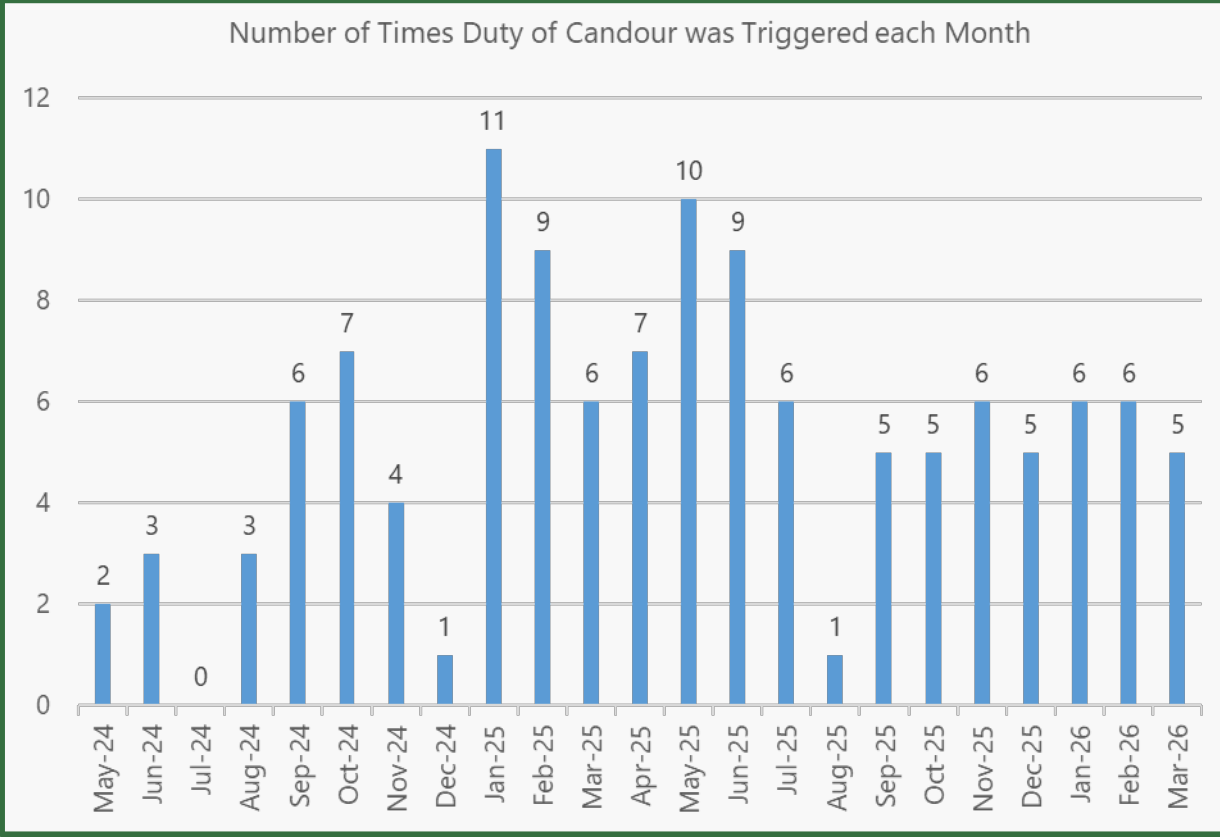
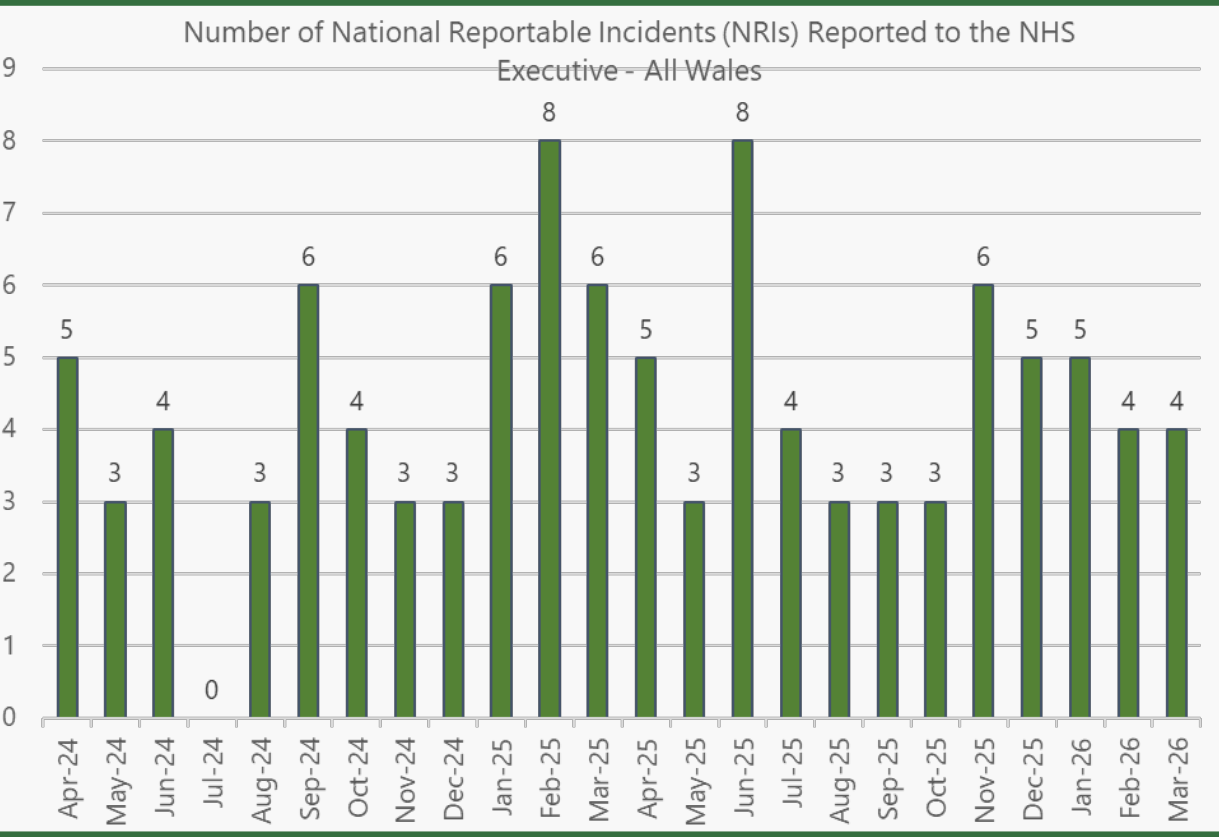
(Responsible Officer: Liam Williams)

Concerns.  
**R**

Self-Assessment:  
Strength of Internal  
Control: Moderate

Health & Care Standard  
Health - Safe Care / Timely  
Care

### Responses Indicators



### Analysis

Performance against the 5 working day Welsh Government target to register and acknowledge complaints has improved back to 100% and sustained over a 2-month period.

- Monthly compliance figures for providing concerns responses within 30 working days are recovering but as a lagging metric, will likely demonstrate the impact of Recovery improvement over the coming quarter. The Trust has reduced overdue complaint volumes by two thirds.
- The volumes of complaints received demonstrates a significant upwards shift since last year. Complaint volumes in 2025/26 were 50% higher than in 2023/24.
- 5 NRIs were reported to the NHS Wales Performance & Improvement team following review at the Serious Case Incident Forum.

The Trust's Patient Safety team have provided Duty of Candour written notification letters within 5 working days of contact for every case where successful contact was made.

### Remedial Plans and Actions

A Concerns Management Improvement Programme Proposal was endorsed by the Executive Leadership Team (ELT) in March 2026. The Programme is underpinned by three clear aims.

- The first is the recovery of statutory performance, achieved through the reduction of the existing backlog of concerns, complaints, and investigations, and stabilisation of response times.
- The second is preparing the organisation for implementation of the new "Listening to People" regulatory framework from April 2026.
- The third, longer term aim is the development of a sustainable, Trust wide concerns management model, providing clear accountability, timely and proportionate investigations, and stronger organisational learning.

Central to this ambition is delivering a compassionate, person-centred experience for those raising concerns and providing broader opportunities for feedback and engagement.

### Expected Performance Trajectory

It should also be noted with the introduction of the new Listening to People Regulations; the Trust is yet to receive the performance metrics by which organisational compliance to the regulations will be measured.

\*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

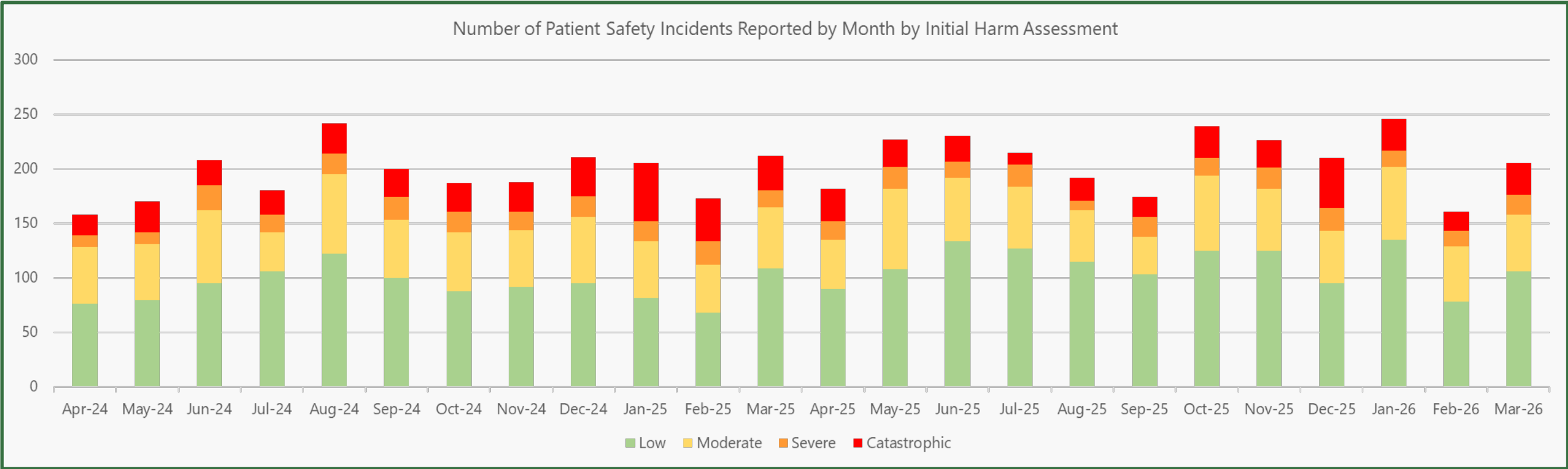
# Our Patients: Quality, Safety & Patient Experience

## Patient & People Safety Indicators

(Responsible Officer: Liam Williams)

Health & Care  
Standard  
Health – Safe Care

Self-Assessment:  
Strength of  
Internal Control:  
Moderate



### Analysis

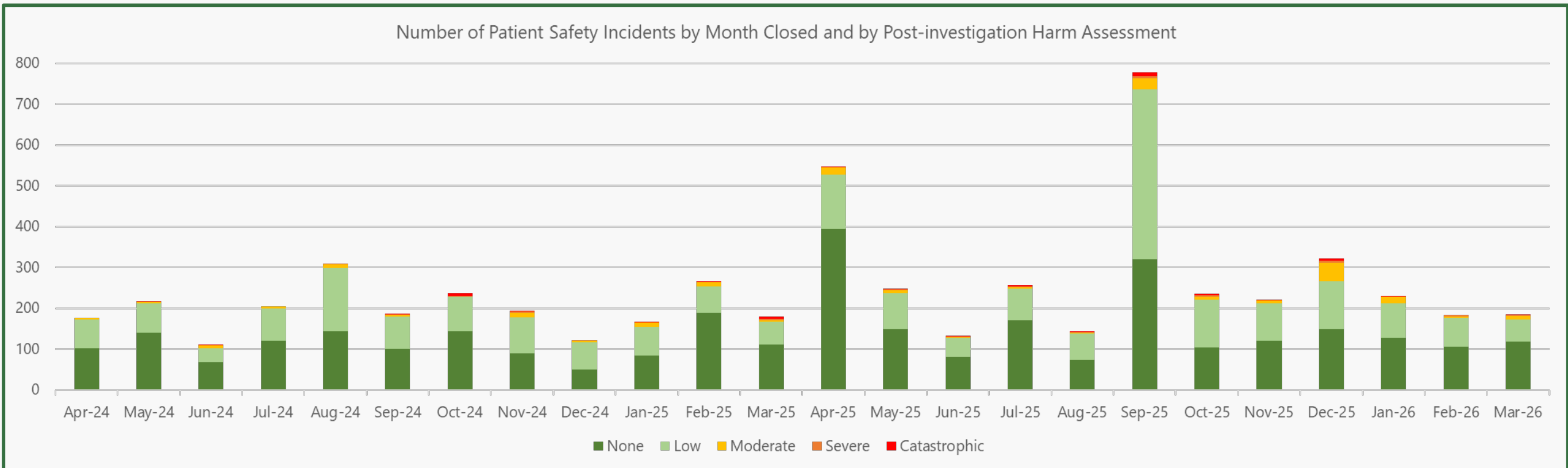
The number of investigations needing to be shared with other NHS Wales organisations is demonstrably lower in volume in comparison to last winter. Hospital handover delays remain impactful, as does demand for remote clinical consultation. Incident reporting volumes have increased again while incident closure rates remain low in comparison. Focus on PTR Recovery metrics including external KPIs has taken precedent and efforts to convert incident closure into business-as-usual practice need to be revisited.

### Remedial Plans and Actions

A Concerns Management Improvement Programme Proposal was endorsed by the Executive Leadership Team (ELT) in March 2026. The Programme is underpinned by three clear aims. The first is the recovery of statutory performance, achieved through the reduction of the existing backlog of concerns, complaints, and investigations, and stabilisation of response times. The second is preparing the organisation for implementation of the new "Listening to People" regulatory framework from April 2026. The third, longer term aim is the development of a sustainable, Trust wide concerns management model, providing clear accountability, timely and proportionate investigations, and stronger organisational learning. Central to this ambition is delivering a compassionate, person-centred experience for those raising concerns and providing broader opportunities for feedback and engagement.

### 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

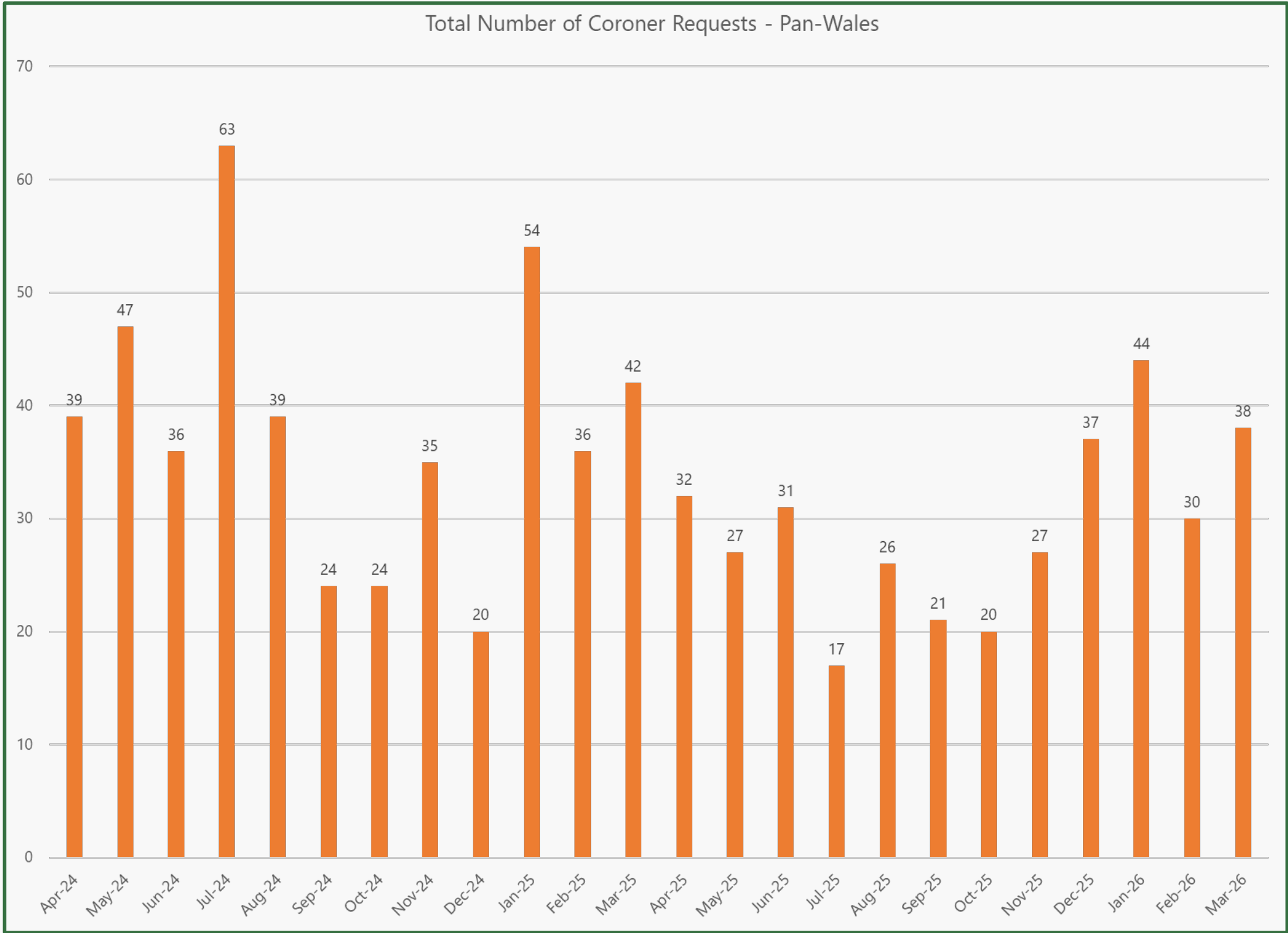
## Coroners, Mortality and Ombudsmen Indicators

(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

The number of overdue inquest statements has been monitored as an adjunct to the main PTR Recovery Task and Finish Group, as shown below. There has been a 50% reduction in overdue statements during the last 4 months. In respect of Medical Examiner referrals, 161 Mortality Review cases were opened during Q3 and Q4 compared to 143 in the first half of the year. This is likely due to seasonal variations during the winter period.

Assurance is offered that Level 1 triage continues to be undertaken in a timely way, ensuring prompt recognition and escalation of cases where the Duty of Candour or other external reporting requirements may apply. Effective and regular functioning of the Level 2 scrutiny and learning forums remains less consistent, and at the time of reporting, 81 cases were awaiting Level 2 review.

### Remedial Plans and Actions

A Concerns Management Improvement Programme Proposal was endorsed by the Executive Leadership Team (ELT) in March 2026. The Programme is underpinned by three clear aims. The first is the recovery of statutory performance, achieved through the reduction of the existing backlog of concerns, complaints, and investigations, and stabilisation of response times. The second is preparing the organisation for implementation of the new "Listening to People" regulatory framework from April 2026. The third, longer term aim is the development of a sustainable, Trust wide concerns management model, providing clear accountability, timely and proportionate investigations, and stronger organisational learning. Central to this ambition is delivering a compassionate, person-centred experience for those raising concerns and providing broader opportunities for feedback and engagement.

### 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 be dependent on senior PTR staff capacity and absence.

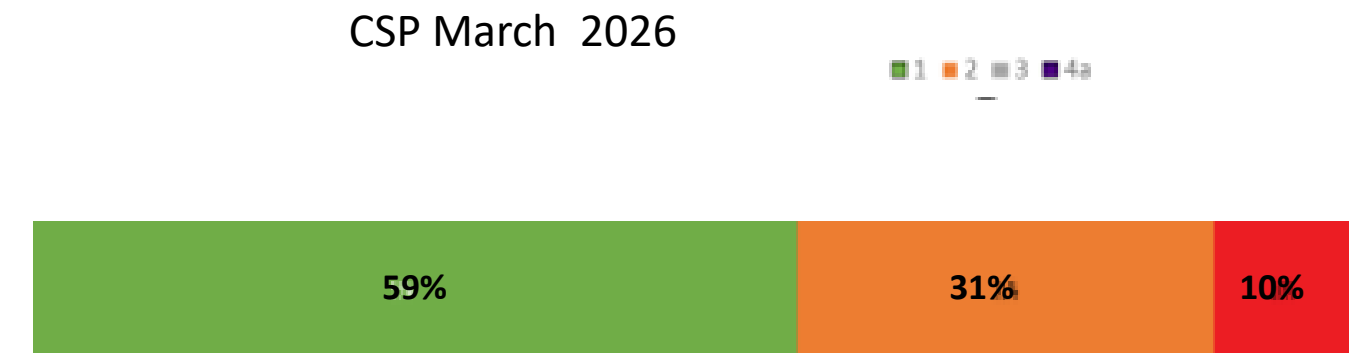
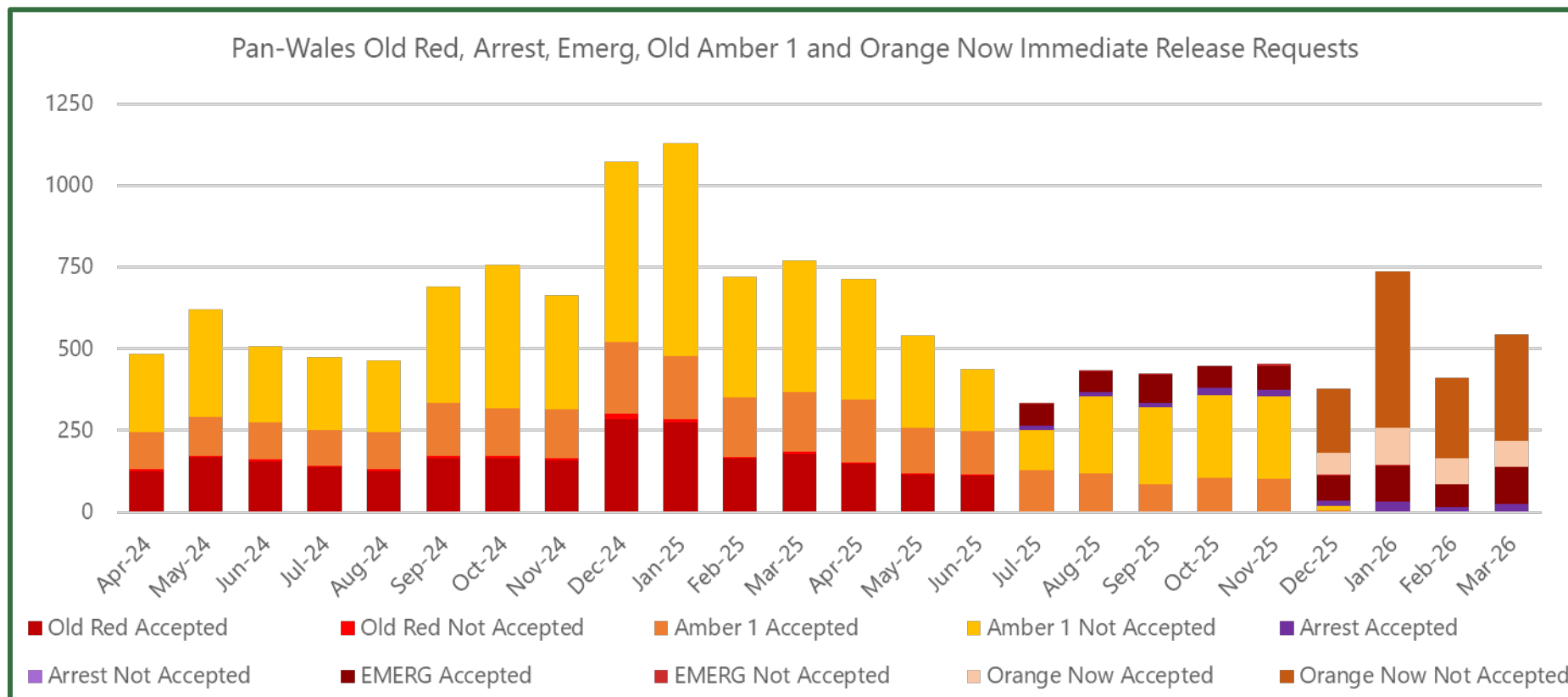
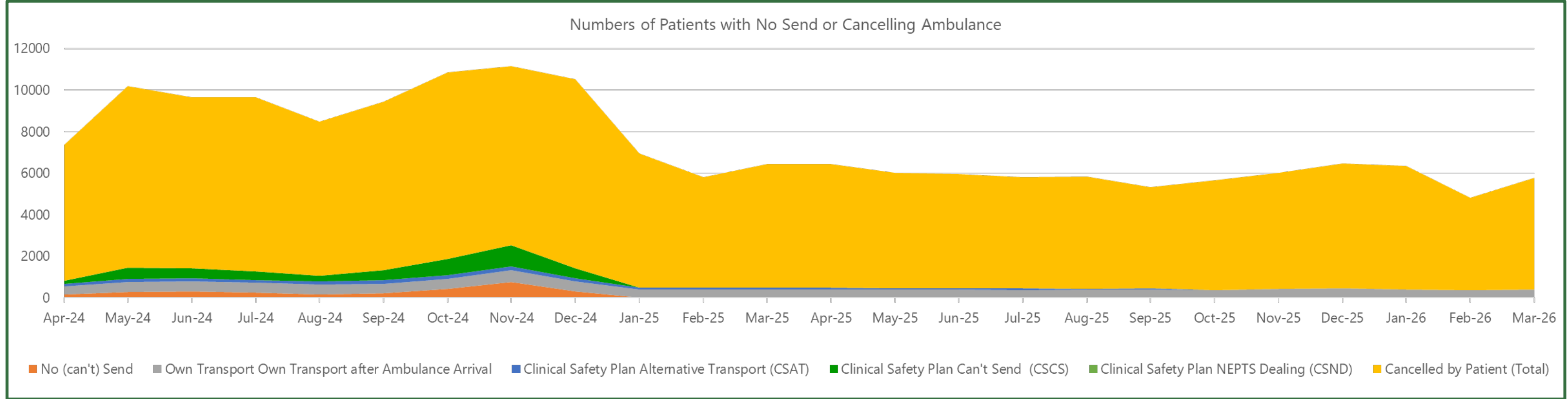
Mortality Reviews Data source: Internal Web Application

# Our Patients: Quality, Safety & Patient Experience

## Potential Patient Harm Indicators

(Responsible Officer: Andy Swinburn)

G



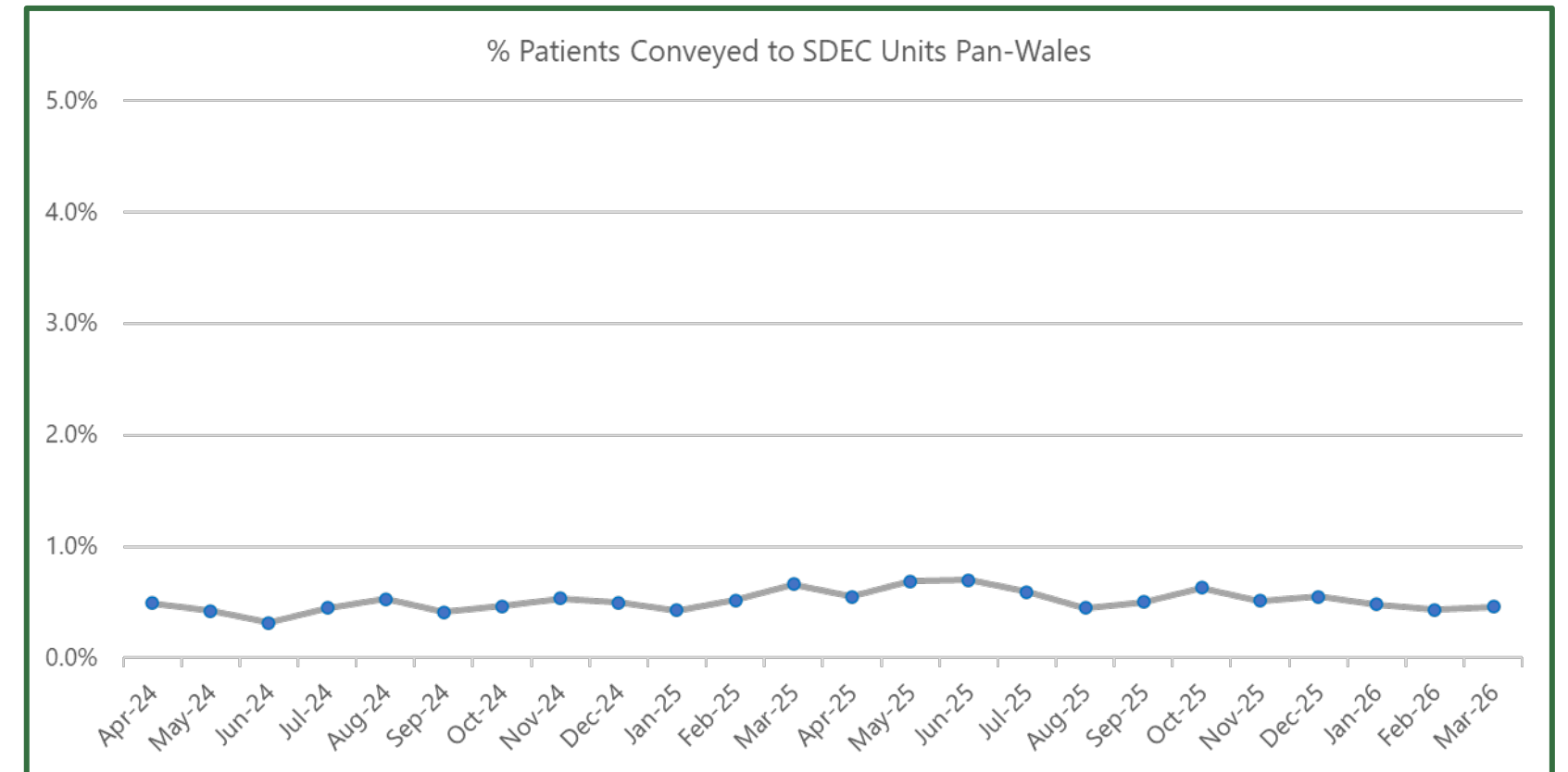
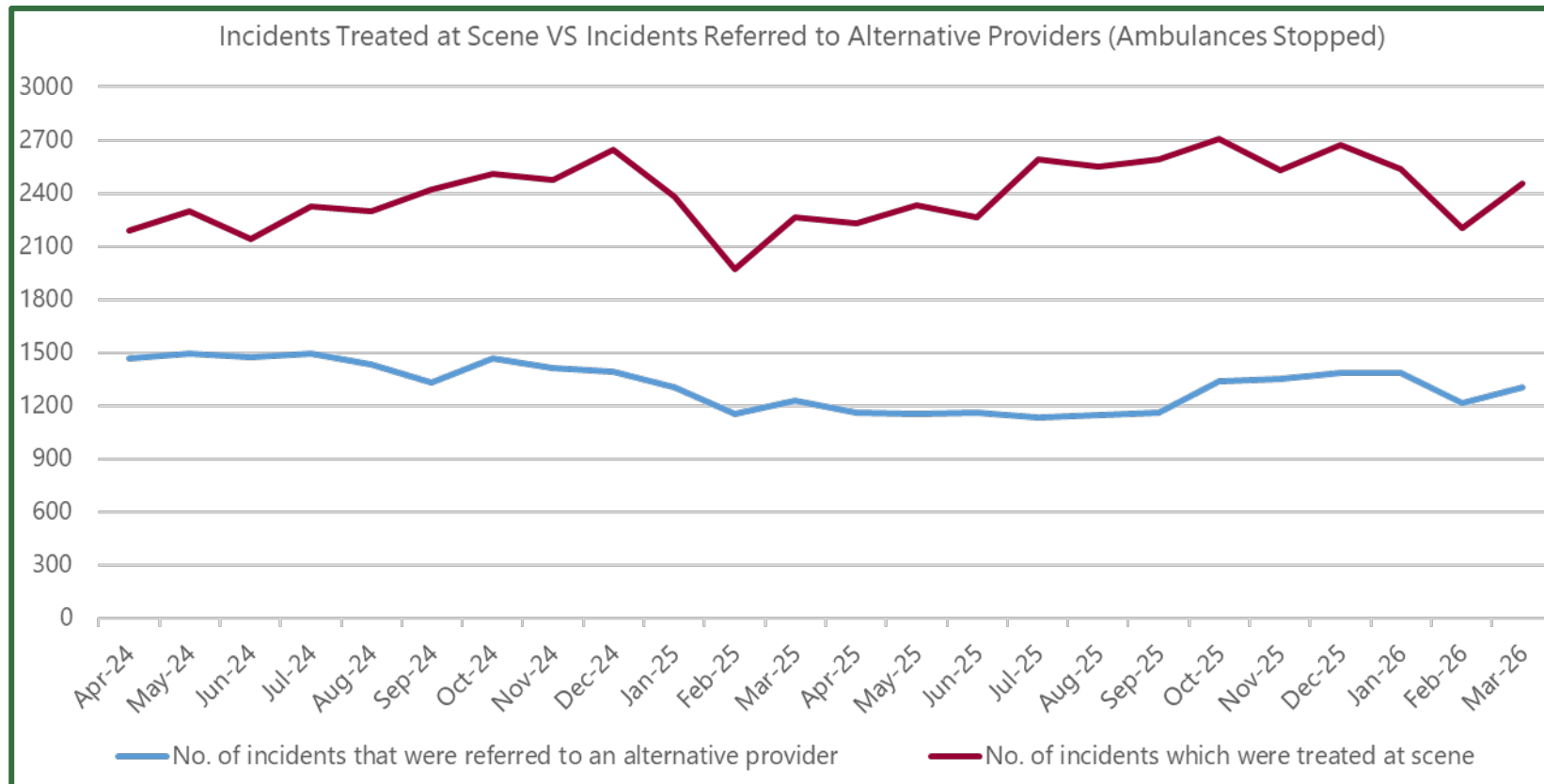
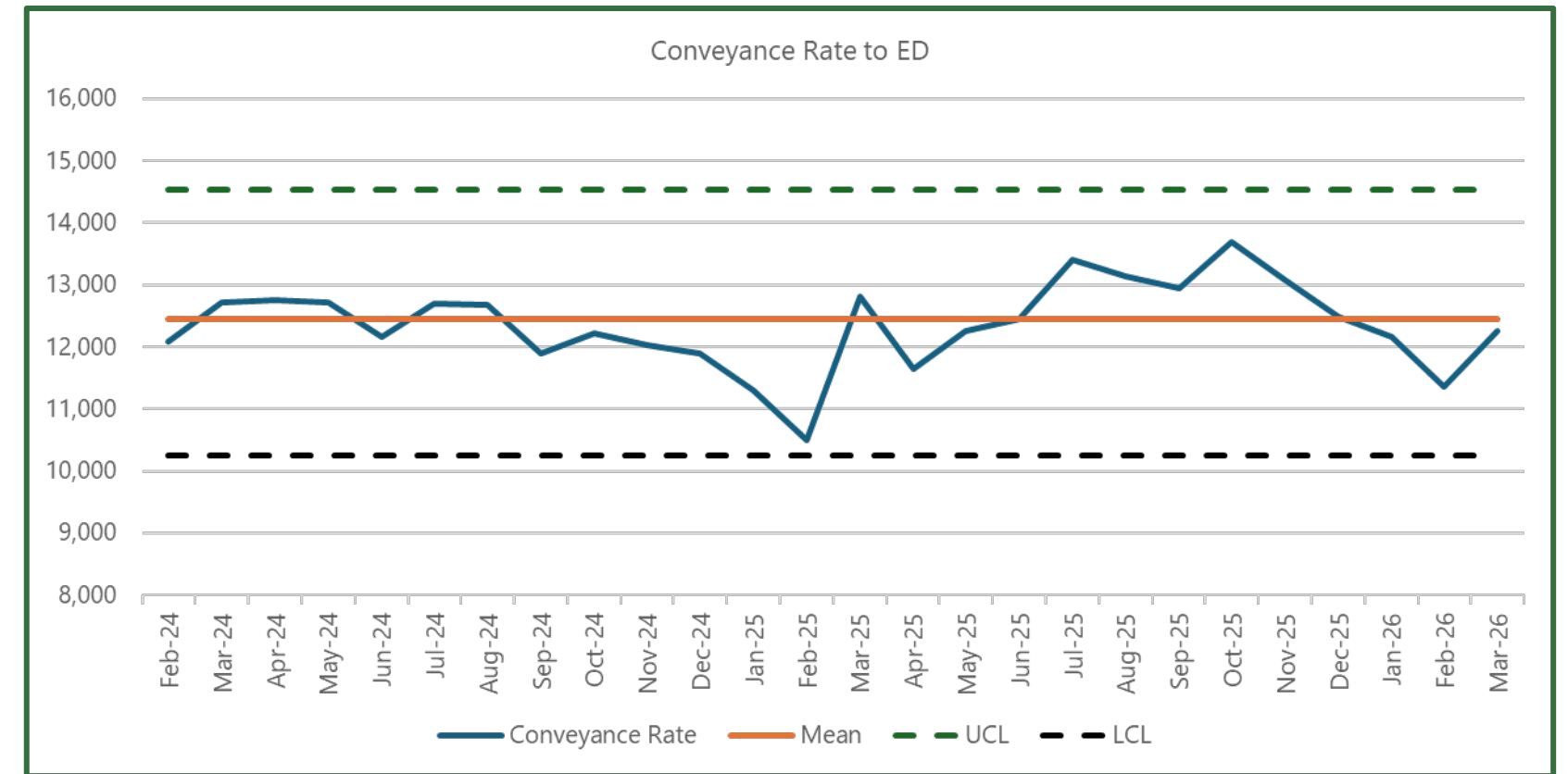
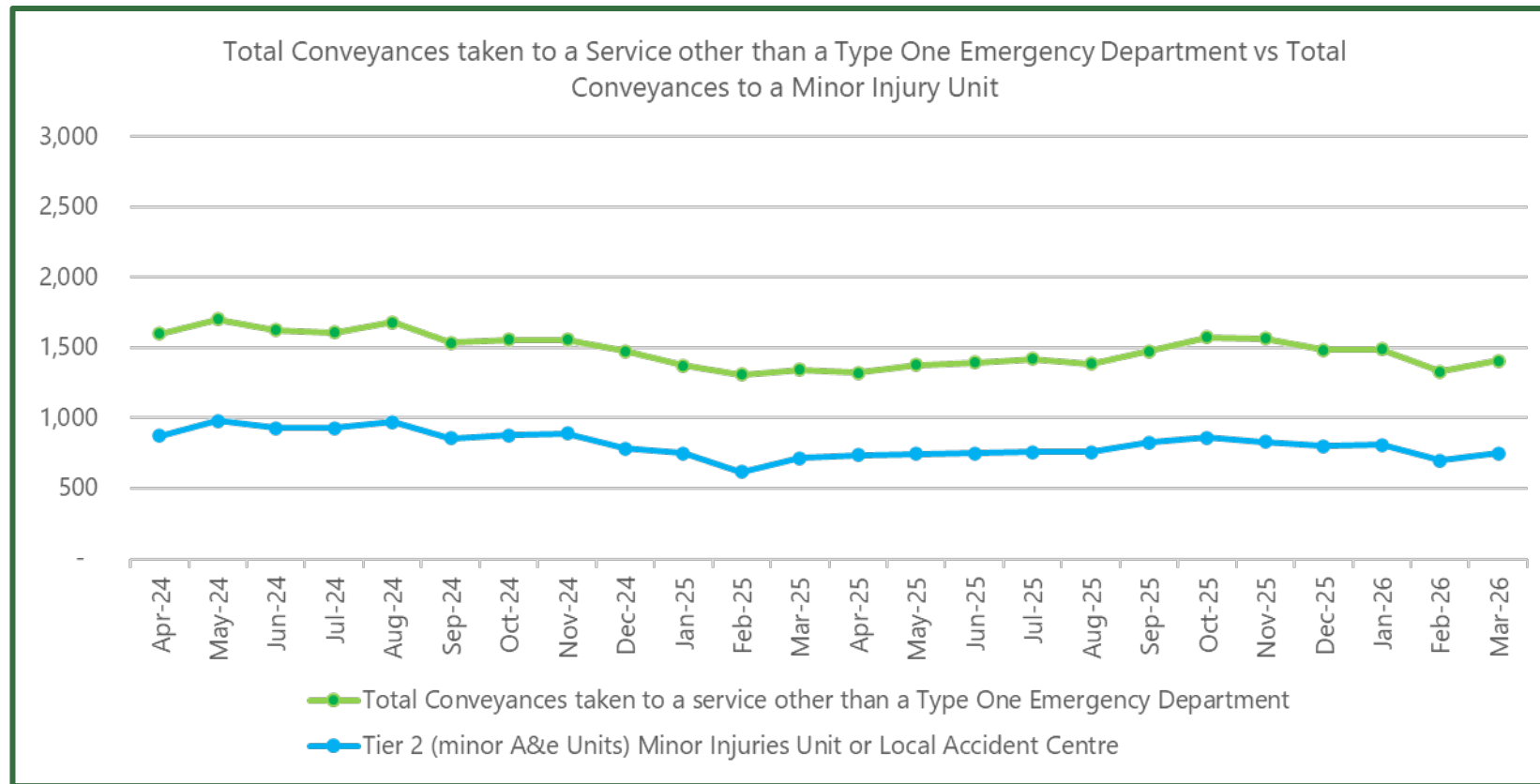
\*NB: Data correct on the date and time it was extracted; therefore, these figures are subject to change

# Partnerships / System Contribution

## Conveyance to ED Indicators

(Responsible Officer: Andy Swinburn)

Ministerial Measure



# Partnerships / System Contribution Handover Indicators

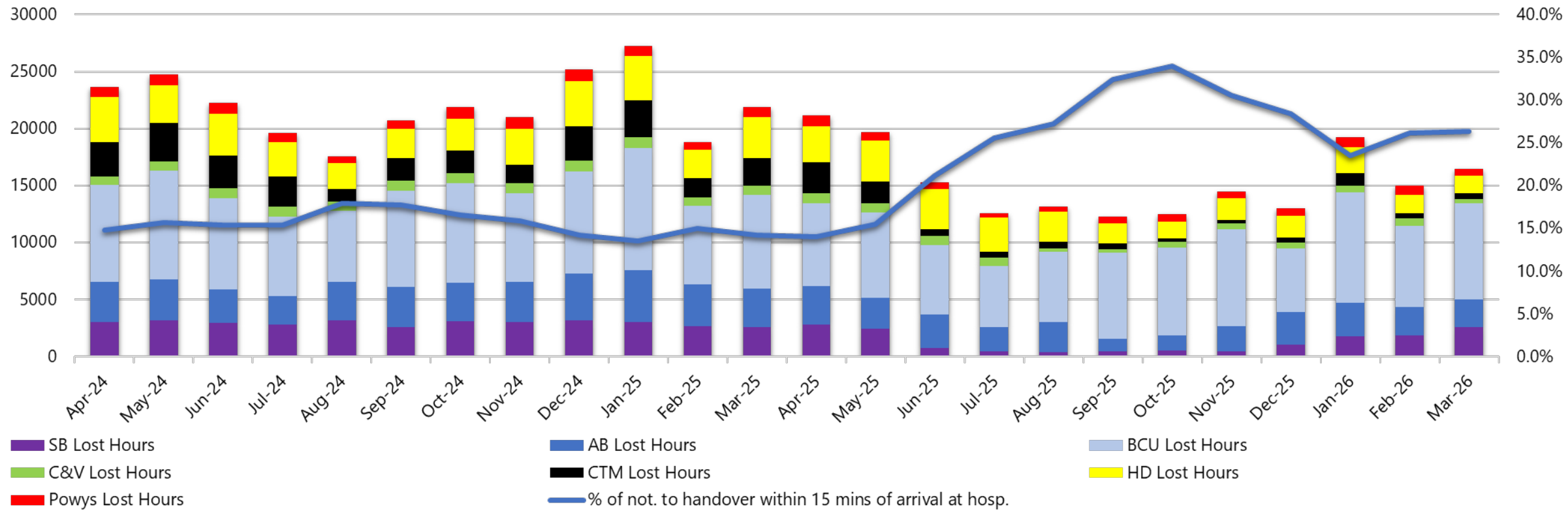
(Responsible Officer: Health Boards)

W45 Lost Hours

R R

CI

Notification to Handover Lost Hours by Health Board



## Analysis

**184,837 hours were lost to Notification to Handover, i.e. hospital handover delays, over the last 12 months (Apr-25 to Mar-26), compared to 264,393 hours over the same timeframe the previous year.** There were 16,469 hours lost in March 2026, which is 24.6% lower than the 21,852 hours lost during March 2025 and is the ninth lowest monthly figure since December 2021.

The hospitals with the highest levels of handover delays during March 2026 were:

- Ysbyty Gwynedd Hospital (BCUHB) at 3,114 lost hours
- Ysbyty Maelor Hospital (BCUHB) at 2,763 lost hours
- Morriston Hospital (SBUHB) at 2,582 lost hours
- Ysbyty Glan Clwyd (BCUHB) at 2,395 lost hours
- Grange University Hospital (ABUHB) at 2,381 lost hours

Notification to handover lost hours averaged 531.2 hours per day during March 2026 (31 days) compared to 705 hours per day in March 2025.

In March 2026, the Trust could have responded to approximately 5,195 more patients if handovers were reduced, which highlights the impact these numbers are still having on the service.

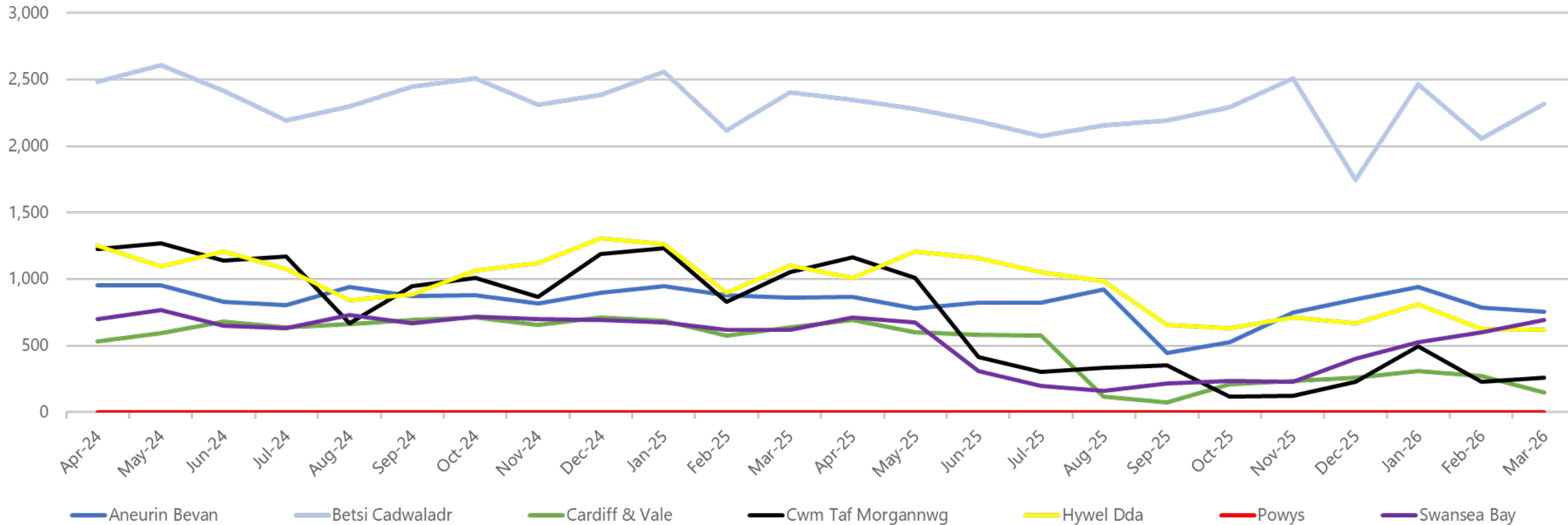
## Remedial Plans and Actions

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).

Handover Rates Over 45 Minutes (including first 15 minutes) by Health Board



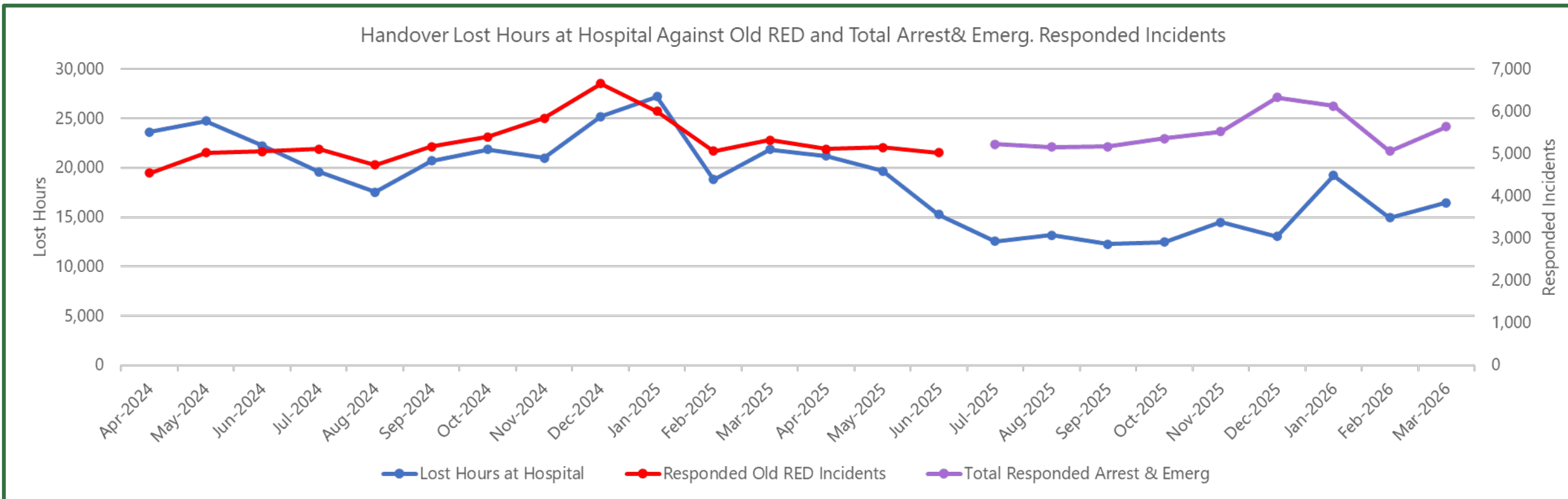
# Partnerships / System Contribution

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

(Responsible Officer: Health Boards)

CI

QUEST



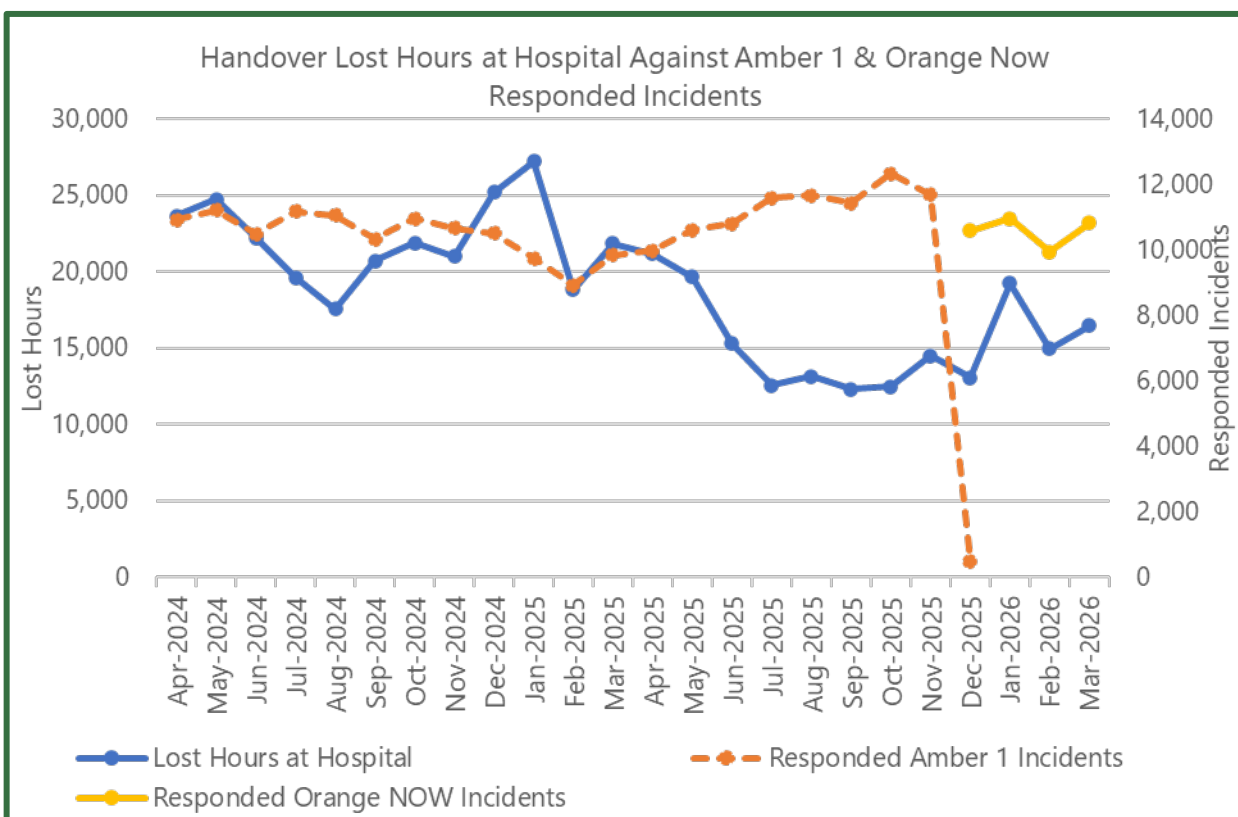
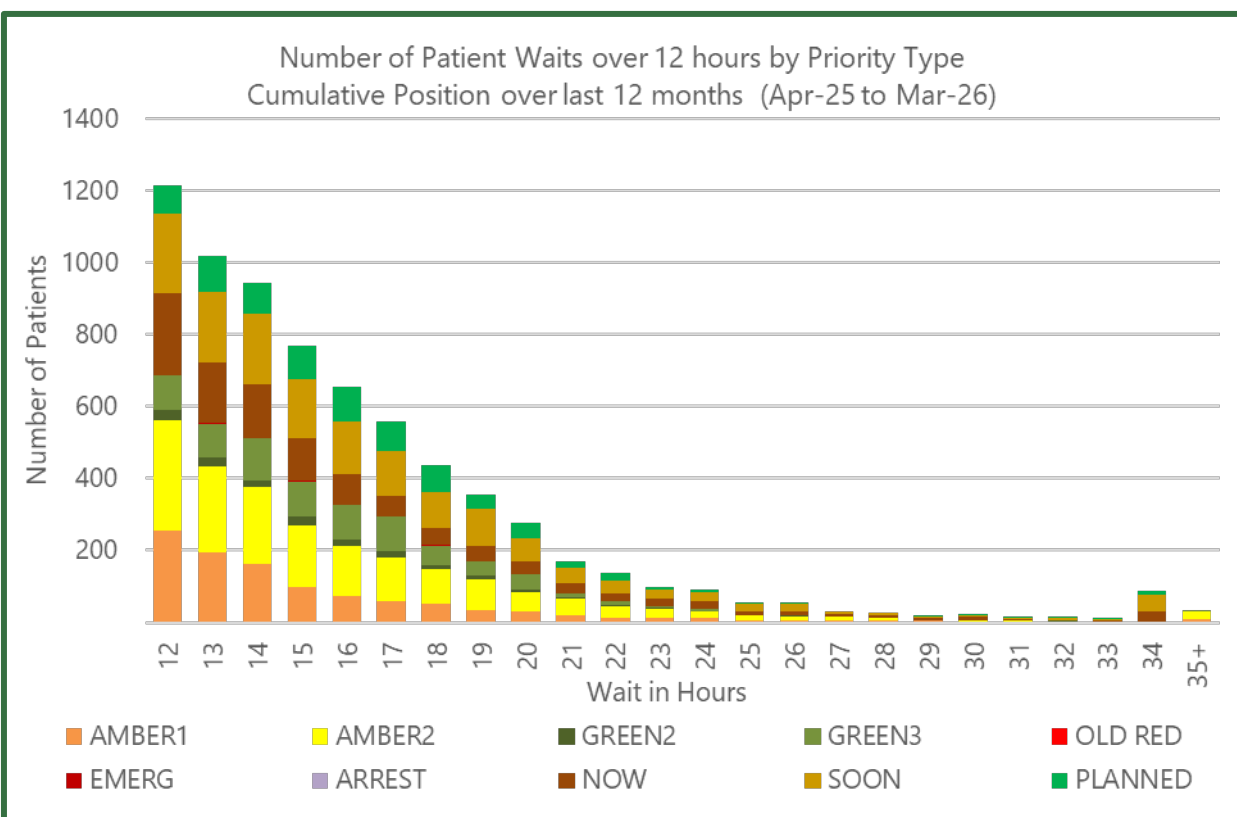
**Analysis**  
 The top graph highlights that when handover lost hours have increased, so to do the number of Old Red, Arrest and Emerg incidents being responded to. This shows that when CSP is in periods of high demand and hospital handover increases, Red responses are protected, even during high pressure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

The bottom right graph illustrates, that there is also a correlation between lost hours decreasing and Now (Orange) incidents being responded to.

In March 2026, 886 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: there were a small number of Amber 1 incidents on 1<sup>st</sup> December 2025*

\*NB: Data correct at time of abstraction

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

# Definition of Indicators

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



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Agenda Item No. 09

## REPORT TITLE

Spotlight on Clinical Indicators – Out of Hospital Cardiac Arrest (OOHCA) - ROSC

## MEETING

Name of meeting	Quality Patient Experience & Safety Committee (QuEST)
Date of meeting	7 May 2026
Public or Private	Public
If private - <a href="#">rationale</a>	n/a

## REPORT SPONSOR

Executive sponsor	Andy Swinburn, Executive Director of Paramedicine
Author(s) of report	Greg Lloyd, Assistant Director of Clinical Delivery

## PURPOSE OF REPORT

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



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## REPORT SUMMARY:

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

1. Continuing with the regular updates on actions to address clinical indicator metrics improvement, this presentation aims to illustrate the actions to improve our outcomes from cardiac arrest (ROSC).
2. Committee will see that each of the actions are being managed within the CMT programme under the OOHCA working group as part of Emergency Response Workstream.

## RECOMMENDATIONS

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

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

1. Receive the presentation;
2. Gain assurance from the actions underway to improve outcomes for cardiac arrest patients; and
3. Discuss the content and gain clarity where required.

## ADDITIONAL PAPERS

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

**Annex 1** OoHCA Presentation



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

### STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

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

### RISK(S) THIS REPORT MITIGATES

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

N/A

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

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

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

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

<input type="checkbox"/> Leadership	<input type="checkbox"/> Workforce	<input type="checkbox"/> Culture
<input checked="" type="checkbox"/> Information	<input type="checkbox"/> Learning Improvement and Research	<input type="checkbox"/> Whole Systems Approach

### WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

<input type="checkbox"/> A socially responsible and inclusive employer	<input type="checkbox"/> An innovative and sustainable organisation	<input type="checkbox"/> A pro-active, accessible and equitable care provider
<input checked="" type="checkbox"/> n/a	<input checked="" type="checkbox"/> n/a	<input checked="" type="checkbox"/> n/a

### IMPACT ASSESSMENTS FOR CONSIDERATION

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

Does this paper require an impact assessment	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
--	--

If yes, what impact assessment is attached

### APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
March 2026	CTM Programme Board



GIG  
CYMRU  
NHS  
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Welsh Ambulance Services  
University NHS Trust

## SITUATION

1. Following introduction of the new Ambulance Performance Framework in 2025, clinical outcome measures, as opposed to simply time-based measures have become the primary performance metric to illustrate the quality of care delivered to our communities.
2. This presentation aims to illustrate a number of the actions underway to drive improvement in this key measure. Each of these actions fall within specific grouping associated with the 'Chain of Survival', which evidence clearly demonstrates are the key interventions required to improve outcomes from cardiac arrest.

## BACKGROUND

3. The OoHCA Group forms part of the Emergency Response Workstream of CMT. Executive lead is Andy Swinburn, with the SRO role being undertaken by Greg Lloyd.
4. Many of the activities within Save a Life Cymru (SaLC) have now been merged into this action plan to ensure alignment with this group groundbreaking work and that of the wider organisation.

## ASSESSMENT

5. This programme of work is evolving and what has become clear is that shifting the focus to outcome-based metrics is quickly increasing our understanding and insight into how we best manage OoHCA and the action necessary to drive improvement.

## RECOMMENDATIONS

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

Welsh Ambulance Services University NHS Trust

# Out of Hospital Cardiac Arrest



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Version: 1  
Meeting: 23rd February 2026

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Greg Lloyd



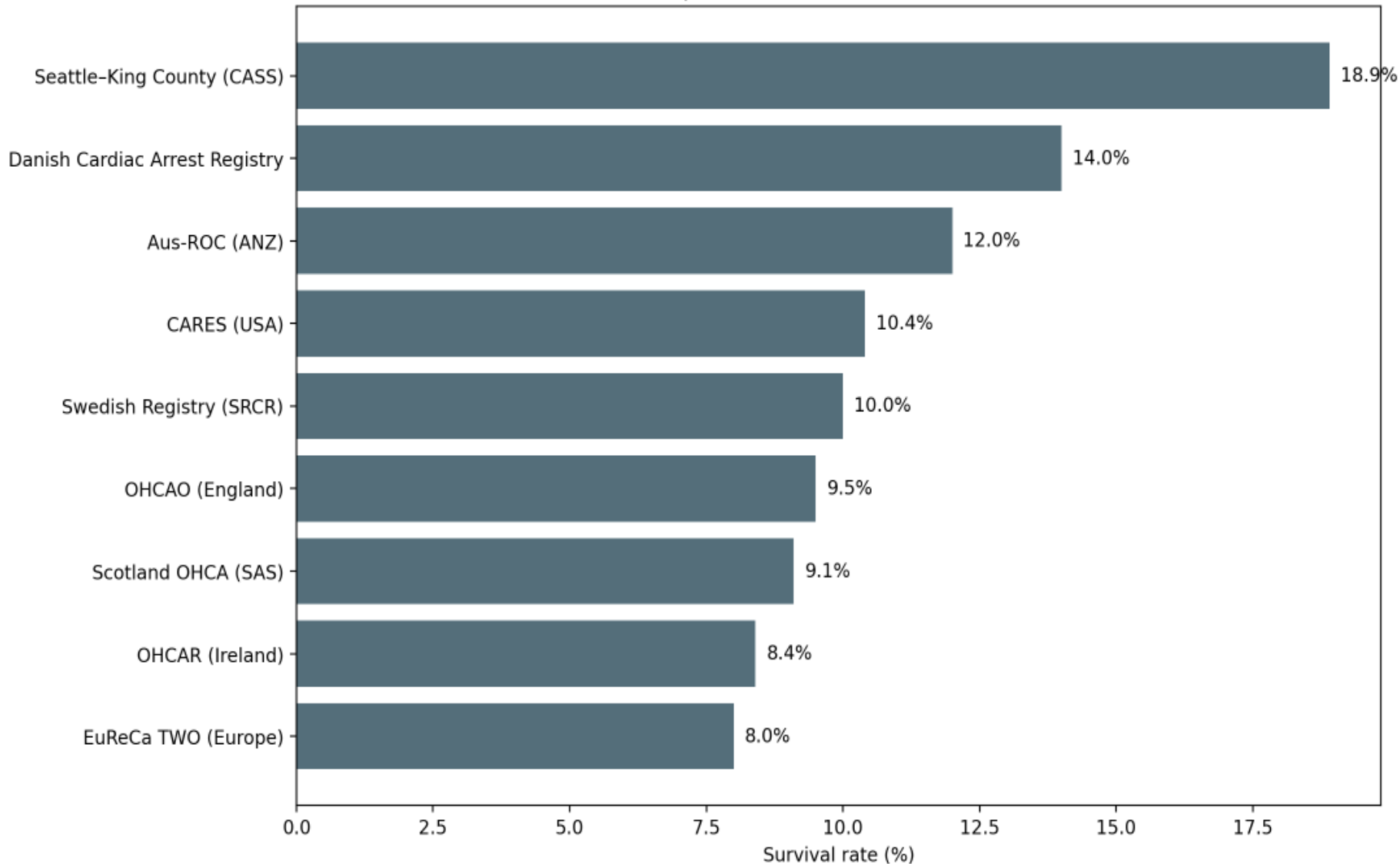
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# Context & Case for Change

Survival after EMS-treated Out-of-Hospital Cardiac Arrest (OHCA)  
Updated with Scotland 2022-23



*Denmark quadrupled survival (2001-2023)*

*Scotland increased from 5% in 2015 to 9.1% in 2022*

*Seattle increased survival by 4.2% in 15 years*

Welsh survival data is unknown

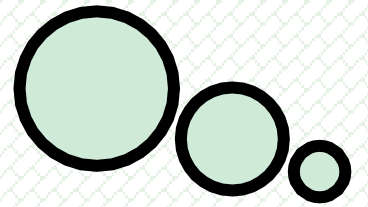
Sustained incremental improvements was key to all of the above increases in survival



# CMT deliverable

**Out of Hospital Cardiac Arrest Delivery Group purpose:**

**Deliver a system wide action plan to accelerate improvements in OHCA outcomes in Wales by implementing targeted interventions in public awareness, CPR training, defibrillator access, advanced life support and data/analytics**





# OHCA CMT Milestones

## Key milestones OHCA 26/27



**Out of Hospital Cardiac Arrest**

*Q1-Deliver updates to Welsh Government learning platform and develop bespoke bilingual CPR resources for schools to develop a generation of life savers to improve the likelihood of bystander CPR for future cardiac arrest patients*

*Q2- Roll out new clinical practice guidelines on resuscitation and verification of death, reducing the incidence of inappropriate resuscitation attempts and increase ROSC and survival to discharge rates in OHCA*

*Q3- Deliver the Welsh OHCA reporting of survival to discharge for end to end measurement and benchmarking, leading to targeted improvements across the UK and internationally.*

*Q4-Implement PAD map systems to intelligently map the placement of community defibrillators to increase the number of PADs retrieved to the scene of an OHCA and address health inequalities associated with historic PAD placement*





# OHCA delivery plan



**Early Recognition and Call for Help** – Increasing public understanding of cardiac arrest symptoms is essential in enabling individuals to act quickly and confidently, ensuring that help is summoned without delay. Early recognition significantly increases the likelihood of a positive outcome.

## Enhancing CPR awareness to empower early recognition and response

Re-start a Heart Live

Embed CPR training in Universities

School curriculum content

CPR on the WG learning platform

HWB digital learning and teaching platform updates

## Enhancing public awareness and engagement for early cardiac arrest response

SALC communication and engagement strategy

National engagement such as DVSA

## Enhancing call handler capability in cardiac arrest recognition

Identify improvements to call handling training

DNACPR MPDS SOP review

Review of time to hands on chest using WAST and academy data



# OHCA delivery plan



**Early Cardiopulmonary Resuscitation (CPR)** – Empowering the public to begin CPR immediately, before professional help arrives, markedly improves survival chances. WAST and SaLC continue to expand community access to CPR education across Wales, supporting schools, workplaces, voluntary organisations and other local groups. The partnership between SaLC, the Resuscitation Council UK and the Driver and Vehicle Standards Agency (DVSA) further strengthens this approach by embedding CPR and defibrillator awareness into the UK driving theory test, helping to build a generation of confident lifesavers.

## Achieving organisational wide resuscitation readiness to lead and influence

Widen access to CPR and defibrillator training

Increase GoodSAM volunteers internally

## Strengthening partnerships to promote GoodSAM adoption

Engagement with public services to increase community resilience





# OHCA delivery plan



**Early Defibrillation** – Wales now has more than 8,500 Public Access Defibrillators (PADs) registered on the National Defibrillator Network, representing the third largest network in the UK and maintaining a 93% rescue-ready status. However, simply increasing the quantity of PADs does not guarantee improved survival; strategic placement and community engagement are essential. In partnership with Save a Life Scotland, WAST and SaLC are introducing a data-driven optimisation portal that uses advanced modelling to identify the most effective placement of PADs, ensuring they are located where they will save the most lives and addressing inequalities in access.

## Develop a mobile responder network by increasing Goodsam volunteers and defibrillator access

Consider current response radius and evaluate impact

Issue 150 defibrillators to Goodsam responders and evaluate impact

## Enhance resilience in PAD management and maintenance

National process to expedite return of used PAD

Further develop community guardians



# OHCA delivery plan



**Advanced Life Support (ALS) and Post-Resuscitation Care** – Ensuring that patients receive prompt access to enhanced clinical care, specialist cardiac intervention and appropriate rehabilitation significantly influences long-term outcomes. Strengthening clinical pathways and improving coordination between pre hospital care and specialist centres form a core part of this commitment.

**Enhance specialist responder readiness through CPD, training and clinical assurance**

Develop specific CPD for local delivery

**Implement robust audit for all out of hospital cardiac arrests**

Clinical review of all resuscitations

**Build clinician confidence and capability in cardiac arrest decision making**

Implement new JRCALC changes and measure impact



# OHCA delivery plan



**Data & Analytics** – High-quality system-wide data supports meaningful evaluation, equitable decision-making and targeted intervention. By understanding variation in outcomes and identifying communities with greater need, WAST can work with partners to deliver interventions that reduce inequalities and continually improve the effectiveness of OHCA response.

## Data and analytics

Trial PAD map systems using mathematical modelling

Implement WG OHCA registry

## Research and quality improvement

Teacher survey to understand barriers

Post CPR support-end user survey

Barriers to CPR being performed on women

Bespoke resources for ethnic minority groups



# Benefits & Evaluation



## Emergency Response Benefits and Measures

**Vision Statement:** We will transition to a clinically prioritised emergency response model that ensures that the most critically unwell patients receive the fastest possible care. Through Rapid Clinical Screening of 999 calls and the introduction of revised, outcome based call categories aligned with the Chain of Survival principles, high-risk patients - such as those in cardiac arrest - will be identified and responded to more quickly, enabling earlier life-saving interventions. At the same time, patients with less acute needs will be directed to the most appropriate remote clinical or community-based care, making best use of clinical resources and improving outcomes across the system.

### Our Patients

- Clinically determined priority for all patients requiring a conveying resource, ensuring that the assigned category is aligned with acuity, reducing the risk of under-triage.
- More timely response, improving outcomes for the most critically unwell patients.

Indicator	Target	Baseline
PURPLE (Arrest) response: Return of Spontaneous Circulation (ROSC) rates	Increase	TBC
PURPLE (Arrest) response: Time to identify arrest	Decrease	TBC
PURPLE (Arrest) response: Time to CPR instruction	Decrease	TBC
PURPLE (Arrest) response: Time to PAD arrival	Decrease	TBC
PURPLE (Arrest) and RED (Emerg) response: % within 6-8 minutes (Range)	-	TBC
RED (Emerg) response: Clinical indicators in development	-	TBC
RCS0 response: Time from code to clinician	-	TBC
RCS0 response: % of RCS0 calls recoded to PURPLE or RED	-	TBC
Balancing Measure: 20-minute backstop for PURPLE (ARREST) and RED (EMERG) response	90-95%	TBC

### Partnerships & System Contribution

- More timely response, improving outcomes for the most critically unwell patients.

Indicator	Target	Baseline
PURPLE (Arrest) and RED (Emerg) survival rates (linked to hospital data)	Increase	TBC
Community Engagement: Bystander CPR	Increase	TBC

### Value

- More 999 originating patients are appropriately referred for remote assessment or alternative specialist community response, avoiding unnecessary EMS response.
- More efficient allocation of conveying resources.

Indicator	Target	Baseline
Volume of RCS0 calls screened by final code	-	TBC
% of RCS activity referred to RICS (or other alternative WAST service i.e. UCR)	-	TBC
Balancing Measure: % of RCS activity referred to RICS (or other alternative WAST service i.e. UCR) passed back to EMS Dispatch (time out, recoded) (onward referred and passed back)	-	TBC
% ED conveyance following F2F response for RED (Emerg) - N.B. dependent on appropriate activity flowing to RICS.	Increase	TBC
Pre-arrival cancellations	Decrease	TBC
% of conveying resource production hours responding to PURPLE (Arrest) and RED (Emerg) calls - N.B. specific efficiency measure to be confirmed - review definition pack, link to enhanced care response	Increase	TBC

### Our Staff

No specific benefit statement for WAST staff, however the creation of a senior clinical role was an immediate benefit realised demonstrated by the proportion of Clinical Navigators recruited internally. Longer-term benefits could include improved staff experience as a result of stabilised performance and improved patient outcomes, resulting in improved retention and work-related sickness/absence rates.

Indicator	Target	Baseline
Staff perception measure: Custom data capture for those directly impacted by the change/experiencing a different way of the business operating (led by Head of Change and People Insights)	-	-
Role specific retention rates (Clinical Navigators, EMSC, EMS Response)	Increase	-
Role specific work-related sickness/absence rates (Clinical Navigators, EMSC, EMS Response)	Decrease	-

Long-term and/or suggested benefit /measurements - Data may not be readily available or we may only realise the benefit following a longer period of operational delivery.



# Next steps

Establish a sub group to develop a multi year strategy for OHCA improvement (SALC focussed)

Development of a 'four nations' approach with SALC, Save a Life NI, Save a Life for Scotland (plus RCUK and AACE)

Review National OHCA specifications to ensure consistency, reduced variation and inclusion criteria

Review impact of deprivation in Wales to inform local initiatives (higher incidence and lower survival)

Work with stakeholders to review impact of population health factors on survival rates to inform future strategy





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Welsh Ambulance Services  
University NHS Trust

Agenda Item No. 10

## REPORT TITLE

Internal Audit Report: Cymru High Acuity Response Unit (CHARU)  
Feedback from the Audit Risk and Assurance Committee (ARAC)

## MEETING

Name of meeting	Quality Patient Experience and Safety Committee (QuEST)
Date of meeting	7 May 2026
Public or Private	Public
If private - <a href="#">rationale</a>	n/a

## REPORT SPONSOR

Executive sponsor	Trish Mills, Director of Corporate Governance/Board Secretary
Author(s) of report	Sarah Harland, Corporate Governance Officer

## PURPOSE OF REPORT

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



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## REPORT SUMMARY:

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

1. The Audit Risk and Assurance Committee (ARAC) received and discussed the **Cymru High Acuity Response Unity [CHARU] Internal Audit Report** at its meeting on 2 March 2026. This report summarises the discussion from this meeting in reference to this report. The assurance opinion given was 'reasonable'.
2. This audit reviewed the effectiveness of CHARU in delivering improvements to patient care. The committee welcomed the audit findings and noted agreement with the recommendations, recognising that the report provided a clear direction for strengthening training oversight, governance representation and benefits realisation.
3. Members discussed the wider challenge of evaluating benefits within fast-moving change programmes, acknowledging the importance of maintaining discipline in measuring impact. It was noted that this is a common issue across NHS Wales, with new clinical indicators beginning to offer improved intelligence to support evaluation.
4. The committee sought clarification on the data improvements underpinning higher ROSC (return of spontaneous circulation) rates and noted that the key factor related to clinicians' exposure to relevant cases rather than differences in patient outcomes, highlighting the need for tailored support in rural areas.

## 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 Cymru High Acuity Response Unity (CHARU) Internal Audit Report and note the discussion at the meeting of the Audit, Risk and Assurance Committee on 2 March 2026.

## 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** Cymru High Acuity Response Unity [CHARU] Internal Audit Report



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

### STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

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

### RISK(S) THIS REPORT MITIGATES

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

N/A

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

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

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

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

<input checked="" type="checkbox"/> Leadership	<input checked="" type="checkbox"/> Workforce	<input type="checkbox"/> Culture
<input checked="" type="checkbox"/> Information	<input type="checkbox"/> Learning Improvement & Research	<input checked="" type="checkbox"/> Whole Systems Approach

### WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

<input type="checkbox"/> A socially responsible and inclusive employer	<input type="checkbox"/> An innovative and sustainable organisation	<input type="checkbox"/> A pro-active, accessible and equitable care provider
<input checked="" type="checkbox"/> n/a	<input checked="" type="checkbox"/> n/a	<input checked="" type="checkbox"/> n/a

### IMPACT ASSESSMENTS FOR CONSIDERATION

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

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

### APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
2 March 2026	Audit, Risk and Assurance Committee

# Cymru High Acuity Response Unit

## Final Internal Audit Report

2025/26

Welsh Ambulance Services University NHS Trust



Reasonable Assurance

### Contents

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Review Reference

Fieldwork

Executive Sign Off

Audit Committee

Executive Lead

Audit Team

WAST-2526-08

September 2025 - January 2026

18 February 2026

2 March 2026

Andy Swinburn, Executive Director of Paramedicine

Osian Lloyd, Head of Internal Audit; Felicity Quance, Deputy Head of Internal Audit



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Cydwasaethau  
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Shared Services  
Partnership  
Audit and Assurance Services



# Executive Summary

## Purpose

A review of the effectiveness of the Cymru High Acuity Response Unit (CHARU) in delivering improvements to patient care.

## Scope and Limitations

As defined in the agreed audit brief, the scope of this review focused on assessing the effectiveness of CHARU in improving patient care and outcomes. It did not include an evaluation of the utilisation or deployment levels of CHARU services across Wales.

## Overview

CHARU was introduced in 2022, replacing the previous Rapid Response Vehicle (RRV) model. It was designed to provide a more clinically focused approach to respond to high-acuity calls, ensuring that paramedics with enhanced skills and equipment are dispatched to incidents where they can deliver the greatest clinical benefit. This represents a shift from an emphasis on time-based targets to a focus on patient outcomes. When the role was introduced, 51 of the previous 71 RRV Paramedics chose to apply for the CHARU posts, with the remainder transferring to the Emergency Ambulance (EA) roster. At the date of audit fieldwork, there were 124 CHARU Paramedics in post, with an effective model of delivery considered achievable with a total complement of 153 (including 12.5 FTE of Senior Paramedic contribution).

Our audit found that CHARU is demonstrating clear strengths. Recent reporting shows improved Return of Spontaneous Circulation (RoSC) outcomes, indicating a strong clinical impact, and performance data confirms that CHARU performs favourably compared to the former RRV model when responding to Red incidents, supporting its intended focus on higher-acuity care.

The training programme is well structured, equipping staff with enhanced clinical skills such as ketamine administration, advanced airway management and mechanical CPR, reinforced through scenario-based assessment. Operational oversight is provided by Duty Operational Managers, Senior Paramedics and the availability of 24/7 clinical on-call support. Paramedics interviewed described the role as more stimulating and professionally rewarding than the previous model.

Governance arrangements are well established, with the Steering Group meeting quorate and CHARU activity routinely monitored through the Monthly Integrated Quality & Performance Report (MIQPR), Integrated Medium-Term Plan (IMTP) and Operations Quarterly Update Reports.

We have concluded reasonable assurance on this area. The matters requiring management attention include:

- There is no central evidence available to support the completion of six-monthly training portfolios for CHARU Paramedics. Portfolios are paper-based and monitored locally, limiting assurance of consistent completion and oversight.
- Beyond targeted analyses, there has been no comprehensive benefits realisation review of the CHARU model against its original intended outcomes, echoing issues previously identified in our APP report and Senior Paramedic Role audit report (issued November 2023: Reasonable Assurance); and no structured mechanism to gather systematic feedback from operational staff and Emergency Ambulance crews to confirm benefits or learning.
- There is no CHARU Paramedic representation on the CHARU Steering Group, limiting direct frontline insight to inform decision-making. The planned merger with the Senior Paramedic Steering Group should ensure appropriate representation going forward.

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

For management information, we have highlighted that the *Scope of Practice* requires updating to fully reflect all applicable CHARU variations within the skill requirements of the General Paramedic (Band 6) role. At present, reference is limited to the use of Ketamine and does not include the Mechanical Compression Device (LUCAS). However, we acknowledge that these expectations are clearly set out within the CHARU role advertisement and the associated training provision. As this represents an opportunity for enhancement, it does not impact the overall opinion.

## Scope & Assurance Summary

**Objectives** The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

		Related Findings	Assurance
1	Roles and responsibilities for CHARU have been clearly defined and consistently adopted across Wales.	1,2	<b>Reasonable</b>
2	Appropriate arrangements are in place to ensure CHARU staff receive adequate training and supervision to support their role effectively.	1	<b>Reasonable</b>
3	Mechanisms are in place to ensure CHARU staff are effectively supporting and enhancing patient care, including their contribution to the development and performance of their designated clinical teams.	2,3	<b>Reasonable</b>
4	Robust governance arrangements are in place to monitor the performance and effectiveness of CHARU, including how the service aligns with and supports the Trust's strategic objectives.	2,3	<b>Reasonable</b>

### Management Actions

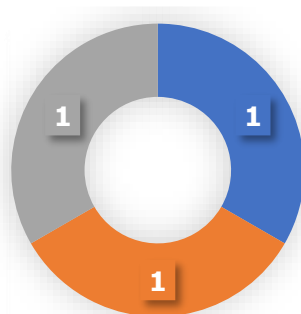


High Priority



Medium Priority

### Themes



■ Governance

■ Lessons Learnt

■ Training & Development

### Risk Types

Public Perception & Reputational Risk

Quality or Safety Issues

# Findings & Agreed Action Plan

**Objective 1:** Roles and responsibilities for CHARU have been clearly defined and consistently adopted across Wales.

**Reasonable**

A risk workshop held in 2021 identified concerns regarding the ability to meet hourly staffing requirements for the Rapid Response Vehicle (RRV) model. Subsequent analysis confirmed the issue, which was escalated to senior leadership.

Although no formal business case was submitted, a presentation outlining the proposed CHARU model presented to the Strategic Transformation Board in June 2021, set out the anticipated benefits, workforce implications, and an implementation plan. A paper presented to the EMS Demand and Capacity Review in January 2022 indicated the CHARU model could deliver over 2,500 additional hours compared to the RRV model. Further options for remodelling and addressing staffing gaps were later presented to the Senior Leadership Team and Executive Leadership Team.

All 71 permanent RRV paramedics were informed of the transition to CHARU via individual letters and an intranet bulletin. These communications detailed transition arrangements, training requirements for new medicines and equipment (e.g. mechanical compression devices), and expectations regarding clinical and supervisory responsibilities. All were advised that if they did not wish to transfer to the CHARU resource, they had the option to revert to an emergency ambulance (EA) roster.

The intention behind development of the CHARU role was to support clinicians with the relevant skills and aptitude to further develop their practice in managing higher acuity patients, while maintaining their Paramedic role. As such, there is no CHARU specific job description – rather, that for a General Paramedic (Band 6) is applied, with reference to the 'Scope of Practice' (SoP) which sets out the variations in the skill requirements for roles within this banding. Review of the SoP noted that only use of Ketamine has been defined for the CHARU role and excludes reference to the use of Mechanical Compression device (LUCAS). Given that this expectation is clearly outlined in the CHARU role advertisement and supporting training (see Objective 2), no recommendation has been made; the issue is instead highlighted for management attention.

In order to assess the roles and responsibilities of the CHARU role, interviews were held with a CHARU Paramedic from each health board area. Conclusions drawn were that overall, the role met expectations, but some issues were noted:

- The furtherance of clinical skills (refer to *Objective 2* and **Key Finding 1**).
- Call allocation processes are inconsistent with expectations, e.g., calls downgraded from Purple/Red to Orange (previously Amber) still require attendance because they were initially allocated as high priority.
- Impact of geographical postings limits the number and type of calls that can be attended, particularly in rural areas.

Noting the lack of benefits realisation undertaken since the introduction of CHARU (refer to *Objective 3* and **Key Finding 2**) such feedback has not yet been formally considered by the Trust.

The Trusts' RISC (Resuscitation in Special Circumstances) Faculty is made up of Health Board Clinical Leads and Senior Paramedics. It oversees CHARU recruitment, operational support provided to CHARU across Wales, and delivery of the CHARU training programme. This is delivered over three days with coverage including:

- Ketamine: Coverage on the use of this restricted pain relief medicine, which is limited to CHARU and Senior Paramedics (SPs), with emphasis on strict protocols around administration and permissions.
- Advanced airway management: Focussing on rapid assessment, maintaining airway patency, and applying structured algorithms to ensure effective oxygenation and ventilation while minimising delays and complications.
- CPR (Cardiopulmonary Resuscitation) / Mechanical CPR (LUCAS): Training to support the identification of patients who may benefit from resuscitation and those where cessation is appropriate, understanding the critical care needs of a ROSC (return of spontaneous circulation) patients, and the correct and safe use of the LUCAS device.
- RiSC: Integration of themes such as critical thinking, civility, legal and ethical awareness, human factors, professionalism, and a patient-centred care. This supports the development of non-technical skills essential for effective RISC practice, consolidates learning from the wider programme, and enhances practical application.
- Crew Resource Management (CRM): Principles to support effective team coordination during critical incidents. Although CHARU staff do not hold formal leadership roles, CRM supports collaborative incident management.

The programme concludes with two scenario-based assessments and a summative examination.

Post successful completion of the training programme and embarking on the operational role, CHARU paramedics must undergo a six-monthly consolidation and assessment phase with their Duty Operational Manager (DOM) and SPs. As part of this process, they are required to complete a portfolio identifying areas of good practice and areas for improvement, supporting personal development and alignment with HCPC (The Health and Care Professions Council) standards of conduct, performance and ethics. We note that the current requirement for the portfolio is paper-based and monitored at a local level, with no requirement to formally submit to the RISC Faculty, therefore limiting the assurance that such are completed in line with expectations (see **Key Finding 1**). Interviews with CHARU Paramedics indicated opportunities to further develop clinical skills within the role; the associated development needs of such could be addressed through a review of existing portfolios.

In relation to Statutory and Mandatory training, compliance was 85% for the 124 CHARU Paramedics in post at the time of fieldwork (data as at 16 December 2025). However, 33 CHARU Paramedics (27%) had not attended a MIST Day within the year. Our recent Mandatory In-Service Training report (issued December 2025: reasonable assurance) highlighted weaknesses in accountability structures for reporting and addressing individual non-compliance, with no formal arrangements for managing persistent issues. Recognising this is currently being monitored through the Trust's internal audit recommendation tracker, we have not sought to replicate the recommendation in this report.

Direct line management for CHARU Paramedics is undertaken by the DOMs, including the required administrative supervision (i.e. annual leave, PADR, training). Clinical supervision is primarily provided by the SPs, who also complete as a minimum one ride-outs (the expectation is two per annum, but as included in our Senior Paramedic Role report (issued November 2023) the second is not routinely being undertaken) and observational assessments. We were also advised that the Health Board Clinical Leads are regularly available and there is a 24/7 clinical on-call service providing additional support.

Key Findings	Risk & Impact	Agreed Management Action
<p>1 <b>Training Portfolios</b></p> <p>In line with the CHARU training programme, CHARU Paramedics are required to complete six-monthly reviews outlining good practice and areas for improvement. These reviews are monitored locally and are not formally submitted to the RiSC Faculty, resulting in no central assurance that they are being completed consistently or in accordance with expectation.</p> <p>We understand that transitional arrangements are in progress to transfer the portfolio onto Learn365 to enable central oversight by the RiSC Faculty.</p> <p>Further, interviews with CHARU Paramedics identified a desire for furtherance of clinical skills within the role; expected coverage of such which could be identified through review of portfolios.</p>	<p>Inadequate oversight of CHARU Paramedics' ongoing competency for high-risk interventions.</p>	<p><b>Agreed Action:</b></p> <ul style="list-style-type: none"> <li>• Complete the transition to Learn365 to facilitate a central assurance process to confirm that 6-monthly reviews are completed consistently and in accordance with the programme standards.</li> <li>• Review compliance data on a quarterly basis reporting to the newly established joint SP and CHARU steering group to provide assurance and escalation, where applicable.</li> <li>• Development of CHARU-specific Continuing Professional Development (CPD) sessions to facilitate additional training as appropriate.</li> </ul> <p><b>Expected Evidence of Implementation:</b></p> <ul style="list-style-type: none"> <li>• Review module on Learn365 confirming routine upload of portfolios.</li> <li>• Central monitoring reports which have been reported to the joint SP and CHARU Steering Group.</li> <li>• CPD sessions and timetable.</li> </ul>
<p><b>Theme:</b> Training &amp; Development</p>	<p><b>Medium Priority</b></p> <p>Control Operation</p>	<p><b>Officer:</b> Greg Lloyd, Assistant Director of Clinical Delivery</p> <p><b>Target Implementation Date:</b> 30 September 2026</p>

The proposed benefits of CHARU were presented as follows:

To deliver high quality clinical care to the highest acuity patients	Platform to provide infrequent and bespoke interventions if required
Improve Return of Spontaneous Circulation (ROSC) rates in Wales	Offer some marginal resilience to red performance
Provide enhanced analgesia to patients with significant trauma	Ensure a more reliable and consistent provision of extended skills
Provide clinical leadership at the scene of such incidents by clinicians who have the necessary knowledge and skills	Utilise mechanical chest compression device when necessary following recommendations set out in the European and UK Resuscitation Guidelines (2021)

No formal measurement of the effectiveness of the role, and achievement of all intended benefits, has been undertaken. (**see Key Finding 2**). However, we were advised of only two areas where outcomes have been assessed which can reasonably be attributed to this cohort:

- ROSC rates: When the RRV model was remodelled into the CHARU model, Trust-wide ROSC rates for 2019/20 averaged 13.8%, the lowest in the UK at that time. The most recent data shows an average RoSC rate of 26% between October 2024 and June 2025. A further reported increase to 81% between July and October 2025 was attributed to changes in dispatch criteria (refer to *objective 1*)
- Ketamine: A clinical audit (October 2025) reviewed electronic Patient Clinical Records (ePCRs) involving Ketamine administration, examining the presence of documented pain scores and evidence at least one point reduction after administration. This audit will have encompassed ketamine use by CHARU Paramedics, SPs operating in CHARU capacity, and Advanced Paramedic Practitioners.

In addition, were provided with data showing that between September 2002 and October 2025, CHARU Paramedics accounted for an average of 70% of the vehicle types arriving first on scene.

We also acknowledge the work of the CHARU Steering Group (CSG) including its focus on utilisation, performance, workforce considerations and job-cycle reviews, all of which contribute to the ongoing monitoring and oversight of the CHARU role (see *objective 4* for further details).

Interviews with CHARU Paramedics indicated that their primary contribution to enhanced patient care relate to ketamine administration for pain relief, and increased exposure to airway and cardiac arrest cases, enabling experience with higher-acuity incidents. However, they highlighted:

- disparities in call profiles between rural and urban areas, largely due to socio-economic factors, limiting the consistency of opportunities to use CHARU-specific skills.
- concerns regarding potential skill fade where exposure is lower; and
- the need for improved clinical oversight within Clinical Contact Centres to ensure appropriate call allocation.

Given that utilisation and deployment of CHARU Paramedics were outside the scope of this review, no further analysis of these concerns was undertaken. CHARU staff generally felt they support Emergency Ambulance crews and suggested introducing mechanisms to obtain feedback to help assess impact (see **Key Finding 3**).

Key Findings	Risk & Impact	Agreed Management Action
<p>2 <b>Evaluation and Lessons Learned</b></p> <p>Although some data analysis has been undertaken across the CHARU role since its inception, there has been no comprehensive review or formal reporting to evaluate the role's overall impact, comparative performance, or benefits realisation.</p> <p>There is no evidence to determine if the Trust has proactively sought structured feedback from operational staff regarding the effectiveness, support, and integration of the CHARU model within frontline services.</p> <p>In the absence of a structured assessment, lessons learnt and opportunities for optimisation may not be identified, and the Trust is unable to provide assurance that the role is delivering its intended operational and clinical benefits.</p> <p>Noting the role supports the Emergency Ambulance crews, feedback from the same could be considered as route through which to assess the impact/effectiveness of the CHARU role as well.</p> <p><b>Theme:</b> Lessons Learnt</p>	<p>Potential issues in deployment, resource utilisation, or clinical support may go unidentified, leading to inefficiencies.</p> <p><b>Medium Priority</b></p> <p>Control Design</p>	<p><b>Agreed Action:</b></p> <ul style="list-style-type: none"> <li>• Completion of a structured evaluation of the CHARU role to assess overall impact, comparative performance and benefits realisation</li> <li>• Evaluation to include quantitative service data with structured qualitative feedback from EA crews and other stakeholders.</li> <li>• Evaluation reported through the joint SP and CHARU Steering Group and into Senior Operations Team (SOT) as a AAA update.</li> </ul> <p><b>Expected Evidence of Implementation:</b></p> <ul style="list-style-type: none"> <li>• Evaluation report.</li> <li>• Papers / minutes of evaluation report being taken to the joint SP and CHARU Steering Group; AAA reports from SOT.</li> </ul> <p><b>Officer:</b> Greg Lloyd, Assistant Director of Clinical Delivery</p> <p><b>Target Implementation Date:</b> 30 June 2026</p>

**Objective 4:** Robust governance arrangements are in place to monitor the performance and effectiveness of CHARU, including how the service aligns with and supports the Trust’s strategic objectives.

**Reasonable**

The CHARU Steering Group (CSG) was established prior to the introduction of the CHARU role in early 2022. The group typically meets monthly and considers recruitment and workforce planning, training and development, utilisation and operational performance, and job cycle reviews. The Terms of Reference (ToR) were updated in April 2025 and approved by the Senior Operations Team (SOT). Quoracy is defined as the Chair plus four members, and attendance records show that at all meetings reviewed (January to October 2025) were quorate.

Review of the CSG membership indicates that CHARU Paramedics are not currently represented (see **Key Finding 3**). This gap was also raised during interviews, where staff noted the absence of a mechanism to provide insight into the day-to-day operational challenges faced on the ground.

The ToR state meetings should take place “monthly or as otherwise directed by the Chair.” While meetings have been less frequent during the year (not held February, March, June or July 2025), discussions with the Assistant Director of Clinical Delivery confirmed that as the role has become embedded within business-as-usual processes, the need for monthly meetings has reduced. We understand that during 2026, the CSG will merge with the Senior Paramedic Steering Group (SPSG) to provide a more aligned governance structure across both roles. As the SPSG includes SP representation, consideration will be needed to ensure consistent representation for CHARU Paramedics (see **Key Finding 3**).

As defined in the ToR, an AAA (Assure, Advise, Alert) report of each CSG meeting should be submitted to SOT, which in turn reports into the Executive Leadership Team (ELT). Our review of SOT AAA reports found no onward escalations relating to the CSG during the year.






The Trust’s Monthly Integrated Quality & Performance Report (MIQPR) provides a detailed analysis by vehicle type, including pan-Wales utilisation, average job cycle, and average jobs per shift. The reports note that CHARU performance, in supporting Red incidents, compares favourably with the previous Rapid Response Vehicle (RRV) model. CHARU Unit Hours Production (UHP) is also routinely reported and monitored against the full roll-out requirement outlined within the Integrated Medium-Term Plan (IMTP), although we note this requirement has not yet been fully achieved. Both the MIQPR and the IMTP are presented to the Trust Board and all relevant sub-committees at each meeting. Additional CHARU updates are also included within the Operations Quarterly Update Report presented to Board sub-committees.

In addition, a high-level update was presented to the Finance and Performance Committee by the Executive Director of Operations in September 2024. This report outlined key metrics, including contribution to red calls, response by priority, incident arrival order, and utilisation. It emphasised that ambulance resource utilisation, including CHARU, is an output metric reflecting deployment during service delivery, rather than a performance measure of effectiveness or efficiency. We note that a formal benefits realisation exercise against the original objectives of the CHARU role has not been undertaken (see **Key Finding 2**). The same was applicable within our audit report of the Senior Paramedic role (issued November 2023: reasonable assurance). Our consideration of the intended benefits, against available evidence notes some benefits have been achieved however, a broader clinical and operational evaluation would provide stronger assurance regarding the effectiveness of the role.

Key Findings	Risk & Impact	Agreed Management Action
<p>3 <b>CHARU Steering Group Membership</b></p> <p>Review of the ToR, supported by interviews with CHARU Paramedics during fieldwork, identified that the CSG does not include operational CHARU Paramedic representation. This limits the group's ability to receive direct, current insight into the day-to-day challenges faced by the service. Without operational CHARU input, the Steering Group may make decisions based on incomplete or inaccurate understanding of frontline realities. This increases the risk of delays in addressing operational issues, reduced effectiveness of the CHARU model, diminished staff engagement, and potential negative effects on resource utilisation, service performance, and ultimately the quality and consistency of patient care.</p> <p>We understand there is a planned merger of the CSG with the SPSG. As the latter includes SP representation, membership requirements should be reviewed to ensure appropriate and consistent representation is maintained.</p> <p><b>Theme:</b> Governance</p>	<p>The absence of CHARU representation increases the risk of ineffective governance, misaligned priorities, and reduced ability to identify emerging operational issues.</p> <p><b>Medium Priority</b></p> <p>Control Design</p>	<p><b>Agreed Action:</b></p> <ul style="list-style-type: none"> <li>As part of the planned merger of the CSG and SPSG, review and update the terms of reference to ensure appropriate and consistent operational representation from the CHARU workforce.</li> <li>Establish a mechanism for structured operational feedback ensuring emerging issues and service challenges are consistently escalated and discussed.</li> </ul> <p><b>Expected Evidence of Implementation:</b></p> <ul style="list-style-type: none"> <li>Updated terms of reference.</li> <li>Structured feedback mechanisms e.g., agenda sections / standing agenda items relating to operational oversight.</li> </ul> <p><b>Officer:</b> Greg Lloyd, Assistant Director of Clinical Delivery</p> <p><b>Target Implementation Date:</b> 30 April 2026</p>

# Appendix A: Assurance Opinion & Prioritisation of Findings

## Assurance Opinion

	<b>Substantial</b>	Few matters require attention and are compliance or advisory in nature. <b>Low impact</b> on residual risk exposure.
	<b>Reasonable</b>	Some matters require management attention in control design or compliance. <b>Low to moderate impact</b> on residual risk exposure until resolved.
	<b>Limited</b>	More significant matters require management attention. <b>Moderate impact</b> on residual risk exposure until resolved.
	<b>Unsatisfactory</b>	Action is required to address the whole control framework in this area. <b>High impact</b> on residual risk exposure until resolved.
	<b>Advisory</b>	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
<b>High</b>	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
<b>Medium</b>	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)

## 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 Non-Executive Directors or officers including those designated as Accountable Officer. They are prepared for the sole use of the Welsh Ambulance Services 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 Services 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.





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Agenda Item No. 11

## REPORT TITLE

Duty of Quality Annual Report 2025/26

## MEETING

Name of meeting	Quality, Patient Experience & Safety Committee
Date of meeting	7 May 2026
Public or Private	Public
If private - <a href="#">rationale</a>	n/a

## REPORT SPONSOR

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

## PURPOSE OF REPORT

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

## REPORT SUMMARY:

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

- As part of the Duty of Quality Statutory Guidance 2023 there is a requirement for each Local Health Board, NHS Trust and Wales-only Special Health Authority to publish an Annual Report on the steps it has taken to comply with the Duty of Quality. Section 9 of the Duty of Quality Statutory Guidance 2023 (**Annex 2**) sets out the reporting requirements for the Duty of Quality.



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2. The Duty of Candour Statutory Guidance 2023 requires NHS bodies to report annually on compliance with the duty and to publish these reports specifying if the duty has been triggered within the reporting period and if so, how often, in what circumstances and the action taken to mitigate similar circumstances in future. To streamline annual reporting in Wales and reduce duplication of content Duty of Candour reporting should be included in the Putting Things Right Report which should be published in line with regulation 51 of 2011 Regulations by 31 October each year. The high-level Duty of Candour reporting continues to be included within the Duty of Quality Annual Report, along with information on Learning from Death.
3. In order to streamline reporting the Annual Safeguarding Report and the Annual Infection Prevention Control Report have been absorbed into the Duty of Quality Annual Report 2025/26 to reduce duplication.
4. In line with the Statutory Guidance the report includes a look back at what has been achieved over the previous 12 months together with a forward look at our quality priorities and ambitions for the upcoming year alongside how progress will be monitored. There should also be continuity between Annual Reports across subsequent years. The report demonstrates continued progress in embedding the Duty of Quality across the organisation, whilst recognising ongoing challenges in evidencing outcomes, strengthening timely organisational learning, and supporting sustainable assurance arrangements under the new Listening to People Framework.
5. Last year we introduced the report utilising the Microsoft SWAY platform in order to support accessibility tools for publication, as recommended by our Partnership & Engagement Team. Whilst the platform provides the accessibility functions we require, to make the report valuable to all cohorts of our community, drafting such a large report into a single SWAY document made the navigation challenging. As a result, we have taken a different approach this year creating a main document with additional chapters linked through the report and the contents list to allow readers to select the content they are most interested in without having to scroll through the whole document.
6. The use of SWAY as a reporting platform allows us to analyse access with the report. The 2024/25 report has received 288 total views in English and further 16 views in Welsh. The majority of those accessing the report did not read the report in depth. By breaking the report into manageable chunks which are easy to navigate it is hoped that those accessing the report will find content they wish to engage with.
7. The link attached in the additional papers section will allow Committee members to engage with the draft of the Duty of Quality Annual Report for 2025/26. The report has already received endorsement from both the Clinical and Quality Governance Group and Executive Leadership Team. Committee endorsement is sought to support onward approval by Trust Board and publication in line with statutory requirements.



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## RECOMMENDATION(S)

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

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

1. Endorse the Duty of Quality Annual Report for 2025/26 for onward approval by Trust Board; and
2. Receive assurance regarding the Trust's progress in meeting the requirements of the Duty of Quality, the Duty of Candour and the Health & Care Quality Standards for Wales, recognising areas requiring continued improvement and oversight.

## 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** [Duty of Quality Report 2025/26 DRAFT](#)

**Annex 2** Duty of Quality Statutory Guidance 2023



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

## STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

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

## RISK(S) THIS REPORT MITIGATES

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

n/a

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

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

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

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

<input checked="" type="checkbox"/> Leadership	<input checked="" type="checkbox"/> Workforce	<input checked="" type="checkbox"/> Culture
<input checked="" type="checkbox"/> Information	<input checked="" type="checkbox"/> Learning Improvement & Research	<input checked="" type="checkbox"/> Whole Systems Approach

## WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

<input type="checkbox"/> A socially responsible and inclusive employer	<input type="checkbox"/> An innovative and sustainable organisation	<input checked="" type="checkbox"/> A pro-active, accessible and equitable care provider
<input checked="" type="checkbox"/> n/a	<input checked="" type="checkbox"/> n/a	<input type="checkbox"/> n/a

## IMPACT ASSESSMENTS FOR CONSIDERATION

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

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

## APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
20 April 2026	Clinical Quality Governance Group
24 April 2026	Executive Leadership Team (circulation)
7 May 2026	Quality, Patient Experience & Safety Committee
28 May 2026	Trust Board

# Duty of Quality Annual Report 2025-2026

1. Foreword
2. Quality Management
3. Quality Assurance
4. [Audit & Inspection](#)
5. [People's Experience](#)
6. Welsh Language
7. Looking Back at 2025/26
8. [Patient Safety](#)
9. Safeguarding
10. Infection Prevention and Control
11. [Health and Care Quality Standards](#)
12. Look Forward to 2026/27
13. Summary
14. Feedback

## Foreword

## Quality Management

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*The Duty of Quality created through the Health and Social Care (Quality and Engagement) (Wales) Act 2020 defines quality as:*

**‘Continuously, reliably and sustainably meeting the needs of the population we serve’**

*This includes, but is not limited to, the effectiveness of health services; the safety of health services; and the positive experience of individuals to whom health services are provided.*

*We achieve this through our Quality Management System (QMS).*

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#### **Quality Improvement Definition**

Consistent implementation of strategic and everyday improvements by those closest to the work, using a standardised methodology to test, learn, implement, scale and spread improvements in the quality of services and population outcomes.

#### **Quality Control Definition**

Daily management to monitor quality and sustain results by creating and maintaining the culture and processes for those closest to the work to take action to keep the system in control, escalating when appropriate.

#### **Quality Assurance Definition**

Effective structure, systems and standards provide a clear line of sight across the organisation giving assurance both internally and externally to stakeholders, that the desired improvements to services and population outcomes are being achieved and sustained.

#### **Quality Planning Definition**

Planning to improve the quality of services and outcomes for the population, by understanding and prioritising the needs of citizens and stakeholders. Designing policies, structures, systems and processes to achieve this.



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*We are working with partners across Wales to strengthen the Quality Management Systems across the Trust through the **QMS Learning and Delivery Network** facilitated by NHS Wales Performance and Improvement. We share our own experiences and learn from other organisations to ensure our QMS evolves and improves.*

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## Quality Assurance



### **Quality Self-Assessments**

Many of our services this year have completed quality self-assessments. Our services have been assessing how well they fulfil the 12 Health and Care Standards and how they evidence this.

We have been pleased to note some common positive themes running throughout the self-assessments. These include well-established governance structures and reporting processes, collaborative working (both internally and pan-Wales), and a commitment to staff development and wellbeing. Themes around opportunities for improvement include

improved frameworks for quality indicators and more automated reporting. A key theme amongst our corporate teams is a need for more structured feedback mechanisms.

We will use the learning from these self-assessments to create an improvement plan over the next 12 months. We will report back to you on this in our next Duty of Quality report.

### **Quality Assurance Dashboard**

This year has seen the development of an automated dashboard designed to strengthen the Trust's approach to organisational learning and improve the Quality Assurance elements of our Quality Management Systems across the organisation.

The dashboard will support operational leaders to identify trends, themes and areas for further investigation. Incorporating run charts to display trends over time across three levels of incident reporting will enhance the ability of our leaders to recognise emerging risks. The dashboard also allows for analysis of final harm levels where the harm level is moderate or above.

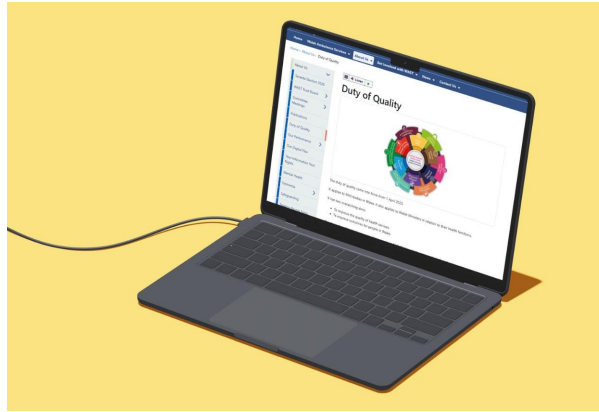
The second iteration of the dashboard, expected later this year, will include sections for complaints analysis and more comprehensive harm analysis.



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*You can read more about how we assure the quality of our services in our section on Audit and Inspection [here](#).*

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**Our website includes information on our services, our committees and our Trust Board. You can also find documents and papers that have been discussed and the decisions we have taken over the last year. There is also a section dedicated to our response to the Duty of Quality: [Welsh Ambulance Services University NHS Trust](#)**

## People's Experience



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*NHS Wales define peoples experience as **the sum of all interactions, shaped by the culture of the organisation, staff and systems.** It incorporates every encounter and touchpoint, and acknowledges how an organisation, its staff and systems shapes, impacts and influences an individual's experience of the care and service provided.*

*Our 'Experience Cycle' covers each touchpoint someone has with our service. It helps us to improve by listening to people's feedback and acting on it to drive continuous quality improvement.*

*In capturing experiences, methods will vary but generally include:*

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- Experience surveys

- *Individual/patient stories*
  - *SMS text*
  - *'Have your Say' online facility*
- 



People's experience is important within the dimension of healthcare quality, alongside clinical excellence and patient safety. Over the year there has been a stronger focus on understanding and improving the patient's journey and overall experience, primarily in response to the Peoples' Experience Framework (PEF).

This has been incorporated within our approach to being quality led and along with the introduction of the National People's Experience Survey (PES) and Patient Reported Experience Measure (PREM), Welsh Friends and Family Test, Civica and Datix compliment code changes has ensured that the Trust has been positioned to capture and record against the required datasets within the PEF.

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*You can read more about People's Experience in our Experiences Section [here](#).*

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## Welsh Language

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*The Welsh Language (Wales) Measure 2011 provides a clear legal framework requiring WAST, along with other public sector bodies, to comply with specific standards relating to the Welsh language. More than a statutory obligation, it offers a valuable opportunity to strengthen and enhance the quality and availability of our services through the medium of Welsh.*

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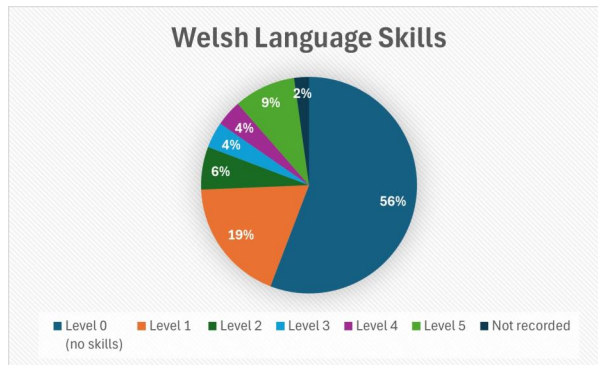


### **Translation Services**

We told you in our 2023-24 report about the recruitment of a Welsh Language Translator. We have made great strides in improving how we deliver our services, including written correspondence and telephone calls, through the introduction of our own translation service. This means we can now translate letters, communication channels and publications more quickly and efficiently. However, we recognise that further progress is needed to ensure that our reception services provide a welcoming first point of contact for Welsh speakers.

### **Leadership**

Strong leadership has been essential in promoting the Welsh language within our organisation. The Board actively champions the Welsh language, ensuring it is included in all aspects of our planning and decision-making. Our commitment to offering Welsh language services is central to our wider work on equality, diversity and inclusion, sitting alongside our Strategic Equality Plan and People and Culture Plan. The Board oversees these plans and our Welsh Language Standards Annual Report, ensuring progress and accountability for all our staff and the communities we serve.



1 - Breakdown of staff language skills from ESR

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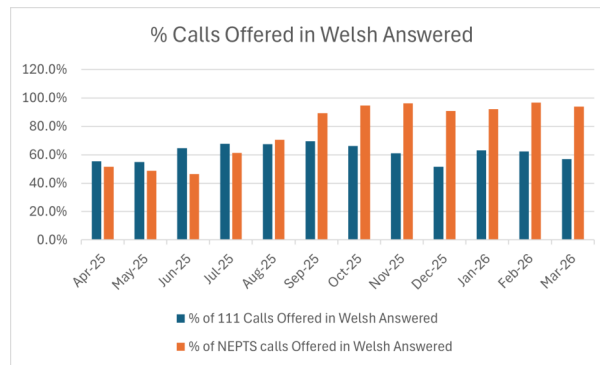
### **Welsh Language and our Workforce**

*Operational standards compliance (i.e. the use of Welsh internally) is growing stronger each year, with a significant increase in the number of resources available to our people. From a total of 4,579 members of staff, 4,477 (97.77%) have self-assessed and recorded their Welsh language skills on the Electronic Staff Record (ESR) system.*

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### **Clinical Consultation Plan**

This year a key deliverable within our Integrated Medium-Term Plan (IMTP) was the development of a revised five-year clinical consultation plan. The focus of the plan is how the Trust will seek to deliver remote clinical care consultations in Welsh. We have worked in partnership with the Welsh Language Commissioner's Office to support a sustainable increase in bilingual service provision. We will keep you updated on our progress in delivering this plan through our Duty of Quality reports each year.



2 - Data on service users accessing services in Welsh

## Accessing our Services in Welsh

There has been a steady increase in the number of service users accessing our Welsh language services when calling NHS 111 Wales and Non-Emergency Patient Transport Services.

### NHS 111 Wales

62% of calls offered in Welsh were answered in Welsh

### Non-Emergency Patient Transport Services

74% of calls offered in Welsh were answered in Welsh

## Communication Needs

The Trust continues to engage with service users to help us improve our communication. We recognise that people have different communication needs and we are striving to ensure that people can access information about our services easily.

We have been reaching out to communities who do not speak English or Welsh as their first language, as well as members of the deaf community, to better understand their experiences when using our services. By attending events such as the Big Halal Expo, the Mela, and dedicated Deaf Community Focus Groups, we have listened to service users' feedback on how we can improve accessibility and support. In response, we have set up a steering group to review and enhance how we provide interpretation and translation support across all areas of the Trust.

Our aim is to join a shared business framework that will give us greater access to telephone interpretation and translation services within our contact centres. This new approach will also help us make significant savings, with the potential to reduce costs by over £100,000 each year.



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### *British Sign Language (BSL)*

*We have expanded our use of Sign Video to our Ambulance Care Teams which will help our deaf service users when booking transport and have built relationships with BSL interpreters to provide interpretation for our Trust Board meetings.*

*We welcomed the introduction of the BSL (Wales) Act and have played an active role in Welsh Government's consultation process.*

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## Looking Back at 2025-26

### **Public Accountability Meeting**

This year the Cabinet Secretary for Health and Social Care in Wales held a series of public accountability meetings with each health body as part of arrangements to hold the NHS to

account for delivering against Welsh Government priorities. These meetings focused on how we are delivering against our plans including quality, safety and risk. On 5 March 2026, Welsh Ambulance Services University NHS Trust leaders met with the Cabinet Secretary and other members of Welsh Government. This meeting was streamed live for the public to view in real-time and is also available as a recording.

Embed://https://www.gov.wales/welsh-ambulance-services-university-nhs-trust-public-accountability-meeting-recording-5-march-2026



### **Working in Partnership**

Over the past year, the Trust has continued to turn our commitment to partnership into practical action. We have worked closely with Welsh Government, commissioners, health boards and wider system partners to embed our refreshed clinical model, strengthen community-based pathways and support more people to receive the right care at the right time, closer to home. Collaboration has been central to progress on initiatives such as single points of access, same-day emergency care, improved hospital handovers and the expanding role of remote clinical services. We have also deepened our engagement with patients, staff and communities, using feedback, lived experience and co-production to shape service improvement and innovation. While challenges remain, particularly in managing demand and system pressure, the Trust's approach remains grounded in transparent dialogue, shared accountability and collective problem-solving. Working in partnership is not an ambition for the future alone; it is how we are delivering change now, in line with our purpose to support, to serve and to save.

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*You can read more about some of the initiatives we have undertaken through partnership in our 'Whole Systems Approach' update in our Standards section [here](#).*

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### **Public and Patient Reference Group**

Last year, we committed to stronger collaboration with patient and community groups through the development of a formal public and patient reference group. Over the course of the year, we have continued to progress this commitment, building on feedback from earlier engagement activity. This has included continued engagement through existing forums, targeted conversations with community and voluntary sector partners, and the use of feedback from public events and engagement activities to inform service priorities. Our existing People and Community Network has more than 100 members and continues to play a vital role in informing and improving services. They regularly receive updates and are invited to observe and submit questions to our Trust Board. In February 2026, they contributed to a planned event exploring what quality means in health care delivery.

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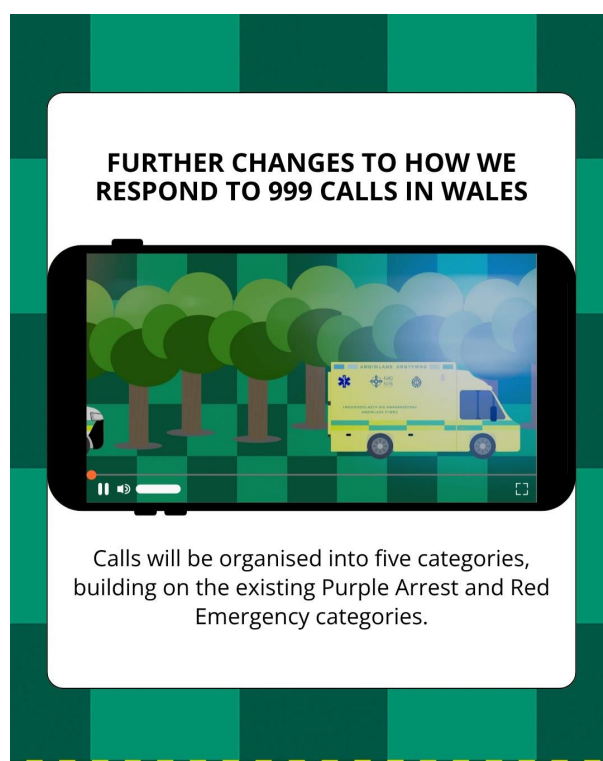
*You can read more about our People and Community Network in our Experiences Section [here](#).*

### ***Delivering Our Integrated Medium-Term Plan***

*Last year, as part of our ongoing effort to transform how we provide care, we shared our commitment to collaborating with partners in order to better respond to people's needs, enhance the workforce experience and ensure we have the necessary resources to deliver timely and effective care so every patient has the best chance at a positive outcome. We gave you an overview of some key initiatives aimed at improving our service quality. Throughout this Duty of Quality Annual Report for 2025-26, you'll find updates covering a*

*variety of services and standards, highlighting both our achievements and the challenges we continue to face as we strive to enhance the quality of care you receive.*

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### **Evolving the Clinical Model**

Over the past year, our ambulance service has continued to change how we respond to 999 calls, moving away from measuring success purely by response times and instead focusing on delivering the right care, at the right time, based on clinical need. From summer 2025, we began piloting Welsh Government's new Ambulance Performance Framework that prioritises patients with the most life-threatening conditions, such as cardiac arrest, using measures that reflect patient outcomes and quality of care rather than speed alone. Building on this, further changes were introduced later in the year to improve how we respond to people with serious and urgent conditions, such as stroke or chest pain, by introducing clearer response categories and more tailored clinical responses. Together, these changes support a more patient-centred approach, help our clinicians make better decisions and aim to improve care and outcomes for communities across Wales.

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*You can see more information about how our services have changed and what that means for you on our website [how our service is changing - Welsh Ambulance Services University NHS Trust](#)*

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### **Quality Improvement**

During 2025-26, our Quality Improvement Team has gone through an exciting period of change. We have set out a new mission “Assuring Quality, Driving Excellence”, and put in place clear goals and values to guide our work. Our aim is to make sure that everything we do leads to better care and higher standards across the service. *To make the biggest difference*, our team is now offering even more advice and support. We’re building a network of improvement champions across the country who help turn good ideas into real solutions. Working with partners like WAST Education and Development and NHS Wales Performance and Improvement, our team will deliver Improvement Cymru courses. To help achieve this, our Quality Improvement Team is completing a Certificate in Education and Training (CET) as well as a Certificate of Assessing Vocational Achievement (CAVA) and Internal Quality Assurance of assessment processes and practice (IQA) certification.



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*Sicrhau Ansawdd, Ysgogi Rhagoriaeth*  
*Assuring Quality, Driving Excellence*



***To help improvement happen***, we’ve designed a digital platform where staff can safely share their ideas for change, either at any time or through special challenges. We carefully review all projects to make sure they fit with our goals and have the best chance of making a positive impact. Our online Q Hub offers digital training, brings people together to share knowledge and keeps everyone up-to-date through dashboards and regular updates.

***To understand how we’re doing and where we want to go***, we’re mapping out how different parts of our organisation work together, spotting areas to improve and making sure our systems are joined up. By measuring and comparing our standards, we can see what’s working well and where we need to get better. This helps us set clear goals for quality right across the organisation, making sure we’re always moving forward and delivering the best possible care.

## Patient Safety

**During 2025–26, our approach to the Duty of Candour, Learning from Deaths and Safeguarding reflected a continued commitment to openness, compassion and accountability in everything we do.** We remained focused on being open and honest with people and families when care did not go as expected, ensuring that apologies, explanations and support were provided in a timely and sensitive way, and that learning was identified and acted upon.

Learning from deaths remained a vital part of our quality and safety arrangements, helping us to understand where care could be improved and to strengthen systems to prevent harm in the future. Safeguarding continued to be central to our responsibilities, with clear arrangements in place to identify, escalate and respond to concerns relating to children and adults at risk.

Together, these areas support a culture of learning and improvement, reinforce public trust and underpin our commitment to providing safe, high-quality and person-centred care across Wales.

### **Putting Things Right**

During the last year, the Trust has experienced sustained difficulty in being able to provide timely responses when people raise concerns with us. Over the course of the year from April 2025 to March 2026, the organisation experienced a significant increase in the volume and complexity of concerns received, alongside rising demand for services.

Timely management of concerns is a critical component of the Trust's quality governance framework. Complaints, incident investigations and coronial processes provide important opportunities to identify learning and improve patient care. Delays in the investigation or response to concerns can therefore impact the organisation's ability to identify and act on patient safety learning. Most importantly, we acknowledge the impact this had had on people waiting for explanations and apologies, particularly where a loved one may have died or has been very severely affected by a health condition.

Since the establishment of a programme of support to monitor and improve our compliance to the national response time of 30 working days, overdue complaint volumes have steadily reduced. The total number of open complaints in April 2026 is at its lowest level since November 2024 and we are providing considered and careful responses in the timeframe that the public deserves.



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### *Listening to People*

*The Listening to People guidance is a new NHS Wales approach to how concerns and complaints about NHS-funded care are handled. It replaces the previous system known as Putting Things Right and is designed to make the experience fairer, kinder and easier for patients, families and carers. At its heart, the guidance recognises that when something goes wrong, people want to be listened to properly, treated with respect and kept informed about what will happen next. The new approach puts compassion, openness and clear communication at the very start of the process.*

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A key change under Listening to People is that everyone who raises a concern will be offered a listening conversation at an early stage. This can take place face-to-face, over the phone or by video call, depending on what suits the individual. The aim is to give people the opportunity to explain what has happened in their own words and feel heard, rather than relying only on letters or forms. There is also a new early resolution stage, which allows concerns that can be resolved quickly to be dealt with within 10 working days, helping to reduce stress and avoid unnecessary delays.

The guidance also strengthens expectations around honesty and transparency. When harm may have occurred, NHS organisations must be open, provide a clear explanation, and

apologise where appropriate. Timeframes are clearer, with concerns acknowledged within five working days and responses written in plain, accessible language rather than medical or legal jargon. For people who have experienced distress or loss, this aims to create a more humane and supportive process at an already difficult time.



Overall, the benefits of Listening to People are intended to be felt by everyone. Members of the public should find it easier to raise concerns and feel more confident that they will be treated with dignity, listened to carefully and kept informed. For the NHS, listening earlier and learning more effectively from concerns helps improve safety, prevent future harm and build greater trust with the communities it serves. The focus shifts from simply processing complaints to genuinely hearing people and using their experiences to make care better for all.

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*You can read more about our response to the Duty of Candour, Learning from Deaths and Safeguarding in our Patient Safety section [here](#).*

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## Safeguarding



Safeguarding means making sure that people are protected from abuse, neglect or harm. Our Safeguarding Team works to ensure that everyone in our care, including children and

adults who may be at risk, is looked after and listened to if there are any concerns about their safety.

This important work is overseen by the Assistant Director of Safeguarding, who leads a team of specialists. Together, they make sure we meet our legal responsibilities to protect those who need help most.

We follow clear policies and procedures and provide essential training so that safeguarding is always at the heart of what we do. Our specialists offer expert guidance across the organisation, helping to create and deliver a safeguarding plan that follows the law and responds to the latest issues affecting people in Wales

Our Corporate Safeguarding Team works together with other organisations to help keep people safe. This includes collaborating with local, regional and national partners throughout Wales. By working closely with groups such as Public Health Wales, Community Safety Partnerships, and the Children's and Older People's Commissioners, the team supports the Welsh Government's priorities for safeguarding.

At the Welsh Ambulance Services University NHS Trust, we promote a positive and supportive workplace culture. Staff are encouraged to speak up if they have concerns, ask questions when something does not seem right, and take action to protect anyone who may be at risk or in need of care and support.

Our Corporate Safeguarding Team works with colleagues across the Trust to create a safe environment for everyone. They also partner with other organisations throughout Wales to help protect people from harm.

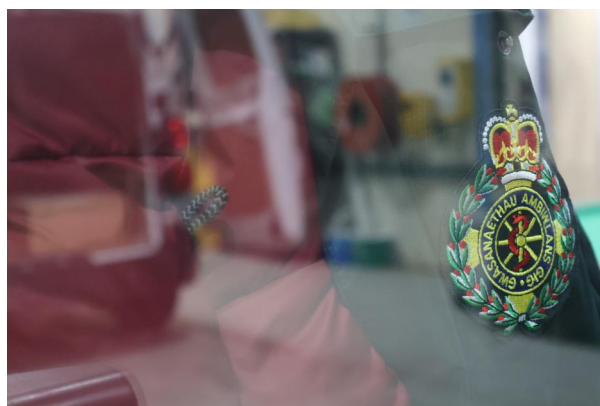


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*You can read more about our approach to safeguarding in our Patient Safety section [here](#).*

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## Infection Prevention and Control



Throughout 2025, the Infection Prevention and Control (IPC) team navigated a range of **operational and organisational challenges**. These included leadership transitions, workforce changes, staffing shortages and reduction in training opportunities, all of which affected the team's overall capacity and effectiveness. Despite the challenges faced, there has been **significant progress** within the IPC service. The team, which is newly established and supported by a new Head of Service and experienced IPC specialists, has focused on building a robust baseline from which sustained development and improvement can continue.

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*Despite these pressures, core statutory and regulatory responsibilities were maintained. No evidence has been identified of increased infection-related harm attributable to service disruption during this period. Risks associated with reduced capacity were monitored through established governance arrangements, with prioritisation protocols in place to protect high-risk areas.*

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Over the past year, the team has successfully introduced a **comprehensive annual IPC audit programme**. This programme includes systemic audits of emergency and non-emergency vehicles, ambulance premises, hand hygiene, bare below the elbow (BBE) and personal protective equipment (PPE) compliance. These foundations have created a clearer picture of current performance, enabling **targeted improvement activity**, strengthened independent assurance and governance oversight, and improved organisational visibility of IPC compliance and variance.



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*Audit activity during 2025 has not identified any recurring or widespread IPC concerns. Where isolated areas of non-compliance were observed, corrective actions were agreed with local leads and monitored through to completion. This shift towards structured, data-informed assurance has strengthened organisational visibility and oversight.*

*You can read more about our findings in our Audit and Inspection section [here](#).*

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The IPC team has focused its efforts on building strong relationships and increasing confidence in the IPC service. The profile of the IPC portfolio has been significantly raised across the Trust and has been met with strong support and engagement. During this period, we have undertaken a thorough review of existing IPC arrangements and mapped out the requirements and priorities for the next 12 months. While there remains further development to achieve full service maturity, meaningful progress has been made in establishing systematic assurance processes aligned to the organisation's Duty of Quality responsibilities, with a defined improvement trajectory for 2026.

## Health & Care Quality Standards 2023



3 - Health & Care Quality Standards 2023

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*The 12 Health and Care Quality Standards help us to understand what good quality means and how we can apply it in practice.*

*They provide a guide to measure quality across the services we provide to the population and our stakeholders, helping us to plan, make decisions, deliver and monitor quality.*

*You can read more about how we are complying with the Health and Care Quality Standards in our Standards section [here](#)*

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## Look Forward to 2026-27

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### ***Integrated Medium Term Plan 2026-29***

*Our updated Integrated Medium -Term Plan for 2026-29 focuses on making the improvements we have already introduced work well and consistently for people across Wales. Rather than making lots of new changes, this plan is about strengthening and settling our services so that patients can rely on them, even during a time of high demand and limited funding. We are bringing together our 999, NHS 111 Wales and patient transport services to work as one joined-up system, helping people get the right care, at the right time, in the right place. By concentrating on quality, safety and making the best use of our*

*resources, we aim to improve reliability, support our staff and ensure we continue to listen to patient feedback while delivering safe, compassionate care for everyone who needs us.*

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### **Safe Care**

During 2026-27, we will continue to strengthen safety through a stronger focus on clinical outcomes, particularly for high-risk patient groups. The **Out of Hospital Cardiac Arrest (OHCA) delivery plan**, developed in partnership with Save a Life Cymru, brings together actions to improve early intervention, defibrillator access, community readiness and post-resuscitation care.

### **Timely Care**

Improving timely access to advice, assessment and care remains a core priority for the next year. The Trust will focus on improving time to clinical consultation through the continued development of **Remote Integrated Care Services**, supporting patients to receive early, senior clinical assessment regardless of whether they access services via 999 or NHS 111. A key delivery for 2026-27 will be the implementation of **a single remote clinical queue**, enabling more consistent and timely prioritisation across contact routes.

### **Effective Care**

Effectiveness will be driven through the continued delivery of the Clinical Model Transformation Programme, ensuring services are consistently clinically led and evidence-based. We will continue to strengthen **urgent community response**, including improved use of Advanced Paramedic Practitioners and **enhanced falls pathways**, supporting more patients to be safely treated and cared for closer to home.

### **Efficient Care**

Efficiency and value will be a key focus for 2026-27, supported by the Trust's Financial Sustainability Programme and a strong emphasis on productivity improvement. A dedicated **Non-Emergency Patient Transport Services Improvement Programme** will be established to

improve booking, scheduling and coordination, reducing short-notice cancellations and improving overall service reliability

### **Equitable Care**

The Trust will continue to act to reduce unwarranted variation and improve equity of access and outcomes. During 2026-27, population health **intelligence will be strengthened** to better understand variation for high-risk and vulnerable groups, including those experiencing cardiac arrest, frailty related falls and mental health crisis.

### **Person-Centred Care**

Improving people's experience of care will remain central to the Trust's quality agenda. Over the next year, the Trust will transition further to **real-time, digital approaches for capturing patient experience**, enabling more timely understanding of feedback and earlier identification of themes.

### **Leadership**

**Visible leadership** at all levels will continue to underpin the Trust's approach to quality during 2026-27. Board-level oversight, supported by established quality governance arrangements, will ensure that strategic decisions are made through a quality lens and are aligned to the Duty of Quality.

### **Workforce**

Our workforce is fundamental to the Trust's ability to deliver safe, effective, person-centred and sustainable care. During 2026-27, we will continue to prioritise workforce wellbeing, capability and capacity as key enablers of quality improvement, recognising the direct relationship between staff experience and patient outcomes. This includes **targeted action to reduce sickness absence and work-related stress**, continued **focus on staff safety and psychological wellbeing**, and strengthening leadership capability to support openness, learning and improvement.

### **Culture**

The Trust will continue to foster a culture that values people, encourages openness and promotes psychological safety. During 2026-27, further emphasis will be placed on enabling staff to raise concerns, learn from improvement activity and engage meaningfully in service change.

### **Information**

A continued focus on **strengthening data quality, linkage and insight** will support delivery of the Duty of Quality. During 2026-27, the Trust will enhance its use of quality intelligence by triangulating performance, safety, experience and outcome data to inform decision-making,

prioritisation and assurance. This will support both organisational learning and transparent reporting of improvement.

### **Learning, Improvement and Research**

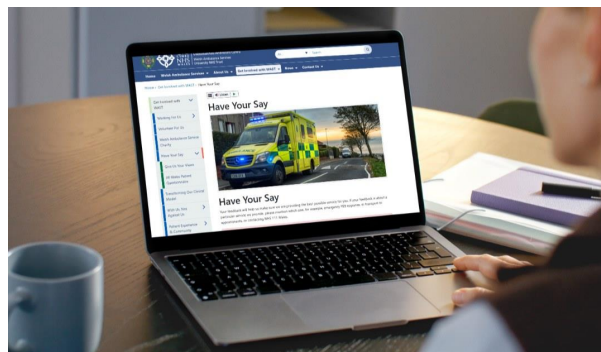
Learning and improvement will remain embedded across the Trust through structured quality improvement, evaluation and research activity. Independent academic evaluation of clinical model changes, alongside **internal benefits realisation** workstreams, will provide robust evidence of impact and identify opportunities for further improvement.

### **Whole-System Perspective**

The Trust will continue to work collaboratively with Health Boards, commissioners, national programmes, voluntary sector partners and communities to improve quality across the wider health and care system. Recognising that many quality challenges are system-wide, actions during 2026-27 will focus on **shared solutions** that improve access, flow, experience and outcomes for the population of Wales.

## Summary

## Feedback



**For more information about Welsh Ambulance Services University NHS Trust, visit our website at [www.ambulance.nhs.wales](http://www.ambulance.nhs.wales)**

To provide us with feedback on our services you can follow the links below

- [Calling 999 Survey](#)
- [Calling 111 Survey](#)
- [111 Website Survey](#)
- [Non-Emergency Transport Survey](#)
- [Communicating in your language of choice](#)

- [Virtual Video Booth](#)



Llywodraeth Cymru  
Welsh Government

**WG23-12**

**The Duty of Quality Statutory Guidance 2023  
and Health and Care Quality Standards 2023**

The Health and Social Care (Quality and Engagement) (Wales) Act 2020

The Health and Social Care (Community Health and Standards) Act 2003

**Date of issue: 1 April 2023**

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### Figure 1

Diagram to demonstrate the quality management cycle

### Figure 2

Diagram to demonstrate the central strategic context of the duty of quality

### Figure 3

Diagram to illustrate the Health and Care Quality Standards.

## Glossary

### Interpretation, in this guidance:

- The 2003 Act means the Health and Social Care (Community Health and Standards) Act 2003.
- “Health care” for the purposes of the 2003 Act means (a) services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness; and (b) the promotion and protection of public health.
- The 2006 Act means the National Health Service (Wales) Act 2006;
- The Act means the Health and Social Care (Quality and Engagement) (Wales) Act 2020.
- NHS body, in the context of the duty of quality in Wales, means -
  - (a) a Local Health Board.
  - (b) an NHS Trust.
  - (c) Wales-only Special Health Authority.
- Where the word **must** is used, it refers to actions that are a legal requirement, as set out in Part 2 of the Act;
- Part 2 of the Act amends the National Health Service (Wales) Act 2006 to insert new provisions 1A, 12A, 20A and 24A into the 2006 Act. For the purposes of those new provisions:
  - “Health services” means any services provided or secured in accordance with the 2006 Act: and
  - “Quality” includes, but is not limited to, quality in terms of –
    - (a) The effectiveness of health services,
    - (b) The safety of health services, and
    - (c) The experience of individuals to whom health services are provided.

## FOREWORD

Introducing a duty of quality through the Health and Social Care (Quality and Engagement) (Wales) Act 2020 <sup>1</sup> ('the Act'), highlights the Welsh Government's commitment to safe, effective and person-centred health services. The Act places an overarching duty of quality on the Welsh Ministers regarding their health-related functions. It broadens the existing duty on NHS bodies (Local Health Boards, NHS Trusts and Welsh Special Health Authorities).

Ultimately, the purpose of the duty of quality is to ensure that Welsh Ministers and NHS bodies secure improvements in the quality of services they provide. The duty represents our ambition of achieving ever-higher standards of person-centred health services in Wales.

Quality is more than just meeting service standards. It needs to be a system-wide way of working to continuously, reliably and sustainably meet the needs of the population that we serve. A culture of continuous learning and improvement is crucial.

In discharging the duty of quality, NHS bodies are required to take into account the Health and Care Quality Standards when making decisions about health services so that improved outcomes are secured. This supports the five ways of working (long term, integration, involvement, collaboration and prevention) within the Well-being of Future Generations (Wales) Act 2015 <sup>2</sup> as well as promoting the well-being goal of A Healthier Wales<sup>3</sup>. The Welsh Ministers must also take into account the Health and Care Quality Standards when conducting reviews of, and investigation into the provision of health care by and for NHS bodies under section 70 of the Health and Social Care (Community Health and Standards) Act 2003. In practice, the role of conducting such reviews and investigations is undertaken by Healthcare Inspectorate Wales (HIW) on behalf of the Welsh Ministers.

The Welsh Government published the Quality and Safety Framework<sup>4</sup> in September 2021. This was intended to serve as a steppingstone to the new duties of quality and candour under the Act whilst we emerged from the coronavirus pandemic.

In order to build clear connections between the duty of quality and standards, this guidance now incorporates the new Health and Care Quality Standards that will replace the Health and Care Standards<sup>5</sup> that were issued in 2015. This new

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<sup>1</sup> Welsh Government (2020) Health and Social Care (Quality and Engagement) (Wales) 2020 Act <https://www.legislation.gov.uk/asc/2020/1/contents>

<sup>2</sup> Welsh Government (2015) Well-being of Future Generations (Wales) Act <https://www.futuregenerations.wales/about-us/future-generations-act/>

<sup>3</sup> Welsh Government (2019) A Healthier Wales: our Plan for Health and Social Care [A healthier Wales: long term plan for health and social care | GOV.WALES](#)

<sup>4</sup> Welsh Government (2021) Quality and Safety Framework: Learning and Improving [https://gov.wales/sites/default/files/publications/2021-09/quality-and-safety-framework-learning-and-improving\\_0.pdf](https://gov.wales/sites/default/files/publications/2021-09/quality-and-safety-framework-learning-and-improving_0.pdf)

<sup>5</sup> Welsh Government (2015) Health and Care Standards <https://www.gov.wales/sites/default/files/publications/2019-05/health-and-care-standards-april-2015.pdf>

approach sets out a clear and simple framework for quality management that will strengthen the connection between the duty, standards and the wider quality management process in Welsh health services.

I am proud that 'Putting quality and safety above all else' is the first core value described in "A Healthier Wales", our long-term strategy for integrated health and care in Wales. As Dr Tedros Adhanom Ghebreyesus, World Health Organisation Director General recently reminded us, "Quality is not a given. It takes vision, planning, investment, compassion, meticulous execution, and rigorous monitoring, from the national level to the smallest, remotest clinic."<sup>6</sup>

We have a significant opportunity to refresh and strengthen our commitment to "A Healthier Wales" through the new duty of quality. We have a collective responsibility to achieve improved quality of services and outcomes for our population.

Eluned Morgan, Minister for Health and Social Services

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<sup>6</sup> World Health Organisation (2022) Fundamentals of Quality <https://qualityhealthservices.who.int/quality-toolkit/new-to-health-system-quality-thinking/fundamentals-of-quality>

## 1. Introduction

- 1.1 The duty of quality, as part of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 (“the Act”), will come into force on 1 April 2023. It is a lever for improving and protecting the health, care and well-being of the current and future population of Wales. The Act aims to ensure a stronger citizen voice and to improve the accountability of services to deliver a better experience and quality of care. Doing so contributes to a healthy and more prosperous country. The Act is intended to have positive benefits for everyone in Wales, supporting a culture and the conditions needed to drive improvements in health care.
- 1.2 This document serves a dual purpose of providing statutory guidance which aims to help NHS bodies in Wales deliver the requirements of the duty of quality, and also sets out the new Health and Care Quality Standards issued under section 47(1) of the Health and Social Care (Community Health and Standards) Act 2003. NHS Bodies are under a duty to take into account these standards when discharging the duty of quality.
- 1.3 The legal basis for the duty of quality is set out in Part 2 of the Act.
- 1.4 The duty of quality supports all people in Wales. The new duty of quality requires the Welsh Ministers and NHS bodies to think and act differently by applying the concept of “quality” across all functions within the context of the health service and health needs of their populations. It requires quality-driven decision-making and planning, to ultimately deliver better outcomes for all people who require health services. It requires involving people in decisions that affect them, balancing short-term needs with planning for the longer-term, with action to prevent problems occurring or getting worse.
- 1.5 The duty also supports the application of prudent and value-based healthcare principles, referred to in the National Clinical Framework<sup>7</sup> as ‘prudent in practice’. This increasingly shifts the focus to person centred care that can support people to stay well, self-manage their condition and, when necessary, provide seamless and appropriate specialist support. The focus is on the person rather than the setting in which the service is delivered.
- 1.6 Value-based health care<sup>8</sup> encourages us to focus on meeting the goals of our patients and to help manage expectations throughout their care or treatment. Value in health encourages us to improve how patients are involved in decision making using the best evidence available, avoiding any unnecessary variation in care, and becoming more creative to determine where our resources are

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<sup>7</sup> Welsh Government (2021) National Clinical Framework: A Learning Health and Care System at [https://www.gov.wales/sites/default/files/publications/2021-05/national-clinical-framework-a-learning-health-and-care-system\\_0.pdf](https://www.gov.wales/sites/default/files/publications/2021-05/national-clinical-framework-a-learning-health-and-care-system_0.pdf)

<sup>8</sup> Welsh Value in Health Care (2022) Value-based Healthcare for Wales at <https://vbhc.nhs.wales/value-based-healthcare-for-wales/policy-and-culture/>

best spent to improve patient outcomes. By working with patients and teams from across the healthcare system in Wales, and collaborating with industry and third sector, we can deliver the outcomes that matter to people with the resources available to us in a way that is sustainable.

- 1.7 The prevailing intention is to build on the positive culture of quality at the heart of the Welsh health system<sup>9</sup>, enacting a broader system-wide duty of quality which strengthens decision-making, action, improvement and ultimately, improved outcomes for the population.

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<sup>9</sup> Organisation for Economic Co-operations and Development (OECD) Reviews of Health Care Quality: United Kingdom 2016: Raising Standards  
[https://www.oecd-ilibrary.org/social-issues-migration-health/oecd-reviews-of-health-care-quality-united-kingdom-2016\\_9789264239487-en](https://www.oecd-ilibrary.org/social-issues-migration-health/oecd-reviews-of-health-care-quality-united-kingdom-2016_9789264239487-en)

## 2. Purpose of the guidance

- 2.1 Improving the quality of our services to achieve better outcomes for people is the right thing to do.
- 2.2 The guidance sets out best practice to assist NHS bodies in the implementation and application of the duty of quality. NHS bodies must have regard to the guidance issued by the Welsh Ministers.
- 2.3 The guidance provides a foundation on which quality management systems, relevant policies and procedures, training and support requirements will be built. It facilitates clarity about the duty of quality, consistency of approach and equity of response to improve the quality of health services and outcomes for people.
- 2.4 The guidance sets out a definition of quality and describes the overarching requirements to strengthen our quality management systems with quality-driven decision-making and planning. In turn, this strengthens our responsibilities to learn and create opportunities to share learning. The purpose of the duty overall is to improve outcomes for our population.
- 2.5 It is intended as a reference for our workforce as well as our population and partner organisations, so we develop a common understanding about the duty of quality.
- 2.6 It is not intended to be a prescriptive document, nor is it intended to be a quality manual or 'how to' guide. It is ultimately for NHS bodies to satisfy themselves that they are complying with the new duty to secure improvement in the quality of health services that is imposed on them in the 2006 Act, though it is envisaged that this guidance will provide a helpful framework to assist such bodies accordingly. Furthermore, this guidance document also sets out new Health and Care Quality Standards which will replace the Health and Care Standards (April 2015) issued under section 47(1) of the Health and Social Care (Community Health and Standards) Act 2003 (which is a power that permits the Welsh Ministers to publish statements of standards in relation to the provision of health care). NHS bodies will be required to take these new standards into account for the purpose of discharging the duty of quality. In addition, the Welsh Ministers are also required to take into account these new standards in conducting reviews of, and investigations into, the provision of health care by and for NHS bodies under section 70 of the Health and Social Care (Community Health and Standards) Act 2003. In practice, the role of conducting such reviews and investigations is undertaken by Healthcare Inspectorate Wales (HIW) on behalf of the Welsh Ministers.
- 2.7 It is acknowledged that implementation of the duty of quality will need to be monitored over the course of several years to determine its success. Welsh Ministers and NHS bodies will need to be able to demonstrate the steps they have taken to improve the quality of services aligned to the duty for implementation to be assessed and monitored.

- 2.8 To that end, Welsh Ministers and NHS bodies must publish an annual quality report on the steps they have taken to comply with the duty of quality.

### 3. Legislative background

- 3.1 The key purpose of Part 2 of the Act is to reframe and broaden the duty of quality which was first set out in section 45(1) of the Health and Social Care (Community Health and Standards) Act 2003<sup>10</sup> (“the 2003 Act”). Section 45(1) of the 2003 Act imposes a duty on Welsh NHS bodies to ensure that appropriate arrangements are in place to monitor and improve the quality of health care<sup>11</sup> provided by or for those bodies.
- 3.2 Section 45(1) of the 2003 Act is repealed and replaced with a revised duty to secure quality in health services in sections 1A (Welsh Ministers’ duty), 12A (Local Health Board’s duty), 20A (NHS Trust’s duty) and 24A (Special Health Authority’s duty) of the National Health Service (Wales) Act 2006<sup>12</sup> (“the 2006 Act”). The 2006 Act (as amended by Part 2 of the Act) also requires those bodies to publish an annual report on the steps it has taken to comply with the duty of quality.
- 3.3 The 2006 Act (as amended by Part 2 of the Act) requires that the Welsh Ministers issue guidance to the Welsh NHS bodies in relation to the duty of quality and the requirement to publish an annual report. Therefore, this guidance document is issued by the Welsh Ministers under Sections 12A (5), 20A (5) and 24A (5) of the 2006 Act in pursuance of that requirement. The new Health and Care Standards, which are also contained in this document, are issued under the powers in section 47 of the 2003 Act (see further on that in paragraph 3.9 below).
- 3.4 The revised duty of quality (which also applies to the Welsh Ministers, as well as NHS bodies) reframes the concept of “quality” by ensuring that it is used in its broader definition. Quality includes the effectiveness and safety of health services and the quality of the experience of users of health services. However, it is not limited to the quality of services provided to an individual nor to service standards. It relates to securing improvement in the quality of “health services” which means any services provided or secured in accordance with the 2006 Act. Accordingly, the revised duty intends quality to be a system-wide way of working with on the intention of improving outcomes. Inserting the new duty into the 2006 Act reflects the importance that the Welsh Ministers place on the new,

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<sup>10</sup> UK Government (2003)\_Health and Social Care (Community Health and Standards) Act  
<https://www.legislation.gov.uk/ukpga/2003/43/contents>

<sup>11</sup> For the purposes of the 2003 Act, “health care” means (a) services provided to individuals for or in connection with the prevention, diagnosis or treatment or illness; and (b) the promotion and protection of public health.

<sup>12</sup> UK Government (2006) National Health Service (Wales) Act.  
<https://www.who.int/publications/i/item/9789240011632>

broader duty, and the Welsh Ministers' intention to further strengthen and embed quality at the heart of decision making for health services.

- 3.5 Welsh Ministers have a duty to exercise any of their functions that relate to the health service with a view to securing improvement in the quality of health services.<sup>13</sup>
- 3.6 Local Health Boards<sup>14</sup>, NHS Trusts<sup>15</sup> and Welsh Special Health Authorities<sup>16</sup> have a duty to exercise **all** of their functions with a view to securing improvement in the quality of health services. The duty of quality therefore applies to all clinical and non-clinical functions.
- 3.7 Reframing and strengthening the duty of quality represents a further step on the journey towards ever-higher standards of person-centred health services in Wales.
- 3.8 Part 2 of the Act also makes consequential amendments to section 47 and section 70 of the 2003 Act.
- 3.9 Section 47(1) of the 2003 Act permits the Welsh Ministers to prepare and publish statements of standards in relation to the provision of health care by and for Welsh NHS bodies. The Welsh Ministers are required to keep the standards under review and may publish amended statements whenever it considers appropriate. The last standards were published under this provision in April 2015.<sup>17</sup> Section 47(4) of the 2003 Act required that the standards set out in statements are to be taken into account by every Welsh NHS body in discharging its duty under section 45 of the 2003 Act. Given that section 45(1) is repealed, section 47(4) is amended such that the standards set out in statements are to be taken into account by a Welsh NHS body in discharging the revised duty of quality in the 2006 Act.
- 3.10 In accordance with the Welsh Ministers' duty to review and the power in section 47 of the 2003 to publish amended statements of standards, the Health and Care Standards (April 2015) are withdrawn and replaced with the Health and Care Quality Standards as set out in this guidance and which align with the new duty of quality. This is to reflect the inextricable relationship that exists between the duty of quality and the standards.
- 3.11 Furthermore, section 70(1) of the 2003 Act provides that the Welsh Ministers have the function of conducting reviews of, and investigations into, the provision of health care by and for Welsh NHS bodies. In practice this function is carried out by Healthcare Inspectorate Wales (HIW) on behalf of the Welsh Ministers. Section 70(3) of the 2003 Act also imposes a specific function of conducting reviews into the arrangements made by Welsh NHS bodies for the

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<sup>13</sup> Section 1A of the 2006 Act

<sup>14</sup> Section 12A of the 2006 Act

<sup>15</sup> Section 20A of the 2006 Act

<sup>16</sup> Section 24A of the 2006 Act

<sup>17</sup> Welsh Government (2015) Health and Care Standards

<https://www.gov.wales/sites/default/files/publications/2019-05/health-and-care-standards-april-2015.pdf>

purpose of discharging the duty of quality. Section 70(3) is amended such that this relates to the revised duty of quality under the 2006 Act. Section 70(4) of the 2003 Act requires the Welsh Ministers to take into account the standards published under section 47 in exercising its functions under section 70.

### **Key messages**

- The key purpose of the Act is to reframe and broaden the duty of quality which was first set out in the 2003 Act
- The duty of quality set out in section 45(1) of the 2003 Act is repealed and replaced with a revised duty to secure quality in health services in the 2006 Act
- The revised duty requires that the Welsh Ministers must exercise their health-related functions with a view to secure improvement in the quality of health services
- The revised duty also requires that NHS bodies must exercise all of their functions with a view to securing improvement in the quality of health services
- The Act makes consequential amendments to section 47 and section 70 of the 2003 Act such that any standards that are issued under the 2003 Act are taken into account by an NHS body in discharging the revised duty of quality in the 2006 Act, and that the Welsh Ministers has the function of conducting reviews of the steps taken by an NHS body for the purpose of discharging the revised duty of quality. The latter function is delegated to Healthcare Inspectorate Wales (HIW).
- The Health and Care Standards (2015) that were issued under section 47 of the 2003 Act are withdrawn and replaced with the Health and Care Quality Standards to reflect the inextricable relationship between the duty of quality and the standards

## 4. Strategic and policy context

- 4.1 A Healthier Wales: our Plan for Health and Social Care ("A Healthier Wales") sets out the vision for a whole system approach to health and social care in Wales.
- 4.2 It lays out the Welsh Government's ambitions for progress and improvement and describes the core values that underpin the NHS in Wales. These are:
- Putting quality and safety above all else
  - Integrating improvement into everyday working
  - Focusing on prevention, health improvement and inequality
  - Working in true partnerships
  - Investing in our staff
- 4.3 The Act supports the ambitions in A Healthier Wales by setting out the requirements for the improvement in the quality of health services.
- 4.4 The Act describes that quality includes, but is not limited to, the safety and effectiveness of health services and the experience of individuals who receive health services.
- 4.5 The Welsh Government published the Quality and Safety Framework in September 2021<sup>18</sup>.
- 4.6 It provides an overview of quality principles and arrangements that need to be in place to ensure high quality services are being delivered.
- 4.7 It requires the NHS to establish effective quality management systems that focus on learning and driven by their boards. It explains how Quality Control, Quality Planning, Quality Improvement and Quality Assurance must work together to form the quality management system that is required.
- 4.8 The intention was for the Framework to provide a steppingstone to the new duty of quality.

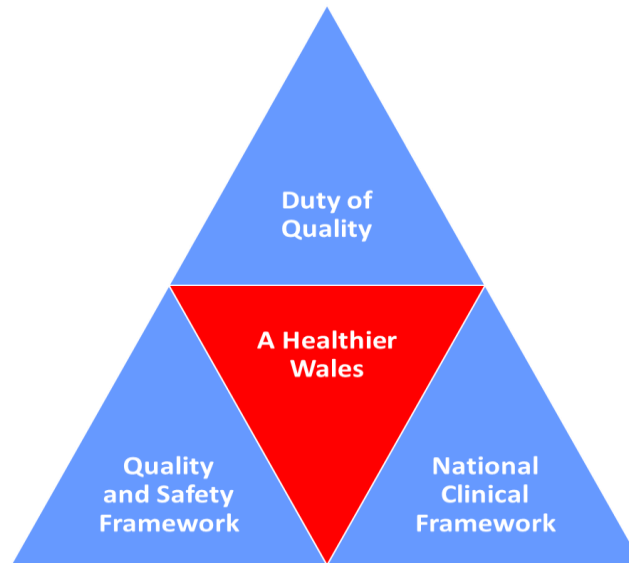
Figure 1  
Diagram to demonstrate the quality management cycle as referred to in the Welsh Government's Quality and Safety Framework (2021).



<sup>18</sup> Welsh Government 2021 Quality and Safety Framework learning and improving. <https://gov.wales/nhs-quality-and-safety-framework>

Figure 2

Diagram to demonstrate the central strategic context of A Healthier Wales alongside the duty of quality, National Clinical Framework and Quality and Safety Framework



### Key messages

- We must put the quality and safety of our health services above everything else
- The duty of quality influences many health-related policies and frameworks
- In turn, these also affect how we approach delivering quality in healthcare services
- Strengthening our quality management system helps us make sure our decision-making focuses on improving the quality of health services

## **5. Who does the duty of quality apply to?**

5.1 The Act lists the following individuals and NHS bodies in Wales as being subject to the duty in Part 2 of the Act:

- Welsh Ministers (in relation to their health functions).
- Local Health Boards.
- NHS Trusts.
- Special Health Authorities that operate on a Wales-only basis.

### **5.2 The duty of quality and Welsh Ministers**

The Welsh Ministers, with regards to their health-related functions, have responsibility for oversight of the NHS in Wales. They must ensure that health services are organised and delivered in such a way that system-wide, continuous improvement in the quality of health services is achieved.

5.3 Welsh Ministers will have to actively consider whether their decisions in relation to the health service are taken with a view to securing improvement in the quality of health services.

5.4 Welsh Ministers must ensure that national bodies with regulatory, performance management or support responsibilities have a cohesive and collaborative approach to system-wide improvement.

5.5 Welsh Ministers must issue guidance to NHS bodies in relation to the requirement to exercise their functions with a view to securing improvement in the quality of health services, and the requirement to publish an annual report on the steps they have taken to comply with this duty. The latter is described in section 9 Reporting requirements.

5.6 Welsh Ministers are required to publish an annual report on the steps they have taken to comply with the duty to exercise their functions in relation to the health service with a view to securing improvement in the quality of health service and within that report to include an assessment of the extent of any improvement in outcomes achieved by virtue of those steps.

### **5.7 The duty of quality and NHS bodies**

The NHS in Wales delivers health services through 7 Local Health Boards and 3 NHS Trusts.

5.8 The Health Boards and Trusts work in partnership with 2 Special Health Authorities – Health Education and Improvement Wales (HEIW) and Digital Health and Care Wales (DHCW).

5.9 Several Local Health Boards and NHS Trusts host national organisations that support the delivery of health services. In hosting the national organisations, the Local Health Boards and NHS Trusts are exercising functions in relation to the health service and therefore must do so with a view to securing

improvement in the quality of health services. The hosted organisations must comply with the duty of quality in line with the governance of their hosting arrangements.

- 5.10 The duty of quality applies to Local Health Boards who are responsible for planning and delivering NHS services in their areas with the aims of:
- Improving physical and mental health outcomes.
  - Promoting well-being.
  - Reducing health inequalities across their population.
  - Commissioning services from other organisations to meet the needs of their residents.
- 5.11 The 3 NHS Trusts and 2 SHAs have their own specific service delivery responsibilities to which the duty of quality will apply.
- 5.12 Accountability for compliance with the duty of quality ultimately rests with the Chief Executive of an NHS body.
- 5.13 Similar in approach to other legislation, it is recommended that NHS bodies designate appropriate senior leads to hold responsibility for the strategic implementation and oversight of the duty of quality. An officer member of the board should be delegated the responsibility to ensure the necessary strategic implementation and oversight. It should be noted however, that the responsibility to ensure due consideration is given to the duty of quality applies to all officer and non-officer board members whilst exercising the functions within their roles.
- 5.14 A designated operational lead to support the implementation of the duty of quality is also recommended.
- 5.15 There is a collective responsibility of all Board members to support the Chief Executive to: -
- 5.15.i) comply with the duty of quality by internal governance and assurance arrangements that are structured within a robust quality management system;
  - 5.15.ii) ensure that health services are organised and delivered in such a way that system-wide, continuous improvement in the quality of health services is achieved;
  - 5.15.iii) actively consider whether the Board's decisions will improve service quality and secure improvement in outcomes for the population;
  - 5.15.iv) demonstrate how they have exercised their functions and improved the quality of services in accordance with the duty of quality. This is described in section 9 Quality reporting requirements.
- 5.16 The duty of quality applies to all health service functions in both clinical and non-clinical settings. Therefore, all staff have responsibility for complying with

the duty within their role and service function. It is a collective responsibility to comply with the duty of quality.

### **5.17 The duty of quality in commissioned services**

It is recognised that health services may be provided across geographical boundaries through commissioning arrangements with NHS and non-NHS service providers. Local Health Boards, NHS Trusts and SHAs must exercise their functions with a view to securing improvement in the quality of health services. The NHS body that is commissioning the health service is exercising its functions and must therefore ensure it is doing so with a view to securing improvement in the quality of the health service. Regardless of who is delivering health services when they are commissioned, the duty is the responsibility of the commissioning body.

#### **5.17.i) Services commissioned by an NHS body from another NHS body in Wales:**

The NHS body that is commissioning the health service is exercising its functions and must ensure it is doing so with a view to securing improvement in the quality of the health service. The duty of quality is the responsibility of the commissioning body. The commissioning body will wish to ensure that health services delivered by the alternative provider will secure improvement in the quality of health services. The Welsh NHS body providing services on behalf of the commissioner must also ensure that they are compliant with the duty that will also apply directly to them for the services they are providing.

**5.17.ii) Services provided by primary medical, dental, optical and pharmaceutical services in Wales:** In accordance with the 2006 Act, each Local Health Board must, to the extent that it considers necessary to meet all reasonable requirements, provide primary medical, dental, optical and pharmaceutical services within its area. Local Health Boards enter into arrangements with primary care providers for the delivery of primary care services in pursuit of those duties. The duty of quality does not directly apply to primary care providers. The duty of quality rests with the Local Health Boards to secure improvement in the quality of health services, and this extends to the services that are delivered by primary care providers on behalf of the Local Health Board. Local Health Boards must therefore exercise their duties in relation to primary care, with a view to securing quality in the provision of services.

**5.17.iii) Services commissioned from non-NHS bodies:** The NHS body that is commissioning the health service from an independent provider is exercising its functions and must ensure it is doing so with a view to securing improvement in the quality of the health service. The duty of quality is the responsibility of the commissioning NHS body. The commissioning body will wish to ensure that health services delivered by the alternative or independent provider will secure improvement in the quality of health services. This may be a consideration in contracting arrangements.

- 5.18 **5.17.iv) Services commissioned outside of Wales:** The Welsh NHS body that is commissioning the health service is exercising its functions and must ensure it is doing so with a view to securing improvement in the quality of the health service. The commissioning body will wish to ensure that health services delivered by the alternative provider will secure improvement in the quality of health services. The service provider will be responsible for the quality of health services they directly provide under the relevant jurisdiction within which the services are provided.
- 5.19 Welsh Ministers and NHS bodies have a responsibility to encourage shared learning and expertise as they progress along their quality improvement journey. Much can also be learnt from high performing care systems globally.
- 5.20 There is a need at all levels to ensure that the health system has the resources, capacity, time and autonomy needed to develop their approaches to improving quality. This is supported by the World Health Organisation's Quality health services: a planning guide in the foundational requirements for quality initiatives<sup>19</sup>.

### Key messages

- The duty of quality applies to Welsh Ministers (in relation to their health functions)
- The duty of quality also applies to Local Health Boards, NHS Trusts and Special Health Authorities that operate on a Wales-only basis
- Accountability for the duty of quality ultimately rests with the Chief Executive of an NHS body who may designate a lead officer and senior operational lead to oversee the implementation of the duty in the organisation
- All Board members are collectively responsible for the implementation of the duty of quality
- Several Local Health Boards and NHS Trusts host national organisations that support the delivery of health services. The hosted organisations must comply with the duty of quality in line with the governance of their hosting arrangements. The duty does not apply directly to primary care providers, non-NHS providers of health services or to NHS providers outside of Wales
- The NHS bodies are responsible for exercising their functions with a view to securing improvement in the quality of health services. This includes services that they commission from other providers
- The duty of quality will ensure that health services are organised and delivered in a way that seeks to secure continuous improvement in quality and improves outcomes for the population
- Welsh Ministers and NHS bodies will have to actively consider whether their decisions will improve service quality and improve outcomes
- Welsh Ministers and NHS bodies will need to be able to demonstrate, supported by evidence, how they have complied with the duty of quality
- All staff have a role in achieving improved service quality; the duty of quality applies to all health service functions in both clinical and non-clinical settings
- System-wide learning and sharing is actively encouraged

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<sup>19</sup> World Health Organisation (2020) Quality Health Services: a planning guide  
<https://www.who.int/publications/i/item/9789240011632>

## 6. Defining quality

- 6.1 Numerous definitions of quality relating to health and care services have been described by various global organisations, including the Institute for Healthcare Improvement<sup>20</sup> and World Health Organisation<sup>21</sup>.
- 6.2 For the purposes of this guidance, quality is considered to be defined as continuously, reliably, and sustainably meeting the needs of the population that we serve. In achieving this, Welsh Ministers and NHS bodies will need to ensure that health services are **safe, timely, effective, efficient, equitable and person-centred**<sup>22</sup>.
- 6.3 NHS bodies and Welsh Ministers will need to continually seek to understand the needs of their population to inform their decision-making and secure improvement in outcomes. The population too, will have their own part to play to inform the process.

### 6.4 Domains of quality

Welsh Ministers and NHS bodies should ensure the decisions they make deliver care that is **safe, timely, effective, efficient, equitable and person-centred**. These quality dimensions provide a framework to assess quality and guide improvement. Therefore, it is important to explain what the quality dimensions aspire to achieve and what we intend them to mean in Wales as part of the duty of quality.

#### 6.4.1 Safe

##### Safe

Our healthcare system is a high quality, highly reliable and safe system that avoids preventable harm, maximising the things that go right and learning from when things go wrong to prevent them occurring again. People's health, safety and welfare are actively promoted and protected; risks are identified and monitored and where possible, risks to safety are reduced or prevented. We promote and protect the wellbeing, and safety of children and adults who become vulnerable or at risk at any time. Where children or adults may be experiencing or are at risk of abuse or neglect, we take appropriate, timely action and report concerns.

<sup>20</sup> Sampath B, Rakover J, Baldoza K, Mate K, Lenoci-Edwards J, Barker P. Whole System Quality: A Unified Approach to Building Responsive, Resilient Health Care Systems. IHI White Paper. Boston: Institute for Healthcare Improvement; 2021. <https://www.ihl.org/resources/Pages/IHIWhitePapers/whole-system-quality.aspx>.

<sup>21</sup> WHO (2020) Quality health services: a planning guide <https://www.who.int/publications/i/item/9789240011632>

<sup>22</sup> Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, D.C: National Academy Press; 2001.

#### 6.4.2 **Timely**

##### **Timely**

Our healthcare system ensures people have access to the high-quality advice, guidance and care they need quickly and easily, in the right place, first time. We care for those with the greatest health need first, and where treatment is identified as necessary, we treat people based on their identified and agreed clinical priority.

#### 6.4.3 **Effective**

##### **Effective**

Our healthcare system ensures decision-making, care and treatment reflects evidence-based best practice, to ensure that people receive the right care to achieve the optimal and possible outcomes that matter to them. We design transformative, evidenced-based, whole-of-life pathways that cover prevention, care and treatment, rehabilitation and embed these into local service delivery.

#### 6.4.4 **Efficient**

##### **Efficient**

Our health care system takes a value-based approach to improve outcomes that matter most to people in a way that is as sustainable as possible and avoids waste. We make the most effective use of resources to achieve best value in an efficient way. We only do what is needed and undertake treatments that ensure any interventions represent the best value that will improve outcomes for people.

#### 6.4.5 **Equitable**

##### **Equitable**

Our health care system provides everyone with an equal opportunity to attain their full potential for a healthy life which does not vary in quality by organisation providing care, location where care is delivered or personal characteristics (such as age, gender, sexual orientation, race, language preference, disability, religion or beliefs, socio-economic status or political affiliation). We embed equality and human rights in our health care system.

#### 6.4.6 Person-centred

##### **Person-centred**

Our health care system meets people's needs and ensures that their preferences, needs and values guide decision-making that is made in partnership between individuals and the workforce. We care about the well-being of individuals, their families, carers and our staff. We ensure that everyone is always treated with kindness, empathy and compassion and we respect their privacy, dignity and human rights. We are committed to working better together to put people and their families at the centre of decisions, seeing them as experts working alongside professionals to get the best outcome and experience.

#### 6.5 Quality enablers

A system-wide approach to quality requires a culture that embeds continuous learning and improvement at its heart. This should be underpinned by a clear definition and understanding of what good quality looks like utilising national and benchmarked standards, peer review and audit.

- 6.6 Learning from internationally recognised organisations that have well-established and effective approaches to quality provides a blueprint for what good quality should look like. The quality enablers underpin and influence this blueprint to ensure a system-wide approach to improving quality.
- 6.7 Experience has shown that maturing and embedding these concepts can take a number of years. It is recognised that there has been a positive culture with quality being “at the heart of the Welsh health system”<sup>23</sup>.
- 6.8 The quality enablers that underpin this blueprint to ensure a system-wide approach to improving quality are:

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<sup>23</sup> Organisation for Economic Co-operations and Development (OECD) Reviews of Health Care Quality: United Kingdom 2016: Raising Standards at <https://www.who.int/publications/i/item/9789240011632>

### 6.8.1 Leadership

#### **Leadership**

Our health care system has visible and focused leadership at all levels, with its activities driven by the organisations' vision and values for quality. Our leaders and managers take a long-term, stakeholder-centric view to develop a clear organisational vision. They have the appropriate skills and capacity to create the conditions for a functioning quality management system. We ensure our governance, leadership and accountability is effective in sustainably delivering care.

### 6.8.2 Workforce

#### **Workforce**

Our healthcare system recruits, retains, develops and extends roles to ensure we have enough, confident people with the right knowledge and skills available at the right time to deliver safe care. We value our people and the commitment and resilience they demonstrate in the care they provide. We care about their wellbeing, protect their rights and support them to feel well and happy at work; and provide them with the tools, systems and environment to work safely and effectively. Our workforce planning focuses on investing in our people and nurturing, growing and transforming our workforce to create a sustainable workforce for the future.

### 6.8.3 Culture

#### **Culture**

Our healthcare system creates the right climate and culture to nurture and encourage quality and system safety, valuing people in a supportive, collaborative and inclusive workplace so that our people feel psychologically safe to raise concerns and try out new ideas and approaches. Relationships within teams and with the people we serve are effective and based on transparency, accountability, ethical behaviour, trust and just culture, where people can thrive.

#### 6.8.4 Information

##### **Information**

Our healthcare system ensures information is available and shared appropriately for all who need it. We turn data to knowledge by triangulating quantitative and qualitative performance, experience and outcome measures to understand the quality of services, efficacy of improvement work and impact of decisions made. We monitor, report and escalate indicators through our governance structures to ensure that appropriate action is taken at every level in terms of learning, improvement and accountability.

#### 6.8.5 Learning, improvement and research

##### **Learning, improvement and research**

Our healthcare system creates the conditions and capacity for an organisation and system-wide approach to continuous learning, quality improvement and innovation, which it actively promotes. We use new knowledge to influence improvements in practice and to inform our decision-making. We ensure our learning and improvement activity is linked to our strategic vision to deliver transformational, organisation-wide change. We commit to participating in research because research-active organisations provide improved quality of care and outcomes for people.

#### 6.8.6 Whole systems approach

##### **Whole systems approach**

Our healthcare system ensures safety in healthcare goes beyond individual patient safety. We will look within and beyond our organisational boundaries to learn how we can continually, reliably and sustainably meet the evolving needs of people. We will strengthen relationships and work with all of our partners to achieve good outcomes. Our policies incorporate the broader ambitions within the seven well-being goals and five ways of working in the Well-being of Future Generations Act.

- 6.8.7 The six quality enablers complement the implementation of a methodology and approach to managing quality, as set out in the Quality and Safety Framework (2021).
- 6.8.8 Together, the domains of quality and quality enablers create our new Health and Care Quality Standards. See also section 7.
- 6.8.9 Welsh language needs and choice of people must be considered through the quality lens. See also section 11.
- 6.8.10 The insights, learning and expertise created within NHS organisations across primary, community and secondary care will drive improvements in quality within Regional Partnership Board footprints and accelerate efforts to improve quality across the whole health and care system in NHS Wales.

### Key messages

- Quality is defined as continuously, reliably, and sustainably meeting the needs of the population that we serve
- Welsh Ministers and NHS bodies will need to ensure that health services are **Safe, Timely, Effective, Efficient, Equitable and Person-centred**
- These quality dimensions provide a framework to assess quality and guide improvement
- Quality enablers have been identified which underpin and influence a blueprint to ensure a system-wide approach to improving quality
- The quality enablers are **Leadership; Workforce; Culture; Information; Learning, improvement and research and Whole-systems approach**
- Together, the quality domains and enablers comprise the **Health and Care Quality Standards**
- Maturing and embedding a quality management system takes time, vision, ambition, and an active commitment to learning and improving

## 7. Health and Care Quality Standards

- 7.1 Section 47(1) of the 2003 Act permits the Welsh Ministers to prepare and publish statements of standards in relation to the provision of health care by and for Welsh NHS bodies. The Welsh Ministers are required to keep the standards under review and may publish amended statements whenever it considers appropriate. The last standards were published under this provision in April 2015.<sup>24</sup>
- 7.2 Section 47(4) of the 2003 Act (as amended by Part 2 of the 2006 Act) requires that the standards set out in statements are to be taken into account by a Welsh NHS body in discharging its duty of quality in the 2006 Act. Accordingly, there is an inextricable relationship that exists between the duty of quality and the standards issued under section 47(1) and such standards should therefore align with and support the duty of quality. In developing the duty of quality guidance and reviewing the April 2015 Standards the Welsh Ministers have withdrawn the Health and Care Standards (April 2015) and replaced them with the Health and Care Quality Standards, as set out in section 6 of this guidance. This change is being made as the introduction of the duty of quality provides an opportunity to directly align the standards not only with the duty but with wider quality management practice in health. The domains as described in this guidance are widely used in health care and are being implemented in the wider Welsh health system. The revised Health and Care Quality Standards are designed to simplify the requirements and be flexible with the wide remit of the duty of quality.
- 7.3 Healthcare Inspectorate Wales (who exercise functions on behalf of the Welsh Ministers) will also have to take these standards into account for the purpose of undertaking reviews and investigations relating to the provision of health care in Wales under section 70 of the 2003 Act. The Health and Care Quality Standards provide a high-level framework for describing, implementing and monitoring the duty of quality. The Health and Care Quality Standards set out what people in Wales can expect when they access health services.
- 7.4 The Health and Care Quality Standards provide a structure on which to implement the duty of quality, whether at a national policy level or by service providers and are relevant in all clinical and non-clinical services and settings. The Health and Care Quality Standards integrate with the wider health system.
- 7.5 It should be noted that A Healthier Wales introduced 'quality statements' to describe the outcomes and standards expected in high quality, person-

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<sup>24</sup> Welsh Government (2015) Health and Care Standards  
<https://www.gov.wales/sites/default/files/publications/2019-05/health-and-care-standards-april-2015.pdf>

focussed services, setting out the ambitions to be delivered consistently across Wales.

- 7.6 This was further described in the National Clinical Framework. It explained that quality statements will set out the policy expectations for the future planning and accountability arrangements for the NHS in Wales.
- 7.7 The Health and Care Quality Standards are high level organisational standards. Detailed service standards are usually produced by professional and advisory bodies.

Figure 3

Visual to illustrate the six domains of quality supported by six quality enablers. Together, these comprise the Health and Care Quality Standards.



## **Key messages**

- **Welsh Ministers have a duty to review standards issued under section 47 of the 2003 Act and may publish amended statements of standards whenever it considers appropriate**
- **The Health and Care Standards (2015) are withdrawn and replaced by the Health and Care Quality Standards, comprised of six domains of quality and six quality enablers, to reflect the inextricable relationship between the duty of quality and standards**
- **The revised Health and Care Quality Standards ensures direct alignment between the duty of quality and standards, ensuring the simplified framework can be widely and flexibly applied**
- **The Health and Care Quality Standards set out the high-level standards that people in Wales can expect when they access health services**
- **The wide remit of the Health and Care Quality Standards is intended to provide a structure on which to implement the duty of quality, whether at national policy level or by service providers and they are intended to apply to all clinical and non-clinical services and settings. They integrate with the wider health system.**
- **It is anticipated that the duty of quality will ensure an aligned approach to improving the quality of our services to achieve better outcomes for the population, applied through the Health and Care Quality Standards**

## 8. Meeting the duty of quality

8.1 The duty of quality requires:

8.1.1) Welsh Ministers to exercise their functions in relation to the health service with a view to securing improvement in quality of health services.

8.1.2) Each Local Health Board, NHS Trust and Wales-only Special Health Authority to exercise their functions with a view to securing improvement in the quality of health services.

8.2 This means that the duty of quality requires the Welsh Ministers (in respect of its functions in relation to the health service) and NHS bodies (in respect of all its functions) to:

8.2.1) Ensure that all strategic decisions are made through the lens of improving the quality of health services and outcomes for the population.

8.2.2) Exercise their functions in a way that considers how they will improve quality and outcomes on an ongoing basis.

8.2.3) Actively monitor progress on the improvement of quality services and outcomes and routinely share this information with their population.

8.2.4) Strengthen governance arrangements by reporting annually on the steps taken to comply with the duty of quality and assess the extent of improvements in outcomes.

8.2.5) Ensure that NHS organisations develop their quality management system with appropriate focus on quality control, quality planning, quality improvement and quality assurance with the aim of achieving a learning and improving environment; and create a culture of quality within organisations.

8.3 In accordance with section 47(4) of the 2003 Act, NHS bodies must take into account the Health and Care Quality Standards described in this guidance and issued under section 47(1) of the 2003 Act in discharging the duty of quality.

8.4 Furthermore, there are six steps that an NHS body should take to plan, deliver and sustain the necessary focus on improving quality, which should be underpinned by a clear understanding of what good quality looks like for the organisation<sup>25</sup>:

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25 The Health Foundation (2019) The improvement journey: Why organisation-wide improvement in health care matters, and how to get started <https://www.health.org.uk/publications/reports/the-improvement-journey>

#### **8.4.1) Securing Board support**

The Board has collective responsibility for ensuring the duty of quality is delivered and they must demonstrate this in their actions and behaviours. They must demonstrate their long-term commitment to improving quality when setting the strategic direction and seeking assurance of delivery. This should be underpinned by a willingness and financial support to develop the skills and infrastructure for implementation. The Board should prioritise national and regional initiatives along with recommendations that fit the organisation's way of working. The Board needs to ensure they adhere to the duty of quality in their decision-making and seek assurance with regard to decisions made by others.

#### **8.4.2) Assessing readiness**

There needs to be system-wide understanding of what good quality looks like for the broad range of services. NHS bodies should understand their 'readiness for change' to be clear about where the capability gaps are and have a plan to address them. They should use regular assessments, investigations and measurement over time to identify areas to improve quality. The NHS body should consider psychological readiness in addition to having the infrastructure, governance, system understanding and leadership in place for change.

#### **8.4.3) Securing wider organisational buy-in and co-creating a vision**

NHS bodies should create a compelling vision for improved quality that is recognised and intrinsically motivates staff at each level of the organisation. A culture of distributed leadership gives staff at all levels the permission, opportunity and confidence to test new ideas to improve quality that are aligned to the organisation's vision. Leaders should champion improvements in quality that are strategically aligned, driven and owned by the teams responsible for delivering health services.

#### **8.4.4) Developing improvement skills and infrastructure**

NHS bodies need a systematic approach to managing quality that includes building improvement capability to ensure teams at each level of the organisation have the general and specialist improvement skills needed. This should be accompanied by a suite of measures and a system that collects, analyses and feeds back on the impact of the improvements. Standard operating models to standardise core processes and activities should also be developed to address variations in quality.

#### **8.4.5) Aligning and coordinating activity**

NHS bodies need to ensure that initiatives to improve quality are consistent with their overall strategy and mission and barriers are identified and unlocked.

A leader with oversight of all the organisation's activity should ensure that all strands of activity align over time. They should ensure that learning from success and weaker areas continue to shape the improvements in quality that are required.

#### **8.4.6) Sustaining an organisation-wide approach**

NHS bodies must invest in maintaining the momentum for improvements in quality and recognise that this is a longer-term journey. A focus on early wins shifts to the challenge of maintaining success and continuing to engage staff and stakeholders, with the Board managing expectations and supporting staff to maintain a focus on improvements aligned to the organisation's purpose. The Board should seek assurance that quality improvement activities are sustainable with appropriate assurance mechanisms to maintain the improvements.

##### **Key messages**

- **Welsh Ministers must exercise their functions in relation to the health service with a view to secure improved quality of health services**
- **NHS bodies must exercise its functions with a view to securing improvement in the quality of health services**
- **Welsh Ministers and NHS bodies will need to ensure that strategic decisions are made through a quality lens**
- **Welsh Ministers and NHS bodies must exercise their functions in a way that considers improvement in quality and outcomes on an ongoing basis**
- **The focus must be on improving the quality of services and outcomes for the population**
- **NHS bodies should develop their quality management system and create a culture of quality within their organisations**
- **There are six steps an NHS body should take to plan and sustain the focus on improving quality, underpinned by a clear understanding of what good quality looks like for the organisation. These are:**
  1. **Securing Board support**
  2. **Assessing readiness**
  3. **Securing wider organisational buy-in and co-creating a vision**
  4. **Developing improvement skills and infrastructure**
  5. **Aligning and coordinating activity**
  6. **Sustaining an organisation-wide approach**

## 9 Quality reporting requirements

- 9.1 The Welsh Ministers are required to publish an annual quality report on the steps they have taken to comply with the duty to exercise their functions in relation to the health service with a view to securing improvement in the quality of health services. The report must include an assessment of the extent of any improvement in outcomes achieved by virtue of those steps, and the Welsh Ministers must lay a copy of the report before the Senedd.
- 9.2 Each Local Health Board, NHS Trust and Wales-only Special Health Authority is required to publish an annual quality report on the steps it has taken to comply with the duty to exercise its functions with a view to securing improvement in the quality of health services. The report must include an assessment of the extent of any improvement in outcomes achieved by virtue of those steps.
- 9.3 This section of the guidance provides guidance about the requirement to publish an annual quality report, the evidence to be used in support of an assessment and the conduct of an assessment.
- 9.3.1 The annual quality report allows actions taken by Welsh Ministers and NHS bodies and quality improvements to be monitored transparently. The report should describe the progress and challenges on the quality journey to their respective population and stakeholders. Quality reporting needs to be meaningful for NHS bodies, their stakeholders and our population if it is to optimise real time learning, improvement and sharing opportunities. Quality reporting should reflect the breadth of the Health and Care Quality Standards and quality management system within its structure and content.
- 9.4 In addition to the annual quality reporting requirement, it is proposed that NHS bodies develop a so-called ‘always on’ reporting mechanism. ‘Always on’ means that organisations collate, monitor and make information about the quality of their services readily available to their population and stakeholders, both within the organisation and externally.
- 9.4.1 ‘Always on’ reporting requires organisations to have a whole system approach to the routine use of information across their quality management system. ‘Always on’ encourages recognition and sharing of good practice and early escalation and intervention when signals suggest that action is necessary.
- 9.5 NHS bodies may choose to use various qualitative and quantitative data and information to support their quality reporting duty. They should focus on information that will demonstrate the duty of quality in decision-making, action taken following learning, quality improvement and ultimately, improved outcomes for the population. The Health and Care Quality Standards and quality management system components provide a quality report structure.

- 9.5 It is recognised that there is already significant work underway across the health system relating to indicators and measures. The intention is that NHS bodies will make use of information and reporting mechanisms already in place wherever possible. They will need to adopt an agile approach to mature their quality report as outcome measures develop, aligned to the Health and Care Quality Standards.
- 9.6 The annual quality report is intended to summarise and reflect an NHS body's progress to improve the quality of their services and population outcomes. It is anticipated that NHS bodies will sign-post readers to the information provided through the 'Always on' reports that outline learning and improvements that have been made at regular intervals through the year.
- 9.7 The annual quality report should include a look back at what has been achieved, including where things may not have gone well, together with a forward look about the organisation's quality priorities and ambitions for the upcoming year, alongside how progress will be monitored. There should be continuity between annual reports across subsequent years.
- 9.8 The annual quality report will describe what key strategic decisions have been taken by the NHS body, and how the duty of quality has informed these decisions.
- 9.9 The annual quality report should be prepared as soon as practicable after the end of each financial year. To streamline reporting requirements and reduce duplication, it is suggested that NHS bodies align the annual quality report to their Annual Report and Accounts process.
- 9.10 Additional information will be available in a supplementary reporting framework, as a supporting resource.
- 9.11 Examples of evidence to be used to assess the duty of quality and the extent of any improvement in outcomes includes:**
- 9.11.1) Existing performance, outcome and delivery indicators and measures from the quality management system
  - 9.11.2) Patient Reported Outcome Measures and Patient Reported Experience Measures (PROMS and PREMS)
  - 9.11.3) Mortality data
  - 9.11.4) Information contained within the Once for Wales Concerns Management System such as incidents and concerns
  - 9.11.5) Patient and staff stories
  - 9.11.6) Strategic decision-making that has been driven by the Health and Care Quality Standards
  - 9.11.7) Reports following external reviews or inspections by inspectorate and licensing bodies

9.11.8) Consideration of the recommendations and implications of significant national reports, for example, following national inquiries

9.11.9) It should be noted that this list provides illustrative examples and is not exhaustive

**9.12 NHS bodies will conduct the assessment of the extent of any improvement in outcomes achieved through:**

9.12.1) Self-assessment

9.12.2) Peer review and feedback

9.12.3) National clinical audit

9.12.4) Internal audit

9.12.5) External review, for example, Wales Audit Office

9.12.6) Inspections, for example, Healthcare Inspectorate Wales

9.12.7) It should be noted that this list provides illustrative examples and is not exhaustive.

9.12.8) It is recognised that there are strengths and weaknesses to the various forms of assessment outlined. Thus, NHS bodies should seek to ensure a range of assessments are considered.

9.13 It is of crucial importance that NHS bodies actively engage with their population to ensure their voice is heard and to promote working in partnership to achieve the aims of the duty of quality.

9.14 Information about the provision of services through the Welsh language should be included in quality reports. Uptake of the Active Offer<sup>26</sup> and capturing people's experience through patient and staff stories provide monitoring opportunities through quality reporting requirements.

9.15 It is important to ensure that UK General Data Protection Regulation (UK GDPR) is adhered to when accessing and processing information to prepare for the duty of quality reports.

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<sup>26</sup> The Active Offer is described in the Welsh Government (2022) More than just words: Five Year Plan 2022 – 2027 as providing a service in Welsh without someone having to ask for it. It means creating a culture that places the responsibility on health and social care providers to provide a proactive language offer so that people can access care, as equal partners, through the medium of Welsh.  
<https://www.gov.wales/sites/default/files/publications/2022-07/more-than-just-words-action-plan-2022-2027.pdf>

## **Key messages**

- **Welsh Ministers and NHS bodies must exercise their functions with a view to secure improved quality of health services**
- **Welsh Ministers and NHS bodies must publish an annual quality report that sets out the steps they have taken to secure improved quality of health services**
- **The annual quality report must include an assessment of the extent of any improvement in outcomes achieved**
- **This guidance sets out guidance about the conduct of this assessment and evidence to support it, as well as the requirement to submit an annual quality report**
- **Annual quality reports must be a transparent reflection of progress and challenges on the quality journey. Forthcoming quality priorities and how they will be monitored should be set out**
- **The annual quality report must assess any improvement in outcomes**
- **It should demonstrate how the duty of quality has informed strategic decision-making**
- **It should outline action taken as a result of learning and describe how that has been shared**
- **The annual quality report should be prepared as soon as practicable after the end of the financial year to coincide with the Annual Report and Accounts process**
- **It is recognised that data to support the quality reporting process is a developing area and it will take time for a suite of outcome measures to be in place. Therefore, an agile approach to use of indicators and measures will be required**
- **In addition to annual quality reporting, NHS bodies are encouraged to develop an ‘always on’ reporting process where they collate, monitor and share quality information with their population at regular intervals during the year**
- **‘Always on’ reporting promotes routine use of information to inform decision-making and quality improvement. It supports recognition and sharing of good practice as well as allowing early escalation and intervention when action is necessary**
- **It is of crucial importance that NHS bodies actively engage with their population to ensure their voice is heard and to promote working in partnership to achieve the aims of the duty of quality**

## **10. Decision-making, monitoring and assurance**

- 10.1 The duty of quality requires the Welsh Ministers and NHS bodies to think and act differently by applying the concept of quality across all functions within the context of the health services and health needs of their populations.
- 10.2 The duty requires quality-driven decision-making and planning to ultimately deliver better outcomes for all people who require health services. It means involving people in decisions that affect them and balancing short-term needs with planning for the longer-term; it requires action to prevent problems occurring or getting worse.
- 10.3 It needs a system-wide approach with acknowledgement that the duty of quality is a collective responsibility.
- 10.4 The focus of the duty of quality is on learning and improving, not on punitive sanctions when those to whom the duty applies fall short in their implementation of it.
- 10.5 However, NHS bodies must consider how effective implementation and monitoring of the duty of quality can be integrated into existing corporate governance frameworks, processes and procedures. This includes existing performance and quality reports.
- 10.6 When designing or introducing new structures and processes it will be necessary to embed the duty of quality within them.
- 10.7 When considering review processes and assurance mechanisms they must also take account of the duty of quality. This includes, for example, planning of the annual internal audit and clinical audit programmes.
- 10.8 In respect of NHS bodies, the Board will be required to seek assurance that the duty of quality is being appropriately discharged as a system-wide and collective responsibility. As such, it is for all committees to report to the Board regarding the duty of quality; it is not only for the quality and safety committee.
- 10.9 In seeking assurance in NHS bodies, the committees will look to ensure that sustainable quality improvement is being made and quality improvements are maintained.
- 10.10 When the Board considers and agrees the Board Assurance Framework and strategic risk register, it should also comply with the duty of quality.
- 10.11 Welsh Ministers and NHS bodies must ensure the effective implementation and monitoring of the duty of quality. It must be integrated into existing governance frameworks, processes and procedures with regular updates to the relevant committees and board meetings for assurance purposes.
- 10.12 Compliance with the duty will also form part of the matters considered by Healthcare Inspectorate Wales (HIW) when inspecting and reviewing the provision of health care.

10.13 The annual quality report and 'always on' approach provides information to the public, the NHS body itself, the Welsh Government and other key partners to ensure transparency and accessibility to information about the implementation of the duty of quality.

#### **Key messages**

- **The duty of quality requires Welsh Ministers and NHS bodies to ensure quality-driven decision-making and planning is in place to ultimately deliver better outcomes for all people who require health services**
- **Quality needs to be system-wide; applied across all clinical and non-clinical services within the context of the well-being and health needs of the population**
- **The focus is on learning and improvement rather than punitive sanctions when the duty of quality has been compromised**
- **The duty must be integrated into existing corporate procedures, including but not limited to, planning, performance, quality, Internal Audit reviews**
- **It must be embedded within all structures and processes that are established**
- **The Board will be required to seek assurance that the duty of quality is being appropriately discharged as a system-wide and collective responsibility**
- **The Board will need to seek assurance that sustainable quality improvement is being made, with appropriate assurance mechanisms in place to ensure that quality improvements are maintained**
- **When the Board considers and agrees the Board Assurance Framework and strategic risk register, it should also comply with the duty of quality**
- **Compliance with the duty of quality will be monitored. It will be integrated into existing monitoring mechanisms. The various monitoring mechanisms across the health system must embed the duty of quality within their processes**
- **The annual quality report and 'always on' approach will be integral to the monitoring process to ensure the duty of quality is being delivered**

## 11. Welsh Language

- 11.1 It is recognised that health services in Wales are delivered within a bilingual nation.
- 11.2 **More than just words** (2022) is the Welsh Government's plan to strengthen Welsh language provision in health and social care. Its aim is to support Welsh-speakers to receive services in their first language, because receiving services in Welsh should be an integral part of person-centred care.
- 11.3 The ambition is to Actively Offer people their care in Welsh. It is the responsibility on health and social providers to offer services in Welsh rather than people having to request it.
- 11.4 Being able to access services in the Welsh language makes a significant positive difference to the quality of the overall experience and health and well-being outcomes for many Welsh-speakers.
- 11.5 People have reported that it can be difficult to access services they need in the Welsh language and can feel reluctant to ask if Welsh-language services are not offered.
- 11.6 The Welsh Government's plan to strengthen the provision of Welsh language in health and social care aligns to the duty of quality. It is important for Welsh language considerations to be embedded in culture and leadership, quality planning, supporting and developing the skills of the workforce and sharing best practice through an enabling approach.
- 11.7 Welsh language requirements must also be considered through the lens of the Health and Care Quality Standards and as an integral component of the quality management system.
- 11.8 Welsh language must also be included in quality reports. Uptake of the Active Offer and capturing people's experience through patient and staff stories provide monitoring opportunities through quality reporting requirements.

### Key messages

- **Being able to access services in the Welsh language makes a significant positive difference to the overall experience for many Welsh-speakers**
- **Being able to access services in the Welsh language can improve the quality, safety and outcomes for Welsh-speakers**
- **Welsh language considerations must be embedded in the culture of quality**
- **Welsh language responsibilities must be embedded in quality reports**

## 12. Conclusion

- 12.1 The fundamental intention of the duty of quality is to build on the positive culture of quality at the heart of the Welsh health system.
- 12.2 The duty of quality strengthens system-wide decision-making, action, improvement with the intention of ultimately improving outcomes for the population.
- 12.3 The duty of quality applies to Welsh Ministers with regards to their functions in relation to the health service and NHS bodies (Local Health Boards, NHS Trusts and Special Health Authorities that operate on a Wales-only basis) in relation to all their functions.
- 12.4 The duty of quality does not directly apply to primary care services or non-NHS providers of health services. The NHS body that directly provides or commissions the service holds the duty of quality responsibility.
- 12.5 Whilst accountability for implementing the duty of quality ultimately rests with the Welsh Ministers and Chief Executive of an NHS body, responsibility for operational implementation and oversight may be delegated to appropriate leaders.
- 12.6 Implementation of the duty of quality is a collective responsibility. It applies to everyone in clinical and non-clinical services, including Welsh Government policy makers.
- 12.7 The guidance provides a definition for quality for guidance purposes. It outlines a framework through which quality can be assessed and improved using the Health and Care Quality Standards. These, in turn, support the maturing of our quality management systems.
- 12.8 The Health and Care Quality Standards set out in the guidance are high level aspirations that describe what people in Wales can expect when they access health services. In order to ensure alignment between standards and the duty of quality, the Health and Care Standards (April 2015) are withdrawn and replaced with the Health and Care Quality Standards. NHS bodies are required to take into account the Health and Care Quality Standards in discharging the duty of quality, and HIW (on behalf of the Welsh Ministers) are required to take into account the Health and Care Quality Standards in conducting reviews and investigations of the provision of health care by and for those NHS bodies.
- 12.9 There are several steps an organisation should take to prepare to meet the duty of quality<sup>27</sup>.

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<sup>27</sup> The Health Foundation (2019) The improvement journey: Why organisation-wide improvement in health care matters, and how to get started

<https://www.health.org.uk/publications/reports/the-improvement-journey>

- 12.10 NHS bodies are placed under a duty to report on the steps they have taken to comply with the duty of quality on an annual basis.
- 12.11 NHS bodies should develop a so-called 'always on' reporting mechanism to provide timely information about the quality of their services to their population and stakeholders.
- 12.12 NHS bodies must ensure the effective implementation and monitoring of the duty of quality. It must be integrated into existing governance frameworks, processes and procedures with regular updates to the relevant committees and board meetings for assurance purposes.
- 12.13 Welsh language considerations must be embedded in the culture of quality.
- 12.14 It is acknowledged that culture change takes time. The duty is in force from the 1 April 2023 at which point NHS bodies will need to be able to demonstrate how they are complying with the duty. Developing the infrastructure to progress 'always on' quality reporting with appropriate outcome-focused measures will need to be an agile and iterative process.
- 12.15 Essentially however, principles of quality improvement methodology will need to be robustly in place for Welsh Ministers and NHS bodies to build quality as a broad system-wide way of working that is embedded in a culture of continuous learning and improvement.
- 12.16 Our active and heightened efforts to ensure a relentless focus on quality and safety, as a priority above all else, are needed more than ever in the history of the NHS.



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Agenda Item No. 12

## REPORT TITLE

Strategic Quality Plan 2025-2028 Quarterly Update (Quarter 4 2025/26)

## MEETING

Name of meeting	Quality, Patient Experience & Safety Committee
Date of meeting	7 May 2026
Public or Private	Public
If private - <a href="#">rationale</a>	n/a

## REPORT SPONSOR

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

## PURPOSE OF REPORT

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



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## REPORT SUMMARY:

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

1. This paper provides the Quarter 4, 2025/26 update on delivery of the Strategic Quality Plan 2025-2028, setting out progress against the Implementation Plan, key achievements to date, emerging risks and mitigations, and areas where delivery timelines have been impacted by competing priorities and system constraints.
2. Overall delivery is currently reported as off track and requires active management. 16% of implementation tasks are complete, with 32% of priority/high-priority tasks completed; 9% of tasks (8) are overdue and several actions report low delivery confidence.
3. While progress has been made against priority actions, delays in critical enablers including data linkage, Datix infrastructure and quality management processes present a risk to full delivery of the Strategic Quality Plan and the Trust's ability to evidence sustained compliance with Duty of Quality expectations and Audit Wales recommendations.
4. Highlights this quarter include strengthening outward-facing resources to better reflect service user needs and communication preferences, including improved accessible formats (easy read and pictorial information), translation support and British Sign Language (BSL) functionality, alongside new bereavement support materials.
5. Internal capability has been supported through new digital learning packages on civility and compassionate communication (available via Learn365), with further Modules planned (including a multi-generational package in development for Quarter 1, 2026).
6. Work to strengthen co-production and community involvement has progressed through completion of a compact that sets out shared principles and ways of working, with partnership and engagement arrangements continuing to evolve.
7. Key challenges include system-wide constraints on data sharing and linkage (limiting our ability to evidence patient outcomes), delays to digitising balanced scorecards for Clinical Model Transformation (CMT) due to Intelligence & Data Services (IDS) capacity and reduced external engagement capacity within Health Boards due to financial constraints.



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## RECOMMENDATION(S)

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

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

1. Note that delivery of the Strategic Quality Plan remains off track against original implementation timelines;
2. Receive assurance regarding progress against priority actions and mitigating controls in place;
3. Endorse the revised delivery approach and timeline extensions where required; and
4. Support continued cross-organisational work to address key system dependencies, including Insight & Data Services capacity and Commissioner alignment, where these remain critical to delivery.

## ADDITIONAL PAPER(S)

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

n/a



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

### STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

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

### RISK(S) THIS REPORT MITIGATES

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

n/a

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

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

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

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

<input checked="" type="checkbox"/> Leadership	<input checked="" type="checkbox"/> Workforce	<input checked="" type="checkbox"/> Culture
<input checked="" type="checkbox"/> Information	<input checked="" type="checkbox"/> Learning Improvement and Research	<input checked="" type="checkbox"/> Whole Systems Approach

### WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

<input type="checkbox"/> A socially responsible and inclusive employer	<input type="checkbox"/> An innovative and sustainable organisation	<input checked="" type="checkbox"/> A pro-active, accessible and equitable care provider
<input checked="" type="checkbox"/> n/a	<input checked="" type="checkbox"/> n/a	<input type="checkbox"/> n/a

### IMPACT ASSESSMENTS FOR CONSIDERATION

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

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

### APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
20 April 2026	Clinical & Quality Governance Group



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## SITUATION

1. The Strategic Quality Plan 2025-2028 was endorsed by the Quality, Patient Experience and Safety (QuEst) Committee before onward approval by Trust Board in May 2025 as the Trust's overarching framework for delivering its statutory duty of quality obligations, strengthening quality management, and improving assurance against the Health & Care Quality Standards for Wales.
2. A detailed Implementation Plan supports delivery of the Strategic Quality Plan 2025-28 and is monitored and updated by a Task & Finish Group of key internal stakeholders who meet monthly. Progress is reported through Clinical Quality Governance Group (CQGG) and QuEst Committee as part of the Trust's formal assurance arrangements and in response to Audit Wales recommendations regarding quality governance oversight.
3. This Quarter 4 update provides the Committee with an overview of delivery, key achievements, emerging risks and areas where implementation timelines have been impacted by competing organisational priorities, workforce capacity constraints, and system dependencies. Whilst progress has been made against a number of priority actions, delivery confidence in some areas remains limited due to competing organisational priorities, workforce capacity constraints and system dependencies. Revised timelines and continued oversight are supporting delivery against the overall strategic objectives.

## BACKGROUND

4. The Strategic Quality Plan was developed through extensive stakeholder engagement and aligns with statutory and regulatory responsibilities, under the Health and Social Care (Quality and Engagement) (Wales) Act 2020, the Duty of Quality, and the Health & Care Quality Standards for Wales, alongside the Trust's Long-Term Strategy.
5. The plan provides the overarching Quality Framework through which other organisational strategies and improvement programmes are aligned, ensuring delivery of the quality agenda is coordinated, measurable and capable of providing assurance to Committee and Board. Audit Wales Quality Governance Follow Up Review 2024 (Recommendation 2, 2024) specifically requires that progress against the Strategic Quality Plan is routinely reported through the QuEst cycle of business to strengthen Board assurance regarding delivery of the Trust's quality governance arrangements.



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6. The Strategic Quality Plan is designed to improve quality outcomes for patients and communities whilst recognising the financial, workforce and system pressures facing the NHS in Wales. A pragmatic prioritisation approach was therefore taken to focus delivery on actions most likely to strengthen assurance, improve patient experience and support measurable improvement within available resources. prioritise improvements that are achievable within existing resources. Through engagement, with a broad range of stakeholders both internal and external, the Strategic Quality Plan has been shaped to reflect the needs and expectations of patients, staff and communities. This includes a strong emphasis on inclusivity, equity, compassionate communication and personalised care, supporting both the Duty of Quality and the wider Listening to People agenda.

## ASSESSMENT

7. The implementation of the Strategic Quality Plan is progressing however delivery timelines are impacted by competing priorities and as such implementation is reporting as off track. 16% of the implementation tasks are completed with key actions aligned with Compassionate Communication, Quality Management and Inclusivity & Equity. However, 9% of Project Tasks (8) are overdue and a number are also reporting low delivery confidence which threatens the achievement of the strategic objectives. Whilst many overdue actions relate to enabling infrastructure rather than direct patient facing service delivery, delays in these areas reduce the pace at which assurance improvements can be evidenced and require continued oversight.
8. Of the 8 tasks reporting as overdue only 3 were priority or high priority activities as part of the prioritisation exercise previously undertaken. This provides assurance that delivery remains focused on the most strategically significant actions, although delayed enabling workstreams continue to affect wider delivery confidence.
9. The Health & Care Quality Standards Self-Assessment is being reprioritised to allow the completion of the Quality Assurance Self-Assessments which have now been framed around the Health & Care Quality Standards.
10. The delivery of balanced score cards for CMT Workstreams is set out in more detail in the challenges and delays section of this update. It is noted that manual score cards are in place and that a Benefits Realisation Group is now in place to support the monitoring and evaluation of the CMT. Manual scorecards provide interim assurance; however, full digitisation remains necessary to support sustainable 'always on' reporting and stronger Board assurance.



11. Whilst we continue to work collaboratively with Commissioners to develop a nuanced data set for monitoring and assurance, the governance transition from Emergency Ambulance Services Committee (EASC) to Joint Commissioning Committee (JCC) is fluid with new groups now meeting. Recognising it is ultimately the JCCs responsibility to progress work in this area, we continue to work collaboratively and have recently fed back to Commissioners regarding the Duty of Quality. Reports for Phase 1 and 2 of the CMT have been submitted to Commissioners and our response to the Public Accountability Meeting (PAM) also provided further detail. Ultimately the balanced scorecards are required as part of both internal and external monitoring and assurance.
12. When considering the number of tasks completed it should be noted that 32% of the tasks identified as priority or high priority have been completed.

### **Deferred Timelines**

13. Last quarter we updated that three tasks had received deferred timelines for delivery. These tasks remain deferred as previously reported but no further deferrals have been identified.

### **Extended Timelines**

14. Last quarter we updated that five tasks had received extended timelines for delivery but remained within the timeline of the overall Strategy.
15. The development of revised Quality Impact Assessment (QIA) documentation and processes was 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 (PHW) and consider implications of new legislation associated with Health Impact Assessments. The collaborative digital application for the QIA has now been shared by PHW however the introduction of Health Impact Assessments and the overlap with both QIA and Equality Impact Assessment (EQIA) means that having a streamlined and integrated approach to Impact Assessments is more important than ever. PHW have indicated that due to the complexity of their app they do not intend to amalgamate Health Impact Assessments, instead focussing on producing a separate process. This does not align with initial thoughts within the Welsh Ambulance Services University NHS Trust (WAST) and as such the introduction of a new QIA process and digital platform will be reprioritised and a Task & Finish Group introduced to review the Health Impact Assessment legislation and implementation for WAST.



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16. Building capacity & conditions for our people to balance change management principles with quality improvement methodology was 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. The current proposal for agreement between the teams is to have a light touch connectivity between teams in terms of signposting to learning resources. The proposal looks to align with 'Our WAST Way' by focusing on how we lead, behave and work together when improving services to ensure that quality improvement and change management reinforce one another in a practical, people centred way.
17. Next steps are to set the core principles and behaviours that underpin quality improvement so that they can be woven into the Leadership Development Framework. Due to long term absence within the Quality Improvement Team progress against the next steps have been impacted effecting the already extended timeline.
18. The provision and support of quality improvement training had 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. However long-term absence within the Quality Improvement Team is having a detrimental effect on this deliverable and the activity is yet to be fully completed. It should be noted that Certificate in Education & Training (CET) training has now be redesigned to mitigate any absenteeism moving forward.
19. In last quarter's report we noted the development of Quality Statements and Quality Assurance Self-Assessments, across organisational Directorates and Departments, have been extended by 3 months each. Progress continues to be made in this area with 50% of Statements and 80% of Self-Assessments now complete. However, the focus of some teams in supporting the Putting Things Right (PTR) Recovery and Improvement Programme has impacted capacity and so delivery confidence is now reduced. Progress continues to be monitored through the Quality Management Group.
20. Six further tasks have received reviewed and extended timelines for delivery which remain within the overall strategy timescales, one of which has now been completed.
21. The expansion and embedding of an Annual Review of actions taken to improve services based on user voices was due for completion by the end of Quarter 3, 2025/26. This activity is now part of the Terms of Reference for the Quality Management Group, which receives monthly updates and thematic analysis of experiential intelligence. However, to provide appropriate governance of the



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achievement of this task the timeline has been extended to 30 April 2026 to ensure the scheduled review is completed prior to closure. The review has commenced and is on track to achieve the revised timeline.

22. As part of our intention to celebrate diversity and create fair opportunities for all our people we committed to achieve the Carer Confident Employer level 2 award. The application for the level 2 award is currently being finalised and subject to additional information from the Recruitment Teams which is expected in April 2026. For sufficient time to have passed to understand whether this application is successful the timeline has been extended to the end of Quarter 1, 2026/27.
23. Enhancing the governance and configuration of Datix Cymru to ensure it is an appropriate and embedded improvement tool fit for purpose for the organisation a structure of Governance Forums have been introduced. The development of these Forums has been completed for some time, with appropriate membership and governance already in place. However, as a result of the closure of the Senior Quality Team (SQT) Forum in April 2025 a parent group is outstanding for the Datix Governance Group and as a result an extension was applied to this task until the end of Quarter 4, 2025/26. The lack of parent group has been explored with a number of Corporate Forums without success. This issue is escalated to the Clinical Quality Governance Group and corporate governance support is engaged to identify an appropriate parent group for this infrastructure. Whilst formal confirmation of a parent governance route remains under discussion, the operational governance arrangements are established and functioning, and ongoing oversight continues through existing governance arrangements. On this basis, the implementation task has been closed.
24. Further work to enhance the governance and configuration of Datix Cymru included the introduction of change logs and configuration definitions which was due for completion by the end of Quarter 4, 2025/26. Change logs are being maintained manually by the Datix System Lead to track system changes, especially those which are not auditable through the system, and work continues to update and clearly define system user profiles however due to the significant work required as a result of CMT, PTR Recovery and Improvement Programmes and the introduction of the new Listening to People Regulations, completion of this task has been extended to Quarter 2, of 2026/27.
25. It is recognised that the Datix System Team currently equates to 1.8 Whole Time Equivalent (WTE) to monitor and maintain the system across two platforms and 7 Modules. This forms the basis of the organisational change currently underway in the Quality Governance Team structure to better support the Datix Cymru



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platform as a well configured and maintained system for quality control and organisational learning.

26. Interim manual controls remain in place to support safe system governance; however, sustainable resolution is dependent on sufficient system capacity and completion of the planned organisational change.
27. Similarly, the delivery of accessible training materials and guides to support teams utilising the Datix Cymru platform have also been impacted by capacity within the team and competing priorities across the organisation. As a result, the time for delivery has been extended until the end of Quarter 2, 2026/27. Core Training materials are in place and have been delivered across several teams within the organisation as well as providing self-service training opportunities. However ongoing Datix system configuration and improvement as well as quarterly system upgrades mean materials require regular updating. Core training materials remain available and existing support arrangements continue to mitigate immediate operational risk whilst fuller training resources are developed.
28. As part of ensuring appropriate quality control infrastructures are in place, the Quality & Performance Management (QPM) Steering Group are monitoring Departmental Self-Assessment against the organisations Quality & Performance Management Framework. As part of the Workplan this was expected to be completed by the end of the fiscal year 2025/26. 64% of Self-Assessments have been completed and presented to the Steering Group however a number of drafts are expected to be presented in April 2026 (bringing the completion total to 78%) with further submissions scheduled on the Steering Group agenda in May 2026. As a result, the timeline for delivery has been extended to 29 May 2026 to ensure that all Self-Assessments are not only completed but have been reviewed and approved by the Steering Group before the completion of this task is agreed. This phased approach supports appropriate scrutiny and strengthens assurance by ensuring submissions are reviewed and approved prior to closure.

### **Highlights & Achievements**

29. Our Strategic Quality Plan commits to strengthening person-centred care by ensuring people can access clear, timely information in a format and language that meets their needs, particularly at times of stress and uncertainty. Improving the accessibility and consistency of our public-facing resources supports equitable access for Welsh speakers, people with sensory loss, learning disabilities and other needs, and helps us reduce avoidable barriers to care and advice. Part of our work in this area is to strengthen our outward-facing information and resources, so they better reflect what matters to service users and the ways



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people prefer to communicate with us. This includes refreshing key public-facing platforms and materials, expanding accessible formats (including easy read and pictorial information), and maintaining translation and BSL functionality to support inclusive access. We have also developed useful materials around the impacts of bereavement and the services available to support families during this difficult time. This work supports our compassionate communication commitment by improving clarity, choice and consistency in how we share information and engage with patients, carers and communities. This work strengthens equitable access to information and supports earlier identification of communication barriers, improving both patient experience and organisational assurance regarding inclusive service delivery.

30. In addition, we have enhanced the guidance available to our people by introducing digital learning packages focussed on embedding civility and compassionate communication. This digital learning package is now available via Learn365 and has been developed by our Essential Skills Team which has focused on individuals who have previously lacked educational achievement in communication, such as those without GCSE English or Welsh. The content currently contains 2 items 'embedding civility in how we work and communicate' and 'short guide to writing effective, civil and compassionate emails'. This package will be expanded as part of ongoing Educational Plans including a multi-generational package which is in development for release during Quarter 1 of 2026. This supports wider organisational expectations around culture, professionalism and compassionate communication, strengthening both staff experience and the quality of interactions with patients and families.
31. The development of a compact, establishing a clear and shared framework to support coproduction, collaboration and community involvement has been finalised and shared with relevant networks, providing agreed principles, expectations and ways of working. Next steps include developing associated partnership and engagement arrangements which are evolving, with elements of the compact informing broader system level engagement structures. This provides greater clarity and consistency in how co-production and community engagement are undertaken, supporting stronger governance and more meaningful involvement of people and communities in service improvement.

### **Challenges and Delays**

32. As previously reported critical tasks within the Implementation Plan aligned with data linkage continue to face risks to delivery due to limited system wide data sharing and prioritisation of capacity within IDS. Whilst internal progress is strong the lack of comprehensive and systemic data linkage restricts our ability to



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measure ultimate patient outcomes and hinders system wide improvement. This continues to limit the organisation's ability to fully evidence the impact of service changes and demonstrate improvement outcomes, which affects the strength of assurance available to Committee and Board.

33. Part of the commitment to monitoring and evaluation of transformational change was to review our metrics to ensure an improving focus across a broad range of factors. The delivery of initial balanced score cards for the CMT is impacted by the competing priorities for IDS expertise. Five balanced score cards for the workstreams have been approved and an overall scorecard is currently in development however these score cards are currently being maintained via excel spreadsheet due to demand and capacity challenges within the IDS Team. Scorecards are ready for conversion and further iterations and improvements to scorecards are planned. Additional capacity planned for May will assist with the manual management of these scorecards but ultimately digitisation is required to meet our intentions of 'Always On' reporting capabilities. Manual scorecards provide interim oversight; however, full digitisation will strengthen sustainable assurance, timely performance visibility and Board oversight of CMT outcomes.
34. Our commitment to community involvement has centred on establishing ongoing engagement cycles that help report impacts and outcomes, ensuring experiences shape service changes. One key objective in this area was building a partnership with Health Board Engagement Teams to maximise the use of collaborative resources. However, a risk to delivery has been identified due to limited engagement capacity within Health Boards. The restructuring of these teams, caused by financial constraints and staff vacancies, has significantly reduced resources for collaboration and stakeholder participation. Further challenges are posed by the need to give priority to statutory and regulatory duties within restricted budgets, which has led to some engagement activities being postponed or reassigned. Existing partnership arrangements continue to support priority engagement activity, with work focused on maintaining meaningful involvement where it has the greatest impact on service improvement and patient experience.

## RECOMMENDATION

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



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## NEXT STEPS

36. Task & Finish Group will continue to meet and monitor the delivery of the Strategic Quality Plan, with particular focus on overdue actions, revised timelines and areas reporting reduced delivery confidence.
37. Quarterly updates will continue to be provided to Committee to support assurance regarding delivery progress, mitigating actions and improvement in delivery confidence across the Strategic Quality Plan.
38. A commitment to review the plan and our ability to deliver the intentions set out in the Implementation Plan now forms part of the Integrated Medium Term Plan deliverables for this year. As such initial engagement is being scheduled with Strategic Leaders across Quality, Planning and Corporate Governance. This review will support alignment of priorities, strengthen delivery confidence and ensure the Strategic Quality Plan remains realistic, deliverable and capable of providing effective Board assurance.



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Agenda Item No.

13

## REPORT TITLE

Respiratory Protective Equipment (RPE) Report - Overview and Update

## MEETING

Name of meeting	Quality, Patient Experience and Safety Committee
Date of meeting	7 May 2026
Public or Private	Public
If private - <a href="#">rationale</a>	n/a

## REPORT SPONSOR

Executive sponsor	Liam Williams, Executive Director of Quality & Nursing
Author(s) of report	Sarah Morgan, Head of Infection Prevention & Control

## PURPOSE OF REPORT

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



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## REPORT SUMMARY:

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

1. This report provides the Quality, Patient Experience and Safety Committee (QuEst) with assurance regarding the Trust's current Respiratory Protective Equipment (RPE) arrangements following the organisational transition from Filtering Facepiece 3 (FFP3) respirators to Powered Air-Purifying Respirators (PAPRs). The Trust has successfully transitioned to a PAPR-based Model, with no current indicators of systemic equipment failure or immediate staff safety concerns. Further work is underway to strengthen organisational reporting, maintenance consistency and governance arrangements to support continued assurance and regulatory compliance.

### Background

2. RPE is a critical safety measure in reducing staff exposure to infectious agents transmitted through aerosol and airborne routes, particularly within the Ambulance Service, where environments are uncontrolled and clinical risk can rapidly change. The Trust predominantly relied on FFP3 respirators, supported by a formal fit-testing programme. However, challenges with ongoing fit-testing capacity, high fit-test failure rates, and operational sustainability prompted a shift to PAPRs in 2024.
3. A comprehensive review has been undertaken by the Infection Prevention and Control (IP&C) Team following the transition to PAPR systems. The purpose of this review is to ensure that the RPE Model adopted by the Trust is safe, fit for purpose, operationally sustainable and fully compliant with national standards. The PAPR solution chosen, 'the Versaflo TR-300+ system', provides enhanced respiratory protection for staff exposed to aerosol and airborne pathogens during high-risk clinical activity. PAPR units were deployed across all emergency vehicles, with a number also allocated to Ambulance Care vehicles, to support operational resilience and staff safety.
4. PAPRs offer consistent and reliable respiratory protection without the need for annual fit-testing and provides higher Assigned Protection Factors (APF) in line with national guidance for high-risk exposure scenarios. The transition occurred post COVID-19 and aligns with the requirements set out in the UK Pandemic Inquiry Module 3 Report, ensuring that our processes are robust, reflect regulatory standards relating to infection prevention and control, equipment management and organisational preparedness.
5. The transition has also been considered against regulatory expectations under Health and Safety Executive (HSE) Guidance relating to Respiratory Protective Equipment, ensuring the Trust's approach reflects statutory requirements for risk assessment, suitability and maintenance of RPE.



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6. It is important to note that Student Paramedics and volunteers continue to receive FFP3 fit testing in university and as part of the Trust induction process.

## Training & Education

7. The Education and Development (E&D) Department were assigned responsibility for leading the organisational transition to PAPRs. In fulfilment of this remit, the department developed a comprehensive eLearning Module on the Learn365 platform, to ensure staff receive the necessary theoretical instruction for safe PAPR use, and the donning and doffing procedures for both standard respiratory infections and High-Consequence Infectious Diseases (HCIDs). Furthermore, the E&D Team trained **98 RPE champions** across Emergency Medical Services (EMS) and Ambulance Care, to deliver the face-to-face practical training component, which includes hood assessments and the issuing of personal hoods.
8. E&D training records indicate that **2,123** staff have completed the eLearning Module and **1,985** EMS and **83** Ambulance Care staff have subsequently undertaken the face-to-face practical session. However, PAPR training is not currently mandated or recorded within the Electronic Staff record (ESR), which limits the Trust's ability to obtain an accurate and reliable current compliance position. The dataset also includes individuals who have left the Trust. The Operational Teams maintain local training records and are actively working to improve compliance across their respective areas. At present, EMS records indicate compliance levels of **between 83% and 100%** for both the eLearning and practical elements of the training. Ambulance Care training compliance data is currently being consolidated at locality level and will be incorporated into the next quarterly IP&C Assurance Report. Based on initial discussions with Operational Leads, no concerns regarding access to training or equipment competence have been raised.
9. Whilst local compliance levels appear encouraging, the absence of mandated recording within ESR means the Trust cannot demonstrate definitive, organisation-wide compliance with RPE training requirements. In the event of regulatory scrutiny, incident investigation or legal challenge, reliance on locally held records may not provide sufficient corporate assurance.
10. Work is underway to mandate PAPR training within ESR and align job roles to the appropriate mandatory training matrix. Subject to system configuration timelines, implementation is expected by May 2026. This will enable reliable compliance monitoring, improve data integrity and strengthen corporate assurance closing the current assurance gap relating to training recording. Annual refresher training on the use of PAPRs, including both donning and doffing procedures, will be implemented to ensure continued competency.



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## PAPR maintenance

11. The PAPR Standard Operating Procedure (SOP) clearly outlines the maintenance requirements for the equipment, including the expectation that three-monthly maintenance checks are undertaken either by the nominated person for each site or by the designated user when the equipment has been deployed. Recent IP&C audit activity identified a small number of vehicles and sites where documented three-monthly maintenance checks had not been completed within the required timeframe. The Heads of Service have since confirmed that PAPR maintenance spot checks are conducted on a monthly basis, with the outcomes submitted through the relevant governance structures. A total of 331 spot checks were undertaken on emergency vehicles during the previous reporting period. Of the total, nine units were identified as not being stored within the designated storage containers. Notwithstanding this, all units were found to be within date and appropriately tagged. Audit and spot check findings are reviewed through locality governance meetings and escalated via IP&C reporting structures where recurring themes are identified. No equipment failures impacting staff safety have been reported.
12. Recent IP&C audit activity identified expired Personal Protective Equipment (PPE) stock in a number of localities, primarily relating to coveralls, over boots and fluid resistant surgical facemasks (FRSMs). Whilst no safety incidents have been linked to this finding it highlights inconsistency in stock rotation processes.
13. To date, **70%** of required Action Plans have been received. Remaining areas have been formally reminded with follow-up through locality management structures. Compliance recovery will be monitored monthly through IP&C governance routes until full resolution is achieved.

## Governance arrangements

14. The PAPR SOP, together with the HCID SOP, PPE policy and all other associated documents, are currently under review. These documents will be updated to reflect national guidance and forthcoming changes to the National Infection Prevention and Control Manual (NIP&CM). Draft documents will be shared with key stakeholders for comment and contribution, and the updated documents will progress through the relevant governance structures for review and endorsement.
15. Updated policies will clearly define individual and managerial responsibilities for RPE checks, maintenance and replenishment. Expectations will be reinforced through operational leadership briefings and incorporated into the revised SOP framework to ensure clarity of accountability.



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16. Once PAPR training has been mandated on ESR, it will be significantly easier to generate accurate compliance reports for both EMS and Ambulance Care and identify areas requiring additional support. PAPR training compliance will be incorporated into the IP&C Quarterly Report presented to the IP&C Strategic Group, and any concerns escalated accordingly.
17. Overall, the Trust has successfully transitioned to a PAPR-based RPE Model, with full deployment across the emergency fleet and defined governance oversight arrangements in place.
18. Assurance is currently assessed as moderate. The Equipment Model is clinically appropriate and aligned to national guidance; however, governance controls relating to training recording, maintenance consistency and stock management require strengthening to provide full assurance. Defined improvement actions are in place with clear Executive oversight through the Infection, Prevention and Control Strategic Group.

## RECOMMENDATION(S)

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

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

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

## ADDITIONAL PAPER(S)

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

n/a



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

### STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

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

### RISK(S) THIS REPORT MITIGATES

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

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. Implementation of the improvement actions outlined within this paper is expected to strengthen the control environment and support future risk reduction.

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

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

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

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

<input checked="" type="checkbox"/> Leadership	<input type="checkbox"/> Workforce	<input type="checkbox"/> Culture
<input type="checkbox"/> Information	<input type="checkbox"/> Learning Improvement & Research	<input checked="" type="checkbox"/> Whole Systems Approach

### WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

<input type="checkbox"/> A socially responsible and inclusive employer	<input type="checkbox"/> An innovative and sustainable organisation	<input checked="" type="checkbox"/> A pro-active, accessible and equitable care provider
<input checked="" type="checkbox"/> n/a	<input checked="" type="checkbox"/> n/a	<input type="checkbox"/> n/a

### IMPACT ASSESSMENTS FOR CONSIDERATION

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

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

### APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
23 March 2026	Clinical Quality Governance Group



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Agenda Item No.

14

## REPORT TITLE

Patient Experience and Community Involvement (PECI) Bi-Annual Report  
(October 2025- March 2026)

## MEETING

Name of meeting	Quality, Patient Experience & Safety Committee
Date of meeting	7 May 2026
Public or Private	Public
If private - <a href="#">rationale</a>	n/a

## REPORT SPONSOR

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

## PURPOSE OF REPORT

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



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## REPORT SUMMARY:

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

1. This report presents the work of the Patient Experience and Community Involvement Team (PECI) during October 2025 - March 2026. The work presented within this report is in line with 'The Peoples Experience Framework' (PEF) (WHC2024/015) and the Health and Social Care (Quality and Engagement) (Wales) Act 2020-21.
2. Overall, this report provides a balanced level of assurance, with strong mechanisms in place to capture and act on experience, alongside recognised system pressures impacting consistency and reach.
3. Against the backdrop of the Organisational Change Process (OCP) the team have focused their resources on people's experience ensuring measurable contributions to the Trust's transformation and quality ambitions.
4. For reference, NHS Wales define peoples experience as '**the sum of all interactions, shaped by the culture of the organisation, staff and systems**'. This definition can also be applied to staff working within NHS organisations. It incorporates every encounter and touchpoint, acknowledges how an organisation shapes an individual experience, how staff impact on individual experience and how systems used also influence how and individual experiences the care and service provided.

## RECOMMENDATION(S)

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

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

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

## ADDITIONAL PAPER(S)

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

**Annex 1** Patient Experience & Community Involvement (PECI) Bi-Annual Report October 2025 - March 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](#)]

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

### RISK(S) THIS REPORT MITIGATES

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

N/A

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

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

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

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

<input checked="" type="checkbox"/> Leadership	<input checked="" type="checkbox"/> Workforce	<input checked="" type="checkbox"/> Culture
<input type="checkbox"/> Information	<input type="checkbox"/> Learning Improvement and Research	<input checked="" type="checkbox"/> Whole Systems Approach

### WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

<input type="checkbox"/> A socially responsible and inclusive employer	<input type="checkbox"/> An innovative and sustainable organisation	<input checked="" type="checkbox"/> A pro-active, accessible and equitable care provider
<input checked="" type="checkbox"/> n/a	<input checked="" type="checkbox"/> n/a	<input checked="" type="checkbox"/> n/a

### IMPACT ASSESSMENTS FOR CONSIDERATION

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

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

### APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
14 April 2026	Clinical And Quality Governance Group



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## SITUATION

1. Peoples' experience is a core component of healthcare quality that compliments clinical excellence and patient safety and has a growing focus on understanding and improving the overall patient journey.
2. The Peoples Experience Framework has been incorporated within the revised quality governance structure to align fully with the statutory duty on the Trust to demonstrate continuous improvement in the quality of and considering the voice of people using its services. The expectation across NHS Wales is that experience insight is used as a driver for continuous improvement and learning.
3. Experience themes have continued to be reported through the Quality Management Group, with agreed actions demonstrating active learning and quality improvement informed by lived experience. Insights from people's experiences are included within the Bi-Annual Report.
4. Feedback consistently highlights concerns around long waits and timeliness across all service areas, with continued anxiety about meeting expectations for prompt responses, particularly for emergency care. This indicates that system-level delays remain the primary driver of negative experience and present an ongoing risk to patient confidence and perceived safety.
5. Positive feedback has also remained strong; however, this positive experience is often experienced despite system pressures rather than because of system performance. Many compliments recognising staff as kind, caring and compassionate; these continue to be shared and promoted widely.
6. As the Trust moves beyond traditional time-based metrics, greater emphasis is being placed on a balanced approach that integrates clinical outcomes, patient safety and experiential measures in line with national policy and statutory requirements.

## BACKGROUND

7. We have a legal duty to capture and act on peoples' experiences and to engage with communities to listen and capture feedback so that their voices and lived experiences influence the ongoing design and delivery of our services as set out in:
  - The People's Experience Framework (WHC2004/015)
  - NHS Wales Performance Framework
  - Social Services and Well-being (Wales) Act 2014-18
  - Well-being of Future Generations (Wales) Act 2015-19



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- The National Principles for Public Engagement in Wales (2011)20
- Health and Social Care (Quality and Engagement) (Wales) Act 2020-21
- The Quality Standards - April 2023
- A Healthier Wales 2022

## ASSESSMENT

8. The PECl Team's key contributions and deliverables, focused on understanding and improving people's experiences, service quality, and the Trust's reputation across communities, are reported in the Bi-Annual Report.
9. Whilst mechanisms to capture and utilise experience are well established, insight consistently highlights that access delays and system flow remain the dominant drivers of poor experience, presenting ongoing risk to equity, confidence and outcomes.
10. During the organisational change period, community engagement activity has been reduced, which presents a temporary risk to the breadth and consistency of citizen voice; mitigating actions are in place through local models and strengthened feedback mechanisms.

## RECOMMENDATION

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

## NEXT STEPS

12. Experiential data will continue to be reviewed through Quality Management Group using a multidisciplinary team's approach in identifying learning outcomes and improvements with a focus on translating insight into measurable improvement actions and strengthening alignment to Trust Risk and Assurance Frameworks.

# Patient Experience & Community Involvement (PECI) Bi-Annual Report October 2025 – March 2026



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## Peoples Experience within the Welsh Ambulance Service

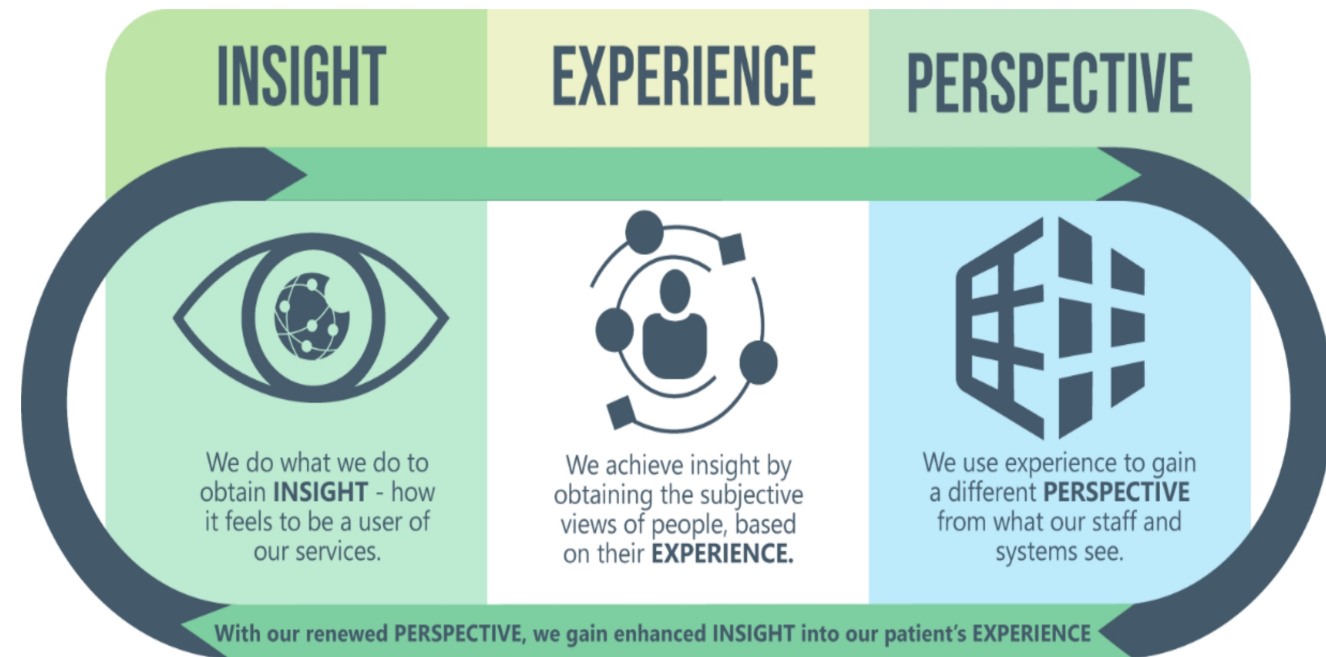
The information in this report has been gathered through multiple channels, including service experience surveys, patient stories, and the online *Have Your Say* platform.

The Welsh Ambulance Services NHS Trust (WAST) is committed to ensuring that people have the best possible experience when accessing our services.

People's experience is a key component of person-centred care and is shaped by our staff, individual expectations, and the impressions formed throughout their care journey. It reflects how people feel about accessing and receiving care, based on their feelings of the treatment and support provided.

People's experience is a core component of the Trust's Quality Management System, providing assurance on the safety, effectiveness and person-centredness of services. It supports delivery of the Duty of Quality, Listening to People requirements and Health & Care Quality Standards.

### 'The Experience Cycle'



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

# **Section 1**

## **People's Experience – Strategic Overview**



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# Insights into People's Experience

## Quality Management Group (QMG)

Throughout the year experiential data has consistently been presented to the QMG on a 4-weekly rotation of focused areas to support embedding a quality management system into all areas of the Trust.

The four focus areas have been:

- EMS, (including EMS Coordination, EPRR and Volunteers)
- Ambulance Care
- Integrated Care
- Resourcing and Corporate Services

PECI have provided service user feedback for review and provide assurance that, where applicable, action has been taken to improve the quality of services and experiences of its service users.

Where recurring concerns or deterioration in experience are identified, these are escalated through Directorate governance routes and triangulated with incidents, complaints, safety intelligence and operational performance to support targeted improvement and executive oversight.

## Main takeaways

At the end of March 2026, the experience position across the focus areas are:



## EMS (including EMS Coordination, EPRR and Volunteers)

- Positive patient feedback for communication, compassion, and professionalism.
- Compliments show strong themes of rapid response, life-saving interventions, compassionate communication, and helping people feel safe.
- Bereavement-related compliments are significant, showing deep appreciation for staff empathy at moments of grief.
- Falls service feedback is positive.
- Negative feedback reflects system pressures such as waiting times and handover delays.
- SMS PREM launch preparations (April) are well advanced, expected to increase feedback volume and representativeness.

## Falls Assistant Experience Survey

Overall experience is very positive:

- 87.9% rated their experience as "Very good"
- Strong feedback on staff compassion, professionalism, and reassurance

However, system pressures significantly affect experience:

- Long waits for Falls Assistant attendance in some cases
- Extended waits for ambulance/hospital following assessment.
- Patients left in vulnerable situations (e.g. on the floor) for prolonged periods.

Feedback shows that the Falls Service delivers excellent care and patient experience when it reaches patients, but is constrained by wider system delays, with many people going on to say that they still needed to be conveyed to hospital and waited many hours for an ambulance to arrive after Falls Assistance attendance.

This creates a clear patient safety and dignity risk, particularly where prolonged floor time increases risk of deterioration, pressure damage, dehydration and avoidable conveyance.

Staff behaviour is a core strength and defining feature of the service, with staff consistently described as kind, calm, and highly professional in distressing situations:

- "A very kind, reassuring professional who made a very scary situation feel that much better."
- "Professional, reassuring, made me feel safe and supported."
- "Supportive, empathetic and professional."

Patients value feeling informed, calm, and supported during vulnerable moments. This reassurance and communication are key drivers of perceived safety.

Waiting times are the most consistent negative theme:

- "Waited well over 4hrs."
- "A wait of 7 hrs."
- "Mother was on the floor for 20 hours before anyone attended."



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# Insights into People's Experience

## Ambulance Care

Overall experience stays consistently positive, supported by surveys, Friends & Family Test (FFT) data, compliments, and thematic analysis.

Positive themes repeatedly highlighted as:

- Staff kindness, professionalism, compassion;
- Dignity and reassurance for frail or mobility-limited patients
- Keen sense of safety and trust during transport with FFT scores staying high

Compliments emphasise:

- 'going above and beyond' with empathy, patience, and practical support

Key ongoing concerns include:

- same-day cancellations causing missed appointments and delays to treatment;
- Long waits for return journeys; Communication gaps about delays or expected wait times. These issues have emotional and physical impacts, especially for older and complex patients

## System context

- Pressures and capacity constraints have been the main drivers of negative experience not staff behaviours.
- Temporary winter capacity helped stabilise experience, but indicators suggest it may worsen when temporary support is withdrawn.

## Communication Improvements

Several improvements have been introduced that are showing early positive impact including:

- Courtesy callbacks
- SMS messaging, and
- Digital tools

However, awareness is still low with patients, but plans are in place to address this.



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# Insights into People's Experience

## Integrated Care

The 111 experience survey paints a picture of a service that can work very well for some people but fails others.

- Around one-third of respondents describe the service as helpful, with some rating it extremely or very helpful.
- However, almost half say their call was “not at all helpful”, and over half of respondents rate their overall experience as poor or very poor.

This polarisation is reflected strongly in the free-text comments.

By far the strongest and most consistent theme is access:

- Long waits to get through (often 30–90+ minutes).
- Frequent reports of promised call-backs that never happen or come many hours – or even days – later.
- “Call-back” systems that still require people to wait on hold again.

These issues appear throughout the entire six-month period, including the most recent March 2026 comments.

Many patients report giving up, remaining in pain, or eventually attending A&E because 111 support did not materialise.

## Overall interpretation of Integrated Care

Stable strengths, persistent pressures

- **Strengths:** Compassionate staff, good clinical care *once accessed*, strong individual professionalism remain consistent..
- **Weaknesses:** Access delays, unreliable call-backs, inconsistent advice, limited alternative contact routes continue to drive poor experience and reduced confidence.
- **Trend over time:** These issues remain persistent across the six-month period, indicating systemic rather than isolated concerns.

Improvement work is focused on access, call-back reliability and patient communication, with themes routinely reviewed through service governance and Quality Management Group to support targeted action and executive oversight.

In summary, frontline care is often excellent; however, system access and reliability remain the principal risks to patient experience, confidence and equitable access.



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# Insights into People's Experience

## Whole System People Experience Overview

### What is working well

- Frontline staff across all services are consistently excellent
- Patients report high levels of compassion, professionalism, and safety
- When care is delivered, it is often described as life-saving, effective, and reassuring

### What is working less well

- Access to services is difficult for some (especially NHS 111 and NEPTS booking)
- Reliability (call-backs, transport delivery, response delays)
- System flow (handover delays, delays between services)

Overall, frontline care remains consistently strong; however, system access and flow constraints are the primary drivers of negative experience and represent the key risk to patient confidence and equitable care.

## Cross-System Strengths - Consistent Across All Services

### Exceptional Staff – The System's Strongest Asset

Across EMS, NEPTS, and 111 staff are described as kind, compassionate, professional. Staff are the single biggest driver of positive experience across the entire system

### Strong Care Once Patients Reach Services

EMS: Life-saving, rapid clinical care; NEPTS: Safe, supportive transport enabling care access; 111: Effective triage, advice, and signposting. The issue is not quality of care but getting patients into and through the system.

### High Perception of Safety and Trust

EMS & NEPTS: Very high "felt safe" scores. 111: Strong reassurance when contact is made. Trust is strong once contact is established



ReciteMe is a cloud-based accessibility and language support tool that enhances website inclusivity and usability.

Between October 2025 and March 2026, the toolbar was accessed by 688 users, with 57% using mobile devices, highlighting the importance of mobile-optimised accessibility.

Usage was recorded across 25 countries, including the USA, Spain, Italy, and Norway, although most of the access originated in the UK.

Funding responsibility for accessibility support will transfer as part of the OCP arrangements, with continuity of provision being considered through wider organisational planning.

Total pages viewed

2649

## Translation



The translate tool was used **5,906** times, far more than other features.

Users selected translations in **115** languages highlighting a strong need for multilingual access. Languages such as Assamese, Armenian, Serbian and Czech were among the most frequent chosen.

## Styling



Other commonly used features included font changes, colour adjustments, and cursor size modification, all supporting readability and reducing visual strain.

October 2025	<b>57</b>	January 2026	<b>75</b>
November 2025	<b>35</b>	February 2026	<b>49</b>
December 2025	<b>35</b>	March 2026	<b>47</b>

During the reporting period, the Welsh Ambulance Service received a significant volume of positive feedback across Emergency Medical Services, Integrated Care and Ambulance Care. These compliments provide valuable insight into the lived experiences of patients and families, and they reflect the organisation's continued commitment to delivering safe, compassionate and person-centred care under challenging system pressures.

Across all service areas, compliments consistently referenced:

- **Compassion and dignity** shown by staff in often distressing or traumatic situations
- **Clear communication** and reassurance for patients, carers and families
- **Professionalism and clinical expertise**, including timely recognition of deteriorating patients
- **Kindness and humanity**, particularly in end-of-life scenarios
- **Strong teamwork** between crews, control room staff, first responders, partner agencies and 111 clinicians



Click the green 'Staff Compliments' button on the PECL page on Siren to discover what the public have been saying about our #TeamWAST colleagues!

Please share your cards and emails with the PECL team so that they can be accurately recorded.



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# Reporting of Compliments

**The National Compliments Workstream** has implemented a new set of subjects in Datix to provide a more consistent, meaningful, and patient-centred way of theming compliments received right across NHS Wales.

These subjects reflect key aspects of people experience and involvement, such as communication, empathy, dignity and shared decision-making, enabling compliments to be recorded in a way that clearly captures what mattered most to patients and their families.

Introducing a standardised set of themes supports improved insight, learning and reporting at local and national level, helps highlight good practice and staff behaviours that align with our values, and ensures positive feedback can be analysed alongside other people experience intelligence to drive continuous improvement.

## **Subjects which compliments can now be tagged with are:**

- Family have been involved in the care
- I experienced good communication from the staff involved
- I felt understood
- I was listened to
- I was treated with dignity and respect
- My dietary needs were met
- Shared decision making – I felt involved and included in discussions around care
- Staff demonstrated empathy towards me or the person I was accompanying
- The environment was suitable for my needs
- The level of service was beyond what I expected
- The staff went the extra mile
- The staff were professional and caring.
- Other, please specify



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# Reporting of Compliments

**Emergency Medical Services (EMS)** received the highest volume of positive feedback, reflecting the complexity and visibility of emergency frontline care. Compliments frequently referenced:

- **Life-saving interventions** in cases such as cardiac arrest, stroke, sepsis and major trauma
- **Exceptional compassion** during frailty, palliative care, mental health crises and bereavement
- **Professionalism under pressure**, including complex extrications and major incidents
- **High-quality communication** that maintained dignity and reassurance
- **Effective multidisciplinary working** with EMRTS, police, fire services, community first responders and hospital teams

EMS staff are repeatedly described as “kind”, “calm”, “reassuring”, “skilled” and “a credit to the NHS”.

Compliments for **NHS 111 Wales** primarily focused on communication and emotional support, including:

- **Empathy and active listening**, particularly for anxious callers and those with mental health needs or caring responsibilities
- **Clear, practical clinical advice** that supports safe self-care or timely escalation
- **Effective navigation of care pathways**, including GP access, prescriptions, dental care and emergency dispatch
- **Reassurance and continuity** during periods of distress

This feedback reflects the essential role of NHS 111 Wales in early intervention, reducing avoidable ambulance demand and improving access to appropriate care.



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# Reporting of Compliments

In **Ambulance Care**, compliments received demonstrate the essential contribution these teams make to patient wellbeing, independence and continuity of care. Key themes include:

- **Kindness, patience and dignity** when supporting people with mobility issues, long term conditions, cancer treatment or regular appointments
- **Reliability**, with many long-term service users praising staff who “go the extra mile” to ensure safe and comfortable journeys
- **Emotional and practical support**, including help with personal belongings, communication needs, reassurance, and maintaining patient dignity
- **Positive impact on quality of life**, especially for patients who rely on NEPTS as a lifeline to access essential treatment

Feedback also reflects strong relationships built over time, demonstrating the value of consistency and familiarity in patient transport services.

## Overall Assurance from Compliments

The volume and quality of positive feedback received for services delivered by the Welsh Ambulance Service offers positive assurance regarding staff behaviours of the Trust’s continued strengths in compassionate care, effective communication, professionalism, and teamwork.

These compliments offer assurance that, despite sustained operational pressures, staff are still committed to delivering high-quality, person-centred care, which is noticed and appreciated by our patients, their families and loved ones.

These themes also reinforce key strategic priorities within the IMTP, including:

- Strengthening patient experience and co production
- Improving the safety and quality of care
- Supporting staff wellbeing and professional development
- Enhancing integrated, person centred urgent and emergency care pathways

Whilst compliments provide strong assurance of staff behaviours and compassionate care, they must be considered alongside consistent feedback on access and delays.



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# Patient Stories & Digital Storytelling

## Patient Storytelling

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

Stories are told by patients, relatives, or carers about their first-hand experiences of using our services. They are co-produced with the storyteller to ensure that the published story fully expresses the key messages which they wish to convey.

## Video booth and Podcast

We continue to explore new ways to present people's lived experiences, including our online video booth and the development of a patient stories podcast.

Our online video booth continues to provide a means for people to remotely record and send their stories directly to us without the need to meet face-to-face.



Following a rigorous development process, a trial version of our first patient story podcast has been completed and is undergoing finalising before publishing in quarter 2.

## Extending Our Offer

We are expanding the skill-base of our team by training more staff to be able to capture patient accounts as digital stories.

This will broaden the range of platforms available for recording individual experiences and enable us to prepare for the expected increased demand for stories which may arise when the new *Listening to People* guidance comes into force in April 2026.

## Patient Stories Information Pack

We are compiling an information pack to explain the story-making process. The pack will be sent to anyone who expresses an interest in making a story and is intended to give them a fuller understanding of why we make stories, how they are recorded, and what happens to their story after it is published.

## Patient Stories Explainer Animated Video

As part of ongoing work to raise awareness of our patient storytelling offer to the public, we are developing a short-animated video in-house which aims to encourage people to come forward and share their experiences by making a story with us.

## Embedding Stories in Governance and Learning

- Patient stories continue to be presented routinely at Trust Board, QuEst Committee, and Quality Management Group, ensuring lived experience directly informs strategic discussion and decision-making.

- Stories are used to triangulate with quantitative experience data, strengthening assurance and organisational insight.

## Regional and National Contribution

- The Peci Team actively contributes to the All-Wales Digital Storytelling Network, sharing learning and good practice.
- The Trust's submission to the 2026 Storytelling for Health and Wellbeing Conference has been accepted, with a patient story being presented in June, showcasing WAST's approach and impact.



# **Section 2**

## **Citizen Voices &**

### **Community Involvement**



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# Internal commissioning

The PECl Team (PECl) continued to be commissioned under an IMTP aligned model; with activity commissioned through direct requests from teams to take forward engagement work to help progress key service deliverables. Examples of activities include:

- **Digital Directorate** - team were commissioned to canvas patient networks, including disability and learning disability groups, for involvement in both 111 webchat point of contact and a broader digital strategy session. This work supported a 'proof of concept' to test a new NHS 111 Wales webchat service and a light, low-risk trial of a live chat function on the 111 website, designed as an added option for people who may prefer alternatives to using the phone.
- **Welsh Language** – PECl to engage the People & Community Network to undertake an assessment of the Trusts service delivery, performance, and staff compliance against Welsh Language standards from the service user perspective.

- **Ambulance Care** – The Driver & Passenger App is being developed by the Ambulance Care Team to improve non-emergency patient transport by providing clearer journey updates for patients and more efficient job management for drivers. The aim is to reduce uncertainty for patients and improve overall service experience and efficiency. The PECl Team will support usability testing to ensure the app is easy to use, accessible, and genuinely patient-centred, reflecting the needs and expectations of patients and carers.
- **Quality Improvement** - PECl commissioned to support an initiative aimed at increasing engagement with the NEPTS experience survey. This work involves collaborating with Senior Quality Leads (SQL) and Digital Team to identify a project that will incorporate a digital approach to quality improvement and address key questions that will help determine the feasibility of their proposed digital solution.

## 101 Network members

The Trusts' People & Community Network continues to play a vital role in informing and improving services. They have regularly received updates highlighting the breadth of activity across the Trust and its ongoing commitment to community involvement.

Members have been consistently informed and invited to observe Trust Board and submit questions in advance. In January one member submitted a question and reported he was satisfied with the response. Limited feedback received has related to some difficulty following the Trust Board discussions, people don't often know who is speaking at times.

In February, members were invited to contribute to a planned event exploring what quality means in healthcare delivery. Views were sought on factors affecting health and wellbeing, and how the Trust could improve its support. Feedback has included:

- Recognition that staff are working within a strained NHS system, including workforce shortages and systemic pressures beyond their control.
- Primary impact on wellbeing is long ambulance waiting times, often lasting hours rather than minutes.
- Frustration with lengthy, scripted emergency call processes that can feel rushed and lack empathy or understanding of distress.
- Concern that callers (especially those calling on behalf of others) do not always get adequate opportunity to explain the situation fully.
- Desire for better basic care while waiting in ambulances, such as access to water and toilet facilities.
- Emphasis that ambulance services could support wellbeing through faster arrival times, improved privacy during patient loading, and greater patience.
- Repeated calls for increased empathy, understanding, tolerance, and recognition of stress felt by patients and their families.



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# Community Involvement

During this period, the PECI Team has prioritised strategic capture, analysis and application of patient experience feedback, with direct attendance at community engagement events undertaken on a targeted, risk-based basis. This reflects both organisational change arrangements and a deliberate shift toward a more locally led model of engagement, supported by central oversight and assurance

The organisational change process (OCP) affecting the Team has, at times, created some ambiguity across WAST regarding responsibility for community engagement activity, particularly between corporate functions and local operational teams.

In response, the Team has prioritised the strategic capture, analysis and application of patient experience feedback to support service improvement, organisational learning and quality assurance, focusing capacity where greatest all-Wales value and impact can be achieved.

This supports a transition toward a more locally led model of community engagement, with the PECI Team providing central oversight, guidance and assurance to strengthen consistency, recording and organisational learning.

**Risk:** Reduced direct engagement during OCP may limit breadth of citizen voice captured.

**Mitigation:** Locally led engagement supported by central oversight, strengthened recording processes, and improved governance reporting to maintain assurance and visibility.

Community engagement activity has continued through a more locally led approach, with the PECI Team providing support, advice and guidance to operational teams to enable meaningful engagement within their localities and service areas.

The Team has also been developing tools and processes to support the consistent recording and reporting of engagement activity across the organisation, improving oversight, reducing duplication and strengthening assurance regarding the scale, quality and impact of engagement work.

This approach supports a sustainable model of community involvement, enabling the PECI Team to maintain a strategic focus on capturing people's experience, organisational learning and quality improvement, while ensuring citizen voice continues to inform service development and decision-making.

During this reporting period, the PEI Team attended two key community engagement events in partnership with the Trust's Inclusion Team, supporting engagement with under-represented groups and promoting more inclusive access to ambulance services.

## Women's Health Conference

The Team attended a Women's Health Conference organised by Betsi Cadwaladr University Health Board, hosting an engagement stall to listen to women's experiences of accessing urgent and emergency care, raise awareness of WAST services and promote routes for feedback and involvement. This provided valuable insight into barriers to access, specific health needs, and opportunities to strengthen partnership working across women's health services.

## Big Halal Lifestyle Event

The Team also attended the Big Halal Lifestyle Event in Cardiff, engaging with Muslim communities and wider minority ethnic groups to better understand cultural needs, perceptions of emergency services, and barriers to access or trust. This supported open dialogue around inclusion, patient experience and culturally sensitive care.

## Assurance and Impact

Attendance at both events demonstrated a targeted, partnership-based approach to inclusive engagement, helping the Trust better understand community needs, reduce inequalities in access, and strengthen assurance that equality, inclusion and patient experience considerations are embedded within service planning and delivery.



**Shoctober** is an annual educational campaign, established in 2016, aligned with A Healthier Wales and the NHS Wales Out-of-Hospital Cardiac Arrest Plan (2017).

The programme delivers face-to-face sessions for pupils in Years 4 - 6, focusing on appropriate use of 999 and the development of basic lifesaving skills. Its core aim is to build long-term community resilience and improve cardiac arrest survival rates across Wales.

Whilst the full impact of Shoctober is realised over the longer term, feedback continues to demonstrate meaningful real-world benefit. Recent examples include children confidently guiding adults in administering CPR following previous Shoctober training, providing practical evidence of increased confidence, awareness and early intervention capability.

The campaign also supports delivery of the Well-being of Future Generations (Wales) Act 2015 and the United Nations Convention on the Rights of the Child, reinforcing the Trust's contribution to prevention, education, health improvement and future population resilience.

Although impact is primarily long-term, Shoctober provides early prevention benefits and supports wider public health and community resilience objectives.



Delivery during the reporting period was impacted by reduced volunteer availability, resulting in fewer school engagements than in previous years. Despite this, the programme has continued to deliver meaningful community benefit and remains an important prevention and education initiative.

As part of the organisational change process (OCP), responsibility for Shoctober will transition from the PECCI Team to the Clinical and Medical Directorate, providing closer alignment with clinical leadership, strengthening strategic ownership, and supporting the long-term sustainability and development of the programme.

**41** Volunteers Involved

**35** Hours Delivered

**950** Pupils Engaged

## Blue Light Hub app

Following the launch of the CPR game last year, and informed by feedback from teachers, young testers and the BMJ Open evaluation, full bilingual voiceovers have been developed to improve accessibility for children with lower literacy levels and for those whose first language is not English.

This supports a more inclusive learning experience and strengthens the app's value as both an educational and engagement tool, helping improve confidence in CPR awareness and emergency response from an early age.

This work supports the Well-being of Future Generations (Wales) Act by contributing to a Healthier Wales through improved CPR knowledge, a More Equal Wales by reducing language and literacy barriers, and a Wales of Vibrant Culture and Thriving Welsh Language through strengthened bilingual provision.

The updated version is due for release in Quarter 1 (2026/27), with staff and volunteers reminded that the app can also be used as a play and distraction tool when supporting children during observations or conveyance to hospital.



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**Meet Jack and Kim, our Welsh Ambulance Service mascots, in our free Blue Light Hub app.**

Play exciting games to learn about calling 999 and sending ambulances to help people.  
The better you do, the more rewards you can win!

- > Expert approved
- > Hwb accredited
- > 4.9 star rating
- > Age 7–12

Scan the QR to download now

AMBIWLANS

Between 1 October 2025 and 24 March 2026, the app was installed by 214 Android users and 60 iOS users. Since launch, total installations are 14,908 on Android and 5,594 on iOS, providing assurance of sustained reach and continued public engagement.

The app supports prevention, education and early intervention by improving CPR awareness and extending inclusive access to learning across communities.

# **Section 3**

# **Patient Reported Experience Measures (PREMs)**

# People's experience of calling 999

## EMS/999

**Period:** October 2025 – March 2026

**Responses:** 56 respondents

### Executive Summary

Overall experience remains very strong, with PREM feedback providing positive assurance regarding frontline care, compassion and patient trust.

- 82.6% rated their experience as **Very Good**
- Patients consistently describe staff as compassionate, professional and life-saving
- High levels of reassurance, dignity and confidence in crews and call handlers

However, system pressures remain clearly visible:

- Delays in ambulance response times
- Extended hospital handover waits
- Anxiety during delays and inconsistent communication at first contact

### Key Messages

Frontline care remains a significant strength; however, delays in response and hospital handovers continue to impact patient experience, public confidence and exposure to potential harm.

While response volumes remain modest, findings are consistent with wider experience intelligence including compliments, complaints, patient stories and quality governance reporting.

### Overall Experience

★ Very Good	<b>82.6%</b>
👍 Good	4.3%
😐 Neutral	4.3%
👎 Poor / Very Poor	8.7%

Overall experience is very strong, with >80% rating "Very good"

### Response Time Experience

Much shorter than expected	41.5%
Shorter than expected	9.4%
About right	26.4%
Longer than expected	22.6%

Majority positive. But 1 in 5 experienced delays

**Assurance:** feedback provides positive assurance regarding frontline care, compassion and patient trust, triangulated with compliments, patient stories and wider quality intelligence.

**Risk:** Delays in ambulance response and hospital handovers continue to impact patient experience, confidence and exposure to potential harm.

**Action:** Continued focus on system flow, communication improvements and reduction of handover delays through wider organisational and system action.



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# People's experience of calling 999

## What was good?

### Compassionate, Caring and Professional Staff

**The strongest and most consistent theme was the exceptional attitude of ambulance staff — described as kind, reassuring, empathetic and highly professional.**

- "Incredibly patient & kind ambulance crew. Holistically & methodically provided safety & high-quality care."
- "The crew were kind sympathetic understanding and couldn't have been any better."
- "The understanding, care and compassion... was exceptional and without them I don't think I would of got through the night."

**Theme summary: Consistent feedback provides strong assurance that staff compassion, professionalism and communication remain a core strength of EMS delivery.**

### Life-Saving, High-Quality Clinical Care

**Many respondents directly linked the care they received to survival, recovery, or prevention of deterioration.**

- "The care I received saved my life."
- "Because of their timely and accurate treatment, he is alive today."
- "Managed the situation above and beyond expected."

**Theme summary: Patient feedback provides strong assurance that frontline EMS care is clinically effective, timely and frequently life-saving.**

### Reassurance, Communication and Feeling Safe

**Patients valued being kept informed, reassured, and supported, particularly during frightening or uncertain situations.**

- "The first responder and the ambulance crew were very reassuring... made me feel less stressed."
- "Appreciate that the call handlers kept us updated with the wait times."
- "When I lost the ability to speak it was comforting to still hear the 999 operator on the line."

**Theme summary: Clear communication and reassurance significantly improve patient confidence, reduce anxiety and strengthen perceived**



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# People's experience of calling 999

## **Assurance**

Patient feedback provides strong assurance regarding staff behaviours, compassion, communication, and clinical care.

## **Risk**

System delays and hospital handover pressures can undermine otherwise positive patient experience and reduce public confidence.

## **Action**

Continued focus on communication during delays and reducing operational flow pressures.



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# People's experience of calling 999

## What was bad?

### Long Waiting Times for Ambulances

**The most consistent negative theme was delays in ambulance arrival, especially in serious or distressing situations.**

- "Waiting five hours for ambulance after ringing 999."
- "Waiting time for a serious incident... I had to phone four times."
- "Other than the wait for the ambulance as both my wife and I thought I was dying."

**Theme summary: Delays in ambulance response times remain the most significant driver of negative experience, increasing anxiety, reducing confidence and creating potential exposure to patient harm.**

### Hospital Handover Delays and Time Spent Waiting in Ambulances

**Some respondents described long waits outside hospitals, which extended the overall experience.**

- "5 hours outside hospital still in Ambulance."
- "It took the hospital staff around 18 hours to take me in."
- "During a 6 hour wait outside the hospital..."

**Theme summary: Prolonged hospital handover delays negatively impact patient dignity, comfort and safety, while also reducing ambulance availability and wider system resilience.**

### Communication Gaps and Lack of Reassurance at Point of Contact

**While communication was often praised, some respondents reported poor reassurance or unclear messaging, particularly during the initial 999 call.**

- "The 999 call was very frustrating."
- "Did not provide any reassurance that help was coming."
- "Wouldn't allow an ambulance to be called despite a change in our ability to self-admit."



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# People's experience of calling 999

## **Assurance**

These themes are consistent with wider quality intelligence, including complaints, incidents, and patient stories, and are routinely reviewed through service governance and Quality Management Group.

## **Risk**

System delays and access pressures continue to create the greatest risk to patient experience, confidence, and exposure to potential harm.

## **Action**

Continued focus on reducing response delays, improving handover performance, and strengthening communication during unavoidable waits.



# People's Ambulance Care experience

## Non-Emergency Patient Transport Service (NEPTS)

**Period:** October 2025 – March 2026

**Responses:** 1,613

### Executive Summary

Overall experience remains strong, with patient feedback providing positive assurance regarding frontline care, patient dignity and safety during transport.

- 93.8% happy with transport received
- 97.0% say crews are polite and helpful
- 97.4% felt safe during their journey

However, reliability and access issues are significant

- Frequent late cancellations and no-shows
- Difficulty getting through to book transport
- Poor communication around delays and changes

### Key messages:

Care quality remains high; however, reliability and access continue to undermine patient confidence and outcomes.

For many vulnerable patients, NEPTS is essential to accessing treatment. Service failure can result in missed appointments, delayed diagnosis and avoidable deterioration, not simply inconvenience.

### Overall Experience Snapshot

😊 Happy with transport 93.8%

👩 Crew polite & helpful 97.0%

🔒 Felt safe during journey 97.4%

☎ Call handler polite 98.2%

Very high satisfaction with staff behaviour, safety and care delivery

### Booking & Access Experience

Booking easy 94.9%

Call-back worked well 15.0%

Call-back failed 2.5%

Didn't know about call-back 38.4%

Booking is straightforward when accessed, but awareness and reliability of call-back arrangements remain low

**Assurance:** Patient feedback provides strong assurance regarding staff professionalism, patient dignity and safety during transport, supported by compliments and wider quality intelligence.

**Risk:** Reliability, cancellations and access delays continue to impact vulnerable patients' ability to access essential treatment, creating risk to outcomes, confidence and equitable care.

**Action:** Continued focus on improving booking processes, communication, call-back awareness and journey reliability to reduce missed appointments and strengthen patient confidence.



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# People's Ambulance Care experience

## What was good?

### Kind, Caring and Professional Staff

**The most consistent positive theme is the attitude and behaviour of staff, particularly drivers and call handlers, who are frequently described as kind, respectful and supportive.**

- "Everybody I dealt with were very kind and professional. The service has been excellent."
- "The call was dealt with in a very professional and empathetic manner."
- "Always polite and so thoughtful and kind. I feel very safe with these wonderful people."

**Theme summary: Consistent feedback provides strong assurance that staff compassion, professionalism and dignity remain a core strength of Ambulance Care delivery.**

### Helpful, Reliable Support Enabling Access to Care

**Many respondents valued the service as essential for attending appointments, especially where mobility or transport options are limited.**

- "Very good service without which I would not be able to... Thank you very much."
- "It's a wonderful service for people like me."
- "Providing outstanding care and attention at all times to my very ill wife."

**Theme summary: Patient feedback provides strong assurance that NEPTS plays a critical role in enabling access to essential healthcare, particularly for vulnerable and mobility-limited patients.**

### Easy Booking and Helpful Call Handling

**A large proportion of respondents described simple, straightforward booking experiences and helpful call handlers.**

- "The process was very simple... all very easy and very much appreciated."
- "Very helpful on telephone. Straightforward questions to answer."
- "Just phoned and a friendly person helped me."

**Theme summary: Where access systems function effectively, booking is straightforward and call handler support contributes positively to patient confidence and experience.**



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# People's Ambulance Care experience

## **Assurance**

Patient feedback provides strong assurance regarding staff professionalism, patient dignity, safety and the essential role of NEPTS in supporting access to care.

## **Risk**

Reliability, cancellations, and communication failures can undermine patient confidence and create barriers to accessing essential treatment.

## **Action**

Continued focus on improving booking processes, journey reliability, and communication to reduce missed appointments and improve patient experience.

## What was bad?

### Late Cancellations and Transport Not Turning Up

**The most dominant negative theme is unreliable service, including last-minute cancellations and no-shows leading to missed appointments.**

- "Transport cancelled 45 minutes before the appointment... critical appointment was missed."
- "Had a call one hour before my appointment to say the ambulance couldn't pick me up."
- "Missed two appointments because ambulance was cancelled."

**Theme summary: Late cancellations and transport failures are the most significant drivers of poor experience, creating risk of missed treatment, delayed diagnosis and avoidable deterioration for vulnerable patients.**

### Difficulty Getting Through and Poor Booking Experience

**Many respondents reported long waits on the phone, difficulty getting through, or frustrating booking processes.**

- "Difficult to get through. Line busy."
- "Had to phone several times line always busy."
- "Getting through to discuss needs is extremely difficult and takes a long time."

**Theme summary: Difficulty accessing the service, particularly through booking lines, creates barriers to essential care and significantly undermines patient confidence and equitable access.**

### Poor Communication and Lack of Information

**Respondents frequently highlighted lack of updates, unclear communication, or inconsistent information, especially around cancellations and pickup times.**

- "Was not given pickup time, not given phone number to driver... very little information."
- "I wouldn't have known that if I didn't do the phoning."
- "No guarantee that the service is available and is a worry up until I hear from you."

**Theme summary: Poor communication around delays and cancellations increases anxiety, reduces confidence and can leave vulnerable patients feeling unsupported and uncertain about accessing treatment.**



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# People's Ambulance Care experience

## **Assurance**

These themes are consistent with wider experience intelligence, including complaints, compliments, and patient feedback, and are routinely reviewed through service governance to support improvement.

## **Risk**

Reliability, cancellations, and poor communication continue to create the greatest risk to patient access, treatment outcomes, and confidence in NEPTS.

## **Action**

Continued focus on improving booking systems, reducing cancellations, and strengthening communication to improve reliability and patient experience.

# People's NHS 111 Wales experience

## NHS 111 Wales

**Period:** October 2025 – March 2026

**Responses:** 101

### Executive Summary

Experience is highly polarised

- 49.3% reported the service was "Not at all helpful"
- Only 36.6% reported it as "Very/Extremely helpful"

### Clear pattern emerges:

- When the service works, it is highly valued and provides effective clinical support.
- Where access is delayed or call-backs fail, patients report significant difficulty accessing timely care and confidence in the service is reduced.

### Key Messages:

- Individual staff deliver exceptional care and emotional support.
- 111 plays a key role as a system navigator, especially out of hours.
- Call-back reliability remains the most significant driver of poor experience and reduced confidence in the service.

### Overall Helpfulness

👍 Extremely helpful	23.9%
👍 Very helpful	12.7%
😐 Somewhat helpful	7.0%
👎 Not so helpful	7.0%
✘ Not at all helpful	<b>49.3%</b>

Nearly half of respondents found the service not helpful

### Access & Waiting Experience

Very satisfied with wait time	22.9%
Satisfied	14.5%
Neutral	12.0%
Dissatisfied	12.0%
Very dissatisfied	<b>38.6%</b>

Over 50% not satisfied with wait times. Access into the service is a critical frustration point.

**Assurance:** Patient feedback provides assurance that clinical care, empathy and reassurance are strong once patients access the service, supported by wider patient feedback and experience intelligence.

**Risk:** Delays in access and unreliable call-backs continue to limit timely care, reduce patient confidence and create inequity in access to urgent support.

**Action:** Continued focus on improving access, strengthening call-back reliability and developing alternative contact routes to improve patient experience and reduce avoidable escalation to other services.



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# People's NHS 111 Wales experience

## What was good?

### Compassionate, Empathetic and Professional Staff

**Where experiences were positive, they were strongly driven by individual staff members who were kind, supportive and reassuring, particularly in distressing situations.**

- "She was very very reassuring and made me feel better... she legit saved my life."
- "The nurse was so professional, efficient, kind and compassionate... something I'll never forget."
- "The nurse was great, really helpful and listened to my concerns... very empathetic."

**Theme summary: Consistent feedback provides strong assurance that staff empathy, professionalism and emotional support remain a significant strength of NHS 111 delivery, particularly in high-anxiety and mental health presentations**

### Effective Clinical Advice and Resolution

**Some respondents described clear advice, appropriate referrals and successful outcomes, including avoiding A&E or receiving timely treatment.**

- "Resolved my problem in 10-minute consultation."
- "A really efficient, helpful and supportive experience... eternally grateful."
- "The whole process took about 3 hours... amazing service... all the staff were amazing."

**Theme summary: Patient feedback provides assurance that when access is timely and the pathway functions effectively, NHS 111 delivers safe, efficient and clinically valuable care.**

### Reassurance and Guidance During Uncertainty

**Patients valued being listened to, reassured, and given clear next steps, particularly when unsure what to do.**

- "I felt reassured... they gave me a plan for what to do next."
- "It helped talking to someone about my anxiety and depression."
- "I was very reassuring and advised what to do next."



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# People's NHS 111 Wales experience

## **Assurance**

Patient feedback provides positive assurance regarding staff empathy, clinical advice and reassurance once patients access the service.

## **Risk**

Access delays and unreliable call-backs can undermine otherwise positive clinical interactions and reduce confidence in NHS 111.

## **Action**

Continued focus on improving access, call-back reliability, and timely clinical review to strengthen patient experience and reduce avoidable escalation.



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# People's NHS 111 Wales experience

## What was bad?

### Long Waits, No Answer and Failed Call-Backs

**The most dominant theme is inability to access the service, including long waits, unanswered calls, and call-backs that never happen.**

- "Waited an hour for a call back... call was dropped. No way of call back now."
- "Still waiting for a call back... 9 hrs later and counting."
- "Waiting time was 97 minutes... gave up waiting."

**Theme summary: Delays in access and unreliable call-backs remain the most significant drivers of poor experience, reducing confidence and limiting timely access to urgent clinical support.**

### Poor Communication, Lack of Empathy or Dismissive Attitudes

**Some respondents described rude, dismissive, or overly scripted interactions, particularly when dealing with complex or distressing situations.**

- "The call handler was rude and abrupt and not sympathetic."
- "Computer says no attitude... frustrating."
- "Did not listen to what I was saying... spoke over me."

**Theme summary: Inconsistent communication, perceived lack of empathy and overly scripted interactions can significantly reduce patient confidence and trust in the service.**

### Incorrect Advice, Delays in Care and Unmet Needs

**Respondents highlighted incorrect signposting, delays in treatment, or no resolution, sometimes leading to worsening conditions or escalation to A&E.**

- "Wrong advice... no prescribing pharmacists at pharmacy I was told to go to over the weekend."
- "Problem not resolved... still waiting for a call back."
- "My questions unanswered and left in limbo as to where to go."



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# People's NHS 111 Wales experience

## **Assurance**

These themes are consistent with wider experience intelligence and are routinely reviewed through service governance and Quality Management Group to support improvement and executive oversight.

## **Risk**

Access delays, unreliable call-backs and inconsistent patient experience continue to create the greatest risk to confidence, equity of access and timely clinical intervention.

## **Action**

Continued focus on improving access, strengthening call-back reliability and ensuring consistent communication and clinical advice across the service.

# **Section 4**

## **Looking ahead**



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# Looking ahead

## **Listening to People – Survey Requirements and Availability -**

The Listening to People Regulations/Guidance, and the People's Experience Framework require NHS Wales organisations to request feedback from individuals who use the Listening to People process. Organisations are expected to adopt the Listening to People Survey and include survey information in acknowledgement and resolution correspondence.

The survey will be hosted on CIVICA and available in spoken languages, British Sign Language (BSL), and Easy Read formats. Work is underway to ensure organisational readiness, compliance with regulatory requirements, and effective capture of experience feedback within the new complaints process.

**SMS Text Messaging** - In Quarter 1, the Trust will introduce SMS text messaging to strengthen the volume, timeliness and representativeness of patient experience feedback, with regular reporting through QMG to support quality improvement and assurance.

**PECI Organisational Change Process (OCP)** – This is expected to conclude at end of quarter 1, with the teams' functions being embedded within the Trust's quality

management structure. This model is intended to strengthen the integration of lived experience, community insight and co-production within the Trust's quality management structure, ensuring these perspectives continue to inform assurance priorities, improvement activity and decision-making at all levels.

## **Peoples Experience Framework – Safety & Learning**

**Network** - The Trust is represented at this Network by the PECI Team. PECI provides a Trust-level voice within the network, contributing insight from people's experience, compliments, and community feedback supporting shared learning, assurance, and improvement across NHS Wales. Our representation supports continued visibility of lived experience within national learning, assurance and quality priorities, strengthening both organisational and system-wide improvement.

**To conclude:** Focus will remain on strengthening how experience insight is translated into measurable improvement, ensuring readiness for Listening to People requirements, and maintaining strong visibility of citizen voice through organisational change and service transformation.



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Agenda Item No.

15

## REPORT TITLE

Learning from Deaths (Mortality Reviews) Report  
Quarters 3 & 4 (October 2025 – March 2026)

## MEETING

Name of meeting	Quality, Patient Experience & Safety Committee
Date of meeting	7 May 2026
Public or Private	Public
If private - <a href="#">rationale</a>	n/a

## REPORT SPONSOR

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

## PURPOSE OF REPORT

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



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## REPORT SUMMARY

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

1. This report provides an assurance update to the Quality, Patient Experience & Safety Committee on the Trust's Learning from Deaths (Mortality Reviews) arrangements. The report also provides assurance regarding the Trust's clinical and organisational response to two recent Regulation 28 Prevention of Future Death (PFD) Reports.
2. Data analysis of high-level indicators relating to Medical Examiner referrals and coronial activity, support oversight of activity levels and timeliness across mortality governance processes as well as providing insights into thematic learning
3. Medical Examiner referral activity continues to provide valuable system intelligence, with referrals predominantly indicating themes relating to timeliness of care and the impact of wider system pressures on patient experience. The Trust's established multi-professional review structures continue to triage cases proportionately and identify those requiring further review or investigation, alongside thematic learning and improvement opportunities.
4. During the reporting period the Trust received two Regulation 28 Prevention of Future Death Reports and responded within statutory timescales. The Trust responses demonstrate appropriate clinical governance and professional assurance: one PFD focused on clinical assessment and the appropriate application of NEWS in patients with COPD, and the second focused on persistent risk associated with ambulance delays and system flow. Both responses describe the Trust's clinical rationale and the improvement actions already in place, including changes to digital controls within the ePCR and national policy and system improvement arrangements for ambulance handover and emergency response.

## 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 for discussion; and
2. Identify any additional assurance requirements

## ADDITIONAL PAPER(S)

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

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](#)]

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

### RISK(S) THIS REPORT MITIGATES

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

n/a

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

Quality Domains

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

Quality Enablers

<input checked="" type="checkbox"/> Leadership	<input checked="" type="checkbox"/> Workforce	<input checked="" type="checkbox"/> Culture
<input checked="" type="checkbox"/> Information	<input checked="" type="checkbox"/> Learning Improvement & Research	<input type="checkbox"/> Whole Systems Approach

### WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

<input type="checkbox"/> A socially responsible and inclusive employer	<input type="checkbox"/> An innovative and sustainable organisation	<input checked="" type="checkbox"/> A pro-active, accessible and equitable care provider
<input checked="" type="checkbox"/> n/a	<input checked="" type="checkbox"/> n/a	<input type="checkbox"/> n/a

### IMPACT ASSESSMENTS FOR CONSIDERATION

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

Does this paper require an impact assessment	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
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### APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
29 April 2026	Executive Leadership Team



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## SITUATION

1. This Learning from Deaths Report covers the period from 1 October 2025 - 30 March 2026.

This Report covers:

- Medical Examiner scrutiny feedback and implementation of the All-Wales Learning from Mortality Reviews Model Framework (Second Edition)
  - Prevention of Future Death Reports
  - Coronial Inquest activity and performance
  - Organisational learning captured and responded to in the Trust's 'Learning from Death Forum'
  - Bereavement learning and improvement
2. Data presented is accurate at the point of extraction and may change as cases progress through panel scrutiny, governance review, validation activity, and associated clinical governance processes.

## BACKGROUND

3. Learning from deaths is a core component of an effective clinical governance system. It supports the Trust to identify improvement opportunities, detect early warning signals, strengthen patient safety processes and ensure that learning is acted upon at organisational and system levels.
4. The critical importance of good governance and data analysis in respect of Mortality Review Processes have been highlighted in a number of high-profile NHS Independent Inquiries and Reviews. Learning from Deaths is broad and includes capturing good practice, improvement opportunities, any patterns, themes and trends including early warning signals, whilst considering potential inequalities in access to care or experience.
5. The Trust undertakes multi-professional review of Medical Examiner Reports within a staged structure, as outlined in the *All Wales Learning from Mortality Reviews Model Framework (Second Edition)*.

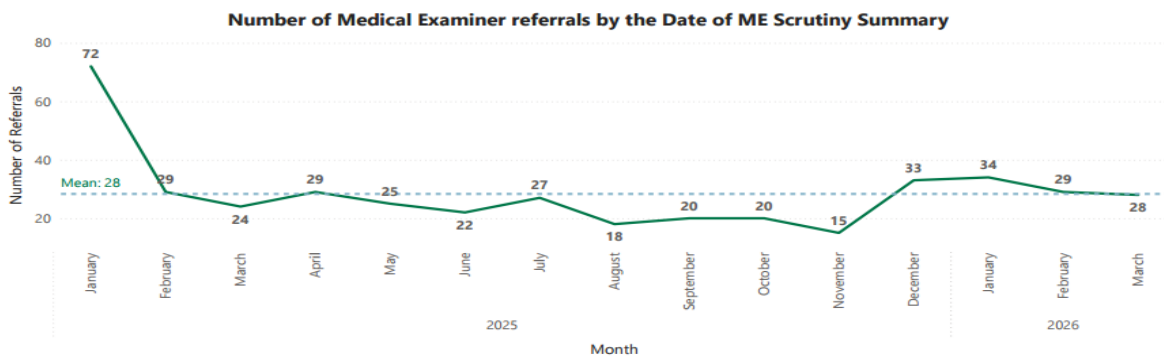


- The Trust’s Learning from Deaths Forum continues to develop its Work Programme, encompassing mortality learning from across the organisation, coronial work, clinical audit, patient experience and concerns management. The Forum has a clear remit to drive increased access, visibility and triangulation of mortality intelligence through digital and data insights.
- The Learning from Death Forum also oversees external learning sources from Prevention of Future Death reporting, National Clinical Audit, National Learning Reports and National Inquiries and these are also drawn through in this Report.

## ASSESSMENT

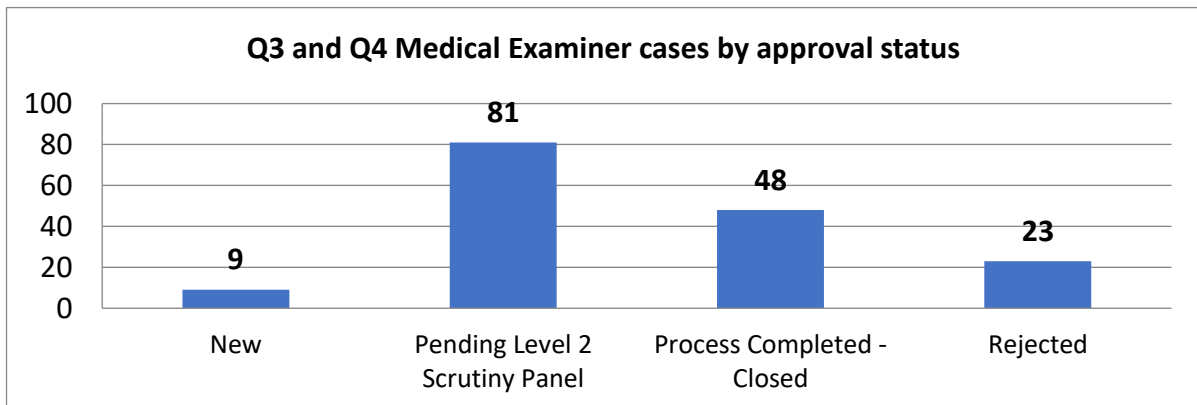
### Learning from Medical Examiner Service Referrals

Graph 1



- Graph 1 displays the volumes of cases reviewed by the Medical Examiners services per month. 161 Mortality Review cases were opened during Quarter 3 and Quarter 4 compared to 143 in the first half of the year. This is likely due to seasonal variations during the winter period.

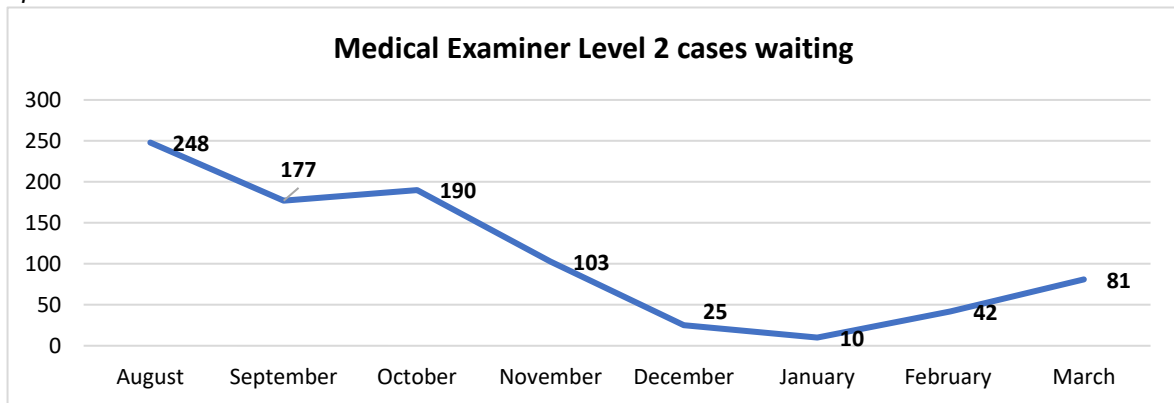
Graph 2





9. The current approval status of those referrals as of 11 October 2025 is shown in Graph 2. The chart provides visibility of referral distribution by approval status, supporting oversight of workflow and governance progression.
10. Assurance is offered that Level 1 triage continues to be undertaken in a timely way, ensuring prompt recognition and escalation of cases where the Duty of Candour or other external reporting requirements may apply.
11. Effective and regular functioning of the Level 2 scrutiny and Learning Forums remains less consistent, and at the time of reporting, 81 cases were awaiting Level 2 review.

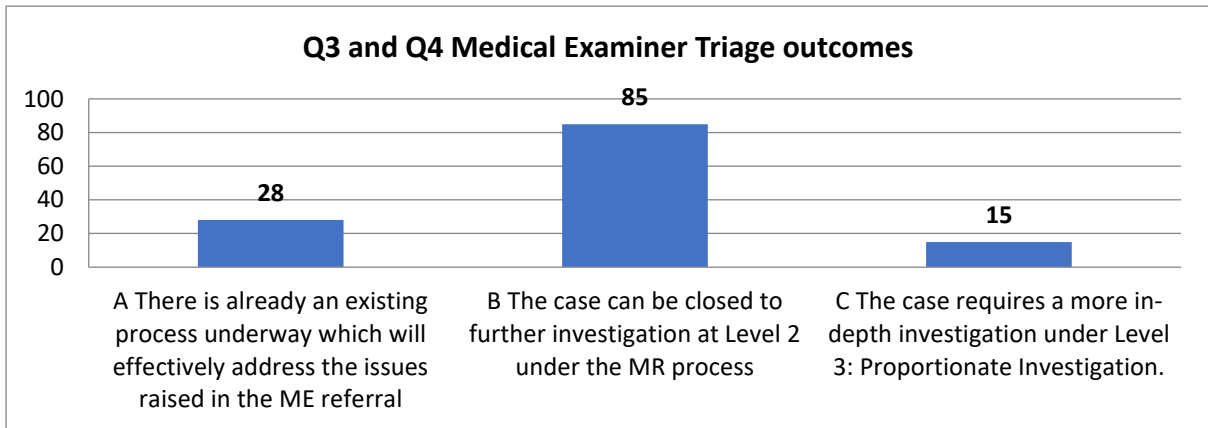
Graph 3



12. Level 2 Multi-Professional Medical Examiner Learning Panels were scheduled at increased frequency to address the number of cases awaiting review. Graph 3 demonstrates the impact of these concerted efforts until Panels were stood down from February 2026. This was due to vacancies and sickness absence within the Putting Things Right (PTR) & Legal Services Department as well as capacity constraints in Operations Quality to review call management.
13. Attendance levels are improving and a commitment to implementing an Integrated Concerns Triage with Operations Quality will help to ensure that this work is given equal prioritisation and that efficiencies created by proportionate review will release capacity to complete this work.



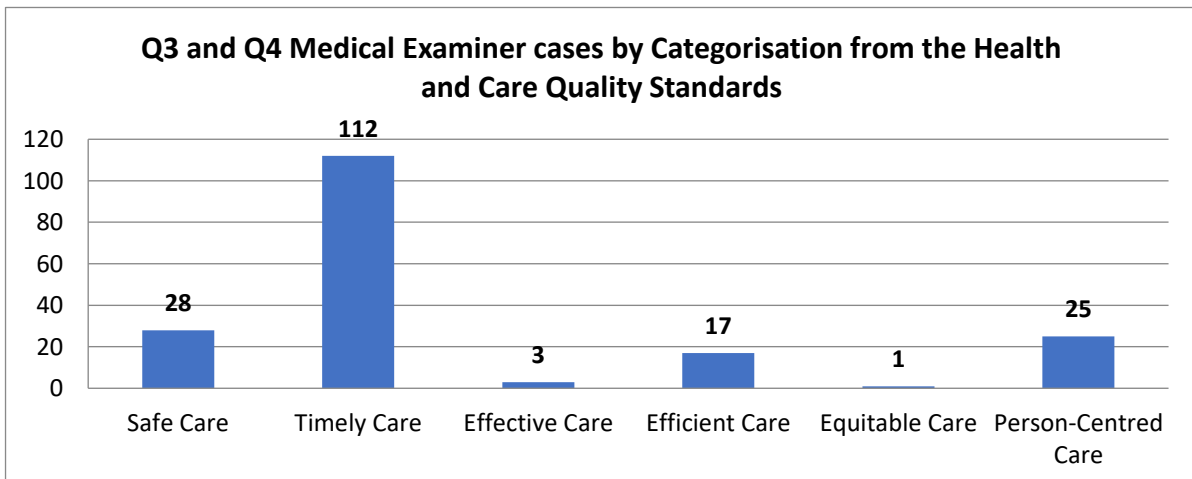
Graph 4



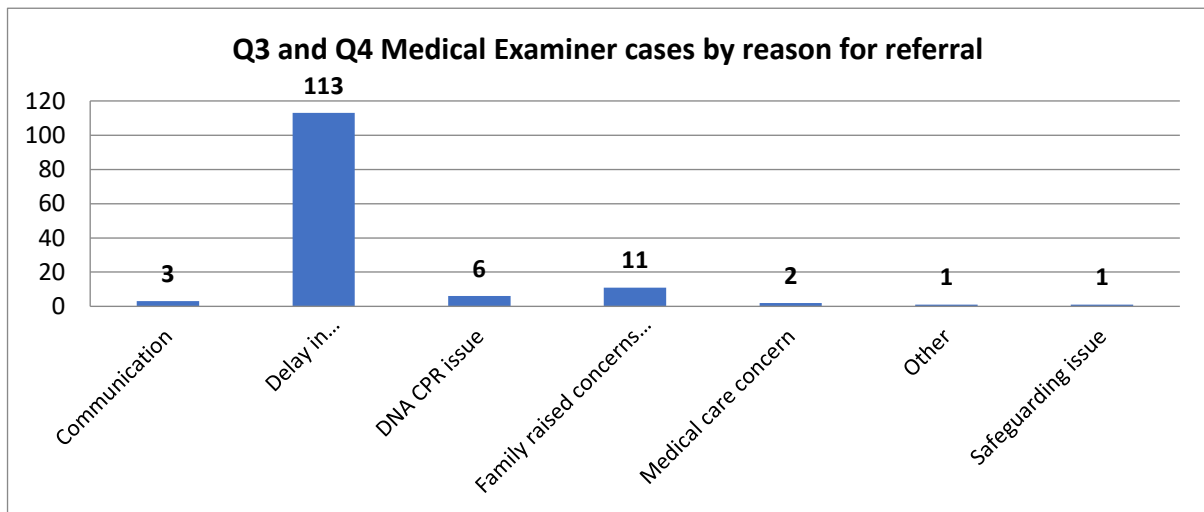
14. The Trust’s Level 2 multi-professional scrutiny arrangements review referrals, determine whether existing processes already address the issues raised, and identify cases requiring further investigation. A proportion of the referrals received progress to further review and proportionate investigation, demonstrating appropriate escalation where additional assurance was required.

15. Graph 4 supports assurance that referrals are being actively managed across different scrutiny outcomes. The chart demonstrates 15 of the cases received progressing straight to Level 3 and undergoing a proportionate investigation. Whilst recognising the importance of seeking external review and feedback, the Trust’s long-term objective in this space is to improve internal assurance and promote earlier identification of cases through our internal incident reporting mechanisms. This would manifest as an increasing rate of cases categorised under A (existing processes underway) and a decreasing rate of cases categorised as C (proportionate investigation required)

Graph 5



Graph 6



16. Medical Examiner referrals continue to provide important insight into patient experience, the quality and timeliness of care, and system constraints affecting delivery. Enhanced thematic coding and analysis has strengthened organisational visibility of referral themes. Graphs 5 and 6 provide information on the reasons for referral and Health and Care Quality Standards related to referrals.

17. It should be noted that Medical Examiner scrutiny is undertaken on a patient rather than organisational basis and it is not possible to distinguish the thematic allocations between the Trust and other organisations involved in the patients last episode of care. The Trust continues to emphasise appropriate interpretation of Medical Examiner data and this is reflected in the Trust's approach to triangulating Medical Examiner learning with internal safety intelligence and system-wide governance mechanisms, ensuring learning is used constructively and proportionately.

18. Learning themes of Medical Examiner Referrals identified and discussed at Medical Examiner Learning Panel remain consistent over time and include recurrent issues related to:

- Deconditioning and long lies
- Possible opportunities for alternative pathways and avoiding conveyance.
- Poor outcomes for time-critical conditions such as stroke and sepsis.
- Absence of Advanced Care Planning and end of life care packages, education and preparation
- Distress caused by provision of CPR instructions where this was against patient/family both in cases with and without a DNACPR in place



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- Very poor patient and family experiences, predominately due to delays in responding in the community because of system pressures. Some cases demonstrate the intensely distressing nature of the situation’s families find themselves in as they are waiting for help.

### Learning from mortality in Coronial work

19. Coronial engagement is managed through established governance arrangements, ensuring that learning is captured, responses are coordinated, and statutory obligations are met.
20. During the relevant period, the Trust received two Regulation 28 Prevention of Future Death Reports and coordinated organisational responses within statutory timescales. The Trust responses provide assurance of appropriate clinical governance, including clinical review and executive oversight, and focus on systemic risk mitigation and improvement actions.

Regional office and PFD concern	Trust response
<p>Gwent Coroner: Concern regarding routine downgrading of National Early Warning Scores (NEWS) for patients with COPD.</p>	<p>The Trust confirmed that clinicians are not supported to routinely downgrade NEWS scores. The response clarified that the updated NEWS2 includes two scales and that use of Scale 2 for patients at risk of hypercapnic respiratory failure (including COPD) represents correct application of the scoring system, not downgrading of risk.</p> <p>This PFD was issued jointly to Aneurin Bevan University Health Board, with similar concern regarding application and calculation of NEWS. Members should be assured by the alignment between organisational responses reflecting the current good practice in place and providing consistent responses to the Coroner’s concerns.</p>
<p>North Wales Coroner: Concern about persistent ambulance delays and the associated risk of avoidable deaths, noting that despite multi-agency efforts “nothing appears to change” and risk remains.</p>	<p>The Trust response describes the system-level improvement actions already underway and does not propose additional actions beyond current work, but sets out a structured summary of the national response model (Wales Emergency Ambulance Performance Framework) and handover improvement activity (National Handover-45 arrangements). The response sought to delineate the actions of the Trust from those required of the wider health and care system.</p>



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21. Organisational learning identified a separate risk where scores could be automatically calculated from incomplete observations. The Trust confirmed that changes are being implemented to the ePCR to prevent NEWS2 calculation unless all required observations are completed, strengthening digital safety controls.
22. The Trust has offered engagement opportunities to several Coronial offices to meet with members of the Executive Team or to visit the Trust's Contact Centres. It is hoped this would promote a deeper understanding of the Response Model and Clinical Model Transformation Programme efforts to reduce the risk of harm to patients.

### **National Inquiries**

23. The Thirlwall Inquiry provided an update in February 2026 that final report drafting remained underway, with a further update expected after Easter 2026.
24. UK COVID-19 Inquiry: Modules 3 and 4 have released their findings during the last quarter. These modules were the potentially those most applicable to the Trust, focusing on 'The impact of the Covid-19 pandemic on the healthcare systems of the UK' and 'Vaccines and therapeutics'. In respect of learning from mortality, relevant findings from Module 3 included the application and family experience of Do Not Attempt Cardiopulmonary Resuscitation notices (DNACPR), avoidable harm from hospital handover delays and surge demand for 111 services. Module 4 details the success of vaccine rollout and uptake.

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

25. There is an expressed duty placed on responsible bodies in the Principal Regulations and Listening to People process to ensure that the identification of learning from concerns and investigations are developed into effective actions to reduce the likelihood of reoccurrence and future harm to others. The development and effective implementation of a Learning Framework is planned to deliver on this duty and learning from death will have explicit inclusion within this.



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26. The new Guidance contains a welcomed focus on bereaved people raising concerns, outlining expectations for concerns management to align with the National Framework for the Delivery of Bereavement Care and the National Bereavement Care Pathway. The Trust has confirmed with Commissioners and external quality and safety stakeholders that this aspect of the Guidance cannot be provided by the Trust as we do not have an internal bereavement service. Signposting for support is therefore provided either to Health Board Bereavement Teams or third sector dependent on the tier of care being provided person's location at time of death.

### **RECOMMENDATION**

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

### **NEXT STEPS**

28. Continue to strengthen timeliness of Medical Examiner scrutiny through panel scheduling and prioritisation, ensuring cases requiring escalation progress proportionately and without avoidable delay.
29. Continue to monitor overdue Coronial activity through existing quality governance mechanisms.
30. Progress the described ePCR improvement to prevent automated NEWS calculation without a complete set of observations, strengthening the reliability of clinical documentation and safety assurance.
31. Continue to support system-wide improvement actions relating to emergency response models and ambulance patient handover, aligning Trust assurance with national expectations and monitoring outcomes through clinically meaningful metrics.



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Agenda Item No. 16

## REPORT TITLE

Medicines Management Assurance Report 2025/26

## MEETING

Name of meeting	Quality Patient Experience & Safety Committee (QuEST)
Date of meeting	7 May 2026
Public or Private	Public
If private - <a href="#">rationale</a>	n/a

## REPORT SPONSOR

Executive sponsor	Andy Swinburn, Executive Director of Paramedicine
Author(s) of report	Huw Jackson, Head of Medicine Management Sofia Fernandez, Lead Pharmacist

## PURPOSE OF REPORT

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



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## REPORT SUMMARY:

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

1. This report covers the financial year 2025/26 with comparisons drawn from previous year's report.
2. Reported measures within the report have been informed in direct response to feedback received from internal audit reviews, QuEST committee and Clinical Directorate Business meeting.
3. Monthly Medicines Management Assurance updates presented at Ambulance Practice Steering Group with quarterly updates presented at the Senior Operations Team.

## RECOMMENDATIONS

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

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

1. Receive the annual Medicines Management Assurance report; and
2. Discuss the report and identify any additional assurance requirements.

## ADDITIONAL PAPERS

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

**Annex 1** Medicines Management Assurance Report 2025/26

**Annex 2** WAST Antimicrobial Report 2025



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

### STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

### RISK(S) THIS REPORT MITIGATES

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

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

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

### WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

### IMPACT ASSESSMENTS FOR CONSIDERATION

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

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

### APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
28 April 2026	Clinical Directorate Business Meeting



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## SITUATION

1. The annual Medicines Management Assurance report is presented to provide assurance around medicines-related quality measures for the financial period 2025/26.

## BACKGROUND

2. The report is a summary drawn from monthly assurance metrics presented to the Ambulance Practice Steering Group.
3. Additionally, quarterly summaries are presented at the Senior Operations Team meetings.

## ASSESSMENT

4. Areas covered in the report are a combination of historically reported metrics approved at the Ambulance Practice Steering Group, responses to previous internal audit reports, and assurance requests from QuEST.
5. Throughout this financial year, the Medicines Team have re-established the Medicines Optimisation Group and have focused on updating expired PGDs and subsequent compliance across the Trust.
6. The Abloy system has been updated with the introduction of an electronic register to confirm receipt of keys, as well as automated processes to respond to access requests.
7. There has been an additional focus on controlled drug occurrence reports and discrepancies, working in conjunction with operational and clinical leadership teams.
8. Following last year's report, there is a continuation of sections dedicated to Pentrox and the inclusion of an antimicrobial stewardship section.



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9. In relation to the national position on antimicrobial usage and stewardship and considering the increased number of Advanced Practice Paramedics (APPs) and non-medical prescribers in the organisation, the team have brought forward several workstreams. PGDs are continuously reviewed to align with national guidelines, ensuring APPs always have access to appropriate first- and second-line treatments for infections.
10. In parallel, a WAST-specific non-medical prescribing formulary has been defined. This supports safe, expert prescribing, reduces unwarranted variation, and strengthens antimicrobial stewardship. The formulary is now available online [[Formulary](#)].

## RECOMMENDATIONS

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

## NEXT STEPS

12. A business case was submitted in mid-2025 to secure replacements for the existing Omnicell cabinets, which require updating. The team will seek to secure funds during this financial year.
13. Following MHRA inspections within the Health Board pharmacy supply chain supplying medicines to WAST, it was highlighted that the current system is exposed to risks relating to resilience, continuity of supply, and financial pressure. A business case was submitted to progress an internal Medicines Hub solution, procuring medicines for WAST from one supply wholesaler and distributing through an internal logistics solution.



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# Medicines Management Assurance Report

Annual update for 2025 - 2026

This report provides an overview of medicines-related quality measures, drawn from monthly Medicines Management Assurance Reports (MMAR) for the financial period 2025-2026, including 2024-2025 data for comparison. A number of the measures reported have been initiated in direct response to feedback received from Internal Audit reviews. MMAR reports are presented to the Ambulance Practice Steering Group monthly.

## Vehicle Medicines Audit (CD05)

Vehicle Medicines Audits (VMAs) have been established in WAST for several years. The main purpose of the audits is to check that the stock levels of vehicle-controlled drug (CD) safes are consistent with the vehicle CD safe register, and that the stock levels of the vehicle drug case are consistent with the contents list and are in date. The quality measure for this audit is for every Locality to complete at least one VMA (one vehicle) per month. **Table 1** shows an increase in compliance across Wales, with all 7 health board areas achieving the required 95% compliance. This year, HART was added to the monthly MMAR, and this has had a positive impact, with compliance increasing from 25% to 100%.

LHB Area	% Compliance	
	2024-2025	2025-2026
Aneurin Bevan	100	98
Betsi Cadwaladr	94	97
Cardiff and Vale	92	100
Cwm Taf Morgannwg	97	100
HART	25	100
Hywel Dda	94	100
Powys Teaching	100	100
Swansea Bay	100	100

Table 1: VMA Compliance by Health Board Area for the financial period 2025-2026

## Omnicell Cabinet Monthly Cycle Count

Omnicell Cycle Counts are aimed at ensuring stock levels in the cabinets are accurate and can support operational requirements at all times. A cycle count is considered to be complete if a minimum of 27 of 32 'POM' items and all 4 'CD' items have been counted. In **Table 2** below, compliant counts are represented in **GREEN** and non-compliant counts in **RED** for the 2025-2026 period.

**Table 3** shows a vast improvement in cycle count compliance for the period 2025-2026, compared to the previous year. Only one Omnicell missed a cycle count, and upon investigation, it was found to be due to high sickness levels in the DOM and SP teams in that area at that time. The 2024-2025 report highlighted that Ysbyty Gwynedd and West Wales General Hospital sites required attention; however, no sites require any attention following this report. The increase in compliance can be attributed to the introduction of automated emails being generated on the 10<sup>th</sup> and 20<sup>th</sup> of each month. These emails are sent to the relevant teams responsible for conducting the cycle counts. If no cycle count has been conducted by the 27<sup>th</sup> of the month, the Head of Medicines Management contacts the Locality Manager and Health Board Clinical Lead for escalation. If an area has achieved the required 95% compliance, this is shown in **GREEN**.

As reported in the 2024-2025 report, the data in tables 2 and 3 does not currently include any Advanced Paramedic Practitioner (APP) medications. With the introduction of the Senior Advanced Paramedic Practitioner role, it is anticipated that this could be added to future reports.

HB	Cabinet	Apr-25		May-25		Jun-25		Jul-25		Aug-25		Sep-25		Oct-25		Nov-25		Dec-25		Jan-26		Feb-26		Mar-26	
		POM	CD	POM	CD	POM	CD	POM	CD	POM	CD	POM	CD	POM	CD	POM	CD	POM	CD	POM	CD	POM	CD	POM	CD
%		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	95%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
ABUHB	GUH	32	4	31	4	31	4	32	4	32	4	32	4	32	4	31	4	32	4	32	4	28	4	32	4
ABUHB	Nev Hall	32	4	32	4	32	4	30	4	31	4	32	4	0	1	31	4	32	4	32	4	31	4	32	4
SBUHB	Morrison	32	4	32	4	32	4	31	4	32	4	32	4	32	4	31	4	32	4	32	4	32	4	32	4
BCUHB	YGC	31	4	31	4	31	4	32	4	32	4	32	4	32	4	31	4	32	4	29	4	29	4	32	4
BCUHB	YG	32	4	32	4	32	4	32	4	32	4	31	4	32	4	32	4	32	4	32	4	32	4	32	4
BCUHB	Wrexham	32	4	32	4	32	4	32	4	32	4	32	4	32	4	32	4	32	4	32	4	32	4	32	4
BCUHB	Dobshill	32	4	31	4	31	4	32	4	32	4	32	4	32	4	32	4	32	4	32	4	32	4	32	4
CVUHB	UHW	32	4	32	4	32	4	32	4	32	4	32	4	32	4	32	4	32	4	32	4	32	4	31	4
CVUHB	UHL	32	4	32	4	32	4	32	4	32	4	32	4	32	4	32	4	32	4	32	4	32	4	32	4
CTMUHB	Prince Charles	31	4	31	4	31	4	32	4	32	4	32	4	32	4	32	4	32	4	32	4	32	4	32	4
CTMUHB	POW	32	4	32	4	32	4	32	4	32	4	32	4	32	4	32	4	32	4	32	4	32	4	32	4
CTMUHB	R Glam	32	4	32	4	32	4	32	4	32	4	32	4	32	4	32	4	32	4	32	4	32	4	32	4
HUHB	Bronglais	32	4	32	4	31	4	32	4	32	4	32	4	32	4	32	4	32	4	32	4	32	4	32	4
HUHB	Withybush	32	4	32	4	32	4	31	4	32	4	32	4	32	4	32	4	32	4	32	4	32	4	32	4
HUHB	WWG	31	4	32	4	32	4	29	4	32	4	32	4	32	4	32	4	32	4	32	4	32	4	32	4
HUHB	Prince Philip	31	4	32	4	32	4	31	4	32	4	32	4	32	4	32	4	32	4	32	4	32	4	32	4
PTHB	Newtown	32	4	32	4	32	4	32	4	32	4	31	4	32	4	32	4	32	4	32	4	32	4	32	4
PTHB	Welshpool	32	4	32	4	32	4	32	4	32	4	32	4	32	4	32	4	32	4	32	4	32	4	32	4
PTHB	Brecon	32	4	32	4	32	4	32	4	32	4	32	4	32	4	32	4	32	4	30	4	30	4	32	4
PTHB	Llandrindod	31	4	32	4	32	4	32	4	32	4	31	4	32	4	32	4	32	4	32	4	32	4	32	4

Table 2. Omnicell cycle count by HB area and cabinet site 2025 – 2026

HB	Cabinet	2024-2025 % Compliance		2025-2026 % Compliance	
		POM	CD	POM	CD
ABUHB	GUH	100	100	100	100
ABUHB	Nev Hall	100	83	92	92
SBUHB	Morrison	100	100	100	100
BCUHB	YGC	100	100	100	100
BCU	YG	42	67	100	100
BCU	Wrexham	100	92	100	100
BCU	Dobshill	100	67	100	100
C&V	UHW	100	100	100	100
C&V	UHL	92	100	100	100

CT	Prince Charles	92	92	100	100
CT	POW	100	75	100	100
CT	R Glam	92	92	100	100
HD	Bronglais	100	100	100	100
HD	Withybush	100	100	100	100
HD	WWG	42	83	100	100
HD	Prince Philip	92	67	100	100
POW	Newtown	100	100	100	100
POW	Welshpool	100	100	100	100
POW	Brecon	100	92	100	100
POW	Llandrindod	100	100	100	100
	<b>TOTAL</b>	<b>93</b>	<b>90</b>	<b>99</b>	<b>99</b>

Table 3. Omnicell cycle count by HB area and cabinet site percentage of compliance per financial year

### Unresolved CD Discrepancies on Omnicell System

Omicell discrepancies are reported by Health Board area monthly, as part of the MMAR. **Figure 1** below shows the total number of CD discrepancies created across Wales by month, along with those that were unresolved. **Table 4** compares the number of CD discrepancies created and left unresolved between the reporting periods. During the 2025-2026 period, the number of discrepancies created decreased, and the percentage of unresolved discrepancies improved.

CD discrepancies on the Omnicell cabinet usually occur due to user error in counting the number of items in a specific area. In the CD area of the cabinet, users are required to count the number of items in a specific area (secure bin), prior to removing the required number of items. Most discrepancies occur because a user has removed an item, then counted the remaining items. If the number of items entered by the user is below that expected by the cabinet, a discrepancy alert is created and emailed directly to Duty Operations Managers (DOM)/Senior Paramedics (SP) and includes the user's details. This mechanism is designed to ensure that DOMs/SPs can contact the user within minutes of the discrepancy, determine the cause, and resolve it at the cabinet. CD discrepancies must be resolved within 7 days, with automated emails sent at 8 am each day until they are resolved.

As shown in **Figure 1**, all CD discrepancies have been resolved between January and March 2026. This is as a result of change in practice. Alongside the DOMs and SPs, the Head of Medicines Management now also receives automated emails. If the CD discrepancy has not been resolved by day four, the local DOM team are contacted via the Gamma line to request that either a DOM or SP attend the site to resolve the discrepancy.

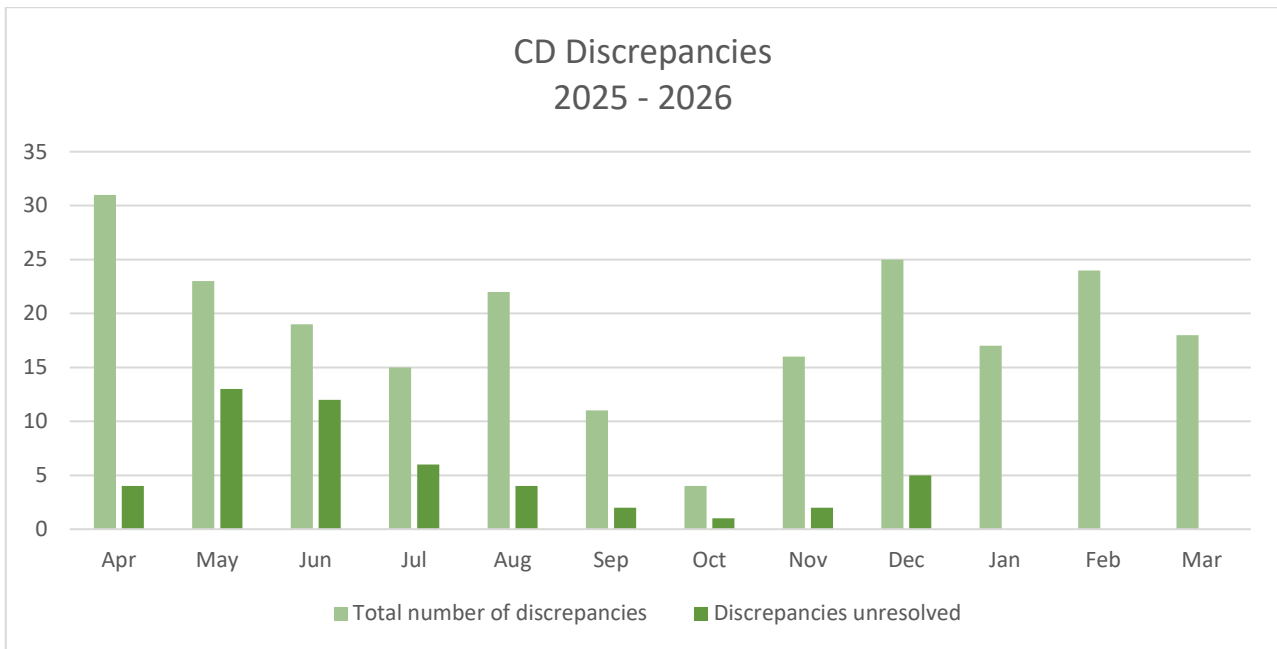


Figure 1. Omnicell CD Discrepancies 1<sup>st</sup> April 2025 to 31<sup>st</sup> March 2026

	2024-2025	2025-2026
<b>Total Discrepancies</b>	238	225
<b>Percentage Unresolved</b>	22.7	22.2

Table 4. Comparison of the total number of Omnicell CD discrepancies and the percentage unresolved per financial year

### Patient Group Direction – evidence of signed authorisations

Patient Group Directions (PGDs) are a legal mechanism that permits groups of WAST clinicians (registrants) to administer drugs not currently included in Schedule 17 of the Human Medicines Regulations (2012). There are four EMS-specific PGDs for intravenous use by WAST paramedics: Diazepam 10mg/2ml, Tranexamic Acid 100mg/ml, Co-amoxiclav 1200mg and Magnesium Sulfate 20%. Compliance is reported as the proportion of signed authorisations held on file by WAST Medicines Management, calculated as the number of paramedics in each Health Board area minus abstractions (maternity leave, suspension, career break).

Reporting of compliance against the 'Paramedic' PGD medicines began in January 2022. **Table 5** below shows national compliance for the 'Paramedic' PGDs. The latest reissue date of each PGD is shown in each column. Following the successful recording of Magnesium Sulfate compliance on ESR, all PGD and drug protocol compliance was transitioned to ESR starting in June 2025. This change, along with bi-monthly reports from the ESR team, support from local leadership teams, and oversight by the medicines management team, has led to the best rates of PGD compliance since records began. For the first time ever, all health board areas are over the 95% target, with the national average being 99%, a 17% increase on the previous year (see **Table 6**). This increase in incompliance puts WAST in a strong position both legally and clinically. Target compliance for all PGDs is 95%, represented as a GREEN cell.

Health Board	Diazepam (August 2023)	TXA (August 2024)	Co-amoxiclav (April 2024)	Magnesium Sulfate (March 2025)
Aneurin Bevan	99%	98%	98%	99%
Betsi	98%	98%	98%	97%
Cardiff & Vale	100%	100%	100%	98%
Cwm Taf	99%	98%	97%	98%
HART	100%	100%	100%	100%
Hywel Dda	98%	98%	98%	98%
Powys	100%	100%	100%	100%
Swansea Bay	100%	100%	100%	98%
SAPPs	100%	100%	95%	95%
<b>Overall</b>	<b>99%</b>	<b>99%</b>	<b>98%</b>	<b>98%</b>

Table 5. PGD Compliance for 'Paramedic' medicines as of 31<sup>st</sup> March 2026

Health Board	Total Annual % Compliance for all PGDs	
	2024-2025	2025-2026
Aneurin Bevan	62%	99%
Betsi	69%	98%
Cardiff & Vale	94%	100%
Cwm Taf	73%	98%
HART	93%	100%
Hywel Dda	82%	98%
Powys	96%	100%
Swansea Bay	85%	100%
SAPPs	N/A	98%
<b>Overall</b>	<b>82%</b>	<b>99%</b>

Table 6. Comparison of PGD Compliance for 'Paramedic' medicines per financial year

Advanced Paramedic Practitioners (APPs) have access to an additional 17 PGDs. Following the introduction of Senior Advanced Paramedics (SAPPs), the need to differentiate their compliance from that of APPs has arisen. **Table 7**, below, shows the compliance of SAPPs in Wales.

PGD	WALES
Amoxicillin	100
Clarithromycin	95
Co-Amoxiclav	95
Codeine Phosphate	95
Doxycycline	95
Flucloxacillin	90
Fosfomycin	95
Ibuprofen	100
Loperamide Hydrochloride	100
Nitrofurantoin	100
Oral Rehydration Salts	100
Paracetamol	95
Penicillin 'V	95
Prednisolone	100
Prochlorperazine	100
Salbutamol MDI	100
Trimethoprim	100
<b>Average</b>	<b>97</b>

Table 7: 'Senior Advanced Paramedic Practitioner' PGD Compliance as of 31<sup>st</sup> March 2026

The regional PGD compliance for Advanced Paramedic Practitioners, as of 31<sup>st</sup> March 2026, is shown in **Table 8**. As with Paramedic PGDs, all APP PGD compliance was transitioned across to ESR from November 2025. Again, following bi-monthly reports from the ESR team, support from the APP leadership teams, and oversight from the medicines management team, compliance in this cohort of staff has vastly improved, achieving the highest compliance since records began. The national average is now 99%, an increase of 22% on the previous year (see **Table 9**).

PGD (APPs)	North	Central & West	South East	Total
	% Compliance 2025-2026			
Amoxicillin	100	100	100	<b>100</b>
Clarithromycin	100	100	100	<b>100</b>
Co-Amoxiclav	100	100	96	<b>98</b>
Codeine Phosphate	100	100	96	<b>98</b>
Doxycycline	100	100	100	<b>100</b>
Flucloxacillin	100	100	100	<b>100</b>
Fosfomycin	100	96	100	<b>98</b>
Ibuprofen	100	100	96	<b>98</b>
Loperamide Hydrochloride	100	100	100	<b>100</b>
Nitrofurantoin	100	100	100	<b>100</b>
Oral Rehydration Salts	100	100	100	<b>100</b>
Paracetamol	100	100	96	<b>98</b>
Penicillin 'V'	100	100	100	<b>100</b>
Prednisolone	100	100	100	<b>100</b>
Prochlorperazine	100	100	100	<b>100</b>
Salbutamol MDI	100	100	100	<b>100</b>
Trimethoprim	100	100	100	<b>100</b>
<b>Regional Average</b>	<b>100</b>	<b>99</b>	<b>99</b>	<b>99</b>

**Table 8: 'Advanced Paramedic Practitioner' PGD Compliance as of 31<sup>st</sup> March 2026**

PGD (APPs)	Total Annual % Compliance	
	2024-2025	2025-2026
Amoxicillin	41	100
Clarithromycin	95	100
Co-Amoxiclav	39	98
Codeine Phosphate	93	98
Doxycycline	95	100
Flucloxacillin	44	100
Fosfomycin	51	98
Ibuprofen	79	98
Loperamide Hydrochloride	85	100
Nitrofurantoin	95	100
Oral Rehydration Salts	84	100
Paracetamol	93	98
Penicillin 'V'	43	100
Prednisolone	85	100
Prochlorperazine	87	100
Salbutamol MDI	72	100
Trimethoprim	97	100
<b>Regional Average</b>	<b>77</b>	<b>99</b>

**Table 9. Comparison PGD Compliance for 'Advanced Paramedic Practitioner' medicines per financial year**

TAPPs are grouped to indicate their progress toward qualifying as an APP, with the year of study added to the title. TAPPs in the first year of training do not have access to any advanced practice PGDs. Second year (TAPP2) students are permitted to use the following 7 PGDs: Amoxicillin, Clarithromycin, Doxycycline, Ibuprofen, Paracetamol, Penicillin 'V', and Prednisolone. Penicillin 'V' was added to their formulary in August 2025. TAPPs in the third and final year of study (TAPP3) can access the full range of advanced practice PGDs. Compliance for TAPP3s and TAPP2s, by region, is presented below (**Tables 10 and 12**). It should be noted that at the beginning of March 2026, a large proportion of TAPP2s transitioned to TAPP3s. This predominantly affected the South East Region, where the majority of those staff work. This significantly reduced the South East Region's average score, from 98% in February 2026 to 85% in March 2026. Despite this, the national average compared to the 2024-2025 financial year (see Tables 11 and 13), TAPP3s and TAPP2s PGD compliance has improved. Unfortunately, recording TAPP2 and TAPP3 PGDs on ESR is not possible because their profiles are configured differently. Recording compliance for this group of staff remains a manual process undertaken by the medicines management team.

PGD (TAPP3s)	North	Central & West	South East	Total
	% Compliance 2025-2026			
Amoxicillin	100	100	100	100
Clarithromycin	100	100	100	100
Co-Amoxiclav	100	100	64	78
Codeine Phosphate	100	100	86	91
Doxycycline	100	100	100	100
Flucloxacillin	100	100	86	91
Fosfomycin	100	100	71	83
Ibuprofen	50	100	93	87
Loperamide Hydrochloride	100	100	71	83
Nitrofurantoin	100	100	86	91
Oral Rehydration Salts	100	100	71	83
Paracetamol	100	100	93	96
Penicillin 'V'	100	100	100	96
Prednisolone	100	100	100	100
Prochlorperazine	100	100	71	83
Salbutamol MDI	100	100	86	91
Trimethoprim	100	100	71	83
<b>Regional Average</b>	<b>97</b>	<b>100</b>	<b>85</b>	<b>90</b>

Table 10: 'Trainee Advanced Paramedic Practitioner 3' PGD Compliance as of 31<sup>st</sup> March 2026

PGD (TAPP3s)	Total Annual % Compliance	
	2024-2025	2025-2026
Amoxicillin	54	100
Clarithromycin	100	100
Co-Amoxiclav	31	78
Codeine Phosphate	97	91
Doxycycline	100	100
Fosfomycin	46	91
Flucloxacillin	31	83
Ibuprofen	89	87
Loperamide Hydrochloride	89	83
Nitrofurantoin	97	91
Oral Rehydration Salts	89	83
Paracetamol	97	96
Penicillin 'V'	97	96
Prednisolone	80	100
Prochlorperazine	86	83
Trimethoprim	97	91
Salbutamol MDI	74	83
<b>Average</b>	<b>81</b>	<b>90</b>

Table 11. Comparison PGD Compliance for 'Trainee Advanced Paramedic Practitioner 3' medicines per financial year

PGD (TAPP2s)	North	Central & West	South East	Total
	% Compliance 2025-2026			
Amoxicillin	N/A	100	100	100
Clarithromycin	N/A	100	100	100
Doxycycline	N/A	100	100	100
Ibuprofen	N/A	100	83	86
Paracetamol	N/A	100	83	86
Penicillin 'V'	N/A	100	100	100
Prednisolone	N/A	100	100	100
<b>Regional Average</b>	N/A	<b>100</b>	<b>95</b>	<b>96</b>

Table 12: 'Trainee Advanced Paramedic Practitioner 2' PGD Compliance as of 31<sup>st</sup> March 2026

PGD (TAPP2s)	Total Annual % Compliance	
	2024-2025	2025-2026
Amoxicillin	58	100
Clarithromycin	67	100
Doxycycline	67	100
Ibuprofen	58	86
Paracetamol	67	86
Penicillin 'V'	N/A	100
Prednisolone	58	100
<b>Average</b>	<b>63</b>	<b>96</b>

Table 13. Comparison PGD Compliance for 'Trainee Advanced Paramedic Practitioner 2' medicines per financial year

A further three PGD to support the administration of 'Enhanced Analgesia' are available to a limited number of WAST SPs and paramedics working on the Cymru High Acuity Response Unit (CHARU) and Hazardous Area Response Team (HART). The three PGDs (**Table 14**) are Flumazenil, Ketamine and Midazolam. Compliance in these PGDs has increased, with all areas exceeding the 95% target. HART and Senior Paramedic compliance in these PGDs are recorded on ESR. Similarly to TAPPs, it is not possible to record these PGDs against CHARU staff in ESR due to ESR's setup.

Paramedic Grade	Ketamine %		Midazolam %		Flumazenil %	
	2024-2025	2025-2026	2024-2025	2025-2026	2024-2025	2025-2026
<b>CHARU</b>	69	99	69	99	69	99
<b>Senior</b>	98	100	98	100	98	100
<b>HART</b>	67	100	67	100	67	100

Table 14. 'Enhanced Analgesia' PGD compliance per financial year

## Methoxyflurane (Pentrox)

A further sign-off process was added to the Medicines Management database following the introduction of Pentrox, an inhaled analgesia, in early May 2023. This applies to SAPPs, APPs, SPs, CHARU Paramedics, Paramedics, Emergency Ambulance Practitioners (EAPs), Emergency Medical Technicians (EMTs), and Ambulance Care Assistants 2 (ACA2s), all of which are included in **Table 15**. All areas have exceeded the 95% target with a national average of 99%. This is a 6% increase on the previous year (**Table 16**).

Pentrox				
Health Board	Total Staff	Compliant	Non-Compliant	% Compliance
Aneurin Bevan	362	355	7	98%
Betsi	478	476	2	99%
Cardiff & Vale	166	166	0	100%
Cwm Taf	237	233	4	98%
HART	33	33	0	100%
Hywel Dda	324	323	1	99%
Powys	158	157	1	99%
Swansea Bay	192	186	6	96%
SAPPs	21	21	0	100%
<b>Overall</b>	<b>1971</b>	<b>1950</b>	<b>21</b>	<b>99%</b>

Table 15. 'Pentrox Protocol' compliance as of 31<sup>st</sup> March 2026

Health Board	Total Annual % Compliance	
	2024-2025	2025-2026
Aneurin Bevan	87%	98%
Betsi	93%	99%
Cardiff & Vale	92%	100%
Cwm Taf	90%	98%
HART	100%	100%
Hywel Dda	96%	99%
Powys	100%	99%
Swansea Bay	94%	96%
SAPPs	N/A	100%
<b>Overall</b>	<b>93%</b>	<b>99%</b>

Table 16. 'Pentrox Protocol' compliance per financial year

Pentrox compliance also applies to Community First Responders (CFRs) within the Trust, who, due to the volunteering nature of their role, do not possess payroll numbers for identification. The CFR management team are responsible for retaining records of their responders. As of the 31<sup>st</sup> March 2026, there were 286 active CFRs in WAST, all of which were compliant with the Pentrox training and protocol.

## **ABLOY System**

The Trust ABLOY system was rolled out in August 2020 and supports the safer management of CDs. It is a Web-based operating system (controlled access) which reports the following as of 31<sup>st</sup> March 2026:

- individual issue keys – **1,516** issued to paramedics
- percentage of receipts received – **99%**
- number of lost and deactivated keys (since introduction) – **139**
- number of broken keys (since introduction) - **165**

At the start of their shift, paramedics are required to dock their key in the station wall mounted programming device. This action will upload CD access activity for the previous shift, before activating the key for a fixed 15-hour period. Once activated, paramedics can access all vehicle CD safes. Access to station-based CD safes is restricted to specific individuals (DOM/SP/CHARU), dependent on the access profile assigned to their keys.

In July 2025, a new standard operating procedure was agreed upon, which changed paper requests and receipts to digital following the successful development of a medicines management app. This new system has streamlined the process for requesting new or replacement ABLOY keys, reducing the burden on operational managers. Keys are now sent out inactive and are only activated upon receipt of a digital receipt from the key recipient. This introduction has improved the security of CDs in WAST and the compliance with receipts received.

During 2025-2026, with support from the digital engineering teams, the medicines management team installed new back plates and updates to all 86 Generation 1 wall programming devices across Wales. These updates have resulted in reduced system downtime and lost UHP hours.

## **Notification Alerts**

The Trust receives alerts and notifications (medicines, equipment, patient safety) from a range of sources. The Medicines Management Team is responsible for reviewing all medicines-related notifications to assess their impact on the organisation and/or its clinicians. The vast majority of notifications have no implications and therefore require no action. **Table 17** shows the number of notifications received and those that required action in WAST for the 2025-2026 financial year. Most commonly, notifications are related to medicine shortages/supply issues.

Notifications	Public Health Alerts	Applies to WAST
Apr-25	11	1
May-25	10	1
Jun-25	6	1
Jul-25	17	1
Aug-25	8	0
Sep-25	3	0
Oct-25	9	0
Nov-25	6	0
Dec-25	11	0
Jan-26	11	1
Feb-26	12	0
Mar-26	13	0
<b>Total</b>	<b>117</b>	<b>5</b>

Table 17. Total number of medication alerts and the number that required WAST action

### Controlled Drugs Quarterly Occurrence Reports

The UK Government's response to the Shipman Inquiry's Fourth Report, Safer management of controlled drugs (2008), required all healthcare and social care organisations to be accountable for the safe management of the CDs it uses. In Wales, each Health Board is responsible for organising and chairing a Local Intelligence Network (LIN). Chaired by the Health Board Accountable Officer, LIN meetings are generally held on a quarterly basis. Each organisation that uses CDs within the boundaries of a LIN, is required to submit a quarterly occurrence report, detailing the type of incident (loss/theft/discrepancy/breakage), and describing any actions taken to minimise a recurrence. In WAST, the Head of Medicines Management is responsible for reviewing all reported CD incidents and preparing the LIN report on behalf of the Trust Accountable Officer (Executive Director of Paramedicine), which is circulated to each of the 7 LIN in Wales. **Table 18** provides an overview of the number and type of incidents reported over the four quarters of the 2025-2026 financial year.

	No. of incidents	Incident type
2025 Q2	9	<ul style="list-style-type: none"> <li>Accidental breakage = 7</li> <li>Unaccountable Loss = 1</li> <li>Discrepancies = 1 (1 resolved)</li> </ul>
2025 Q3	8	<ul style="list-style-type: none"> <li>Accidental breakage = 3</li> <li>Other Loss = 1</li> <li>Discrepancies = 3 (3 resolved)</li> <li>Unexplained breakage = 1</li> </ul>
2025 Q4	10	<ul style="list-style-type: none"> <li>Accidental breakage = 3</li> <li>Other Loss = 4</li> <li>Discrepancies = 3 (3 resolved)</li> </ul>
2026 Q1	14	<ul style="list-style-type: none"> <li>Accidental breakage = 7</li> <li>Unexplained breakage = 2</li> <li>Other Loss = 1</li> <li>Discrepancies = 3 (3 resolved)</li> <li>Unaccountable Loss = 1</li> </ul>

Table 18. Summary of CD incidents reported to LIN April 2025 - March 2026

## Medication Errors

**Table 19** provides an overview of closed medication errors reported on DATIX up to 31<sup>st</sup> March 2026. Limited resources within the Medicines Management team limit the ability to conduct an in-depth analysis of this data in the time available to prepare this report, but it is hoped to include this in future annual MMARs. **Table 20** shows a 7% decrease in reported medication errors in 2025-2026 compared to the previous year. It should be noted that the DATIX system recorded 58 medication errors for 2025-2026, but a manual review reduced this to 27 due to incorrect categorisation by the reporter or incidents that did not involve WAST staff.

Number of reported incidents by Harm (following investigation)					
Financial Year	No Harm	Low Harm	Moderate Harm	Severe Harm	Total
2025-2026	11	15	1	0	27
Number of reported incidents by Sub-category					
Incorrect medication	Incorrect strength/dose	Expired medication	Administration contraindicated	Incorrect route: 3	Total
6	11	3	4	3	27

Table 19. DATIXs received shown by severity and category for 2024-2025 financial year.

	2024-2025	2025-2026
<b>Total Discrepancies</b>	29	27

Table 20. DATIX recorded medication errors for financial years of periods shown

## **Antimicrobial Stewardship**

The antimicrobial report was undertaken to provide assurance that antimicrobial use within WAST is aligned with national antimicrobial resistance (AMR) priorities and complies with the Welsh Government improvement goals and the UK 20-Year Vision for AMR. A short summary is provided here; the full report is available in **Appendix 1**.

In line with national reporting expectations, this summary focuses on progress against Target 4a (a 10% reduction in total antibiotic use) and Target 4b (achievement of at least 70% use of WHO Access category antibiotics). It also recognises the distinct models through which antimicrobials are used within WAST, including across paramedic antimicrobials (emergency use and advanced practice), and antimicrobials prescribed by WAST non-medical prescribers (NMPs).

WAST continues to demonstrate strong alignment with national antimicrobial stewardship objectives.

Performance against Target 4b is robust across paramedic and NMP practice, with sustained predominance of WHO Access category antibiotics, providing assurance that first-line, lower-resistance-risk agents are being appropriately prioritised.

Progress towards Target 4a remains mixed. Emergency paramedic antimicrobial administrations have increased, although this is likely influenced by service demand and data-capture limitations rather than inappropriate use. In contrast, antimicrobial use within advanced practice and NMP cohorts demonstrates clear compliance with the Target 4a ambition, with activity-adjusted measures showing reductions exceeding the 10% national expectation, providing strong assurance that prescribing intensity in these groups is appropriately controlled.

Overall, current arrangements provide assurance that antimicrobial use within WAST remains proportionate and well governed. Further refinement of activity-adjusted and clinically contextualised metrics is recommended to strengthen future assurance against Target 4a.

To further support antimicrobial stewardship and ensure safe prescribing practices within the expanding NMP workforce, the Medicines Management Team and the Advanced Paramedic Practitioner (APP) Leadership Team have collaborated to develop a prescribing formulary. This formulary supports safe and consistent prescribing practice for patients and the Trust and enables effective audit and assurance. In addition, WAST's selection of antimicrobial PGDs has been reviewed to ensure alignment with national guidance on first and second-line antimicrobial choices.

## **Future Plans**

- Assess the feasibility of including APP medications in the monthly Omnicell cycle count utilising SAPPs
- Look at the potential for bringing medicines distribution in-house to further improve governance
- Further develop the medicines management app to develop a single point of contact for all medicine-related requests
- Develop further SOPs to improve medicines governance
- Maintain levels of PGD compliance

If you require any further information following the Medicines Management Assurance Report, please contact: [AMB\\_MedsManagement@wales.nhs.uk](mailto:AMB_MedsManagement@wales.nhs.uk)

This report was jointly prepared by Huw Jackson, Head of Medicines Management and Dr Sofia Fernandez, Lead Pharmacist.



GIG  
CYMRU  
NHS  
WALES

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

# WAST Antimicrobial Report

Annual update for Year 2025

## 1. INTRODUCTION

This report provides an overview of antimicrobial use within the Welsh Ambulance Services University NHS Trust (WAST). The term “antimicrobial” refers to any antibiotics, antifungals, antivirals and antiparasitic medications.

Antimicrobial use within WAST occurs through distinct mechanisms reflecting the scope of pre-hospital care and prescribing practice. To support clear reporting and assurance, the following terminology is used throughout this document: paramedic antimicrobials and Non-Medical Prescriber (NMP) antimicrobials (Table 1).

<b>Paramedic antimicrobials</b>	<b>Emergency antimicrobials</b> Antimicrobials administered by any of the paramedic workforce for emergency use for the immediate, necessary treatment of sick or injured persons. These can be administered as per Schedule 17 of the Human Medicines Regulations (2012) or as per WAST Patient Group Directions (PGDs).	<ul style="list-style-type: none"><li>• <b>Benzylpenicillin IV</b></li><li>• <b>Co-amoxiclav (IV)</b></li></ul>
	<b>APP antimicrobials</b> Advanced Paramedic Practitioners (APPs) use PGDs for the administration and supply of antimicrobials in non-emergency situations.	<ul style="list-style-type: none"><li>• <b>Amoxicillin</b></li><li>• <b>Clarithromycin</b></li><li>• <b>Co-amoxiclav (oral)</b></li><li>• <b>Doxycycline</b></li><li>• <b>Flucloxacillin</b></li><li>• <b>Fosfomycin</b></li><li>• <b>Nitrofurantoin</b></li><li>• <b>Phenoxymethylpenicillin (Pen V)</b></li><li>• <b>Trimethoprim.</b></li></ul>
<b>NMP antimicrobials</b>	Antimicrobials prescribed and supplied by paramedic non-medical prescribers (NMPs). They are authorised to prescribe any antimicrobial within the WAST INFORM formulary, in accordance with their scope of practice and competence.	<ul style="list-style-type: none"><li>• <b>Any antimicrobial within WAST INFORM formulary</b></li></ul>

WAST is committed to contributing to the UK 20-Year Vision for Antimicrobial Resistance (AMR) which aims to ensure that AMR is controlled, contained and mitigated by 2040 ([DHSC, 2019](#)). Wales and the other UK nations committed to developing a series of five-year national

action plans to prioritise actions and direct resources in areas of highest risk. The UK's second five-year national action plan setting out ambitions and actions for the next five years (2024-2029) was published in May 2024 ([DHSC, 2024](#))

The Welsh Health Circular WHC/2025/039 sets out Wales-specific antimicrobial resistance and healthcare-associated infection improvement goals for 2025 to 2027, that align with, and operationalise at a national level, the ambitions of the UK 20-Year Vision ([Welsh Government, 2025](#)).

Delivery and assurance of these objectives in Wales are supported by Public Health Wales, through national leadership on AMR surveillance, guidance and improvement. This work is coordinated by the Healthcare Associated Infection, Antimicrobial Resistance & Prescribing Programme (HARP), which provides strategic oversight, expert advice, and coordination of the national AMR to reduce the burden of healthcare associated infections and antibiotic resistance across Wales ([PHW, 2024](#)).

Separate improvement goals are set out for primary and secondary care settings. As a pre-hospital service, the Ambulance Service will align with the primary care goals:

- **Target 4a:** by 2029, we aim to reduce total antibiotic use in human populations by 10% from the 2019 baseline.
- **Target 4b:** by 2029, we aim to achieve 70% of total use of antibiotics from the access category (new UK category) across the human healthcare system.

## 2. **METHODS**

### 2.1. **Total Antimicrobials:**

This report includes antimicrobial agents across all groups: antibacterials, antifungals, antiparasitic and antivirals. The reporting of total antibacterial is in line with the UK NAP, and the following antibacterials are excluded from the data set: TB drugs including rifampicin; anti-parasitic drugs including spiramycin and tinidazole; neomycin due to toxicity; drugs whose main use is not for the treatment of bacterial infection i.e. demeclocycline for SIADH, and rifaximin for prevention of hepatic encephalopathy.

#### **A. Administrations per 10,000 ePCRs**

Antimicrobials administered by paramedics in emergency and advance practice settings are reported as **number of administrations**. Data is reported as **Administrations / 10,000 ePCRs**, using the total number of cases attended by paramedics during the reporting year as the denominator as recorded on the electronic Patient Care Record (ePCR).

## B. Number of supplies per APP

While some antimicrobials may be supplied as a course to be completed, rather than as a single administration, the current electronic medicines administration system does not distinguish between supply and administration. For this report, the reported number of events where an antimicrobial has been supplied has been reported due to the lack of recorded information of the number of days supplied. In addition, as the WAST workforce of APPs is increasing year on year, antimicrobial supply activity is reported as **Supplies per APP** to provide a standardised and comparable measure of antimicrobial exposure over time. This approach ensures that changes in overall antimicrobial supplies are interpreted in the context of workforce expansion and supports assurance that any increase in antimicrobial use reflects the number of authorised prescribers, rather than an increase in prescribing intensity at an individual prescriber level.

## C. Defined Daily Doses (DDD) per Non-Medical Prescriber (NMP):

To describe the total number of antimicrobials prescribed by WAST Non-Medical Prescribers (NMPs), we will be using **Defined Daily Doses (DDDs)**. This data is provided by Primary Care Services and it is collected from the dispensed prescriptions submitted by community pharmacies. Reductions in DDDs can be achieved by reducing the number of antimicrobials prescribed, but also by reducing the duration of treatment. As the WAST workforce of NMPs is increasing year on year, antimicrobial prescribing activity is reported as **DDS per NMP** to provide a standardised and comparable measure of antimicrobial exposure over time. This approach ensures that changes in overall DDDs are interpreted in the context of workforce expansion and supports assurance that any increase in antimicrobial use reflects the number of authorised prescribers, rather than an increase in prescribing intensity at an individual prescriber level.

## 2.2. AWaRe categories:

Antimicrobials were assigned AWaRe categories (Access, Watch, Other and Reserve) based on the World Health Organization categories ([WHO AWaRe 2024](#)).

- i. **Access group**: first or second choice antibiotics that offer the best therapeutic value while minimising the potential for AMR
- ii. **Watch group**: first and second choice antibiotics only indicated for specific limited number of infective syndromes as they are more prone to AMR
- iii. **Reserve group**: last resort antibiotics for highly selected patients to ensure their continued effectiveness

### **2.3. Data interpretation**

Several factors should be considered when interpreting the data presented in this report:

- The reporting period is based on a calendar year (1<sup>st</sup> of January to 31<sup>st</sup> of December) to align with data provided by NHS Wales Shared Services Partnership (NWSSP) which is subject to a reporting delay of 2 to 3 months.
- Although the UK AMR reduction target uses 2019 as the national baseline, electronic data for antimicrobial use within WAST is not available before 2023, when the current electronic administration system was implemented. In addition, although NMPs were employed by WAST prior to 2020, widespread implementation of the NMP role occurred in 2020. Therefore 2023 and 202 have been adopted as the baseline for WAST reporting.
- Antimicrobials are being used in WAST through 3 very distinct mechanisms: administration of emergency antimicrobials; administration and supply within advance practice; and prescription of antimicrobials by NMPs. This report seeks to reflect these differing models of use whilst providing an overall organisational overview.
- Additional targeted reports or audits may be undertaken by WAST to provide further assurance that antimicrobial use remains compliant with local and national clinical guidance and antimicrobial stewardship principles.

### 3. RESULTS

#### 3.1 Paramedic antimicrobials

The total number of “Paramedic Antimicrobial” administrations across Wales by Health Board area as recorded on ePCR is shown on Table 2 and visually represented on Figure 1.

This table provides an overview of geographical variation in antimicrobial use, reflecting differences in service demand, case mix, and clinical activity rather than prescribing behaviour alone. A small proportion of records could not be attributed to a Health Board due to incomplete ePCR documentation.

The data highlights higher absolute usage in Betsi Cadwaladr University Health Board compared with other areas. This pattern is likely multifactorial and may reflect established advanced practice and primary care rotational models rather than increased inappropriate use.

	Aneurin Bevan	Betsi Cadwaladr	Cardiff & Vale	Cwm Taff	Hywel Dda	Powys	Swansea Bay	Area not defined	ADMINISTRATIONS in 2025
<b>CO-AMOXICLAV 1000/200MG VIAL</b>	51	78	37	36	48	32	26	3	311
<b>Doxycycline 100mg cap</b>	39	101	19	39	13	15	36	1	263
<b>Amoxicillin ALL formulations</b>	30	46	24	29	15	13	21	1	179
<b>Nitrofurantoin ALL formulations</b>	9	30	13	9	15	4	19	1	100
<b>BENZYLPENICILLIN 600MG VIAL</b>	12	24	12	15	8	13	13	0	97
<b>Clarithromycin ALL formulations</b>	9	15	11	7	9	0	10	2	63
<b>Flucloxacillin ALL formulations</b>	6	13	4	6	1	4	6	0	40
<b>Trimethoprim ALL formulations</b>	3	3	5	4	6	1	1	2	25
<b>Co-amoxiclav 500/125mg tab</b>	1	2	4	1	3	0	0	1	12
<b>Penicillin V ALL formulations</b>	1	2	1	0	2	5	1	0	12
<b>TOTAL number of administrations / supplies PER HEALTHBOARD</b>	<b>161</b>	<b>314</b>	<b>130</b>	<b>146</b>	<b>120</b>	<b>87</b>	<b>133</b>	<b>11</b>	

Table 2: Total number of administrations and supplies of “Paramedic Antimicrobials” in WAST, per Health Board area.

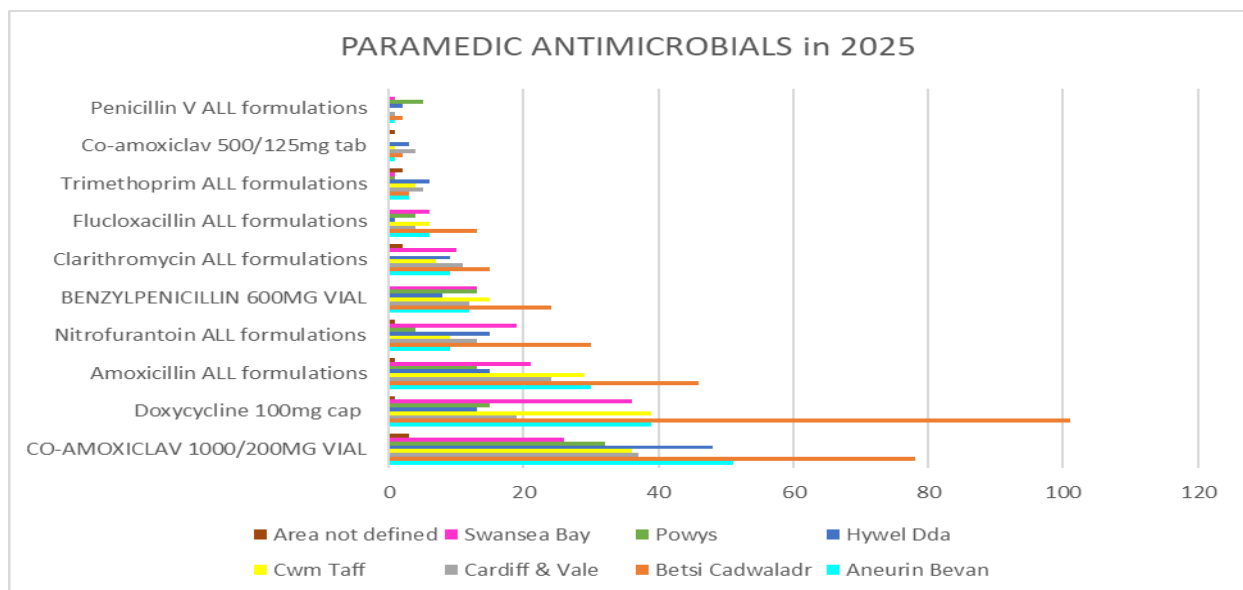


Figure 1: Total number of administrations and supplies of “Paramedic Antimicrobials” in WAST, per Health Board area.

The year-on-year trajectory of “Paramedic Antimicrobial” use within WAST is presented in Tables 3 and 4, and visually illustrated on Figure 2, demonstrating divergent trends across different models of paramedic practice.

Table 3 shows that antimicrobial administrations by paramedics in emergency situations have increased by 38% compared with 2023. This increase remains evident when activity is standardised to administrations per 10,000 ePCRs, indicating a genuine rise in emergency antimicrobial use relative to overall service demand.

In contrast, Table 4 shows that antimicrobial use by APPs using PGDs, has reduced by 17% compared with 2023 when adjusted for the growth in the APP workforce. This reduction suggests a decrease in antimicrobial supply activity per APP and provides reassurance that prescribing intensity within advanced practice has not increased despite workforce expansion.

Together, these findings highlight differing drivers of antimicrobial use across emergency and advanced practice settings and reinforce the importance of interpreting trends within their appropriate clinical and workforce context.

YEAR	TOTAL ADMINISTRATIONS		
	2023 *No electronic records before 2023	2024	2025
BENZYL PENICILLIN 600MG VIAL	81	105	97
CO-AMOXICLAV 1000/200MG VIAL	231	232	311
<b>TOTAL number of ADMINISTRATIONS</b>	<b>312</b>	<b>337</b>	<b>408</b>
ePCRs x 10,000 in one year	29.79	29.07	28.29
<b>TOTAL number of ADMINISTRATIONS per 10,000 ePCR</b>	<b>10.47</b>	<b>11.59</b>	<b>14.42</b>
<b>% Reduction from Year 2023</b>	<b>n/a</b>	<b>-11%</b>	<b>-38%</b>

**Table 3: Trajectory of “Emergency Antimicrobials” (as part of the “Paramedics Antimicrobials”) used in WAST, as total number of administrations per 10,000 ePCRs.**

YEAR	TOTAL CASES WHERE ANTIMICROBIAL SUPPLIED		
	2023 *No electronic records before 2023	2024	2025
Amoxicillin ALL formulations	181	277	179
Clarithromycin ALL formulations	38	76	63
Co-amoxiclav 500/125mg tab	12	21	12
Doxycycline 100mg cap	188	309	263
Flucloxacillin ALL formulations	13	22	40
Nitrofurantoin ALL formulations	85	128	100
Penicillin V ALL formulations	15	18	12
Trimethoprim ALL formulations	32	40	25
<b>TOTAL number of SUPPLIES</b>	<b>564</b>	<b>891</b>	<b>694</b>
Number of APPs in WAST	83.6	101.2	124.5
<b>TOTAL number of SUPPLIES per APP</b>	<b>6.75</b>	<b>8.80</b>	<b>5.57</b>
<b>% Reduction from Year 2023</b>	<b>n/a</b>	<b>-31%</b>	<b>17%</b>

Table 4: Trajectory of “APP Antimicrobials” (as part of the “Paramedics Antimicrobials”) used in WAST, as total number of supplies per APP.

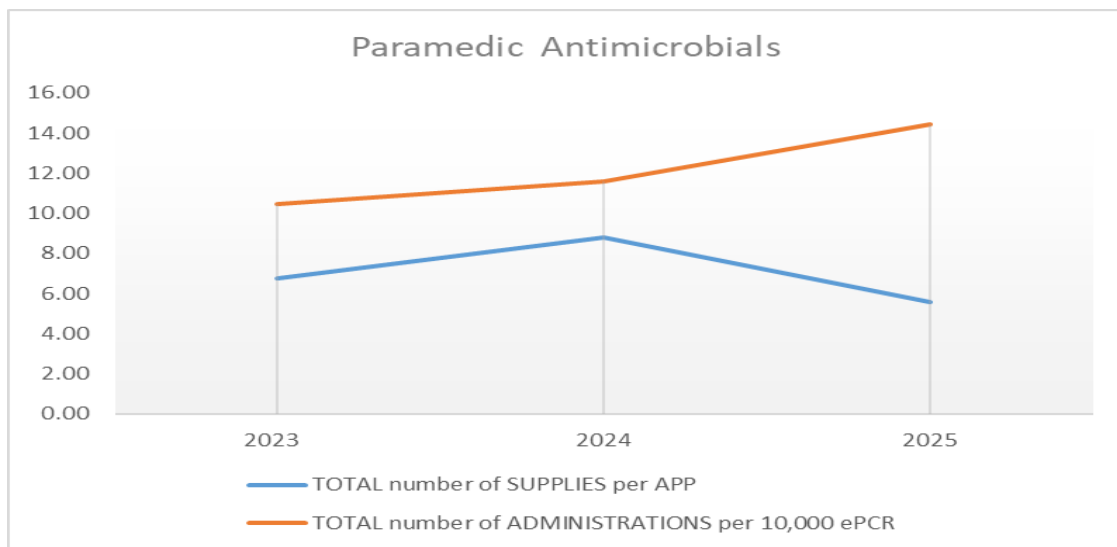


Figure 2: Trajectory of “Paramedic Antimicrobials” used in WAST

Finally, table 5 categorises paramedic antimicrobial administrations by WHO AWaRe classification and presents them as a percentage of total administrations. The table demonstrates that the overwhelming majority of antimicrobials administered by paramedics fall within the Access category, providing assurance that first-line, lower-resistance-risk agents are being used in line with national antimicrobial stewardship objectives.

		YEAR 2025
TOTAL Antibacterial Drugs		1,102
CO-AMOXICLAV 1000/200MG VIAL	Access	311
Doxycycline 100mg cap	Access	263
Amoxicillin ALL formulations	Access	179
Nitrofurantoin ALL formulations	Access	100
BENZYL PENICILLIN 600MG VIAL	Access	97
Clarithromycin ALL formulations	Watch	63
Flucloxacillin ALL formulations	Access	40
Trimethoprim ALL formulations	Access	25
Co-amoxiclav 500/125mg tab	Access	12
Penicillin V ALL formulations	Access	12
<b>Percentage of antimicrobials within the Access Category measured in number of administrations and supplies</b>	<b>94%</b>	

Table 5: “Paramedic Antimicrobial” usage by AWaRe category as percentage of administrations

### 3.2 NMP antimicrobials

Antimicrobial prescribing activity by WAST Non-Medical Prescribers (NMPs) during 2025, expressed in Defined Daily Doses (DDDs), is shown in table 6. The table shows that overall prescribing volumes remain relatively low, reflecting the early stage and controlled expansion of the NMP workforce. Prescribing is predominantly focused on Access-category antibiotics, with doxycycline and amoxicillin accounting for the highest DDDs.

Description	Basic Price	Items	DDD
<b>Antibacterial Drugs</b>	<b>£629.78</b>	<b>171</b>	<b>1,069.50</b>
Doxycycline Hyclate	£27.91	38	256.00
Amoxicillin	£75.60	40	228.00
Clarithromycin	£105.24	21	218.00
Flucloxacillin Sodium	£29.24	10	79.00
Nitrofurantoin	£84.15	16	72.00
Pivmecillinam Hydrochloride	£123.88	05	62.00
Cefalexin	£21.60	06	47.25
Phenoxymethylpenicillin (penicillin V)	£23.70	08	41.25
Fosfomycin Trometamol	£92.34	12	19.00
Co-Amoxiclav (amoxicillin/clavulanic ac)	£05.82	03	17.00
Ciprofloxacin	£02.38	02	14.00
Metronidazole	£03.38	03	9.00
Trimethoprim	£01.45	01	7.00
Co-Trimoxazole(trimethoprim/sulfamethox)	£33.09	06	0.00
<b>Antifungal Drugs</b>	<b>£14.84</b>	<b>05</b>	<b>8.75</b>
Fluconazole	£00.69	01	0.75
Nystatin	£14.15	04	8.00
<b>Antiviral Drugs</b>	<b>£12.08</b>	<b>03</b>	<b>21.00</b>
Aciclovir	£12.08	03	21.00

**Table 6: “NMP Antimicrobials” in 2025: antimicrobials prescribed by WAST NMPs**

The trajectory of antimicrobial prescribing by NMPs over time is shown on table 7 and visually represented on Figure 3.

The data shows a gradual increase in total DDDs, which is consistent with the increasing number of authorised NMPs within WAST. This increase should therefore be interpreted as a workforce and service development effect rather than increased antimicrobial exposure per prescriber. However, when represented as total DDDs per NMPs, 2025 has shown a 13% reductions compared to baseline year 2020, supporting assurance that stewardship principles are being maintained during workforce development.

YEAR	2020	2021	2022	2023	2024	2025
DDD - Antibacterial Drugs	218	147.5	323.5	760	911.17	1,069.50
DDD - Antifungal Drugs	2	0	6	8	8	8.75
DDD - Antiviral Drugs	0	6.85	7	0	0	21.00
<b>Total number of DDDs</b>	<b>220</b>	<b>154.35</b>	<b>336.5</b>	<b>768</b>	<b>919.17</b>	<b>1099.25</b>
Number of NMPs in WAST	8	12	21	29	34	46
<b>Total DDS per NMPs</b>	<b>27.50</b>	<b>12.86</b>	<b>16.02</b>	<b>26.48</b>	<b>27.03</b>	<b>23.90</b>
<b>% Reduction from Year 2020</b>	<b>n/a</b>	<b>53%</b>	<b>42%</b>	<b>4%</b>	<b>2%</b>	<b>13%</b>

Table 7: Trajectory of “NMPs Antimicrobials” in WAST

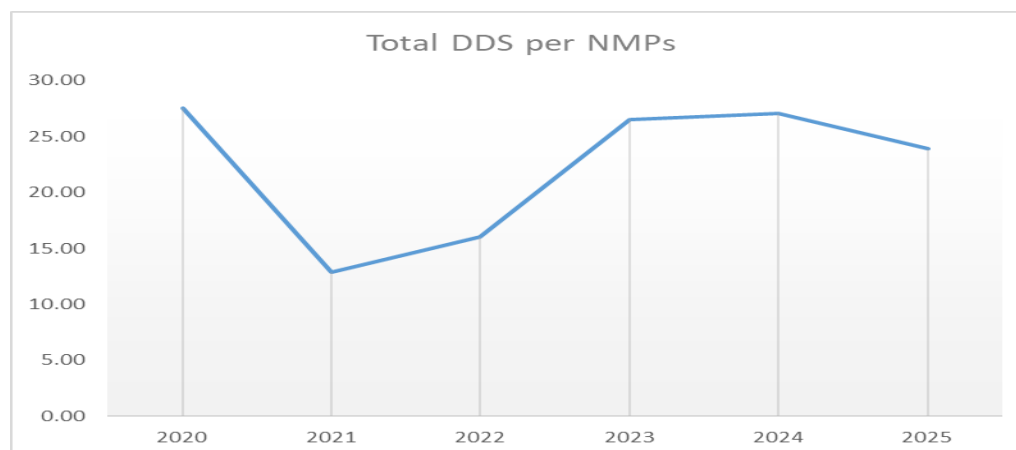


Figure 3: Trajectory of “NMP Antimicrobials” in WAST

Table 8 summarises NMP antimicrobial prescribing by AWaRe category, expressed as a percentage of total DDDs. The table demonstrates that 77% of prescribed antimicrobials fall within the Access category, exceeding the national target of 70%. Limited use of Watch agents and absence of Reserve antibiotics provide reassurance regarding appropriate antimicrobial selection by NMPs.

Description		DDD in 2025
TOTAL Antibacterial Drugs		1,070
Doxycycline Hyclate	Access	256
Amoxicillin	Access	228
Clarithromycin	Watch	218
Flucloxacillin Sodium	Access	79
Nitrofurantoin	Access	72
Pivmecillinam Hydrochloride	Access	62
Cefalexin	Access	47
Phenoxymethylpenicillin (penicillin V)	Access	41
Fosfomicin Trometamol	Watch	19
Co-Amoxiclav (amoxicillin/clavulanic ac)	Access	17
Ciprofloxacin	Watch	14
Metronidazole	Access	9
Trimethoprim	Access	7
Co-Trimoxazole(trimethoprim/sulfamethox)	Access	0
<b>Percentage of antimicrobials within the Access Category measured in DDDs</b>	<b>77%</b>	

Table 8: "NMP Antimicrobial" usage by AWaRe category as percentage of DDS

## 4. SUMMARY

This report was undertaken to provide assurance that antimicrobial use within WAST is aligned with national antimicrobial resistance (AMR) priorities and complies with the Welsh Government improvement goals and the UK 20-Year Vision for AMR.

In line with national reporting expectations, the summary focuses on progress against Target 4a (a 10% reduction in total antibiotic use) and Target 4b (achievement of at least 70% use of WHO Access category antibiotics), recognising the distinct models through which antimicrobials are used across paramedic practice (emergency use and advanced practice), and non-medical prescribing roles.

### 4.1 “Paramedic Antimicrobial” use

#### **Target 4a: Reduction in total antibiotic use**

Year-on-year analysis demonstrates differing trends within Paramedic Antimicrobial use when stratified by model of practice.

Emergency antimicrobial administrations by paramedics have increased by 38% compared with 2023. This increase remains evident even after standardising for administrations per 10,000 ePCRs, suggesting a rise in antimicrobial use relative to overall emergency activity. This trend may reflect increasing clinical demand for emergency antimicrobial interventions and supports the need for continued monitoring and stewardship oversight in relation to Target 4a. However, this finding should be interpreted with caution, as the ePCR denominator includes all emergency cases, irrespective of whether infection was suspected or treated. Consequently, the observed increase may not necessarily indicate increased antimicrobial prescribing intensity or inappropriate use. It does highlight however the need to develop more clinically contextualised metrics to support future assurance against Target 4a.

In contrast, antimicrobial use by APPs using WAST PGDs has reduced by 17% compared with 2023 when adjusted for the expanding APP workforce. This reduction provides assurance that antimicrobial supply activity per APP has decreased over time, indicating that stewardship principles are being maintained within advanced practice despite workforce growth.

#### **Target 4b: Proportion of Access category antibiotics**

Target 4b continues to be exceeded for paramedic antimicrobials. The majority of antimicrobials administered by paramedics fall within the WHO Access category, substantially surpassing the national target of 70%. This provides strong assurance that first-line, lower-resistance-risk agents remain the primary choice in pre-hospital paramedic care, in alignment with PHW antimicrobial stewardship priorities.

### 4.2 “NMP Antimicrobial” use

#### **Target 4a: Reduction in total antibiotic use**

Antimicrobial prescribing by WAST NMPs remains low in absolute terms and continues to represent a controlled and proportionate contribution to overall antimicrobial exposure. While total DDDs have increased over time, this aligns with the planned expansion of the NMP workforce rather than increased prescribing intensity at an individual prescriber level.

When standardised as DDDs per NMP, prescribing activity demonstrates a 13% reduction compared with the 2020 baseline, providing assurance that progress towards Target 4a is being maintained within this cohort as the service continues to develop. Although there is no evidence of inappropriate increase in antimicrobial prescribing by NMPs, continued monitoring is required as the workforce grows.

#### **Target 4b: Proportion of Access category antibiotics**

Target 4b has been achieved for NMP antimicrobials. In 2025, 77% of NMP antimicrobial prescribing fell within the WHO Access category, exceeding the national target of 70%. Use of Watch antibiotics remains limited, and there is no use of Reserve antibiotics, providing assurance that NMP prescribing aligns with national stewardship priorities and local antimicrobial guidelines.

## **5. CONCLUSIONS**

WAST continues to demonstrate strong alignment with national antimicrobial stewardship objectives.

Performance against Target 4b is robust across paramedic and NMP practice, with sustained predominance of WHO Access category antibiotics.

Progress towards Target 4a remains mixed. Emergency paramedic antimicrobial administrations have increased, although this is likely influenced by service demand and data-capture limitations rather than inappropriate use. In contrast, antimicrobial use within advanced practice and NMP cohorts demonstrates clear compliance with the Target 4a ambition, with activity-adjusted measures showing reductions exceeding the 10% national expectation, providing strong assurance that prescribing intensity in these groups is appropriately controlled.

Overall, current arrangements provide assurance that antimicrobial use remains proportionate and well governed, with further refinement of activity-adjusted metrics recommended to strengthen future assurance against Target 4a.

## 6. REFERENCES

- DHSC (Department of Health and Social Care) (2019). *UK 20-year vision for antimicrobial resistance*. [online] Available at: <https://www.gov.uk/government/publications/uk-20-year-vision-for-antimicrobial-resistance> [Accessed 13 Apr. 2026].
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- PHW (Public Health Wales) (2024). *Antibiotics and Infections*. [online] Available at: <https://phw.nhs.wales/services-and-teams/antibiotics-and-infections/> [Accessed 13 Apr. 2026].
- Welsh Government (2025). *Antimicrobial resistance and healthcare associated infection improvement goals: 2025 to 2027 (WHC/2025/039)*. [online] Available at: <https://www.gov.wales/antimicrobial-resistance-and-healthcare-associated-infection-improvement-goals-2025-2027-whc2025039> [Accessed 13 Apr. 2026].



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Gwasanaethau Ambiwllans Cymru  
Welsh Ambulance Services  
University NHS Trust

Agenda Item No. 17

## REPORT TITLE

Risk Management and Board Assurance Framework Report

## MEETING

Name of meeting	Quality, Patient Experience & Safety Committee
Date of meeting	07 May 2026
Public or Private	Public
If private - <a href="#">rationale</a>	n/a

## REPORT SPONSOR

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

## PURPOSE OF REPORT

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

## REPORT SUMMARY:

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

1. The purpose of the report is to provide assurance in respect of the management of the Trust's principal risks, specifically the two risks that are relevant to Committee's remit.
2. A summary of these risks is set out in Annex 1 with a detailed description contained within the Board Assurance Framework (BAF). All updates are highlighted in blue and show changes to the narrative, mitigating actions, controls, and assurances.



3. The BAF extract (Annex 4) for the Trust's two highest risks, **223** and **224**, is included for review. Members are reminded that reporting to the Trust Board has evolved, with greater detail now provided through the Actions to Mitigate Avoidable Harm paper. This includes the current position and treatments for both risks, incorporating pathway specific harm indicators and new Phase 2 of the Ambulance Performance Framework measures including STEMI, stroke, and indicators of deterioration during long waits.
4. The committee continues to provide detailed oversight of these risks, focussing on the effectiveness of controls, the assurance supporting the controls and progress against mitigating actions. All principal risks have been reviewed in line with the agreed schedule (Annex 3), with particular focus on those scoring 15–25. ELT approved the principal risk activity on 8 April 2026, following reviews undertaken by Risk Owners during the reporting period.
5. 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 a strengthening internal control environment. This includes 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.
6. While internal assurance remains strong, ELT agreed that Risk 224 will remain scored at 25 (5x5) pending further analysis to assess whether recent improvements deliver sustained, system-wide risk reduction. Strategic mitigation therefore continues to focus on internal transformation alongside system-wide engagement and national programmes, including the rollout of the 45-minute release standard.
7. 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; and
  - 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 Quality, Patient Experience & Safety Committee is requested to receive the following:

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

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

## STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

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

## RISK(S) THIS REPORT MITIGATES

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

n/a

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

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

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

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

<input checked="" type="checkbox"/> Leadership	<input checked="" type="checkbox"/> Workforce	<input checked="" type="checkbox"/> Culture
<input checked="" type="checkbox"/> Information	<input checked="" type="checkbox"/> Learning Improvement and Research	<input checked="" type="checkbox"/> Whole Systems Approach

## WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

<input checked="" type="checkbox"/> A socially responsible and inclusive employer	<input checked="" type="checkbox"/> An innovative and sustainable organisation	<input checked="" type="checkbox"/> A pro-active, accessible and equitable care provider
<input type="checkbox"/> n/a	<input type="checkbox"/> n/a	<input type="checkbox"/> n/a



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Welsh Ambulance Services  
University NHS Trust

## 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
08 April 2026	Executive Leadership Team

**Annex 1 – Corporate Risk Register Summary**

<b>CORPORATE RISK REGISTER</b>				
<b>RISK ID</b>	<b>NEW RISK TITLE</b>	<b>NEW SUMMARY DESCRIPTION</b>	<b>EXECUTIVE OWNER</b>	<b>RISK SCORE</b>
223 QuEST	The Trust's inability to reach patients in the community causing patient harm and death	<p><b>IF</b> significant internal and external system pressures continue</p> <p><b>THEN</b> there is a risk of an inability and/or a delay in ambulances reaching patients in the community</p> <p><b>RESULTING IN</b> patient harm and death</p>	Director of Operations	<p><b>20</b> <b>(4x5)</b></p> 
224 QuEST	Significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service	<p><b>IF</b> patients are significantly delayed in ambulances outside A&amp;E departments</p> <p><b>THEN</b> there is a risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised</p> <p><b>RESULTING IN</b> patients potentially coming to harm and a poor patient experience</p>	Director of Quality & Nursing	<p><b>25</b> <b>(5x5)</b></p> 

## Annex 2 - Risk Scoring Matrix

Consequence:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
<b>Safety &amp; Well-being - Patients/ Staff/Public</b>	Minimal injury requiring no/minimal intervention or treatment. No time off work. Physical injury to self/others that requires no treatment or first aid. Minimum psychological impact requiring no support. Low vulnerability to abuse or exploitation - needs no intervention. Category 1 pressure ulcer.	Minor injury or illness, requiring minor intervention. Requires time off work for >3 days Increased hospital stay 1-3 days. Slight physical injury to self/others that may require first aid. Emotional distress requiring minimal intervention. Increased vulnerability to abuse or exploitation, low level intervention. Category 2 pressure ulcer.	Moderate injury/professional intervention. Requires time off work 4-14 days. Increased hospital stay 4-15 days. RIDDOR/Agency reportable incident. Impacts on a small number of patients. Physical injury to self/others requiring medical treatment. Psychological distress requiring formal intervention by MH professionals. Vulnerability to abuse or exploitation requiring increased intervention. Category 3 pressure ulcer.	Major injury leading to long-term disability. Requires time off work >14 days. Increased hospital stay >15 days. RIDDOR Reportable. Regulation 4 Specified Injuries to Workers. Patient mismanagement, long-term effects. Significant physical harm to self or others. Significant psychological distress needing specialist intervention. Vulnerability to abuse or exploitation requiring high levels of intervention. Category 4 pressure ulcer.	Incident leading to death. RIDDOR Reportable. Multiple permanent injuries or irreversible health effects. An event which impacts on a large number of patients.
<b>Quality/ Complaints/ Assurance/ Patient Outcomes</b>	Peripheral element of treatment or service suboptimal. Informal complaint/inquiry.	Overall treatment/service suboptimal. Formal complaint (Stage 1). Local resolution. Single failure of internal standards. Minor implications for patient safety. Reduced performance.	Treatment/service has significantly reduced effectiveness. Formal complaint (Stage 2). Escalation. Local resolution (poss. independent review). Repeated failure of internal standards. Major patient safety implications.	Non-compliance with national standards with significant risk to patients. Multiple complaints/independent review. Low achievement of performance/delivery requirements. Critical report.	Totally unacceptable level or quality of treatment/service. Gross failure of patient safety. Inquest/ombudsman/inquiry. Gross failure to meet national standards/requirements.
<b>Workforce/ Organisational Development/ Staffing/ Competence</b>	Short-term low staffing level that temporarily reduces service quality (< 1 day).	Low staffing level that reduces the service quality.	Late delivery of key objective/service due to lack of staff. Unsafe staffing level (>1 day)/competence. Low staff morale. Poor staff attendance for mandatory/key professional training.	Uncertain delivery of key objective/ service due to lack/loss of staff. Unsafe staffing level (>5 days)/competence. Very low staff morale. Significant numbers of staff not attending mandatory/key professional training.	Non-delivery of key objective/service due to loss of several key staff. Ongoing unsafe staffing levels or competence/skill mix. No staff attending mandatory/professional training.
<b>Statutory Duty, Regulation, Mandatory Requirements</b>	No or minimal impact or breach of guidance/statutory duty.	Breach of statutory legislation. Reduced performance levels if unresolved.	Single breach in statutory duty. Challenging external recommendations/improvement notice.	Enforcement action. Multiple breaches in statutory duty. Improvement notices. Low achievement of performance/ delivery requirements. Critical report.	Multiple breaches in statutory duty. Zero performance rating. Prosecution. Severely critical report. Total system change needed.
<b>Adverse Publicity or Reputation</b>	Rumours. Low level negative social media. Potential for public concern.	Local media coverage - short-term reduction in public confidence/trust. Short-term negative social media. Public expectations not met.	Local media coverage - long-term reduction in public confidence & trust. Prolonged negative social media. Reported in local media.	National media coverage <3 days, service well below reasonable public expectation. Prolonged negative social media, reported in national media, long-term reduction in public confidence & trust. Increased scrutiny: inspectorates, regulatory bodies and WG.	National/social media coverage >3 days, service well below reasonable public expectation. Extensive, prolonged social media. MP/MS questions in House/Senedd. Total loss of public confidence/trust. Escalation of scrutiny status by WG.
<b>Business Objectives or Projects</b>	Insignificant cost increase/ schedule slippage.	<5 per cent over project budget. Schedule slippage.	5–10 per cent over project budget. Schedule slippage.	Non-compliance with national targets.10-25 per cent over project budget. Schedule slippage. Key objectives not met.	>25 per cent over project budget. Schedule slippage. Key objectives not met.
<b>Financial Stability &amp; Impact of Litigation</b>	Small loss. Risk of claim remote.	Loss of 0.1–0.25% of budget Claim less than £10,000.	Loss of 0.25–0.5% of budget. Claim(s) between £10,000 and £100,000.	Uncertain delivery of key objective. Loss of 0.5-1.0% of budget. Claim(s) between £100,000 and £1 million. Purchasers failing to pay on time.	Non-delivery of key objective. Loss of >1 per cent of budget. Failure to meet specification. Claim(s) >£1 million. Loss of contract/payment by results.
<b>Service/ Business Interruption</b>	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours. Some disruption manageable by altered operational routine.	Loss/interruption of >1 day. Disruption to a number of operational areas in a location, possible flow to other locations.	Loss/interruption of >1 week. All operational areas of a location compromised, other locations may be affected.	Permanent loss of service or facility. Total shutdown of operations.
<b>Environment/Estate/ Infrastructure</b>	Minimal or no impact on environment/service/property.	Minor impact on environment/ service/property.	Moderate impact on environment/ service/property.	Major impact on environment/ service/property.	Catastrophic impact on environment/service/property.
<b>Health Inequalities/ Equity</b>	Minimal or no impact on attempts to reduce health inequalities/improve health equity.	Minor impact on attempts to reduce health inequalities or lack of clarity on the impact on health equity.	Lack of sufficient information to demonstrate reducing equity gap, no positive impact on health improvement or health equity.	Validated data suggests no improvement in the health of the most disadvantaged, whilst supporting the least disadvantaged, no impact on health improvement and/or equity.	Validated data demonstrates a disproportionate widening of health inequalities, or negative impact on health improvement and/or equity.

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	Frequency:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
1 Highly Unlikely: Will probably never happen/recur	Not for years	1	2	3	4	5
2 Unlikely: Do not expect it to happen/recur but it is possible	At least annually	2	4	6	8	10
3 Likely: It might happen/recur occasionally	At least monthly	3	6	9	12	15
4 Highly Likely: Will probably happen/recur, but not a persisting issue	At least weekly	4	8	12	16	20
5 Almost Certain: Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

### Annex 3 - Frequency of Risk Review

Risk Score	Review Frequency	Risk Rating
15 – 25 Red	Review monthly	High
8 – 12 Amber	Review quarterly	Medium
1 – 6 Green	Review every 6 months	Low

<b>Risk ID</b> 223	<b>The Trust's inability to reach patients in the community causing patient harm and death</b>	<b>Date of Review:</b>	13/03/2026	<b>TREND</b> ➡	<b>OVERALL</b> 20 (4x5)
		<b>Date of Next Review:</b>	13/04/2026		

<b>IF</b> significant internal and external system pressures continue	<b>THEN</b> there is a risk of an inability and/or a delay in ambulances reaching patients in the community	<b>RESULTING IN</b> patient harm and death	<b>External (LxC)</b>			<b>Internal (LxC)</b>			
			<b>Inherent</b>	TBC	TBC	TBC	TBC	TBC	TBC
			<b>Current</b>	TBC	TBC	TBC	TBC	TBC	TBC
			<b>Target</b>	TBC	TBC	TBC	TBC	TBC	TBC

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

Work has continued to contribute to the design and development of a different approach to the Trust's highest scoring risks in a way that describes the internal and external controls, assurances and gaps which have been separated into those that the Trust manages and those that it monitors.

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

Each of the assurances against the controls have been described over three lines of assurance. A future piece of work will be undertaken to score the effectiveness of these controls and assurances.

The way the data is being presented in themes and categories supports the identification of any gaps and escalations required. A more detailed action plan that supports these risks will be held at an operational level. This working draft is for discussion purposes and to highlight the direction of travel. There is still work to be done on this document.

**Risk Appetite Level – Open**

We are open to taking risks regarding changes to processes impacting the right care or advice. We understand that innovation and improvement may involve some risk, and we are prepared to embrace these opportunities to enhance our service delivery.

<b>EXECUTIVE OWNER</b>	Executive Director of Operations	<b>ASSURANCE COMMITTEE</b>	Quality, Safety and Patient Experience Committee
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**Risk Commentary**



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

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

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

<b>Risk ID</b> 223	<b>The Trust's inability to reach patients in the community causing patient harm and death</b>	<b>Date of Review:</b>	13/03/2026	<b>TREND</b> 	<b>OVERALL</b> 20 (4x5)
		<b>Date of Next Review:</b>	13/04/2026		

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

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

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

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

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

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

<b>CONTROLS</b>		<b>ASSURANCES</b>		
MONITOR – External		External <b>Monitor outcomes and provide regular reports to stakeholders. This ensures while external factors may impact the risk it is monitored and managed effectively.</b>		
1. External Handover Improvement Group (NHS Exec)	1. Established handover improvement group led by the Director of Operations, NHS Exec to address persistent delays in ambulance handovers at Emergency Departments. The groups' purpose is to coordinate improvement plans across Health Boards, monitor compliance with national guidance and facilitate audits and performance tracking through NHS Exec oversight. The introduction of 45 MR from 1 October and the efforts made by the majority of Health Boards in the proceeding months, is a welcome step. A clinically led Handover-45 taskforce has been formed and workshops hosted by the NHS Wales Performance and Improvement are ongoing to support local improvement plans.			
2. Welsh Health Circular	2. Setting national standards for 15-minute patient handover timeframe, clinical practice, quality governance and operational safety mandating actions like early warning score implementation and infection control whilst also embedding legal compliance through frameworks e.g. Duty of Quality. Outcomes are primarily overseen by the Welsh Government through a combination of national audit programmes and governance frameworks. The External Handover Improvement Group has been established consider the elements of the Welsh Health Circular.			
3. Mitigating Avoidable Harm Actions	3. Actions were developed in direct response to persisting and escalating system pressures. The avoidable harm paper outlines a strategic framework to reduce patient risk with key measures including the clinical safety plan, Immediate release protocol and governance via the Serious Clinical Incident Forum (SCIF). Outcomes are monitored through risk scores, DATIX reporting, clinical audits and patient harm indicators. Actions were developed in direct response to persisting and escalating system pressures.			
4. Sustainability of 45 MR in Cardiff and Vale, Cwm Taf and Swansea Bay	4. Performance data confirms that Cwm Taff Morgannwg are consistently meeting the 45MR target. Ongoing regular performance reviews, and exception reporting will provide continued assurance that compliance will be maintained throughout the winter period.			
MITIGATE - Internal <b>How do we know the controls are effective. How will these impact the target risk score?</b>		Internal <b>over the three lines of assurance. How do we know the assurances are effective</b> <b>Provide assurance on managing controls to ensure the Trust is doing everything in its capacity to reduce the impact of the risk</b>		
<b>Control 1 – Policies/SOPs</b> Regional Escalation Protocol, Immediate Release Protocol v.1.3 (Released August 2024), Resource Escalation Action Plan (REAP – v5.1	<b>First Line of Assurance</b> Daily conference calls (National Huddle) to agree RE levels in conjunction with health boards, weekly	<b>Second Line of Assurance</b> ODU dashboards, Performance Demand and Capacity performance metrics data and DATIX and compliance reporting to the COO's.		<b>Third Line of Assurance</b> Ministerial Advisory Group and Audit Wales investigation of Urgent and Emergency Care System Audit received June 25, actions being worked through.

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death		Date of Review:	13/03/2026	TREND	OVERALL 20 (4x5)
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released January 2025), Clinical Safety Plan (CSP – released December 2024)	Performance, Demand and Capacity meetings to review REAP levels.					
<b>Control 2 – Performance/Tactics</b> ETA Scripting, CCC Emergency Rule, Red call performance, Transfer of Care, ARA (Swansea and YGC), EMS Demand and Capacity Review.	<b>First Line of Assurance</b> Daily conference calls (National Huddle) to agree RE levels in conjunction with health boards, weekly Performance, Demand and Capacity meetings to review REAP levels. Local Business Meetings performance discussions.	<b>Second Line of Assurance</b> ETA dashboard, UHP reporting in local and business meetings. ODU dashboards, Performance Demand and Capacity performance metrics data, MIQPR (Monthly Integrated Quality and Performance Report). Patient Harm Mitigations Report (Bi-Monthly).			<b>Third Line of Assurance</b> Ministerial Advisory Group, Audit Wales investigation of Urgent and Emergency Care System Audit received June 25, actions being worked through.	
<b>Control 3 – Operational Activities</b> National Risk Huddles, Performance, Demand and Capacity meetings, WAST Serious Clinical Incident Forum (SCIF), Operational Handover Group	<b>First Line of Assurance</b> Daily Risk Huddles, Weekly Performance Demand and Capacity Meetings, Local business meetings.	<b>Second Line of Assurance</b> Patient safety highlight reports. ODU Dashboards, Performance, Demand and Capacity performance metrics, MIQPR (Monthly Integrated Quality and Performance Report). Patient Harm Mitigations Report (Bi-Monthly). Interim Medium Term Plan (IMTP)			<b>Third Line of Assurance</b> Ministerial Advisory Group, NHS Exec Handover Group, Audit Wales investigation of Urgent and Emergency Care System. Audit received June 25, actions being worked through.	
<b>Control 4 – Resources</b> 24/7 Operational Delivery Unit, Strategic, Tactical and Operational 24/7 system to manage escalation plans, APP (Advanced Paramedic Practitioner) deployment model, APP Navigation, CFR recruitment and deployment and CHARU implementation.	<b>First Line of Assurance</b> CSP review and escalation, On Call team start and end of shift, Performance, Demand and Capacity Meetings, Senior Leadership Team meetings.	<b>Second Line of Assurance</b> Shift reports, CSP review, On Call rota review, APP Dashboard, Volunteer performance highlight reporting.			<b>Third Line of Assurance</b> Ministerial Advisory Group, Audit Wales investigation of Urgent and Emergency Care System. Audit received June 25, actions being worked through.	
<b>Control 5 – Clinical Model Transformation (CMT)</b> Consult and Close (including Mental Health Practitioners), Clinical review of code sets, Remote Clinical Support, Rapid Clinical Screening, expansion of See and Treat resources.	<b>First Line of Assurance</b> CPAS, DCR and CQGG Meetings, Clinical Model Transformation Project Board. Senior Leadership Team Meetings. Performance, Demand and Capacity Meetings.	<b>Second Line of Assurance</b> Performance, Demand and Capacity metric reporting, CPAS/DCR reporting, Volunteer highlight reporting, clinical model transformation highlight report.			<b>Third Line of Assurance</b> Audit Wales investigation of Urgent and Emergency Care System. Audit received June 25, actions being worked through.	
<b>GAPS IN CONTROLS</b>		<b>GAPS IN ASSURANCE</b>				
External		External				
1. Inconsistent compliance with 15-minute handover standard by Health Boards which is inconsistent with the National standard set out by the Welsh Health Circular. Although national guidance exists, adherence is variable across sites and Health Boards, limiting WAST's ability to fully mitigate risk independently. These gaps are aligned and consistent with the gaps in Risk 224 of the Board Assurance Framework.		1. While Health Boards have developed handover improvement plans, there is currently no routine, structured mechanism for independent review or validation of their implementation, progress, or effectiveness. External Scrutiny is primarily limited to periodic updates through forums such as IQPD or JCC which may not provide consistent assurance of impact. These gaps are aligned and consistent with the gaps in Risk 224 of the Board Assurance Framework. The 45 MR initiative, once embedded across all Health Boards, will help support to address this gap.				
2. Operational pressures within Emergency Departments and inpatient areas continue to affect the ability of Health Boards to consistently adhere to the 15-minute handover expectation, despite the presence of national guidance. These		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.				

Risk ID	The Trust's inability to reach patients in the community causing patient harm and death		Date of Review:	13/03/2026	TREND	OVERALL 20 (4x5)
223			Date of Next Review:	13/04/2026	➔	
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 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	Director of Digital	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.			

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ensure patients have access to the right care at the right time?							
5. <b>Logistical arrangements for release to Respond</b>	<b>Sonia Thompson</b>		<b>Clinical logistics team have worked up an approach including costs which have been shared with Welsh government – waiting confirmation from Welsh government on if they will take the costs. Work has been done on the protocol on release to respond approach. Awaiting Welsh Government to approve governance</b>				

<b>Risk ID</b> 224	<b>Significant Handover of Care Delays Outside Accident and Emergency Departments Impacts on Access to Definitive Care Being Delayed and Affects the Trust's Ability to Provide a Safe &amp; Effective Service for Patients</b>		<b>Date of Review:</b>	02/03/2026	<b>TREND</b> ➔	<b>OVERALL</b> 25 (5x5)			
			<b>Date of Next Review:</b>	02/04/2026					
<b>IF</b> patients continue to be significantly delayed in ambulances outside Accident and Emergency Departments	<b>THEN</b> there is a continued risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised	<b>RESULTING IN</b> patients coming to significant harm and a poor patient experience	<b>External (LxC)</b>			<b>Internal (LxC)</b>			
			<b>Inherent</b>	TBC	TBC	TBC	TBC	TBC	TBC
			<b>Current</b>	TBC	TBC	TBC	TBC	TBC	TBC
			<b>Target</b>	TBC	TBC	TBC	TBC	TBC	TBC
<b>Strategic objective 1: Providing the right care or advice, in the right place, every time</b>						<b>Risk Appetite Level – Open</b> 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.			
A different approach to the Trust's highest scoring risks in a way that describes the internal and external controls, assurances and gaps which have been separated into those that the Trust manages and those that it monitors has been embedded.									
Testing separate risk scores for internal and external mitigations, to support the demonstration of the impact of actions taken is underway. This will not affect the overall score of 25 (5x5) which reflects the severity of patient harm and death.									
Each of the assurances against the controls have been described over three lines of assurance. A future piece of work will be undertaken to score the effectiveness of these controls and assurances.									
The way the data is being presented in themes and categories supports the identification of any gaps and escalations required. A more detailed action plan that supports these risks will be held at an operational level. This working draft is for discussion purposes and to highlight the direction of travel. There is still work to be done on this document.									
<b>EXECUTIVE OWNER</b>	Executive Director of Quality and Nursing		<b>ASSURANCE COMMITTEE</b>	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 680).									
<b>CONTROLS</b>				<b>ASSURANCES</b>					
MONITOR - External				External - <b>Monitor outcomes and provide regular reports to stakeholders. This ensures while external factors may impact the risk it is monitored and managed effectively.</b>					
1. <b>Welsh Health Circular WHC/2024/041: NHS Wales Hospital Handover Guidance (15-minute standard)</b> National handover standard representing an external system control, with delivery and compliance led by Health Boards.  <b>Internal Monitoring</b> Real-time oversight via ODU and Clinical Safety Plan for extended handover delays. Handover performance monitored through routine performance and quality governance reporting.				<b>External Monitoring / Assurance</b> <ul style="list-style-type: none"> <li>Oversight through Welsh Government, including Six Goals and Joint Commissioning arrangements.</li> <li>Independent scrutiny via national audit and regulatory inspection.</li> </ul>					
2. <b>Six Goals for Urgent and Emergency Care Programme</b> <ul style="list-style-type: none"> <li>National system oversight of urgent and emergency care performance, including ambulance handover.</li> </ul>				2. External performance assurance through Welsh Government oversight arrangements, including Six Goals and NHS Wales escalation frameworks.					
3. <b>NHS Wales Performance Framework 2024-25</b> External monitoring of ambulance handover performance through national performance measures.				External assurance through NHS Wales performance oversight and escalation 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:	02/03/2026	TREND		OVERALL	25 (5x5)
		Date of Next Review:	02/04/2026				
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 <b>How do we know the controls are effective. How will these impact the target risk score?</b>		Internal <b>over the three lines of 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</b>					
<b>Control 1: Policies / SOPs / Resources</b> <ul style="list-style-type: none"> <li>Regional Escalation Protocol, Immediate Release Protocol, Resource Escalation Action Plan (REAP) and Clinical Safety Plan (CSP).</li> </ul> <p>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.</p> <p>While these controls strengthen internal risk mitigation, they do not, in isolation, reduce the overall risk score, which remains dependent on external system performance.</p>	<b>First Line of Assurance (Operational)</b> Real-time operational and clinical oversight through routine escalation and application of agreed escalation and safety protocols.	<b>Second Line of Assurance (Internal Monitoring)</b> Review of handover-related risk and mitigation through internal performance and quality governance reporting, including senior operational and clinical forums.	<b>Third Line of Assurance</b> Independent scrutiny through external audit, regulatory review and national oversight arrangements.				
<b>Control 2: Clinical Guidance for staff</b> <ul style="list-style-type: none"> <li>Trust-approved clinical guidance and notices to support safe clinical decision-making for patients experiencing delayed handover.</li> </ul> <p>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.</p> <p>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.</p>	<b>First Line of Assurance (Operational)</b> Application of clinical guidance and escalation requirements within routine clinical practice.	<b>Second Line of Assurance (Internal Monitoring)</b> Review of handover-related clinical incidents, escalation and learning through internal patient safety and clinical governance reporting.	<b>Third Line of Assurance</b> External scrutiny through regulatory review and national oversight, including MAG.				
<b>Control 3: Clinical Governance mechanisms</b> <ul style="list-style-type: none"> <li>Established clinical governance mechanisms to review learning from patient safety incidents, concerns and mortality related to delayed handover.</li> </ul> <p>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.</p> <p>This control strengthens organisational learning and assurance but does not, in isolation, reduce the overall risk score, which remains dependent on wider system performance.</p>	<b>First Line of Assurance (Operational)</b> Identification and escalation of incidents, concerns and mortality cases through established patient safety processes.	<b>Second Line of Assurance (Internal Monitoring)</b> Review and oversight through clinical governance forums, including SCIF and CAG.	<b>Third Line of Assurance</b> External scrutiny through regulatory review, national oversight and Ministerial Advisory Group (MAG) arrangements.				
<b>Control 4: Implementation of Duty of Quality, Candour &amp; Quality Standards</b> <ul style="list-style-type: none"> <li>Implementation of statutory Duties of Quality and Candour through established internal quality governance arrangements.</li> </ul> <p>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</p>	<b>First Line of Assurance (Operational)</b> Identification and reporting of harm in line with statutory duties and internal quality processes.	<b>Second Line of Assurance (Internal Monitoring)</b> Oversight through internal quality and safety governance arrangements.	<b>Third Line of Assurance</b> 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.				

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:	02/03/2026	TREND		OVERALL	25 (5x5)
		Date of Next Review:	02/04/2026				
<p>accountability. It supports organisational learning and quality improvement during periods of operational pressure.</p> <p>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.</p>							
<p><b>Control 5: Clinical Model Transformation (CMT)</b></p> <ul style="list-style-type: none"> <li>Implementation of the Clinical Model Transformation (CMT) to improve clinical triage, decision-making and demand management.</li> </ul> <p>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.</p>		<p><b>First Line of Assurance (Operational)</b></p> <p>Operational delivery of the Clinical Model Transformation and associated clinical pathways.</p>	<p><b>Second Line of Assurance (Internal Monitoring)</b></p> <p>Programme oversight and performance review through established transformation, operational and quality governance arrangements.</p>	<p><b>Third Line of Assurance</b></p> <p>External scrutiny through national oversight, performance review and MAG arrangements.</p>			
<p><b>Control 6: Integrated Medium-Term Plan (IMTP)</b></p> <ul style="list-style-type: none"> <li>Alignment of IMTP 2025–27 priorities and deliverables with Corporate Risk 224.</li> </ul> <p>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.</p> <p>NEW Control – completed Action 29/12/25</p>		<p><b>First Line of Assurance (Operational)</b></p> <p>Delivery of IMTP actions aligned to agreed priorities.</p>	<p><b>Second Line of Assurance (Internal Monitoring)</b></p> <p>Oversight of IMTP delivery through established planning and performance governance (STB).</p>	<p><b>Third Line of Assurance</b></p> <p>External scrutiny through Welsh Government IMTP assurance and performance review arrangements (F&amp;PC).</p>			
<b>GAPS IN CONTROLS</b>		<b>GAPS IN ASSURANCE</b>					
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.					
<b>Actions to reduce risk score or address gaps in controls and assurances</b>		<b>Action Owner (Internal only)</b>	<b>Completion / Milestone date</b>	<b>Progress Update</b>			
1. Contribution to the development of a national joint investigation learning repository		Assistant Director of PTR	Q1 2026	Pilot completed with Cardiff and Vale UHB. Evaluation concluded (Sept 2025). National roll-out agreed and to be progressed through the Once for Wales Concerns Management Programme.			
2. Delivery and evaluation of the Clinical Model Transformation (CMT)		Assistant Director of Operations, Integrated Care	Q2 2026	Phase 1 go-live completed (July 2025). Phase 2 go-live completed (November 2025). Public communications issued. Programme delivery and evaluation ongoing. Impact on handover risk to be assessed through programme evaluation and system performance data.			
3. Audit Wales review of the urgent and emergency care system		Executive Director of Operations	May 2025 (report received); implementation ongoing	Audit Wales recommendations are being taken forward through agreed system and Trust governance arrangements, with delivery led by the Executive Director of Operations and oversight through ELT and the Board.			



**GIG**  
CYMRU  
**NHS**  
WALES

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

Agenda Item No. 18

## REPORT TITLE

Audit Tracker 25-26 Q4 (Jan-Mar26) - Exception Reporting

## MEETING

Name of meeting	Quality, Safety and Patient Experience Committee
Date of meeting	07 May 2026
Public or Private	Public
If private - <a href="#">rationale</a>	n/a

## REPORT SPONSOR

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

## PURPOSE OF REPORT

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

## EXECUTIVE SUMMARY:

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

- This paper provides the Committee with the 2025/26 quarter 4 position with respect to management actions for audits within the purview of this committee.
- The Audit Handbook notes that it is the responsibility of this committee to:
  - Receive audits in their remit;
  - Monitor management actions to address recommendations; and
  - Scrutinise impact of actions in response to audit recommendations in terms of, for example, quality improvement, the provision of more efficient and effective patient care, improved governance, better use of resources etc.



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3. The Audit Tracker has been updated in quarter 4 of 2025/26. To reduce the volume of papers presented to committee, rather than supply a copy of the tracker, the committee is provided with an audit exception report, of which this is the first version. This will provide the committee with details of high priority audit actions or audit actions from limited assurance audits, where a final revised date has been sought.
4. It is intended that exception reporting will provide committee with the information it requires to receive assurance regarding the mitigation in place to address the risks identified via internal audits, and where appropriate to levy appropriate challenge where further assurance may be needed. The content and format of the exception report will evolve as feedback is received regarding committee requirements.

### Internal Audit

5. During 2025/26 quarter 4, there were a total of 18 open internal audit recommendations relevant to the committee. Of the 18 open internal audit recommendations, six were due to be completed in quarter, and 12 were not yet due.
6. By end of quarter, one internal audit action was confirmed as completed. The action closed related to the 2024/25 Patient Experience and Community Involvement internal audit and was completed by its 2<sup>nd</sup> revised implementation date. Closure of this action concludes the agreed management actions for this internal audit.
7. During quarter 4, there was one high priority key finding on its final revised date (detailed below), but no findings related to limited assurance internal audits on their final revised dates.

Audit Ref & Description	Original Deadline	1 <sup>st</sup> Revised Date	2 <sup>nd</sup> Revised Date	3 <sup>rd</sup> Revised Date
Audit Ref: 686 [High Priority] Electronic Patient Clinical Records: Clinical Compliance Internal Audit [Action 2.2] ~ Develop tenant structure to provide data to assist identification of training needs and compliance.	30/09/2024	31/03/2025	30/09/2025	30/04/2026

In October 2025, it was reported that the clinical tenant structure was complete. The Operations Directorate had requested that the Digital Team build a structure aligned to the Duty Operations Manager (DOM) team makeup – completion of this was expected in November 2025. At that time, further work was needed on the portal frontend to allow the movement of team members – this work was anticipated to be completed by January 2026. However, at the end of quarter two, a 3<sup>rd</sup> revised date of April 2026 was assigned as an exception so that this action would be in line with the three remaining (Medium Priority) actions which are open.



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8. At the end of quarter, there were 17 remaining open actions, which are due for completion as shown below:

Year	Quarter	Period	No. Audit Action Due for Completion
2026/27	Quarter 1	April – June 2026	13
	Quarter 2	July – September 2026	4

### External Audit

9. During 2025/26 quarter 4, there 26 open external audit recommendations relevant to the Committee relating to:

- 2023/24 Quality Governance Follow Up Audit [1 action]
- 2024/25 Welsh Risk Pool (WRP) Concerns Assessment 2024 [23 actions]
- 2025/26 Structured Assessment [2 actions]

10. Of the 26 open external audit actions, 20 were due to be completed in quarter, and six were not yet due.

11. By end of quarter, 18 external audit actions were reported as completed: eight actions being confirmed as closed in quarter, and a further ten actions closed pending supply of supporting evidence. The breakdown of closed actions by external audit is provided below:

Year	External Audit	No. of Completed Actions
2023/24	Quality Governance Follow Up Review	1
2024/25	WRP Concerns Assessment 2024	17

Completion of the final open action related to the 2023/24 Quality Governance Follow Up Review concludes the agreed management actions for this external audit.

12. Of the 18 closed actions, one was completed by its original implementation date, 12 by their 1<sup>st</sup> revised date, and five by their 2<sup>nd</sup> revised date (one of which was closed earlier than planned).

13. Implementation dates have now been assigned to the four WRP Concerns Assessment 2024 actions which were previously reported as 'not set', with all now being due for completion by the end of March 2027.

14. There are currently two remaining open external audit actions on their 2<sup>nd</sup> (final) revised date:

Audit Ref & Description	Original Deadline	1 <sup>st</sup> Revised Date	2 <sup>nd</sup> Revised Date
Audit Ref: EA/2425-013	30/09/2025	31/03/2026	30/06/2026



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Welsh Risk Pool Concerns Assessment 2024 [Action 6b] ~ Undertake an options appraisal of digital action planning software to enhance organisational assurance in respect of action plan completion.			
Audit Ref: EA/2425-015 Welsh Risk Pool Concerns Assessment 2024 [Action 6c] ~ Support work plan of OfWCMS Incident Workstream to provide enhanced definitions and guidance for YCFF and ensure ambulance leaders can utilise it more confidently.	30/04/2025	31/03/2026	30/06/2026

Both of the above external audit actions have been delayed due to staff absence and lack of capacity within the Putting Things Right Team.

15. At the end of quarter, there were eight remaining open actions (six relating to the WRP Concerns Assessments 2024, and two related to the 2025 Structured Assessment), which are due for completion this financial year, as shown below:

Year	Quarter	Period	No. Audit Action Due for Completion
2026/27	Quarter 1	April – June 2026	3
	Quarter 2	July – September 2026	1
	Quarter 3	October – December 2026	0
	Quarter 4	January – March 2027	4

## RECOMMENDATION(S)

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

The Committee is requested to:

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

## ADDITIONAL PAPER(S)

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

n/a



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

### STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

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

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

### WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

### IMPACT ASSESSMENTS FOR CONSIDERATION

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

Does this paper require an impact assessment	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
If yes, what impact assessment	N/A [DPIA Checklist > DPIA not indicated]

### APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
27 April 2026	Director of Corporate Governance/Board Secretary



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Agenda Item No.

19

## REPORT TITLE

Committee Cycle of Business Monitoring Report 2026/27

## MEETING

Name of meeting	Quality Patient Experience and Safety Committee
Date of meeting	07 May 2026
Public or Private	Public
If private - <a href="#">rationale</a>	n/a

## REPORT SPONSOR

Executive sponsor	Julie Boalch, Assistant Director of Corporate Governance and Risk
Author(s) of report	Sarah Harland, Corporate Governance Officer

## PURPOSE OF REPORT

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



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## REPORT SUMMARY:

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

1. This report updates the committee on progress against its agreed cycle of business (CoB). The committee's CoB was approved by the committee in February 2026. Each meeting agenda is set by referencing the cycle, together with the forward planner, action log and highest rated principal risks.
2. The monitoring report is at Annex 1. The 'pre-agenda setting' key indicates that items in green show where these are cycled for a particular meeting. Items in beige indicate that these are a prompt at agenda setting and may be ad hoc items such as business cases or external reports.
3. The 'post-agenda setting' key indicates that 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.
4. There are no matters escalated to the committee on the monitoring report

## 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 May 2026.



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

### STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

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

### RISK(S) THIS REPORT MITIGATES

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

N/A

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

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

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

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

<input checked="" type="checkbox"/> Leadership	<input type="checkbox"/> Workforce	<input type="checkbox"/> Culture
<input checked="" type="checkbox"/> Information	<input type="checkbox"/> Learning Improvement & Research	<input type="checkbox"/> Whole Systems Approach

### WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

<input type="checkbox"/> A socially responsible and inclusive employer	<input checked="" type="checkbox"/> An innovative and sustainable organisation	<input type="checkbox"/> A pro-active, accessible and equitable care provider
<input type="checkbox"/> n/a	<input type="checkbox"/> n/a	<input type="checkbox"/> n/a

### IMPACT ASSESSMENTS FOR CONSIDERATION

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




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





### APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
n/a	n/a

PAPER	PRE C'EE FORUM	FREQUENCY	Q1	Q2	Q3	Q4	LEAD	PURPOSE	COMMENT/COMPLIANCE
<b>QUEST COMMITTEE - CYCLE OF BUSINESS MONITORING REPORT 2026/27</b>									
<b>TERMS OF REFERENCE NOTED IN RED TEXT</b>									
<b>STRATEGY DEVELOPMENT AND DELIVERY</b>									
Quality Plan aligned to Delivering Excellence 2030	CQGG/TB	Initial and cyclical review					EDQN	Approval	It was agreed at the meeting held on 03/02/2026 that the committee supported continued quarterly assurance reporting, with a planned transition towards outcome-based assurance measures as delivery matures.
Clinical Plan aligned to Delivering Excellence 2030	CQGG/TB	Initial and cyclical review					EDP	Approval	
Quality Impact Assessments	CQGG	Ad Hoc					EDQN/DP	Assurance	See Notes
TBC assurance reporting on 'what good looks like' for QUEST remit	STB	TBC					EDQN/DP	Assurance	Reporting to continue to develop from 2025/26 to 2026/27; SH Planning has confirmed this has been removed from the IMTP-SH-08/04/2026
Clinical Transformation Model Programme updates	CQGG/STB	TBC					TBC	Assurance	Placement of the update to be discussed; added in post QuEST 030226
<b>SAFE, EQUITABLE</b>									
Duty of Quality Report (to include Duty of Candour)	CQGG/TB	Annually					EDQN	Endorsement	To include IPC detail
Meds management report	CQGG	Annually					EDP	Assurance	Standalone report in Q1 on meds management (& medical devices by exception) & exception report - see Note 10
External reports	CQGG	Ad Hoc					EDQN/DP	Assurance	
HIW regulatory engagement: new engagement process (2026/27)	CQGG	Annually					EDQN	Assurance	HIW will be holding meetings with us and a desktop inspection is currently ongoing. When published we will need to take this through Committee.
Annual Mental Health Report and dementia standards report	CQGG	Annually					EDQN	Assurance	See Notes re legislative compliance reporting requirement. Regular KPIs being developed 2026/27
Annual IPC report	CQGG	Annually					EDQN	Assurance	To be received as part of the Annual Quality Report; however focus on IPC improvement plan in 26/27 (see action 10-02/26)
Annual safeguarding reports	CQGG/TB	Annually					EDQN	Assurance	Annual safeguarding report (All Wales and WAST). Quarterly metric in MIQPR on risk report data and referrals
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. Focus on PTR Recovery plan throughout 2026/27, as well as implementation of Listening to People Regulations
Near Miss and Low Harm Intelligence Report	TBC	Annually					EDQN	Assurance	Onward assurance is provided to the ARAC regarding these arrangements. This reporting was added in during 2025/26
Patient Harm Intelligence Dashboard (title tbc)	TBC	TBC					TBC	TBC	Note: 24/03/2026 wait for Julie to ascertain from Penny if this is coming in May or later
Policies for review and approval	Policy Group	Ad Hoc					BS	Approval	Board to approve PTR policy (SoRD). Note AW recommendations on PTR and Adverse Incident Policies in the 2024 quality governance review follow up
<b>EFFECTIVE, TIMELY</b>									
Clinical audit plan	CQGG/AC	Annually					EDP	Approval	QUEST report to Audit Committee that plan endorsed. See Note 9
Monitoring report on clinical audit	CQGG	Quarterly					EDP	Assurance	
Spotlight On clinical indicators	CQGG	Quarterly					EDP	Assurance	To provide more focus on clinical care (started in Q2 23/24)
MIQPR annual review of QUEST metrics	ELT	Annually					EDSPP	Approval	To review and agree Board level metrics for coming year. Note: Q1 the MIQPR has the updated metrics agreed by the board for all committees.
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
Mortality Report	CQGG	Bi-annually					EDQN	Assurance	See Note 12
Value-based healthcare report	CQGG	Annually					EDQN	Assurance	The inclusion of this is subject to the approval to the terms of reference for 2026/27.
<b>PATIENT CENTRED</b>									
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.
<b>RISK AND AUDIT</b>									
Audit recommendation tracker	ELT	Quarterly					BS	Assurance	
Audits within purview of Committee	Audit	Ad Hoc					Relevant Director	Assurance	
Board Assurance Framework	ELT	Quarterly					BS	Assurance	
Corporate Risk Register	ELT	Quarterly					BS	Assurance	
<b>SUB-GROUPS</b>									
Where applicable	N/A	Ad Hoc					N/A	N/A	No sub-committees - however may set up task and finish groups from time to time
<b>GOVERNANCE</b>									
Committee effectiveness review annual report	Audit/Board	Annually					BS	Approval	TORs provide that this is the first meeting of the year. Reports go to Audit C'ee in April and Board May
Review of Terms of Reference	Audit/Board	Annually					BS	Approval	TORs provide that this is the first meeting of the year. Reports go to Audit C'ee in April and Board May
Committee Cycle of Business annual refresh	N/A	Annually					BS	Approval	Q1: Dealt with at February 2026 meeting.
Committee Cycle of Business monthly review	N/A	Quarterly					BS	Review	Review against cycle progress at each meeting
Committee Review of Annual Priorities	N/A	Quarterly					BS	Review	
<b>PROMPTS</b>									
Operations Report	SLT	Quarterly					EDO	Information	

EDQN = Executive Director of Quality and Nursing  
EDO = Executive Director of Operations  
EDP = Executive Director of Paramedicine  
EDSPP = Executive Director Strategy, Planning and Performance  
BS = Board Secretary

**Key: Pre-agenda setting**  
 Cycled for each meeting  
 Ad hoc item - prompt for agenda setting  
 Reporting developing

**Key: Post-agenda setting**  
 Presented as cycled  
 Ad hoc / item considered - not programmed  
 Item deferred  
 Reporting developing

1	<b>Putting Things Right Report</b>	<p>Note in February 2024 Quest PTR report that future reports will move to aggregated thematic reviews to determine patterns and trends corporately and at Health Board levels.</p> <p>Audit Wales Quality Governance Review 2022 made recommendations related to quality information. The 2024 Quality Governance Follow Up Review (October 2024) re-opened previously closed recommendations as follows:</p> <ul style="list-style-type: none"> <li>- 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</li> <li>- 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.</li> <li>- 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</li> <li>- 8.4 Develop patient outcome measures to support its existing quality measures. This has been re-opened.</li> </ul> <p>Report says: We found the Trust continues to face challenges in reporting patient outcomes due to differing patient systems in place across organisations. However, there is more the Trust can and should do to triangulate and identify themes and learning.</p> <p>The Putting Things Right report summarises some of the key themes from joint investigations and incidents, but not others such as concerns or mortality reviews. However, neither report (PTR and MIQPR) provides triangulation with other information to identify broader key themes and there is limited information on what is being done to address challenges and identify and implement learning.</p> <p>05 November 2024 meeting: Discussion re reporting of low and no harm events (in relation to the near-miss report). Need to consider how best to receive / frequency.</p>
2	<b>Duty of Quality and Duty of Care</b>	<p>The 2024 Quality Governance Follow Up Review recommendations as follow:</p> <p>R4 - The Trust should take steps to increase compliance rates for duty of quality and duty of candour training to ensure staff have a good understanding of their responsibilities under the requirements</p>
3	<b>Annual Quality Report</b>	<p>H&amp;C (Q&amp;E) Act will have a requirement to publish an annual report setting out the steps taken to secure improvements in the quality of health services. WG is also required to publish an annual report on the steps they have taken to comply with the duty of quality also. Introduced for end of 23/24</p> <p>The 2024 Quality Governance Follow Up Review recommendations as follow:</p> <p>R4 - The Trust should take steps to increase compliance rates for duty of quality and duty of candour training to ensure staff have a good understanding of their responsibilities under the requirements</p>
4	<b>Annual Duty of Candour Report</b>	<p>H&amp;C(Q&amp;E) Act s.7: publish report after the end of the reporting year (s.8(1)). Duty of Candour Regulations will be developed 23/24.</p> <p>Introduced for end of 23/24. The DoC Annual report will not be a standalone annual report. Details will be presented in the Annual PTR report to prevent duplication.</p> <p>The 2024 Quality Governance Follow Up Review recommendations as follow:</p> <p>R4 - The Trust should take steps to increase compliance rates for duty of quality and duty of candour training to ensure staff have a good understanding of their responsibilities under the requirements</p>
5	<b>Dementia Standards</b>	<p>Funding requests made annually to WG for dementia programme. The All Wales Dementia Care Pathway of Standards published in 2021. WG national steering group with WAST representation.</p> <p>Reporting on compliance against the 20 dementia care pathway standards being developed in 23/24 (see Nov 22 QUEST paper for link to standards).</p>
6	<b>QIA</b>	<p>The QIA process was endorsed by QUEST. Thereafter CQGG reviews all QIAs and the Chairs of CQGG will escalate those in their professional judgment should be reviewed by QUEST.</p> <p>QUEST paper 110523 - CQGG will:</p> <ul style="list-style-type: none"> <li>(a) Be assured that there is an appropriate QIA process undertaken for all new and existing Trust wide service redesign/transformation, projects and cost improvements;</li> <li>(b) Receive oversight reports on new and existing Trust wide schemes/projects that have undergone a full QIA to ensure risk planning is robust and the impact on quality and performance is being thoroughly assessed and negative impact mitigated</li> <li>(c) Have oversight of the framework and central repository for all QIA's; initial screening and full QIA</li> <li>(d) have oversight of onward report to the Executive Management Team; Quality, Patient Experience and Safety (QuEST) Committee and; Trust Board, as appropriate.</li> </ul> <p>Reports to QuEST will identify QIAs completed and explicitly identify those that have required EMT review and authorisation.</p>
7	<b>Clinical Audit</b>	<p>Clinical audit is an important way of providing assurance about the quality and safety of services. The Trust's Clinical Audit Team provides training and support to clinical team leaders such as senior paramedics. The type of support provided by the team includes developing audit proposals, preparing and collating data (for example patient clinical records) and writing audit reports. The Trust does not have a clinical audit policy but follows an internal audit recommendation has developed a clinical audit guide and audit proposal template to support staff.</p> <p>QUEST to assure Audit Committee that clinical audit plan in place via AAA from Chair of QUEST.</p> <p>Clinical Audit Internal Audit done in 2023/24 - see recommendations</p> <p>Audit Wales Quality Governance Review Update 2024 made recommendations related to clinical audit:</p> <p>R3 - There are opportunities to further enhance reports on the Trust's Clinical Audit function, by:</p> <ul style="list-style-type: none"> <li>- 3.1 More clearly highlighting any changes made to the approved Clinical Audit Plan, and</li> <li>- 3.2 Capturing key findings, outcomes and learning from completed audits</li> </ul> <p>Report notes that whilst more recent clinical audit progress reports have provided a better summary of progress, there remains scope for reports on clinical audit to provide stronger assurance to the QuEST on its activity. The accompanying clinical audit tracker provides members with an update on recommendations arising from clinical audits, however, our review found it can be difficult to understand the key issues raised from looking only at the recommendations and progress reports do not currently highlight any findings from clinical audits. The Internal Audit review found that actions to address recommendations are monitored via relevant internal groups. However, it remains difficult for QuEST members to be assured about the outcomes of clinical audit activity, and whether learning from clinical audits is becoming embedded to improve the Trust's performance without the inclusion of further narrative within progress reports</p>
8	<b>Meds Management and Medical Devices</b>	<p>Meds management sits in the Ambulance Practice Steering Group that feeds into CQGG. It reviews compliance with controlled drugs; patient group directives (directives for registrants for prescription only drugs e.g. flu vaccine etc) which are regularly reviewed; JRCALC guidelines; meds management and controlled drugs policy; audit of controlled drugs. Standalone report will be presented to QUEST in Q4 setting this out and proposing assurance reporting.</p> <p>Any exception reporting on meds management or medical devices to Quest by exception.</p> <p>MM audit compliance in Q1</p> <p>New Meds Management Policy August 23 says at 16.6 To support the principles of antimicrobial stewardship, an annual audit of antimicrobial use by APs will be conducted and the findings reported to the Trust Ambulance Practice Steering Group, appropriate Trust Committees and where appropriate, National Antimicrobial Stewardship Forum</p>
9	<b>Mortality reviews</b>	<p>In August 2021 the Delivery Unit issued the All Wales Learning from Mortality Review Framework. The Framework is a significant shift from the Trust's previous method of undertaking Mortality Reviews. The Framework document sets out that NHS organisations in Wales should undertake Mortality Reviews in relation to requests for information from the newly formed Medical Examiners Service (MES) in Wales.</p> <p>Mortality review meetings provide a systematic approach for the peer review of patient deaths to reflect, learn and improve patient care. Mortality reviews are conducted when a patient dies whilst in the Trust's care, including whilst waiting for an ambulance to arrive. To aid learning the Trust also reviews cardiac arrests where patients have survived. A Serious Case Incident Forum scrutinises issues identified through mortality reviews. Identification of cases is via several sources including ME referral, incident reporting (internal and from system partners), HM Coroner, internal clinical reviews, clinical audit processes and horizon scanning.</p> <p>See Mortality Reviews Framework (QUEST 110523) with reporting to Quest at 7.1 and proposed to come via the Patient Safety Report with numbers of reviews, learning and actions. Oversight of the mortality review process is by CQGG at least six monthly.</p> <p>Audit Wales Quality Governance Review 2022 made recommendations related to mortality reviews. The 2024 Quality Governance Follow Up Review (October 2024) re-opened previously closed recommendations as follows:</p> <p>R3 The QuEST Committee does not receive adequate assurances on mortality reviews. The Trust should ensure the QuEST Committee receives quarterly update reports to include:</p> <ul style="list-style-type: none"> <li>- 3.1 The number of reviews undertaken, and the numbers of reviews required but not yet complete. <b>This has been re-opened.</b></li> <li>- 3.2 Any significant concerns, lessons learned and what changes have been made as a result. <b>This has been re-opened.</b></li> <li>- 3.3 Updates on actions to address the mortality review backlog. <b>This has been re-opened.</b></li> <li>- 3.4 Updates on progress implementing the all-Wales Learning from Mortality Reviews Framework. <b>This can remain closed.</b></li> </ul> <p>R4 The Trust has a significant backlog of mortality reviews. The Trust should develop an action plan to reduce the backlog, reporting progress at each QuEST meeting. <b>This has been re-opened.</b></p> <p>Report writers should refer to the 2024 follow up report which noted that whilst the Trust has implemented the new framework for mortality reviews, there is fluctuating performance relating to delivering timely mortality reviews and there is scope for more consistent reporting of mortality review activity, outcomes and learning.</p> <p>See Learning From Deaths report to QUEST 13 August 2024 for background detail.</p>
10	<b>Mental Health</b>	<p>Reporting to include compliance Mental Health Act 1983, Code of Practice, and the Mental Capacity Act 2005, DoLS etc. See consent to examination and treatment policy endorsed at ELT 130224 with monitoring through clinical audit plan and responsibilities listed.</p> <p>Mental health KPIs to be developed in 2025/26</p>
11	<b>Quality Plan</b>	<p>Audit Wales Quality Governance Review Follow Up 2024 recommendations:</p> <p>Quality Strategy</p> <p>R1 - As the Trust develops a new Quality Plan in 2024, it should ensure that delivery is achievable within the resources available. The plan should clearly detail the funding required, the risks of under-delivery (due to capacity and resource constraints) and be underpinned with an implementation plan.</p> <p>Quality Strategy monitoring</p> <p>R2 - There is scope to strengthen quality strategy implementation plan delivery reporting. To enhance clarity, the Trust should, in its progress reports:</p> <ul style="list-style-type: none"> <li>- 2.1 Provide timescales for the expected delivery of each action;</li> <li>- 2.2 Differentiate between the progress of individual actions and strategic outputs; and</li> <li>- 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]</li> </ul>