Bundle Finance and Performance OPEN 20 May 2025

Agenda attachments

ITEM 00 Agenda

0 09:30 - OPENING ITEMS

1 Chair's Welcome, Apols and Quorum

2 Declarations of Interest

ITEM 02 Board Member Register of Interests - Updated 26 March 2025

3 Minutes of the Last Meeting: 18 March 2025

ITEM 03 2025-03-18 Draft OPEN F and P Minutes

4 Action Log & Matters Arising

4.1 18 March 2025 Committee AAA Report (alerts)

ITEM 04 Action Log

ITEM 04.1 Finance and Performance Committee Highlight Report March 2025

4.1 FOR APPROVAL, ASSURANCE AND DISCUSSION

5 09:40 - Operations Update - Q4

ITEM 05 Operations Quarterly Report Q4 2024-2025 - FINAL 2

ITEM 05.1 Quarterly Sub-Report March 2025 - QS Day Outcomes FINAL

6 10:00 - Financial Reports

Item 6 Financial Report for Month 12 2024/25

NB:

To streamline meeting materials, a 'reading room' has been established in Ibabs. This digital space hosts documents for additional information, not essential for scrutiny or decision-making. Annexes 1 and 2 are available there. Access to the reading room is through the documents/shared folder in Ibabs' main menu. Documents in the reading room will not be posted on the Trust's website with committee papers; however, copies can be provided upon request

ITEM 06 Finance Report Month 12 24-25 FINAL

7 10:20 - Integrated Medium Term Plan (IMTP) Delivery/Assurance End of year report

ITEM 07 2505 - Executive Summary - IMTP Delivery & Assurance End of Year Report_v0.1

8 10:40 - Monthly Integrated Quality Performance Report

ITEM 08a Annual Review of Metrics

ITEM 08 MIQPR SBAR FPC March April 2025

ITEM 08.1 MIQPR FPC March April 2025

ITEM 08a Revised Appendix - Appendix 1 to SBAR

8.1 10:55 - COMFORT BREAK

9 11:10 - Information Governance Report

Update on the IG Toolkit

ITEM 09 Information Governance Reporting May 2025

10 11:25 - Digital Reporting

To Include update on 25/26 forward plan

ITEM 10 Digital Reporting May 2025 - Cover Paper

ITEM 10.1 Digital Reporting May 2025 - Metrics

11 11:40 - Environment, Decarbonisation and Sustainability Update - May 2025

ITEM 11 DECARB AND SUSTAINABILITY UPDATE FPC May 2025

ITEM 11.1 DECARB AND SUSTAINABILITY UPDATE FPC May 2025 - Appendix 1

12 11:50 - IA report - Energy Management - Feedback from ARAC

ITEM 12 Internal Audit Report Feedback from ARAC - Energy Management

ITEM 12.1 WAST_2425-20_Energy Management_ Final Audit Report

13 12:00 - Report on Commissioning - To Follow

14 12:15 - Risk Management and Board Assurance Framework Repor

ITEM 14 Executive Summary Risk Management Report FPC 200525

15 12:25 - Audit Tracker

ITEM 15 Exec Summary Audit Tracker to Committees - 24-25 Q4 Reporting (Jan-Mar25) - FPC 200525 (Open)

16 12:35 - Policies for approval

Information Risk Policy

ITEM 16 Policies for Committee Approval - FPC 200525

ITEM 16.1 Information Risk Policy v1.5 (030225)

17 12:40 - Feedback from Effectiveness Review, Committee Cycle of Business Monitoring Report and 2025/26 Priorities

ITEM 17 Effectiveness Review Follow Up, Committee Cycle of Business Monitoring Report and 2025-26 Priorities

ITEM 17.1 Annex 1 - FPC Menti Results 18032025

ITEM 17.2 Annex 2 - Changes to board and committee operating arrangements 2025-26

ITEM 17.3 Annex 3 Monitoring report

ITEM 17.3a Cycle Notes

17.1 12:55 - CLOSING ITEMS

18 Reflections and Summary of Decisions/Actions

19 Any Other Business

20 Date & Time of the Next Meeting: 22 July 2025

Length of Meeting:	03:30	Agenda Status:	[OPEN] FINANCE AND PERFORMANCE COMMITTEE - 20 MAY 2025						Deadline: 09/05/25
Time	**Mins allotted**	**Agendum**	**Title**	**Format**	**Item for**	**Item requested by**	**Paper prepared by**	**Item presented by**	**Colleagues to cc**
			OPENING ITEMS						
09:30	00:10	1	Chair's Welcome, Apols and Quorum	Verbal	Information	Standing	n/a	Chair	n/a
		2	Declarations of Interest	Verbal	To State Conflicts	Standing	n/a	Chair	n/a
		3	Minutes of the Last Meeting: 18 March 2025	Paper	Approval	Standing	n/a	Chair	n/a
		4	Action Log & Matters Arising	Paper	Discussion	Standing	n/a	Chair	n/a
		4.1	18 March 2025 Committee AAA Report (alerts)	Paper	Discussion	Standing	n/a	Chair	Trish Mills
			FOR APPROVAL, ASSURANCE AND DISCUSSION						
09:40	00:20	5	Operations Update - Q4	Paper	Discussion	Standing	Ops	Lee Brooks	Toni-Marie Norman
10:00	00:20	6	6 Financial Report for Month 12 2024/25 6.1 Financial Position for Month 1, 25/26	Paper Presentation	Assurance	CoB	FinCor	Chris Turley	Ed Roberts
10:20	00:20	7	Integrated Medium Term Plan (IMTP) Delivery/Assurance End of year report	Paper	Assurance	CoB	SPP	Rachel Marsh	Alex Crawford
10:40	00:15	8	8.1 Monthly Integrated Quality Performance Report Annual Review of Metrics	Paper	Assurance	CoB	SPP	Rachel Marsh	Hugh Bennett, Mark Thomas, Georgia Tizzard, Melanie O'Connor
10:55	00:15		COMFORT BREAK						
11:10	00:15	9	Information Governance Report Update on the IG Toolkit	Paper	Assurance	CoB	Digital	Jonny Sammut	Leanne Smith
11:25	00:15	10	Digital Reporting [To Include update on 25/26 forward plan]	Paper	Assurance	CoB	Digital	Jonny Sammut	Leanne Smith
11:40	00:10	11	Environment, Decarbonisation and Sustainability Update - May 2025	Paper	Assurance	CoB	FinCor	Chris Turley	Jo Williams
11:50	00:10	12	Internal Audit Report: Energy Management	Paper	Assurance	CoB	FinCor	Chris Turley [Osian Lloyd]	n/a
12:00	00:15	13	Report on Commissioning	Paper	Assurance	CoB	SPP	Rachel Marsh	Hugh Bennett
12:15	00:10	14	Risk Management and Board Assurance Framework Report	Paper	Assurance	CoB	Gov	Julie Boalch	n/a
12:25	00:10	15	Audit Tracker [FPC to proactively monitor the actions generated from the Data Quality Internal Audit (24/25) over the coming year]	Paper	Assurance	CoB	Gov	Trish Mills	Lisa Trounce
12:35	00:05	16	Policies for approval - Information Risk Policy	Paper	Approval	CoB	Gov	Julie Boalch	Lisa Trounce
12:40	00:15	17	Feedback from Effectiveness Review, Committee Cycle of Business Monitoring Report and 2025/26 Priorities	Paper	Approval	CoB	Gov	Trish Mills	Alex Payne
			CLOSING ITEMS						
12:55	00:05	18	Reflections and Summary of Decisions/Actions	Verbal	Discussion	Standing	n/a	Chair	n/a
		19	Any Other Business	Verbal	Discussion	Standing	n/a	Chair	n/a
		20	Date & Time of the Next Meeting: 22 July 2025	Verbal	Information	Standing	n/a	Chair	n/a
13:00	**03:30**		**CLOSE**						

LEAD PRESENTERS

Name	Position
Jayne Beeslee	Chair and Non-Executive Director

Julie Boalch	Assistant Director of Corporate Governance and Risk
Carl Kneeshaw	Director of People
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Trish Mills	Director of Corporate Governance/Board Secretary
Jonny Sammut	Director of Digital Services
Chris Turley	Executive Director of Finance and Corporate Resources

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Left Trust
BEAUMONT-WOOD, Rhiannon	**Non-Executive Director** * Member of the Remuneration Committee * Member of the the Audit, Risk and Assurance Committee * Member of the Quality, Patient Experience and Safety Committee	Dorset Integrated Care Board (NHS Dorset), Non-Executive Director	Financial Interest	May 2023		
		Nursing and Midwifery Council (NMC), Designated Council Member for Wales	Financial Interest	June 2024		
		RBW Executive and Professional Coaching Ltd, Company Director (Company No 14938585) and Shareholder	Financial Interest	June 2023		
		Currently on coaching framework with Health Education and Improvement Wales	Financial Interest	June 2024		
		Registered Nurse (NMC)	Non-Financial Professional	January 1995		
		Registered Specialist Community Public Health Nurse	Non-Financial Professional	September 1996		
		Member of the Royal College of Nursing	Non-Financial Professional	2007		
BEESLEE, Jayne	**Non-Executive Director** * Chair of the Finance and Performance Committee * Member of the Remuneration Committee * Member of the Academic Partnership Committee	Employment for interim assignments via Public Sector Resourcing (an agency) regarding the review of major UK government programmes (remunerated net of tax via an Umbrella Company - Danbro Employment Umbrella Ltd)	Financial Interest	01 October 2023		
		Member Representative on the UK Civil Service Pension Board	Non-Financial Personal	01 October 2019		
		Governor on the Finance & General Purposes Committee of Cardiff and Vale Further Education College	Non-Financial Personal	01 February 2024		
		Fellow Chartered Institute of Personnel & Development	Non-Financial Personal	01 April 2006		
BROOKS, Lee	**Executive Director of Operations**	Partner employed by Welsh Ambulance Services NHS Trust	Any Other Interest	July 2019		
		Member of the Order of St John	Any Other Interest	01 March 2023		
		Volunteer – St John's Ambulance Cymru	Any Other Interest	06 April 2023		
		Council Member – St John's Ambulance Cymru Gwent Council	Any Other Interest	06 April 2023		
CURRAN, Peter	**Non-Executive Director** * Chair of the Audit, Risk and Assurance Committee * Chair of the Charity Committee * Member of the Finance and Performance Committee * Member of the Remuneration Committee	Trustee of Action for Children [1097940]	Position in Charity or Voluntary Organisation	01 February 2021		
		Company Director - Action for Children [04764232]	Directorships	01 February 2021		
		Company Director - Action for Children (Wales) Ltd [10011497]	Directorships	05 April 2022		
		Trustee of National Youth Arts Wales [1170643]	Position in Charity or Voluntary Organisation	06 May 2021		
		Company Director - National Youth Arts Wales [10449512]	Directorships	06 May 2021		
		Non-Executive Director for Taff Housing	Position in Charity or Voluntary Organisation	01 May 2022		
		Company Director - Team Police Ltd [12518812]	Directorships	01 January 2022	31 October 2024	
		Independent Board Member of the Project Board - National Contemporary Art Gallery for Wales	Any Other Interest	01 January 2024		
		Interim Finance Director for Torfaen Leisure Trust	Directorships	01 September 2023	29 February 2024	
		Interim Independent Member – Kaplan International Colleges UK Ltd [05268303	Directorships	01 March 2024		
		Independent Member - Kaplan Open Learning (inc member of the Audit & Risk Committee)	Directorships	21 March 2024		
DENNIS, Colin	**Chair of Trust Board and Non-Executive Director** * Chair of Remuneration Committee	Chair - Citizen Housing [Charity] (previously WM Housing Group)	Position in Charity or Voluntary Organisation	01 January 2015		
		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		
		Company Director - North Devon Homes	Directorships	01 April 2022		
		Chair - Green Square Accord (Housing Association)	Position in Charity or Voluntary Organisation	26 March 2024		
		Company Director - LowCarbonLiving Homes Ltd [04207671]	Directorships	26 March 2024		
		Company Director - Green Square Estates Ltd [8719365]	Directorships	26 March 2024		
EVANS, Bethan	**Non-Executive Director** * Chair of Quality, Patient Experience & Safety Committee * Member of Finance & Performance Committee * Member of People & Culture Committee * Member of Remuneration Committee	Managing Director (Employed) at My Choice Healthcare Limited.	Any Other Interest	01 June 2019		
		Non-Executive Board Member at RHA (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 - Springfield (Barqoed) Limited.	Directorships	12 March 2020		
		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*		
		Company Director - Hawthorn Court Property Limited	Directorships	27 April 2022		
		[Previously called My Choice Healthcare (Three) Limited, Company name changed 12.08.2022 - #13371375]	*Directorships*	*27 April 2022*		
		Company Director - Ocean Living Property Limited	Directorships	22 July 2022		
		Company Director - Hawthorn Court Care Limited	Directorships	22 July 2022		
		Company Director - Glyncornel Property Limited	Directorships	01 July 2022		
		Company Director - My Choice Healthcare (Two) Limited	Directorships	01 July 2022		
		Company Director - Carmarthen Care Limited	Directorships	02 January 2024		
		Company Director - Towy Castle Property Limited	Directorships	01 September 2023		
HUTCHINGS, Hayley	**Non-Executive Director** * Member of the Remuneration Committee * Member of the Academic Partnership Committee * Member of the People and Culture Committee	Employed at Swansea University, Professor of Health Services Research	Financial Interest	17 June 1995		
HITCHON, Estelle	**Director of Partnerships and Engagement**	Member of Academi Wales Expert Panel	Position in Charity or Voluntary Organisation	15 July 2024		
		Independent Governor (Non-Executive Director), Coleg Sir Gar/Coleg Ceredigion	Non-Financial Personal	01 January 2025		

REGISTER OF INTERESTS FOR THE WELSH AMBULANCE SERVICES NHS TRUST **TRUST BOARD AND EXECUTIVE LEADERSHIP TEAM**

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Left Trust
JACKSON, Ceri	**Non-Executive Director & Vice Chair of the Trust Board** * Chair of the People and Culture Committee * Member of the Charity Committee * Member of Audit Committee * Member of Quality, Patient Experience & Safety Committee * Member of Remuneration Committee	Management Consultant primarily working in third sector	Interest in Companies and Securities	01 May 2019		
		Associate Director of SamKat Consulting Ltd in my capacity as self-employed management consultant	Directorships	01 June 2021		
		Charity Trustee - Stroke Association Trustee, Chair Wales Advisory Group.	Position in Charity or Voluntary Organisation	08 October 2020		
		Charitable Company - Stroke Association - Company Director	Directorships	08 October 2020		
KILLENS, Jason	**Chief Executive**	Honorary Professor - Swansea University	Personal or Departmental Sponsorship	2019		
		Chairperson – Association of Ambulance Chief Executives (AACE)	Non-Financial Professional	September 2024		
		Company Director of the Association of Ambulance Chief Executives (AACE), Co No. (07761209)	Directorships	September 2024		
		Officer of the Order of St John	Any Other Interest	January 2024		
		Member of the Order of St John	Any Other Interest	2009	2024	
KNEESHAW, Carl	**Director of People**	Chartered Fellow of Chartered Institute of Personnel and Development	Personal or Departmental Sponsorship	April 2020		
		Fellow of Institute of Leadership	Personal or Departmental Sponsorship	October 2020		
		Safeguarding Lead for local outreach charity, Brunstad Christian Church – Huntworth, Bridgwater, Somerset	Position in Charity or Voluntary Organisation	September 2018		
LEWIS, Angela	**Director of Culture Change**	Nil Declaration				
MARSH, Rachel	**Executive Director of Strategy, Planning and Performance**	Nil Declaration				
MILLS, Patricia (Trish)	**Director of Corporate Governance/ Board Secretary**	Nil Declaration				
PARRY, Hugh	**Trade Union Partner**	Nil Declaration				
ROWAN, Hannah	**Non-Executive Director** * Chair of Academic Partnership Committee * Member of Charity Committee * Member of People & Culture Committee * Member of Remuneration Committee	Director, St Martin's Associates (Business consulting and coaching)	Directorships	04 April 2022		
		Non -Executive Director Qualifications Wales (regulator for all non degree qualifications in Wales)	Any Other Interest	01 April 2021		
		Trustee MAE Cymru (Christian charity which champions gender equality in church of Wales)	Position in Charity or Voluntary Organisation	13 November 2021	November 2023	
		Elected member, The governing body of the church in Wales (Parliament of church in Wales - voting member)	Any Other Interest	01 April 2021		
		Relative (Parent) is a Non-Executive Director for Social Care Wales	Any Other Interest	01 April 2017		
SAMMUT, Jonathan (Jonny)	**Director of Digital Services [appointed 26.09.2023]**	Fellow of the British Computer Society – FBCS	Any Other Interest	04 March 2024		
		Panel Member of the UK CIO Advisory Panel – Digital Health	Any Other Interest	05 July 2023		
		Federation of Informatics Professionals - Leading Practitioner	Any Other Interest	25 April 2024		
SWINBURN, Andrew (Andy)	**Executive Director of Paramedicine**	Strategic Advisor to College of Paramedics	Any Other Interest	01 January 2020		
TURLEY, Christopher	**Executive Director of Finance and Corporate Resources**	Treasurer of Royal Gwent Hospital League of Friends.	Position in Charity or Voluntary Organisation	01 February 2022	05 November 2024	
TURNER, Damon	**Trade Union Partner**	Nil Declaration				
WILLIAMS, Liam	**Executive Director of Quality and Nursing [from 01 August 2022]**	Chair/Director - Thornbury Carnival Community Interest Company Voluntary	Position in Charity or Voluntary Organisation	01 August 2019		
		Member Royal College Nursing	Any Other Interest	01 August 2022		
		Committee member - Royal College Nursing, Nurses in Management and Leadership Forum Steering Committee	Position in Charity or Voluntary Organisation	01 August 2022		

MINUTES OF THE MEETING OF THE FINANCE AND PERFORMANCE COMMITTEE (OPEN SESSION) HELD ON 18 MARCH 2025 IN THE CARDIFF MAKE READY DEPOT AND VIA TEAMS

Meeting started at 09:30

PRESENT:

Jayne Beeslee	Non-Executive Director and Chair
Peter Curran	Non-Executive Director
Bethan Evans	Non-Executive Director (Left at item 23/25)

IN ATTENDANCE:

Hugh Bennet	Assistant Director, Commissioning and Performance
Alexander Crawford	Assistant Director of Planning and Transformation (Item 22/25 only)
Mark Harris	Assistant Director of Operations
Wendy Herbert	Assistant Director of Quality and Nursing
Estelle Hitchon	Director of Partnerships and Engagement (joined for 22/25 and 23/25)
Carl Kneeshaw	Director of People (Left at item 23/25)
Osian Lloyd	Head of Internal Audit
Rachel Marsh	Executive Director of Strategy, Planning and Performance (Item 22/25 only)
Trish Mills	Director of Corporate Governance/Board Secretary
Steve Owen	Corporate Governance Officer (Left after Item 23/25)
Hugh Parry	Trade Union Partner
Alex Payne	Corporate Governance Manager
Edward Roberts	Interim Assistant Director of Finance
Jonny Sammut	Director of Digital Services
Chris Turley	Executive Director of Finance and Corporate Resources
Damon Turner	Trade Union Partner

APOLOGIES:

Lee Brooks	Executive Director of Operations
Liam Williams	Executive Director of Quality and Nursing

14/25 PROCEDURAL MATTERS

Jayne Beeslee welcomed all to the meeting and reminded attendees that the meeting was being audio recorded. Members noted that any declarations of interest were contained within the Trust's Register of Interests.

Minutes: The minutes of the open session held on 16 January 2025 were considered by the Committee and confirmed as a correct record.

Action Log: Action number 04/25: *Further detail and clarity was sought on the context and rationale of the strategic intent and integration of the financial sustainability programme with broader strategic objectives, potentially involving Angie Lewis for historical context and alignment with the IMTP.* It was agreed an update would be provided to the Chair by Carl Kneeshaw. A meeting has now been arranged, and it was agreed that this item could be annotated as closed.

Committee Highlight report – 16 January 2025
The Committee highlight report dated 16 January 2025 was received.

RESOLVED: The

(1) Minutes of the meeting held on 16 January 2025 were confirmed as a correct record.
(2) Action log was considered and updated as described above.
(3) Committee highlight report dated 16 January 2025 was received.

15/25 COMMITTEE EFFECTIVENESS REVIEW

Trish Mills provided the committee with a PowerPoint presentation which looked at the Committee Effectiveness Review and drew attention to specific areas as follows:

It was noted that the committee terms of reference contained details of the Strategic Direction and Delivery, and that the committee oversees the long-term strategy (2030 delivering excellence) and various aligned plans, including the digital plan and vehicle procurement strategy.

Trish highlighted the importance of aligning the committee's purpose to health and care quality standards and strategic objectives. She suggested combining and reorganising the terms of reference to reduce duplication and provide clarity.

The Integrated Medium-Term Plan (IMTP) was monitored as the delivery vehicle for the strategy and plans. The committee holds a central overview of all plans, including their links and expiration dates. The commercial plan will be included due to the new head of commercial.

The finance section included monitoring against the annual plan, in-year monitoring, risks, and Welsh Government reporting. Monthly reporting and Welsh Government Monitoring reports were standard and necessary.

Trish Mills suggested attaching PIRs to the business cases that have been approved, with the understanding that there might be a period before the PIR was ready, depending on when the return on investment or the value of the investment can be seen.

Trish proposed removing the item about monitoring progress on a range of development and capital projects from the terms of reference. She suggested that large key developments over £500,000 would be monitored through the strategic transformation board governance and the IMTP.

Trish clarified that the monitoring of the capital programme would still be included in the finance section, ensuring updates on capital projects and any issues such as delays or procurement challenges.

In terms of performance, Hugh Bennett noted the importance of focusing on key performance indicators (KPIs) that were relevant and already in the Monthly Integrated Quality and Performance Report (MIQPR). He suggested instead of reviewing all external performance indicators, the committee should concentrate on the main ones that were significant. Hugh also mentioned the possibility of providing a link to the latest published AQIs (Ambulance Quality Indicators) for reference.

Trish Mills discussed the quality and performance management framework, noting its importance for the committee. She advised that the framework was being refreshed and that it was crucial for providing assurance on the value of outcomes produced. Trish also highlighted the need to monitor progress on KPIs at the board level, to avoid overwhelming the committee with too many metrics.

Jonny Sammut expressed support for the idea of moving digital discussions to a separate committee. He added that conversations around digital were becoming deeper and more frequent, with rapid changes in legislation.

Trish Mills updated the committee on the proposition which sat under the Fleet, estates and Environmental area, to consolidate these under an infrastructure section.

Members also discussed the potential for adjusting committee meeting frequency and the quorum requirement for Non-Executive Directors.

At the conclusion of the presentation Members took part in a Mentimeter quiz. Trish Mills added there was an open invitation to the chairs of the other committees to attend the 1 May ARAC meeting and welcomed any further comments the quiz.

RESOLVED: The Committee:

(1) Assessed whether the committee's remit, as outlined in the presentation and in its terms of reference, remained appropriate for 2025/26. Consideration was given to any desired amendments, additions (such as commercial/business development), or removals, as well as any areas that might be better addressed by another committee.

(2) Evaluated the cycle of business and reflected on the hallmarks of effective assurance reporting. Members proposed potential improvements to enhance the strength and efficiency of assurance processes for the committee, including any individual reports.

(3) Took part in a short Mentimeter quiz during the meeting to answer the following questions:

- **(a) What would help you as report writers/reviewers/receivers of assurance**
- **(b) What works well in this committee**
- **(c) What improvements could we make in this committee**

(4) Reviewed the draft Annual Report and provided any comments ahead of it being finalised and circulated for email approval by Chair's Action.

16/25 FINANCIAL POSITION FOR MONTH TEN AND MONTH ELEVEN 2024/25

Chris Turley gave a presentation on the financial position of the Trust as at month Eleven.

1. The financial position has been broadly stable for several months, with a forecast to land at a break-even position. The Trust was reporting a small revenue surplus £42K for month 10. In line with the financial plans that support the Integrated Medium Term Plan (IMTP), gross savings of £5.924m have been achieved in month 10 against a target of £5.531m.

2. Month 11 was a continued reported revenue underspend against budget of £0.042m In line with the financial savings plans that supported the IMTP.

3. Gross savings of £6.317m have been achieved against a year-to-date target of £5.975m (these included income generation schemes) hence an over achievement of £0.342m. The capital programme continued to be closely monitored as the Trust moved towards the end of the financial year, with a focus on ensuring minimal variation against the Welsh Government set Capital Expenditure Limit (CEL) by the end of the month / year end.

4. The financial risks for the current year have been managed effectively, with no significant risks remaining for the next two weeks. The Trust was confident in its ability to manage any remaining risks and achieve the break-even position.

Peter Curran queried, in terms of the year-end accounting, particularly regarding depreciation, whether there would be any actions taken to accelerate depreciation that would impact the budget either positively or negatively. Chris Turley explained that the depreciation estimates assumed that the full capital allocation will be spent within the year. While there were slight changes in what the capital was being spent on, these changes do not significantly affect the asset lines compared to previous estimates.

RESOLVED: That the Finance and Performance Committee:

(1) Noted and gained assurance in relation to the Month 10 revenue financial position and performance of the Trust as at 31 January 2025.
(2) Noted the delivery of the 2024/25 savings plan, and the context of this within the overall financial position of the Trust.
(3) Noted the brief capital programme update for 2024/25, and
(4) Noted the Month 10 Welsh Government (WG) monitoring returns submission included within *Appendices 1 – 2* (as required by WG).

17/25 INTEGRATED MEDIUM TERM PLAN DELIVERY/ASSURANCE - PROGRESS UPDATE 2024/27

Hugh Bennett explained the report was the interim Q4 2024/25 position. He provided an update on the Integrated Medium Term Plan (IMTP) delivery and assurance, focusing on the following points:

1. The update covered the clinical model transformation programme, progress on other IMTP deliverables, and the Cabinet Secretary's priorities.
2. The assessment of IMTP deliverables was both quantitative and qualitative, using a traffic light system used for assessment which included additional indicators like yellow for cautionary and blue for complete.

Hugh highlighted there were no red indicators, but Remote Integrated Care was marked as yellow (cautionary) due to capacity issues.

1. Health Transport: This was marked as cautionary, needing a more strategic vision from Commissioners and the addressing of capacity management.
2. Change Management: Marked as cautionary due to concerns about the volume and work and the pace of change which was significant.
3. Excellent Clinical Leadership: Marked as cautionary or amber, reflecting the need for associated clinical supervision to catch up with changes.
4. Non Emergency Patient Transport Services (NEPTS) Re-Rostering: This was marked as amber, indicating significant change for 450 staff, with potential for increased patient journeys but facing engagement issues.
5. Discharge and Transfer Service: Marked as amber due to lack of traction with Health Boards. Hugh highlighted the need for a more coordinated and standardised national discharge and transfer service in Wales, rather than having fragmented services.
6. Consultant Connect: This required more prioritisation due to the pace of change in integrated care.

7. Quality Improvement Hub: This had been delayed due to funding but was expected to be complete next year.

8. Civica: The Trust was progressing with the requirement for a data protection assessment.

9. Income Generation: This had been delayed due to unsuccessful appointment of the Head of Commercial position.

10. Strategic Board Assurance Framework (BAF): This was annotated as cautionary but was expected to be completed in the current quarter.

The significant drop in 111 patient survey data was raised by the committee given satisfaction levels have dropped from 88% to 49% and further detail was requested as to the reasons. It was agreed that Hugh Bennett would investigate further and provide details at the next meeting.

The challenges in recruiting to the Head of Commercial position were discussed, with the job description now undergoing a review with plans to re-advertise in the coming weeks.

The committee held a discussion in terms of staff morale and concerns were raised about the pace and change fatigue and the impact of that on staff. Members noted that the changes have introduced new ways of working and emphasised the need to ensure staff well-being and manage the pace of change. In response to the discussion and concerns regarding the impact of the pace of changes over the last year to staff it was agreed to refer to the People and Culture Committee (PCC) to seek assurance on the ways in which morale, wellbeing and support are a focus in the change management programmes in place to support delivery of the IMTP and provide an update back to the FPC.

In terms of the NEPTS roster review Mark Harris outlined significant changes were being implemented which will require extensive engagement work to guide people through these changes.

RESOLVED: The Committee:

(1) Noted the progress in identifying 'what good looks like' through the continuing development of high level outcomes measures.
(2) Noted the CMT programme progress update.
(3) Noted the confirmed Directorate-led IMTP interim position for Q4.
(4) Noted the update against the Cabinet Secretary's priorities set out in the 2024-27 planning framework.

18/25 QUALITY AND PERFORMANCE MANAGEMENT FRAMEWORK – REFRESH

Hugh Bennett provided an overview of the Quality and Performance Management Framework (QPMF) refresh report, highlighting the following key points:

1. The framework was evolving rather than undergoing a complete overhaul, as the current framework sets a high standard.
2. The previous internal audit provided reasonable assurance on the framework but limited assurance on delivery, primarily due to capacity issues within the team. The focus now was on completing what has been started.
3. Organisationally, the top of the organisation was strong in terms of assurance mechanisms, but there was variation in practice across directorates.
4. The framework emphasises self-assessment and reflective practice, allowing directorates to determine what they need to do based on organisational requirements.
5. The framework supports the statutory Duty of Quality, serving as the quality policy of the Trust.
6. A new organisational requirement has been added to strengthen evaluation processes

Bethan Evans expressed her support for the QPMF, welcoming the stronger focus on quality, which was crucial for evidencing the Duty of Quality.

Trish Mills added that the Quality and Performance Management Steering Group reported into the Executive Leadership Team.

The committee were content to endorse the QPMF for Board approval.

RESOLVED: The Finance and Performance Committee endorsed the re-fresh of the Quality and Performance Management Framework for Board approval:

19/25 MONTHLY INTEGRATED QUALITY PERFORMANCE REPORT

Hugh Bennett presented the report and drew out the following key points:

1. Call Abandonment Rate for 111: The rate was 14.8% in December, higher than the target of 5%, but better than previous winters. It stabilised at 8.2% in January and 10.1% in February.

2. P1 Times: Performance was very good, but P2 and P3 times have dipped due to increased demand deflected to clinicians linked to changes in the 999 system.

3. Call Handling 999: This was generally stable, but the 95th percentile was over one minute in December and 33 seconds in February.

4. Red Performance: The recent announcement by the Cabinet Secretary was the main corrective action, and future categorisation of clinical response models will be considered.

5. Clinical Indicators: Good performance on clinical bundles, but stroke call-to-door times were too long. Harm levels remained high, and patient cancellations were dropping due to early intervention by clinical navigators.

6. National Reportable Incidents (NRIs) / Concerns Response: the Trust reported six NRI's to the NHS Executive in January 2025, slightly more than December 2024 (three) and

25 serious patient safety incidents were referred to Health Boards under the Joint Investigation Framework.

7. In February 2025, 5,342 patients cancelled their ambulance (this figure excludes patients who refused treatment), and the Trust was unable to send an ambulance due to the application of the Clinical Safety Plan to approximately 63 callers. Both of these figures were a significant reduction in December 2024 and January 2025 levels.

8. Hours Produced: The Trust produced 127,833 Ambulance Response unit hours in January 2025 and delivered an emergency ambulance unit hours production (UHP) of 97%, achieving the 95% target.

9. Concerns: This was stable at 73% in January and 64% in February, which was good given the winter context.

10. Production and Abstractions: There was good production and low abstractions through winter, but handover issues were affecting overall performance.

11. Sickness Absence: the Trust's overall sickness percentage was 8.46% in January 2025, a decrease on the 8.69% recorded in December 2024. Actions within the IMTP concentrate on staff well-being with an aim to continue to reduce this level supported by the ten-point plan. The 8% is above the 2023/24 IMTP ambition of 6%.

12. Cymru High Acuity response (CHARU): The Trust achieved a 91% CHARU Unit Hours Production (UHP) in February 2025 and is now seeking to close the remain gap through the recruitment of fully qualified paramedics.

Peter Curran questioned why the metric "average jobs per shift" was positioned under the value category as opposed to the partnership system contribution category. Hugh explained that it was under that category as it was connected to the handover delays.

RESOLVED: The committee received the December 2024/January 2025 update and the unverified December 2024 Integrated Quality and Performance Report and noted that it provided sufficient assurance for the committee against progress against the performance indicators.

20/25 DIGITAL REPORTING

Jonny Sammut updated the committee on the following areas:

1. The Clinical Model Transformation programme requires significant input from various Digital teams. These requirements were not known at the time of writing of the Digital Plan and so many of the pre-agreed priorities and timelines for 24/25 were now paused or at risk.
2. Recruitment has been successful, with new posts filled in the Information and Data Services team and ICT team, including senior posts.
3. Progress on the digital transformation and innovation programme was going well, with the creation of an innovation lab to foster digital ideas and problem-solving.

4. Uptime measures for systems have been near perfect, achieving 99.999% uptime, which translated to less than 40 minutes of downtime across the year.
5. The Information and Data Services team continue to face high demand, with turnaround times now around 30 days.
6. The Non Emergency Patient Transport Services (NEPTS) cancellation two-way SMS functionality has been launched, allowing patients to cancel and rearrange appointments via text message.

Jonny also mentioned specific progress on IMTP projects, including the purchase of drones and the completion of scoping work for the Infection, Prevention and Control audit tool.

Trish Mills discussed the presentation of information in reports, specifically highlighting the new format that included highlights, low lights, and red flags.

The responses were positive, with committee members indicating that the format was effective and helpful., and the consensus was that the structured format was beneficial for quickly assimilating information and identifying key points.

RESOLVED: The committee noted the contents of the Digital Report and the trends in metrics presented.

21/25 INFORMATION GOVERNANCE REPORTING

Jonny Sammut presented the report and drew the committee's attention the following points:

1. Information Governance (IG) mandatory training was below the new 85% target, with around 340 people needed to meet this requirement. This shortfall may impact future research participation due to non-compliance with IG toolkit standards.
2. The Trust has recently recruited to the full-time Data Protection Officer role, with an existing member of staff having been appointed. Additionally, the Head of Compliance and Assurance role has been filled internally to bolster freedom of information responses.
3. The Information Governance Toolkit improvement plan was progressing with all items having been achieved save for the mandatory training target.
4. In terms of records management, the Trust was working to migrate paper records held by Denbighshire Country Council to Vantage Point House in Cwmbran.

In terms of Freedom of Information (FoI) compliance rates Trish Mills outlined the challenges involved meeting the required target, as one request could contain several other questions within it and may also require cross directorate engagement.

Damon Turner asked if there were any trends or specific areas where the compliance with the information governance training was lacking. Jonny explained that the IG training compliance issue was primarily within the operations department, which has the highest volume of staff. He mentioned that the training course was initially on the Electronic Staff register (ESR)

platform, which had feedback about the time it took to complete. To address this, the course was moved to the LMS365 platform for a quicker completion process.

RESOLVED: The committee noted the update on information governance for the period December 2024 to February 2025.

22/25 IMTP 2025/28 INCLUDING FINANCIAL PLAN FOR 2025/26

Rachel Marsh gave the committee a PowerPoint presentation and drew their attention to the following areas:

1. It was important to ensure the plan aligned with the long-term strategy of the Trust.
2. There was a need for the plan to be ambitious yet deliverable, considering the Trust's capacity and resources.
3. In terms of the Financial Plan, Rachel stressed the importance of having a credible and sustainable financial plan underpinning the IMTP.
4. The plan should appropriately account for patient outcomes and staff well-being, ensuring that both were prioritised.
5. Rachel mentioned the need for the plan to address risks appropriately, ensuring that potential challenges were identified and mitigated.
6. There were key differences and innovations in the plan this year due to the implementation of several major initiatives, such as the clinical model transformation programme, the development of a new vision for health transport and ambulance care services, and the introduction of virtual assistants and symptom checkers for digital advice.
7. Rachel highlighted the importance of engaging with stakeholders, including the public, Health Boards, and staff, to ensure the plan was comprehensive and inclusive.
8. Rachel also introduced a visual representation of metrics to measure progress towards strategic objectives, focusing on patient care and staff well-being.
9. In the next few months, a vision statement and business case will be finalised and agreed upon with WG and Commissioners. Starting on 1 July 2025, a new system for measuring emergency response will be implemented. This system will focus on "purple arrest" and "red emergency" categories.
10. By the end of this year, a single integrated team of remote clinicians will be established. This team will be supported by a larger number of Community Welfare Responders and enhanced by remote monitoring and technological capabilities.
11. There will be a continued investment, albeit at a reduced rate compared to previous years, in various alternative on-scene response options such as Advanced Paramedic Practitioners, palliative care, mental health services, and falls.

12. In terms of our people, work was focussed around three main areas: culture, capacity, and capability. One of the key priorities included the WAST way, which was the leadership and management development framework with the aim of developing and enabling leaders in every part of the Trust to work better with their teams.

13. A new handover group, clinically led, was being established to quickly identify and implement actions to reduce handover delays.

In summary, Rachel concluded that the plan was ambitious and aimed for significant transformation, but it was not without risks, particularly financial and collaborative challenges. The plan itself was very clear on what was currently assumed as income and funding to support the Trust's estimated expenditure in 2025/26 and what savings were currently required and assessed as being deliverable.

The risk that further savings may be required in year by the Joint Commissioning Committee (JCC) was discussed in some detail, both in relation to the timing of the request and the potential impact on service delivery, patient safety, and performance.

Bethan Evans expressed strong support for the plan, describing it as ambitious and potentially transformational. She acknowledged the substantial risks involved, particularly the significant efficiency targets of £8.5 million. Rachel acknowledged that while there was increased emphasis from the Cabinet Secretary, WG officials, NHS executive officials, and NHS leadership board, she remained slightly anxious about the outcomes.

Peter Curran expressed concerns about the ambitious nature of the IMTP 25-28 plan, highlighting the substantial efficiency targets of £8.5 million. Rachel added that while the current plan remained as is, any further savings or income reductions would require Board discussions to understand risks and implications before making decisions.

Financial Plan for 2025/26

Chris Turley updated the committee on the following points:

1. The financial plan included a 1.77% uplift from the Health Board's allocation, amounting to approximately £5.2 million. This does not cover the full-year effect of everything put in place this year, including the EMT band 5 impacts.

2. The plan required significant savings, with an £8.5 million savings target necessary to achieve a break-even position. There was confidence in delivering around £6.5 million of the required savings, with ongoing work to identify the remaining £2 million.

3. The plan includes detailed estimates of cost and income movements, inflationary pressures, and other cost pressures for the next year.

4. There was a risk associated with the JCC's financial position, which may require further savings discussions.

Chris highlighted that any further savings or income reduction would need to be discussed and agreed upon by the Trust Board, considering the implications and risks involved.

Chris Turley explained that the financial plan presented was balanced, but it did not include any additional savings beyond the current stretched value of £8.5 million. Chris stated that it was highly unlikely that anything beyond the current plan will be achievable in 2025-2026 without significant impacts on resources, capacity, service delivery, patient safety, and performance.

Jayne Beeslee acknowledged the significant efforts of the Executive Leadership Team and other teams in developing the plan. Additionally, she stressed the importance of the revenue budget, and the assumptions made, particularly those dependent on Welsh Government funding.

Trish Mills stressed the importance of the Equality Impact Assessment (EQIA) that accompanied the IMTP. She noted that it was a crucial part of the Board's role to review and consider the EQIA when approving the IMTP.

RESOLVED: The Committee:

(1) Noted the progress made in developing this year's IMTP.
(2) Advised of any further assurance required during the final stages of the planning cycle.
(3) Endorsed the IMTP, including the financial plan for 2025/26 for submission to Trust Board for approval at its meeting on 27 March 2025, subject to any final editing.
(4) Endorsed the EQIA for the Board's review.

23/25 WELLBEING OBJECTIVES

Estelle Hitchon provided an overview of the well-being objectives, noting their long-term nature and alignment with the ethos of the Well-being of Future Generations Act. She mentioned that the objectives were designed to reflect the Trust's contribution to the act's goals. The revised wellbeing objective were as follows:

Objective One: A Socially Responsible and Inclusive Employer

Objective Two: An Innovative and Sustainable Organisation

Objective Three: A Pro-active, Accessible and Equitable Care Provider

Estelle highlighted the Trust's proactive approach, noting that they have been working in the spirit of the act since its inception in 2015. She also mentioned the establishment of a task and finish group involving colleagues and Trade Union partners to develop these objectives.

The committee endorsed the proposed revised objectives, with Estelle adding that the objectives need to be published by 31 March 2025.

RESOLVED: The Committee:

(1) Noted the process of setting the wellbeing objectives, including the feedback received through the process of staff and public engagement and the response made to that feedback.

(2) Endorsed the proposed revised objectives (subject to any additional feedback and amendment) for onward submission to the Board at its March 27, 2025 meeting and thereafter, subject to agreement, their publication by March 31, 2025.

24/25 INITIAL 2025/26 REVENUE BUDGET

Chris Turley presented the initial 2025/26 Revenue Budget Setting Paper and drew attention to the following areas:

1. The budget was based on the financial plan, which included an £8.5 million savings requirement to achieve a balanced budget. This budget will be set assuming the delivery of these savings, even though the final £2 million was still being worked on.
2. The budget included assumptions for the cost of the pay award in 2025-2026 and the additional National Insurance (NI) employers' costs from April 2025, which were expected to be funded by Welsh Government. The NI uplift has been included in the budget with an assumed income stream to support it.
3. The budget reflected the need to balance the financial plan, with detailed breakdowns provided for divisional and directorate budgets. Discussions with individual directors will take place in Q1 to finalise these budgets.

Chris added that the budget was presented as balanced, but there were risks and assumptions that need to be managed throughout the year. The committee endorsed the budget paper for approval by the Board on 27 March 2025.

RESOLVED: Members endorsed the initial 2025/26 revenue budget, building on the WAST Financial Plan included in the IMTP and recommended it for onward approval at Trust Board on 27 March 2025.

25/25 INTERNAL AUDIT REPORT: VEHICLE ACCIDENT MANAGEMENT

The vehicle accident management internal audit was presented. This limited assurance report was discussed at length at the Audit, Risk and Assurance Committee (ARAC) on 6 March, with both this committee and ARAC assured that the actions proposed were reasonable.

1. The audit was initially scoped to review vehicle accident management from a financial sustainability perspective but was expanded to include operational aspects.
2. The audit resulted in a limited assurance rating, primarily due to issues in the operations directorate related to the reporting and management of vehicle accidents.

3. It was found that the cost of vehicle accidents to the Trust was low, and the Trust was better positioned to defend claims due to the use of cameras and GPS tracking.

4. The limited assurance was mainly due to the lack of reporting of incidents when they occur and the identification of damage during routine maintenance or inspections.

5. Management actions have been agreed to address the findings, with a focus on improving reporting and management processes.

26/25 AUDIT TRACKER

The Q3 audit tracker was produced with no escalations reported. Those committee related actions on their third and final date were discussed at ARAC in November 2024 and March 2025 and should be closed in Q4.

The report noted that nearly 70 actions were due this quarter, and new reporting practices have been agreed upon to streamline the process.

A discussion was planned with ELT to consider whether to have two dates instead of three for action closures.

RESOLVED: The Committee:

(1) Received the Finance and Performance Committee extract of the Audit Tracker reporting the position at of 27 December 2024; and

(2) Monitored management actions to address recommendations in the Audit Tracker, and associated updates provided, noting any revised dates for actions (in blue).

27/25 RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK REPORT

Trish Mills provided an overview of the risk management report, noting the following points:

1. The cyber risk has been moved to the closed session due to the need for expanded actions and confidentiality.

2. All risks have undergone their quarterly review, with no changes in score except for the cyber risk.

3. There were discussions about potentially reducing the number of dates for risk actions from three to two, which will be taken to the ELT for further consideration.

4. Trish suggested that the two major risks, 223 and 224, which have been brought into multiple committees, might no longer need to be reviewed by this committee and the People and Culture Committee, as the Board and the Audit, Risk and Assurance Committee (ARAC) already cover them extensively.

Trish emphasised the importance of focusing on the risks relevant to this committee and considering the strategic Board Assurance Framework in future reviews.

The committee decided that risks 223 and 224, which were currently reviewed by the Board ARAC, will no longer be brought to this committee. This decision was made to avoid duplication and ensure that the committee focused on risks directly relevant to its scope.

Damon Turner suggested that it might be useful to have some staff, particularly Trade Union (TU) input, on the scoring of risks. Trish Mills explained that the risk management process was executive-owned and underwent executive oversight through, the Assistant Directors Leadership Team (ADLT), and ELT before reaching committees where TU colleagues could raise concerns.

Wendy Herbert noted the relevance of risks 223 and 224 to the FPC; while these risks were well-rehearsed in the Quest committee, there was a performance risk associated with them due to patient harm and safety elements resulting from handover delays.

RESOLVED: The Committee noted the contents of the report.

28/25 COMMITTEE PRIORITIES AND CYCLE MONITORING REPORT

Members received the Committee Cycle of Business Monitoring Report and Committee Priorities update with no escalations for the Board. It was noted that the Value Based Healthcare item had been deferred for a second time to the May meeting of the committee.

RESOLVED: The Committee received the report.

29/25 REFLECTION: SUMMARY OF DECISIONS AND ACTIONS

Members reflected that the agenda and business was managed well, with sufficient time for each item which ensured comprehensive discussions. There was a focus on quality of information which provides good assurance. Additionally, members acknowledged the need to focus the committee's attention on relevant risks and minimising duplication where business was received at other committees.

Meeting concluded at 14:20

Date of Next Meeting: 20 May 2025

ACTION LOG - CURRENT
FINANCE AND PERFORMANCE COMMITTEE

Action	Date	Agenda Item	Action Note	Responsible	Due Date	Progress/Comment	Status
17/25	18 March 2025	IMTP DELIVERY/ASSURANCE - PROGRESS UPDATE 2024/27	In response to the discussion and concerns regarding the impact of the pace of changes over the last year to staff it was agreed to refer to the People and Culture Committee (PCC) to seek assurance on the ways in which morale, wellbeing and support are a focus in the change management programmes in place to support delivery of the IMTP and provide an update back to the FPC.	Carl Kneeshaw	20 May 2025	Update for 20 May meeting Update has been given to PCC on 15 May by Carl Kneeshaw - We are actively working to embed the principles of effective change management throughout WAST. We recognise that meaningful and sustainable change can only happen when people are brought on the journey and feel supported throughout; wellbeing is a central thread in this work and we are aligning our efforts with our Health and Wellbeing Plan and the emphasis on listening through mechanisms such as Speaking Up Safely. We're also working to ensure that leaders and managers are equipped with the skills and confidence they need to support their teams effectively, including in relation to change, having meaningful, regular 1-1s and crucial conversations, supported through Our WAST Way leadership development framework and the Managers' Essentials programme. Change management capability is intentionally woven throughout Our WAST Way, reinforcing that these are core leadership skills as opposed to additional / separate skills. To help embed these principles more widely, we've established a Change Community made up of colleagues from across the organisation, all of whom have completed accredited change management training. This network is helping to embed change principles at every level, effectively supporting change and building momentum "from within". In larger programmes such as the Clinical Model Transformation CMT programme, we've introduced dedicated Change Leads within each workstream to maintain focus on the people aspects of change (including wellbeing and engagement), offer practical tools and support and bring a structured change lens to delivery. This work is closely aligned with our wider organisational efforts, including our response to the staff survey and our commitment to the three themes of the Our WAST Way leadership and management development framework (Care, Connect, Value Everyone). Any further updates will be provided post PCC meeting. This action is proposed for closure.	Complete
18/25	18 March 2025	IMTP DELIVERY/ASSURANCE - PROGRESS UPDATE 2024/27	It was recognised that in respect of NHS 111 call back times, P2 and P3 performance has dropped away and Hugh Bennett explained it may be due to the amount of deflection that was coming through from the remote clinical screenings which may be a factor. He agreed to investigate this matter further and update the Committee on his findings.	Hugh Bennett	20 May 2025	Update for 20 May meeting The method of calculating P1 to P3 has changed (linked to new system) with the triage now starting only when the patient answers the call back. Prior to the new CAD clock stop was the time we tried to contact the patient.	Complete

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

FINANCE AND PERFORMANCE 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 these meetings can be found by following this link to the Committee page on the Trust website.

Trust Board Meeting Date	27 March 2025
Committee Meeting Date	18 March 2025
Chair	Jayne Beeslee

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. **The Integrated Medium Term Plan (IMTP) for 2025-28** and the **financial plan for 2025/26** was received and endorsed for board approval. Members reviewed the plan with the following considerations in mind:
    - Alignment with the long term strategy
    - Balance of ambition with delivery
    - Underpinned by a credible, sustainable and deliverable financial plan
    - Takes appropriate account of patient outcomes and workforce wellbeing
    - Identifies and mitigates risk
    - Shows appropriate engagement with stakeholders

2. The plan is ambitious and aims for significant transformation, but it is not without risks, particularly financial and collaborative challenges. The financial plan includes an £8.5 million savings requirement, which is considered stretched but achievable. The plan itself is very clear on what is currently assumed as income and funding to support the Trust's estimated expenditure in 2025/26 and what savings are currently required and assessed as being deliverable, in order for the Trust to delivery on its statutory duty to breakeven. The risk that further savings may be required in year by the Joint Commissioning Committee was discussed in some detail, both in relation to the timing of the request and the potential impact on service delivery, patient safety, and performance..

3. Notwithstanding this, the committee were assured on the considerations set out above, and that the planning process was robust, particularly around prioritisation and consequent funding, and that there is close collaboration with health partners to achieve our goals. The Equality Impact Assessment (EqIA) did not indicate adverse impacts of our plan on protected characteristics, however there are some areas of improvement for those areas of 'neutral impact' which will be monitored by the executive.

4. The IMTP and financial plan for 2025/26 is before the board today and will be submitted to Welsh Government following board's approval on 27 March.

5. The Wellbeing of Future Generations Act (WBFGA) has applied to WAST since 30 June 2024. The aim of the Act is to ensure that public bodies across Wales are working together to ensure that Wales develops as a prosperous, culturally rich, economically vibrant, healthy and well educated country, where people can thrive both at work, and at home. The Trust's **Wellbeing Objectives** have been developed in partnership with trade union colleagues and internal and external engagement. The wellbeing objectives were endorsed by the committee and are before the board for approval on 27 March.

6. **Initial 2025/26 Revenue Budget Setting Paper** was received. The issues and risks were discussed, some of which are set out above, and the initial divisional budget breakdowns reviewed. The budget paper was endorsed by the committee for approval by the board on 27 March.

7. The Trust is still not achieving the 85% **information governance training compliance** requirement that it must meet by 31 March to meet minimum standards on the Information Governance Toolkit. There are several consequences of non-compliance: firstly, the organisation will be seen as non-compliant by Welsh Government and Information Commissioner's Office with possible enforcement action, there is also a risk of the UK's Confidentiality Advisory Group denying research requests (as articulated in the BAF Risk 623); secondly, individual staff who are non-compliant will be in breach of the Data Protection Policy and employment T&Cs.

8. The **vehicle accident management internal audit** was presented. This limited assurance report was discussed at length at the Audit, Risk and Assurance Committee (ARAC) on 6 March, with both this committee and ARAC assured that the actions proposed were reasonable.

ADVISE

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

9. The **Quality and Performance Management Framework (QPMF) refresh** was endorsed by the committee and recommended for approval by the Trust Board. Members heard that the framework is an 'evolution rather than a revolution', as the current framework sets a high standard. A recent internal audit on the QPMF provided reasonable assurance overall. The committee were assured that, organisationally, the framework is strong in terms of assurance mechanisms, but there is variation in practice across directorates. The goal is to reduce this variation, and the Executive Leadership Team oversee the work of the steering group in this regard. The framework supports the statutory Duty of Quality, serving as the quality policy of the organisation.

10. Members **reflected** that the agenda and business was managed well, with sufficient time for each item which ensured comprehensive discussions. There was a focus on quality of information which provides good assurance. Additionally, members acknowledged the need to focus the committee's attention on relevant risks and minimising duplication where business is received at other committees.

ASSURE

(Detail here assurance items the Committee receives)

The following items will also be presented to board at their 27 March meeting however members may benefit from the following points of discussion from the committee:

Financial Position for Months 10 and 11 2024/25

11. The financial position has been broadly stable for several months, with a forecast to land at a break-even position. The Trust is reporting a small revenue surplus £42K for month 10. In line with the financial plans that support the IMTP, gross savings of £5.924m have been achieved in month 10 against a target of £5.531m.

12. Month 11 is a continued reported revenue underspend against budget of £0.042m.. In line with the financial savings plans that support the IMTP, gross savings of £6.317m have been achieved against a year-to-date target of £5.975m (these including income generation schemes) hence an over achievement of £0.342m. The capital programme continues to be closely monitored as we move towards the end of the financial year, with a focus on ensuring minimal variation against the WG set CEL by the end of the month / year end.

13. The financial risks for the current year have been managed effectively, with no significant risks remaining for the next two weeks. The organisation is confident in its ability to manage any remaining risks and achieve the break-even position. Overall, the position is stable with a forecast to achieve break-even by the end of the financial year.

Monthly Integrated Quality and Performance Report (MIQPR) for January/February 2025.

14. The board will receive the MIQPR at its March meeting, however of note: there are some early signs of improvements in the indicators as a result of the CMT programme, but handover lost hours went up, despite lower conveyance levels. The committee noted the remedial actions in place where necessary.

Integrated Medium Term Plan (IMTP) Delivery and Assurance Report

15. This report was the interim Q4 2024/25 position. The Board will receive the assurance report at its March meeting, however the committee noted:

- The volume of work and the pace of change is significant. Concerns were raised about this pace and change fatigue and the impact of that on our people. This has now been referred to the People and Culture Committee to review in more detail.
- The significant drop in 111 patient survey data was raised given satisfaction levels have dropped from 88% to 49% and further detail was requested as to the reasons.
- The Non-Emergency Patient Transport Service (NEPTS) re-rostering was discussed, with the committee hearing of the potential benefits (rosters have not been changed for many years), but also the challenges with engagement and implementation.
- The challenges in recruiting to the Head of Commercial position were discussed, with the job description now undergoing a review and with plans to re-advertise the post in the coming weeks.

The following items were only presented to this committee and assurance is provided to the board as follows:

16. The **Digital KPIs** relating to data and analytics, ICT systems, digital services, projects & programmes, and progress against the recently refreshed Digital Plan were presented. Of note:

    - The Clinical Model Transformation programme requires significant input from various Digital teams – including those supporting on changes to CAD or other systems, DOS updates, and data, reporting and analytics for the new call flow and categorisation process. These requirements were not known at the time of writing of the Digital Plan and so many of the pre-agreed priorities and timelines for 24/25 are now paused or at risk. Replanning for next year includes simplified sign-on, lab work, and data quality initiatives. 6
    - Successful recruitment for information and data services team, ICT team, and senior posts.
    - Progress on digital transformation, innovation programme, and innovation lab work to create a safe space for staff to bring ideas and problem statements.
    - Achieved near-perfect uptime (99.999%) for two consecutive years, indicating less than 40 minutes of downtime annually for WAST owned systems and infrastructure.
    - Sustained high demand for data services, with turnaround time now around 30 days. Prioritizing CMT work.
    - Scoping work for IPC audit tool complete
    - Drones purchased for HART and training scheduled
    - NEPTS cancellation 2-way SMS functionality live.

17. The **Information Governance Report** (IG) highlighted ongoing efforts to enhance information governance and data protection within the Trust, addressing both compliance requirements and operational challenges. Of note for the board:

    - The Trust has recently recruited to the full-time Data Protection Officer role, with an existing member of staff having been appointed. Additionally, the Head of Compliance and Assurance role has been filled internally to bolster freedom of information responses.
    - The Information Governance Toolkit improvement plan is progressing with all items having been achieved saved for the mandatory training target (see above alert section).
    - The Trust is working to migrate records held by Denbighshire Country Council.

18. The **Q3 audit tracker** was produced with no escalations reported. Those committee related actions on their third and final date were discussed at ARAC in November 2024 and March 2025 and should be closed in Q4.

19. The committee held is **2024/25 annual effectiveness** review and the annual report and any changes to terms of reference and operating arrangements will be reported to ARAC and the board in May.

20. Members received the **Committee Cycle of Business Monitoring Report and Committee Priorities** update with no escalations for the board.

21. In **closed session** members received the update on the cyber KPIs, cyber audit actions and the cyber risk. There were no escalations to the board.

RISKS

The committee received and reviewed the current board assurance framework. All risks have undergone their quarterly review, with no changes in scores except for the cyber risk. The two major risks, 223 and 224, have been discussed extensively in the Quality, Patient Experience and Safety Committee and the Audit, Risk and Assurance Committee. Given the focus on these two risks at the board as well as these committees, it was agreed that these would not be reported for information to this committee going forward.

Cyber Risk 260: The cyber risk has increased in score during the reporting period and will be moved to the closed session due to the sensitive nature of the actions and details involved. Where necessary matters in relation to this risk would be escalated to the trust board.

Other Risks Raised:

Risks and assumptions related to the 2024/25 financial plan, as well as that for 2025/26 were raised in the appropriate papers on these items

COMMITTEE AGENDA FOR MEETING		
Committee effectiveness review 2024/25	Financial position Months 10 & 11 2024/25	IMTP Delivery/Assurance – Progress Update 2024-27
IMTP 2025/28	Wellbeing Objectives	Initial 2025/26 revenue budget
QPMF Refresh	MIQPR	Digital reporting
Information governance	Internal audit -Vehicle accident management -Audit tracker	Risk management and BAF
Committee priorities and cycle monitoring	Reflections	

COMMITTEE ATTENDANCE						
Name	**14 MAY 2024**	**16 JULY 2024**	**17 SEPT 2024**	**19 NOV 2024**	**16 JAN 2025**	**18 MAR 2025**
Joga Singh (Chair)						
Jayne Beeslee (Chair)						
Kevin Davies		Chair				
Bethan Evans						
Peter Curran			Chair			
Chris Turley						
Rachel Marsh	Hugh Bennett	Hugh Bennett	Hugh Bennett	Hugh Bennett		Hugh Bennett[1]
Lee Brooks						Mark Harris
Liam Williams				From Item 7	Penny Durrant	Wendy Herbert
Angie Lewis						
Carl Kneeshaw						
Jonny Sammut						
Trish Mills	Julie Boalch					
Hugh Parry						
Damon Turner						

[1] Rachel Marsh attended from 12 for the IMTP 2025-28 item

	Attended
	Deputy attended
	Apologies received
	No longer member

OPERATIONS DIRECTORATE
QUARTERLY REPORT FOR COMMITTEES
2024-25 Q4 (January – March 2025)

National Operations & Support

General Update

AACE Ambulance Leadership Forum – Presentation on Community Welfare Responder Project

The National Volunteer Manager was invited to speak at the Ambulance Leadership Forum 2025, providing an overview of the Community Welfare Responder project. This has led to further conversation with NHS Charities Together about potential funding opportunities through 2025/26, for which we will ensure our Head of Charity and other colleagues are involved.

HART Drone Pilot

HART are introducing a drone capability to their list of assets to assist the team and Trust when responding to certain types of incidents. The incidents where the use of a drone will be beneficial are as follows:

- Large incidents to gain spatial situational awareness
- Incidents where operating environments may be hazardous - drone to be used to gain situation awareness and aid in risk assessments (water rescue incidents during nighttime or where daylight is minimal)
- Persons in water (thermal imaging cameras to help identify persons)
- Persons injured in rural areas (able to cover areas and thermal imaging cameras to assist)
- Ability to live stream to incident command rooms through a dedicated and secure server

HART will have 7 pilots (1 per team/watch), along with a Chief Pilot (HART Training Manager) trained to standards in line with the Civil Aviation Authority (CAA). Pilots will receive training in drone operation, pre-flight checks, safety critical process (including pre-flight risk assessments) and how to operate the drone for the incidents listed above.

Training was completed week commencing 31.03.2025 and all operatives successfully passed the course. Plans are in place with the IT Project Management Team to set up some live streaming on an exercise to showcase the capability.

SORT

Since the Trust received confirmation of the SORT enhancement funding, work has been underway to roll out the associated plans. The two band 7 posts have now been recruited and post holders commenced in their roles in March 2025. Some of the equipment items have also been sourced at a cost less than originally anticipated. However, the remainder of the revenue spend remains on track. We were unable to source vehicles from the capital aspect of the case in time for the end of the year and funding was subsequently returned. We anticipate funding of £290,000 to be subsequently returned to us and work is actively underway in relation to vehicle specification, conversion and securing of vehicle chassis. We do anticipate that the capital funds may not cover the full vehicle costs but are unable at this point to provide exact costs for the vehicles until final quotes are received. However, we are actively engaged with WG capital finance colleagues in this respect.

Communications Tactical Advisor (CTA) Courses

The College of Policing delivered a nationally recognised CTA course from March 18th-20th to enhance the CTA cadre within the Trust. Managing Airwave capacity is crucial for coordinated incident response. The Trust has been able to provide funding to achieve a situation whereby all NILOs have achieved this accreditation and therefore the Trust can now demonstrate 24/7 on-call capability. However there remains an operational need to deliver training for key identified roles to bring CTA cover to the 'on-duty' as well as access to the supporting software platform 'Insight'. This is not within the operating budget of WAST to deliver and as such there is a dependency upon additional funding from commissioners. This funding request has been submitted to JCC and a decision is anticipated in Q2/3 of this financial year.

Manchester Arena Inquiry (MAI)

Following the submission of WAST's consideration to the MAI recommendations in August 2024 to commissioners with a copy to the NHS Executive, a series of scrutiny workshops have taken place with commissioners over March and April. These sessions have allowed the commissioners, who called upon the expertise of EPRR leads from Health Boards, to scrutinise the detail in the submission before considering and providing their formal response which expected back to the Trust in August 2025.

Whilst every effort has been made to deliver all MAI recommendations by the end of the 2024/25 financial year, four recommendations (R1, R26, R88, & R111), that were initially on track for timely completion, have experienced some slippage due to factors beyond the project's control. These recommendations have now been transitioned to Corporate Risk 641 for ongoing management.

The actions required are within WAST's capacity to implement and do not currently necessitate additional funding. Work continues on all four recommendations, with R1 and R111 expected to be fully completed by the end of May 2025. This will leave a total of 20 outstanding recommendations on the Corporate Risk register, 18 of which relate to submissions to commissioners.

The Operations Directorate maintains oversight of these actions and is confident in addressing the final four recommendations. Plans for progression routes are established. This update is provided for committee awareness, and it is anticipated that future developments will be documented and updated through the Corporate Risk framework as the MAI project transitions to standard business arrangements.

Resourcing, EMS Coordination and Quality

Challenges

Life X/Control Room Solution

On 23rd January 2025, there was a significant national outage of the Control Room Solution (CRS), utilised by all Ambulance Trusts in England, Scotland and Wales, which impacted on our radio and control room telephony solutions. In response to this outage, WAST implemented business continuity plans that resulted in very little impact on our operations. Consequently, we did not need to declare an incident, such was the effectiveness of our business continuity arrangements.

One of the issues raised during the outage was the lag in time for the system to switch to the fallback data centre, which is a concern for any future fallback arrangements. This prompted the Ambulance Radio Programme (ARP) to instigate a full investigation into the circumstances and root cause of the outage with Frequentis, the software supplier. ARP are working with NHS England who are undertaking external assurance regarding the incident and will be reviewing the plans and actions so that there is external scrutiny on the incident and the response.

A further outage occurred on the 10th March 2025 and again our business continuity arrangement were instigated. The lessons learned from the first outage in January 2025 were implemented and this time the time to recovery of the functionality was far more efficient.

However, this has raised concerns regarding the stability and reliability of the system. As a result, ARP senior management are briefing Westminster Ministers and Senior representatives from within the Department for Health and Social Care to ensure that there is suitable scrutiny applied to the supplier to ensure appropriate prioritisation and associated resourcing is in place to help resolve the underpinning issues. ARP are briefing Trusts via the National Digital Leads Group, which our Director of Digital, is a member.

EMSC Sickness

Sickness absence remains an area of focus across the EMSC centres including an approach to support our people to be in work. Following a workshop undertaken with the EMSC leadership team, trade union partners and People Services, the team agreed key areas to focus on, especially around wraparound support for new Call Handlers. The Managing Attendance Policy has been appropriately applied, a new career structure has been deployed, and working environments are being improved. It has been pleasing to see some signs of improvement however focus shall remain in the foreseeable future.

Overdue investigations

Operations Quality continues to experience challenges in completing and returning investigations for concerns and coroners. There are now 95 outstanding concerns investigations of which 66 have breached the Welsh Government Tier 1 target, and 55 outstanding coroner's statements of which 20 have breached the HMC return date. There continues to be challenges in obtaining information critical to investigations in relation to clinician input (Clinical Support Desk). The teams are working together to expedite required information wherever possible and dynamically prioritise coroner's statements when requested by Legal Services. Audit has been identified as a bottleneck; however it is also important to set out that more audits have been completed than before. The issue is one of capacity to absorb activity, and there are plans for auditor growth in the coming months.

IMTP

Culture

The culture plan was developed in partnership and significant amount of work has been achieved to date, signalling a positive shift. Monthly time-to-talk in all centres are well attended which allows opportunities for increased staff engagement as well as actioning some ideas and concerns from colleagues. Monthly sway newsletter has also been developed to better communicate with our people. People Services have provided learning events for the managers and supervisors in application of managing attendance at work and occupational health processes, policies and procedures.

Estates

Llangunnor estate refurbishment has almost been concluded which will support the wellbeing of our people by providing a fantastic environment that includes training suites and so forth.

The moving of North EMSC from Bryn Tirion to Ty Elwy remains on track with great progress being made. The OCP has concluded in March 2025. Relocation transition is commencing w/c 28th April for Ambulance Care and the resource centre with EMSC moving on the 8th May 2025. The Chief Executive and Executive Director of Operations will join the team on 8 May. There is no requirement for others to attend as plans for a formal opening of the new Centre will follow.

Electronic Timesheets

The project board, team and supporting task and finish groups have now been established, terms of reference, project initiation document and project core principles agreed.

Resourcing Functional Model

Phase 1 of the transition to a functional resourcing model has commenced with the alignment of JCC Pan Wales and NET Centre resourcing aligned to one team (previously aligned to regions). Discussions have taken place to align NEPTS CW with NEPTS North which will be implemented from April.

General Update

EMSC Restructure and Reconfiguration

This is now embedding well with positive feedback from our people. The Operations Manager role has signalled a positive impact on some of our performance measures with real time supportive performance management in place.

MPDS Version 14

All emergency calls received by the Trust are prioritised using MPDS. This system is licensed and regulated by the International Academies of Emergency Dispatch (IAED) which provides the system with an overarching and robust clinical governance structure.

Version 14 of MPDS was successfully implemented in March 2025, this was a seamless transition. The enhancement to specific protocols will enhance patient care at the point of accessing our 999 services and the advice provided.

The implementation of Version 14 introduced substantial updates to the 'Pregnancy/Childbirth/Miscarriage' protocol. Notable changes include the removal of the cord pulse check instructions, the elimination of guidance on tying the umbilical cord with a shoelace, and the incorporation of recommendations to maintain appropriate warmth for both the newborn and the environment. These updates align with ongoing advancements in thermoregulation practices and underscore the Trust's active role in shaping global standards, particularly through its representation on the IAED's Obstetrics Council, ensuring the Trust's influence in these international revisions.

Additional updates include the revised protocol for honey administration in cases of button battery ingestion and enhanced instructions for cardio-pulmonary resuscitation, among other refinements.

Business Continuity Plan revised and updated

Following the implementation of Rapid Clinical Screening, the plans were updated to reflect those changes. Workshops were undertaken with Integrated Care colleagues to ensure robustness of the plans. These were tested during a planned C3 CAD server upgrade outage on the 31st March 2025 which tested the new plans and proved to be fit for purpose with a debrief planned for further learning and enhancement to the plans. This is a good example of the types of procedural or plan changes required as the Integrated Clinical Services Model evolves.

Emergency Medical Service

Challenges

Clinical Model Transformation

Work in progress to review affected SOPs and plan and develop training plans in preparation for implementation 1st July 2025 in line with the Welsh Governments announcement regarding the review of our current red targets and performance metrics and the 12-month trial shifting the emphasis from response times to patient outcomes.

Red Performance

Our ability to respond to the sickest patients remains difficult with the continued level of wider system pressures including handover delays at hospitals. Red performance remains below the 65% target and has done so for the past 12 months

Hospital Handover Delays

Patient transfer of care at the Emergency Departments has continued to be a significant challenge this last quarter. Work continues at both national and local level to improve this position where possible. Following the release of the Welsh Government WHC – Ambulance Patient Handover Guidance, meetings have now been held within the four Service areas with NHS Wales Executive, Health Boards and WAST Head of Service(s) to discuss actions against this guidance and future plans to support patient transfer of care.

IMTP

Advanced Paramedic Organisational Change Process

The APP OCP process is complete and the required number of Senior APPs (SAPP) in place. This saw the SAPP transition from Ops to the Clinical Directorate for management purposes, though the APPs remain within Operations. The remaining APPs throughout the Trust have now been aligned to a SAPP team where clinical leadership and mentorship will be provided. Ongoing APP recruitment against funded and approved vacancies will continue over the coming months.

DOM Roster Review

The final adjustments have been made to the DOM Roster Review process, and this will be completed soon with a concluding paper submitted to SOT & SLT.

General Update

Emergency Ambulance Practitioner (EAP) Training

Throughout this reporting period the EAP training courses have progressed at pace. Across the Trust there have been 6 completed courses and a further 3 ongoing that commenced on 24th March 2025. This means that circa 96 members of staff have completed their EAP course within this period and a further circa 48 actively ongoing.

The general uptake from staff to get allocated to a course date has been extremely encouraging with most staff being allocated to their first-choice course. Most staff who have attended the course have completed it, with a limited number requiring to leave the course for personal reasons. These will be allocated onto a future course to allow them to complete the EAP course objectives. Initial feedback from staff is that they are finding the course enjoyable and now wanting to commence the new EAP role operationally.

Glangwili Hospital End of Shift POD

Following an initiative through our Estates Department we have now opened the newer and larger end of shift handover POD at Glangwili Hospital. This newer POD compliments the PODS already in place in Morriston and YGC Hospitals and now has a capacity of 5 stretcher patients to further promote staff wellbeing and timely end of shift finishing.

To further support end of shift overruns planning has taken place to run a series of workshops in partnership with the aim of jointly determining methods of improving the position and improving staff wellbeing. The first workshop is scheduled to take place on 1st April 2025.

Ambulance Care

Challenges

NEPTS Roster Review

The NEPTS roster review Working Parties have commenced with all areas completing the first 2 working parties of the 4 scheduled. The working parties are planned every 4 weeks to allow for information to be presented and allow station representatives to return to operational teams to discuss and input into the roster design process..

Through the working party process we have received a significant amount of feedback on both the process, rationale for change, methodology and data in addition to the outputs of local engagement for consideration. In addition, several respect and resolution requests were received from a number of staff groups, and a collective respect and resolution from trade unions.

Upon reflection of this feedback, we have decided that rather than continuing to progress upon the existing plan timelines, we need to review the feedback and adjust the timeline to ensure the most optimal methodology is in place to keep the review moving forward.

Further engagement will also be completed with our data modelling partner to identify any alternative solutions to address some of the concerns raised and also deliver improvements to our rostering position and service efficiency.

This will mean that the next working party will be delayed to accomodate this work. An additional session will also be introduced to feedback on the outcome of our considerations, set out the way forward, answer any questions that colleagues may have and consider and respond to any additional support requirements .

The additional time in the process will also allow us to respond to the respect and resolution submissions appropriately, hopefully through the utilisation of a single, combined process.

NEPTS Capacity Management Plan (CMP) Cancellations Update

The NEPTS service uses CMP to prioritise and manage situations where capacity exceeds funded resource available. This can result in patient transport being cancelled at late notice.

Over the past couple of years we have seen the number of times the CMP has been used increase reaching a peak in March 2025 when 900 patient journeys were canceled under CMP, the majority of which were for outpatient appointments . This may mean that patients are not able to attend their appointments and has resulted in an increase in concerns from elected members. Dialysis and oncology patients are continually prioritised.

Data analysis has identifed that increases in the acquity of patients, with proportionally more patients now needing an ambulance vehicle and an increase in the complexity and distance of journeys are directly contributing to reduced patient loading and reduced efficicency. High levels of short notice cancellations by patients and Health Boards also significantly impact on available capacity and a number of workstreams are underway to address this.

The service has been engaging with commisioners for some time on this matter and has illustrated the challenges faced and the actions required to address. Whilst progress is being made on the actions within our gift (which include the roster review), limited progress/feedback on actions that require system support has been received. Of particular concern are the levels of late notice cancellations made by Health Boards and patients, which stood at 5,265 for March 25. Late cancellation of journeys significantly impacts upon resource utilisation; if minimised this lost capacity could significantly reduce CMP cancellations.

IMTP

General Update

SMS Communication

2-way SMS communication has been live since the 24th February 2025 which allows service users that have opted in to cancel their transport if required. This reduces the need to call the Net Centre and has seen a positive increase in the number of cancellations prior to the

commencement of the planning process. Within the last month Ambulance Care has seen 283 cancellation requests made through the system.
Whilst the initial volumes of cancellations are still very low when compared to the overall level of cancellations, upcoming changes to opt in procedures and additional 2-way text functionality will increase this volume.

Integrated Care

Challenges

Absence: this remains a concern; however, we have seen improvement in some areas. Call taker absence remains high but is decreasing (was 14.82% in Feb and 11.84% in March 25), with further improvements in April. Clinician absence has decreased from 14.2% in January 25 to 10.26% in March 2025.

Call Taking Performance: challenges remain in relation to call taking performance. Recruitment is ongoing through March and April 25. Additionally, there have been periods of extended waiting times for call takers accessing Clinical Advice (via the Clinical Advice Line), which has further impacted on call taking performance. Work is underway to explore pinch points and determine improvements.

Service User Experience: a review of patient experience for a 12-month period has demonstrated some elements of negative feedback. This includes issues with access, timeliness of advice/support and satisfaction. Numbers of returns are low (210 returns) for a 12-month period. The Integrated Care Senior Leadership Team (ICSLT) are meeting alongside colleagues from the Quality Management Group to consider improvement actions because of the feedback. Additionally, we will explore options to improve current returns of feedback, to ensure it is representative of the total demand, to inform future learning.

IMTP

General Update

Care Planning-

In collaboration with the Quality Safety and Patient Experience Directorate, the Integrated Care Team successfully secured continued investment for the LUSCII clinical platform, through Welsh Government funding. This platform is essential for the Care Planning function, so that clinicians can provide remote monitoring for patients accessing 999. The

funding through the Small Business Research Initiative was due to end in March 25, but a successful evaluation presented to the Project Board led to continued funding through 25/26. The cross-directorate teams are now considering key metrics, ensuring robust data capture systems and will be working with external organisations to undertake a full evaluation. Further clinicians have also been recruited to continue to build resilience within the Care Planning function. A presentation was delivered at the Ambulance Service Leadership Forum, highlighting the key evaluation findings along with qualitative feedback from clinicians.

LUSCII Evaluation: An evaluation was completed and shared with WAST and the SBRI programme board in March 2025, in relation to the LUSCII clinical dashboard. The evaluation report examined patient outcomes, final dispositions, staff experience feedback and care home staff feedback. The team were able to examine outcomes for incidents which did not require an ambulance response (dealt with by Care Planning) and those incidents which required a response to scene. A total of 291 patients were onboarded onto the LUSCII dashboard from the 22nd of August 2024 to the 13th January 2025, measured by LUSCII. A total of 143 patients were able to be further examined and outcomes captured from the WAST CAD system. A total of 52 incidents (36%) did not require a response to scene. A total of 67% of incidents not requiring a response, were dealt with by the Care Planning Desk function. Data demonstrated an increased clinician confidence, along with higher numbers of referrals to GP in hours/out of hours because of increased clinical intelligence. Care Home staff provided positive feedback, explaining that the LUSCII solution often helped residents to access services, which helped to avoid unnecessary admission to the Emergency Department.

External Evaluations: The team have supported the external evaluation of the Extended Clinical Hub and WAST SICAT. The evaluations are being completed by the South Central and West Commissioning Support Unit and will be available in April 25. The Integrated Care Team along with Insights and Data Services worked to consider metrics, capture appropriate data and provide the insights to support the wider evaluation.

Emergency Communication Nurse System (ECNS)

It was reported to SLT and ELT in January 2025 via a paper prepared by colleagues in Integrated Care to highlight the need for auditing within Integrated Care, specifically for the Call Prioritisation & Streaming System (CPSS) and the Emergency Communication Nurse System (ECNS)

The paper highlights the necessity of audits to ensure the quality and effectiveness of patient assessments. The Clinical Support Desk (CSD) holds the 'Accredited Centre of Excellence' (ACE) standard, which requires strict audit compliance. As CSD transitions to the Remote Integrated Care Service (RICS), it must meet these standards. Currently, there are insufficient audit resources to meet the required standards for CPSS and ECNS.

All Call Handlers use CPSS, and Clinicians use ECNS to assess patients remotely. Audits are essential to maintain service quality and inform individual practice. The CSD must audit 2.5% of all calls, with 93% compliance. At the time of preparing the report, each clinician was receiving an audit however rates of non-compliance were too high.
The introduction of CPSS and ECNS in the 111-service necessitated dedicated auditors. The current audit rate is below the required baseline, and this is inhibiting the Academy from establishing compliance standards.

The paper outlined three options for auditing, considering financial constraints, and subsequently the SLT and ELT agreed that it should sustain an ambition to attain and maintain centre of excellence accreditation standards. There are plans to grow auditors with financial investment this year and prioritise volume of audit ahead of improving the quality of feedback and response to audit outcomes.

111 Roster Review

Status currently is green (on target), with draft recommendations expected in June (phase 1) with likely phase 2 (a formal re-roster). In addition, the review includes some demand and capacity work. Commissioners are represented on the project board, therefore engaged and sighted. A deep dive into call answering performance has been provided to Commissioners.

Operations – Quarterly Sub-Report
Quality and Support Day Key Insights and Developments

Integrated Care

Quality & Support days continue to be a key focus in Integrated Care. These dates are planned well in advance to free up our managers, allowing them to have quality time in face-to-face meetings with staff. This dedicated time is used to listen to staff in a safe space about issues and concerns raised.

We begin each session with a consistent set of wellbeing questions, focusing on wellbeing scores and ways to improve them. By prioritising how staff feel right from the start, we establish a rapport and emphasize their wellbeing, rather than seeking data that only serves the Trust's interests.

The results provide trackable reported wellbeing scores, which we can compare month on month. This should provide earlier awareness of any deterioration in staff morale or increased issues coming to the forefront. These insights are invaluable as they allow us to learn about the underlying factors affecting staff wellbeing and morale. By understanding these factors, we can tailor our support and interventions more effectively.

We utilise themed questions that allow us to deeply dive into specific areas of learning, choosing metrics that align with our objectives.

1. **Communication Styles and Preferences**: Understanding how staff prefer to communicate helped us improve our internal communication strategies and ensures everyone feels heard and understood.
2. **Staff Wellbeing and Morale**: Focusing on the overall wellbeing and morale of staff allowed us to identify areas where support is needed and implement measures to boost morale based on direct feedback from staff at ground roots level.
3. **Sexual Safety at Work**: Addressing the sexual safety topic ensured that staff feel safe and respected in their workplace, which is crucial for a healthy work environment. It allowed space to have conversations around culture, which was prominent in the media at the time of the Quality and Support Day. We were able to identify staff who felt they wanted more training on this topic and utilised the time to signpost to appropriate resources.

4. **You Said – We Did (Feedback Day)**: This theme allowed us to show staff that their feedback is valued and acted upon, fostering a culture of continuous improvement, trust and demonstrating effective listening to our staff.
5. **Christmas Wellbeing**: Focusing on wellbeing during the holiday season helps us address any challenges staff may face during this time of increased pressures and ensures they feel supported. We have been able to establish ideas for improvement on next year's Christmas planning.

These themed days (Item 5.1a) allow us to really probe into how staff feel about particular topics and provided direction and guidance when considering future Quality and Support Day themes. We have been able to link in with other groups such as the Wellbeing Cell, Christmas Planning team and Communications colleagues to work collaboratively, share knowledge, and avoid inundating staff with forms and surveys. We have been able to collate qualitative data that has provided valuable insights into the effectiveness of our initiatives, by learning from these insights, we can continuously improve our approach to staff wellbeing and create a supportive and responsive work environment.

EMS Response

The latest Quality & Support Day took place on 13th February 2025 and saw EMS managers, including DOMs, LMs, SMs & HoS engaging with as many on-duty operational staff as possible. The key focus areas for this particular day were:

- Dyson Bladeless Fans

- Respiratory Protective Equipment (RPE) – Versaflow Hoods

- Use of Shorelines at Hospitals

- Vehicle Security

- Vehicle Communications

An MS Form was designed covering the above subjects to ensure a consistent and transparent approach Trust wide. A total of 85 crews were engaged with at either hospital sites or ambulance stations covering the 7 Health Board areas.

The discussions with crews focussed on raising awareness, promoting appropriate use of equipment and following best practice, and to generally have a supporting two-way discussion. The newly introduced Dyson Bladeless Fans and the vehicle based RPE were extremely topical and timely for the appropriate level of discussion.

Some key learning and future workstream requirements came out of the QSD in relation to vehicle communications. An audit has been completed which showed a depletion in communication devices on board our vehicles. This has obviously initiated some further digging in relation to the locations, connectivity requirements and how we communicate in

2025 in comparison with when the mobile devices were purchased in 2015. A working group lead by the Service Manager, North EMS will be initiated to look into alternative options of communication, firstly at nil cost, but then considerations will be given to other options for completeness. We consider this as a potential risk to the organisation so priority will be given to this piece of work.

We will also be revisiting the Dyson bladeless fans topic once all have been installed at ED sites pan Wales. We felt the data did not represent a true picture of the user experience due to the limited number of fans in situ at time of data collection.

The attached presentation slides (Item 5.1b) summarise the crews' responses to the MS Form feedback which is generally very positive and again demonstrates that the Quality & Support days are very effective tools in increasing manager visibility and providing support to staff.

Ambulance Care

On February 25th, the Quality Support Day focused on enhancing the operational efficiency and safety of ambulance services, particularly through the lens of Shift Start and Vehicle Security during shifts. This initiative aimed to ensure that staff are well-prepared, and vehicles are properly checked before commencing their duties.

Key Areas of Focus

1. **Shift Start SOP Awareness:**

The survey revealed that approximately 25% of staff were not aware of the Shift Start Standard Operating Procedure (SOP). This highlights a significant gap in communication and training, suggesting that more efforts are needed to ensure all staff are familiar with these crucial guidelines.

2. **VDI Completion:**

Vehicle Daily Inspection (VDI) processes showed variability, with 50% of staff completing paper-based forms alongside MDVS (Mobile Data Vehicle System) acknowledgments, while the other 50% relied solely on MDVS acknowledgments. This inconsistency points to the need for a standardised approach to VDI completion to ensure thorough and uniform checks.

3. **Understanding VDI Requirements:**

There was confusion among staff regarding the correct procedure for completing a VDI for a cold vehicle. Responses varied from 5 to 30 minutes, whereas the correct procedure stipulates 15 minutes. This indicates a need for clearer instructions and training to ensure staff are aware of the proper protocols.

Proposed Interventions

Based on the survey results, three focused interventions have been identified to address these issues:

1. **Aligning the Shift Start SOP:**

Minor adjustments are needed to better align the Shift Start SOP with the needs of NEPTS (Non-Emergency Patient Transport Services) teams. This will help ensure that all staff, regardless of their specific roles, are on the same page regarding shift commencement procedures.

2. **Improving VDI Completion:**

Efforts will be made to standardize the VDI completion process, ensuring that all staff follow the same procedures and understand the importance of thorough vehicle inspections. This may involve additional training and clearer guidelines**.**

3. **Reviewing MDVS Functionality:**

The functionality of the MDVS will be reviewed to prevent duplication of VDI checks and streamline the process. This will help make the system more efficient and user-friendly, reducing the likelihood of errors and ensuring that all necessary checks are completed.

The Quality Support Day (presentation Item 5.1c) has provided valuable insights into the current practices and areas for improvement within ambulance care. By addressing the identified gaps and implementing the proposed interventions, the goal is to enhance the overall efficiency, safety, and preparedness of ambulance services. These changes will not only benefit the staff but also ensure better care and service for patients.

NB:

To streamline meeting materials, a 'reading room' has been established in Ibabs. This digital space hosts documents for additional information, not essential for scrutiny or decision-making. Annexes 5.1a, 5.1b and 5.1c are available there. Access to the reading room is through the documents/shared folder in Ibabs' main menu. Documents in the reading room will not be posted on the Trust's website with committee papers; however, copies can be provided upon request

AGENDA ITEM No	**6**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**1**

Financial Performance as at Month 12 – 2024/25

MEETING	Finance & Performance Committee
DATE	20 May 2025
EXECUTIVE	Chris Turley (Executive Director of Finance & Corporate Resources)
AUTHORS	Edward Roberts (Interim Assistant Director of Finance) Steph Taylor (Assistant Head of Capital Planning)
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EXECUTIVE SUMMARY

This paper presents to the Committee the Financial Performance Report of the 2024/25 financial year, the reported position as at Month 12 (March 2025) / year end.

The Committee is asked to review, comment, note and receive assurance on the financial outturn position for 2024/25, ***subject to audit*** and ahead of the Trust Board presentation of the 2024/25 accounts in June 2025.

KEY ISSUES/IMPLICATIONS

Key highlights from the report for the Committee to note are:

- The Trust is reporting a small revenue surplus (£70k) as at month 12, and which will be the basis for the draft accounts for the 2024/25 financial year (*subject to audit*);
- Capital expenditure is fully spent;
- In line with the financial plans that support the IMTP, gross savings of £6.838m have been achieved against a target of £6.421m;
- Public Sector Payment Policy is on track with performance, against a target of 95%, of 97.7% for the number, and 98.9% of the value of non-NHS invoices paid within 30 days.

REPORT APPROVAL ROUTE
• ELT – 16th April 2025 – verbal update on draft m12 / year end position • F&PC – 20th May 2025 – to note • Trust Board – 29th May 2025 – to note

REPORT APPENDICES
Appendices 1 – 2 *– Monitoring returns submitted to Welsh Government for month 12 – as required by WG* ***Appendix 3*** *– Savings performance*

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

WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST

FINANCE & PERFORMANCE COMMITTEE

FINANCIAL PERFORMANCE AS AT MONTH 12 / YEAR END 2024/25

INTRODUCTION

1. This report provides the Committee with a summary of the revenue financial performance of the Trust as at 31st March 2025 (Month 12 2024/25 and therefore the draft 2024/25 year end position), along with an update on the final 2024/25 capital programme spend, both of which are now part of the draft 2024/25 accounts and therefore ***subject to audit***.

BACKGROUND

2. The key points to note in relation to the **delivery of the Statutory Financial Targets for 2024/25** (1st April 2024 – 31st March 2025) are that:

   - The cumulative revenue financial position reported is a small **underspend against budget of £0.070m** (*subject to audit*);

   - In line with the financial plans that supported the submitted Annual Plan within the IMTP for this financial year, gross savings of **£6.838m** have been achieved against a target of **£6.421m**. Now included within this paper is a more detailed analysis of savings including the recurring / non-recurring nature of their delivery;

   - Public Sector Payment Policy is on track with **performance, against a target of 95%, of 97.7% for the number, and 98.9% of the value** of non-NHS invoices paid within 30 days.

3. Any risks previously reported were continued to be reviewed and fully assessed right up to the year end, however there are now no reported financial risks included in the draft year-end position, subject to audit.

4. As Committee members will be aware, the Trust did escalate one financial risk in its reporting to Welsh Government early in the financial year (in month 2) – that in relation to EMT / technician level posts re-banding. Following detailed work over the past few months and the net impact of the Trust previously holding circa 100 WTE positions and thus the reduction in potential backpay for these elements, along with mitigation associated with the roll out of the training wrap around, this risk had been reduced in stages through the financial year, including when it became clear from WG / commissioners that no additional in year funding would

be made available for these additional costs. Discussions continue with commissioners around this issue, along with the more significant impact of future year's cost increases and resulting funding pressure previously highlighted through the submitted business case. It is pleasing to report that we have been able to update the residual risk in relation to this issue, which has now been reduced to zero, this was done by managing other variable spends. As detailed in the 2025/26 financial plan, this is likely to continue to be a significant pressure for 2025/26 onwards though, not least because the costs significantly increase in future years.

REVENUE FINANCIAL PERFORMANCE – MONTH 12 2024/25

5. The table below presents an overview of the financial position for the period 1st April 2024 to 31st March 2025.

Revenue Financial Position for the period 1st April - 31st March				
	Annual Budget	Year to date		
		Budget	Actual	Variance
	£000	£000	£000	£000
Income	-323,197	-323,197	-323,727	-529
Expenditure				
Pay	238,513	238,513	236,138	-2,375
Non-pay	64,126	64,126	67,629	3,503
Total pay & non-pay expenditure	302,638	302,639	303,767	1,128
Depreciation & Impairments / interest payable & receivable	20,559	20,559	19,890	-669
Total	**0**	**0**	**-70**	**-70**

Income

6. Reported Income against the initial budget set to Month 12 shows an overachievement of **£0.529m**.

Pay Costs

7. Overall, the total pay variance at Month 12 is an underspend of **£2.375m**.

Non-pay Costs

8. The overall non-pay position at Month 12 is an overspend of **£3.503m**. In addition, for reporting purposes Depreciation, Impairment and interest is excluded from the above figure, underspend of **£0.669m** hence the total underspend to budget of **£0.070m** *(subject to Audit)*

Savings

9. As above, the 2024/25 financial plan identifies that a minimum of **£6.421m** of planned savings (including Income generation) are required to achieve financial

balance in 2024/25, this equates to c2.2% of the Trusts discretionary income. Of this, **£3.646m** is recurrent and **£2.775m** is currently deemed non recurrent.

10. Month 12 in month performance was, plan of £0.446m and £0.521m achieved, therefore an overachievement of £0.075m (recurrent overachievement of £0.072m and non recurrent overachievement of £0.003m). Cumulative performance was plan of £6.421m and £6.838m achieved, therefore an over achievement of £0.417m* (£0.497m recurrent and -£0.079m non recurrent), as per the below table.

	Annual	In Month			Cumulative			Forecast		
	Plan £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000
Recurrent Schemes / Themes	3,646	238	310	72	3,646	4,143	497	3,646	4,143	497
Non Recurrent Schemes / Themes	2,775	208	211	3	2,775	2,696	-79	2,775	2,696	-79
Overall Total	**6,421**	**446**	**521**	**75**	**6,421**	**6,838**	**417**	**6,421**	**6,838**	**417**

**Please note figures are rounded to the nearest whole number*

11. ***Appendix 3*** provides the overall detail for Month 12 by theme. This is now further split over recurring and non-recurring schemes.

12. Main variances by scheme in Month 12 are as follows.

- Interest receivable overachieved in M12 by £0.020m, FYF is an over achievement of £0.471m.
- Over achievement on corporate vacancies in M12 was £0.013m, FYF is an overachievement of £0.157m.
- Fuel forecourt prices continue to be lower than budgeted and hence has overachieved target by £0.056m for M12, FYF is an overachievement of £0.445m.
- For the planned apprenticeship programmes, income in M12 equalled budget, FYF is an over achievement of £0.064m.
- Workforce efficiencies in M12 was an under recovery £0.010m, FYF is an underachievement of £0.091m.
- Non pay local schemes in Corporate and Operations overachieved in M12 by £0.013m, FYF is an underachievement of £0.276m.
- MS office VAT rebate is now not being achieved this financial year, so this is reporting a FYF underachievement of £0.300m.
- Fleet repair position continues to be challenging and hence has underachieved target by £0.007m for M12, FYF is an underachievement of £0.053m.

Financial Performance by Directorate

13. Whilst there is a small surplus reported at Month 12 there are some small variances between Directorates as shown in the table below, when compared to

the budgets set at the outset of the financial year. Some of this is driven by staffing vacancies. These are fairly minor in nature.

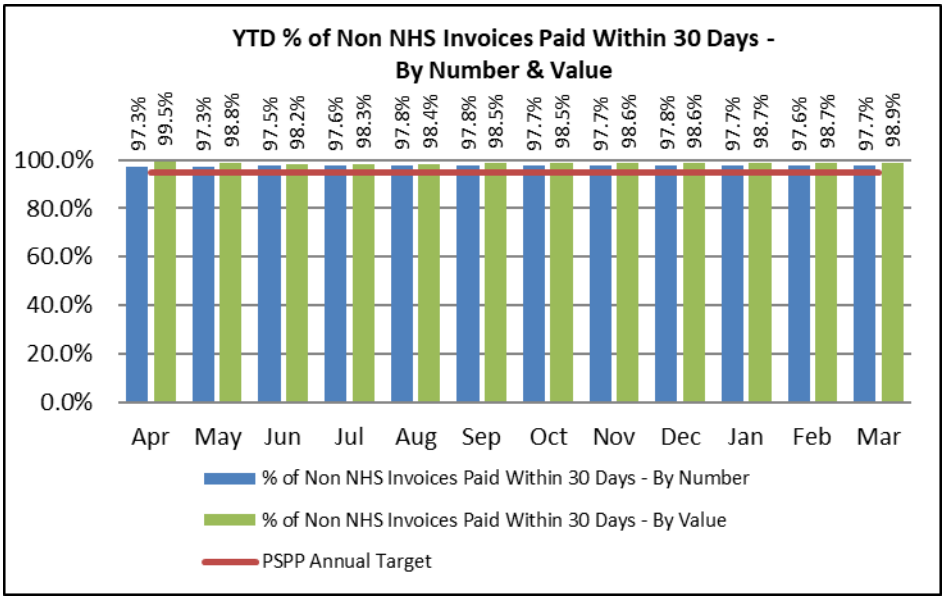
Financial position by Directorate @ 31st March	Annual Budget	Year to date			
		Budget	Actual	Variance	Tolerance 5%
	£000	£000	£000	£000	%
Directorate					
Operations Directorate	212,566	212,566	211,335	-1,231	-0.6%
Chief Executive Directorate	1,970	1,970	2,112	142	7.2%
Board Secretary	672	672	653	-19	-2.8%
Partnerships & Engagement Directorate	522	522	526	4	0.7%
Finance and Corporate Resources Directorate	35,691	35,691	36,732	1,041	2.9%
Planning and Performance Directorate	3,093	3,093	2,953	-140	-4.5%
Quality, Safety and Patient Experience Directorate	6,716	6,716	6,826	110	1.6%
Digital Directorate	15,101	15,101	15,127	26	0.2%
People and Culture	5,686	5,686	5,337	-349	-6.1%
Medical & Clinical Services Directorate	3,860	3,860	3,962	102	2.6%
Trust Reserves	922	922	1,258	336	36.5%
Trust Income (mainly JCC)	-286,799	-286,799	-286,892	-93	0.0%
Overall Trust Position	**0**	**0**	**-70**	**-70**	

14. A brief commentary on significant key variances above is as follows:-

- Most directorates broadly in line with budget plan for Month 12;
- Operations (EMS Response) - mainly due to pay savings across most ADO areas;
- Chief Executive – pay underachieved on savings delivery due to mainly full establishment (some NED vacancies) and non-pay due to increased membership / subscriptions;
- People & Culture – overachieved on apprenticeship income (large receipt in March 25), large vacancies on pay establishment;
- Finance & Corporate Resources - main areas of overspend were fleet maintenance, losses and savings under achievement on MS office rebate offset by interest receivable over recovery;
- Reserves – underachievement on savings target plus impact of some technical / balance sheet adjustments at year end (e.g. increase in TOIL / Annual leave).

PUBLIC SECTOR PAYMENT POLICY PERFORMANCE (PSPP)

15. Public Sector Payment Policy (PSPP) compliance to Month 12 was **97.7%** against the **95%** WG target set for non-NHS invoices by number and **98.9%** by value.



2024-25 CAPITAL PROGRAMME

16. At Month 12, the Trust's approved Capital Expenditure Limit (CEL) set by and agreed with WG for 2024/25 is **£20.449m**. This includes **£14.994m** of All Wales Approved schemes and **£5.455m** for Discretionary schemes.

17. The Trust achieved the CEL target of **£20.449m**, with a very small underspend against plan of **£26.73** *(subject to audit)*. Below is a summary of the year end capital spend across the main headings of the capital plan. Committee members had previously received a more detailed update on how any in year slippage or underspend against previously set capital budgets were to be cash managed over the year end period.

	Actual £'000
All Wales Capital Programme: Schemes:	
ESMCP - Control Room Solutions	164
Efab - Infrastructure	303
Efab - Fire	333
Efab - Decarbonisation	596
MDVS	46
2024-25 Ambulance Vehicle Replacement Programme	12,487
Maintenance Backlog 2024-25	635
Special Operational Response Teams (SORT) Enhancement Equipment	430
Sub Total	**14,994**
Discretionary:	
I.T.	1,357
Equipment	1,584
Statutory Compliance	0
Estates	2,413
Other	102
Unallocated Discretionary Capital	0
Sub Total	**5,455**
Total	**20,449**
Less NBV reinvested	
Total Funding from WG	**20,449**

RISKS AND ASSUMPTIONS

18. There are currently no remaining or expected financial risks to the reported draft year end position (*subject to audit*). Inevitably any audit period has an element of inherent risk and based on the detailed audit plan received from Audit Wales there are some areas of greater focus that will be scrutinised through the accounts audit work, but at this stage there is no expectation that any of this should result in any material changes to the draft year end position, or the detailed notes that accompany this as part of the draft accounts.

2024/25 YEAR END ACCOUNTS AND AUDIT

19. Finalisation of the Accounts and audit work continues in respect of the 2024/25 Trust Annual Accounts. The draft accounts were submitted to WG and Audit Wales, as per the issued guidance, on 2nd May 2025, with the audited accounts to be presented to Audit Committee on 24th June 2025 ahead of seeking final approval of these at Trust Board on 26th June 2025.

20. The 2024/25 year-end audit will again be conducted virtually, maximising the use of technology and building on the experiences of the previous 5 years' audits.

RECOMMENDED that the Committee:

a) **Notes** and gains **assurance** in relation to the Month 12 (and therefore draft 2024/25 year end) revenue and capital financial position and performance of the Trust as at 31st March 2025;

b) **Notes** the delivery of the 2024/25 savings plan, and the context of this within the overall financial position of the Trust;

c) **Notes** the Month 12 Welsh Government monitoring returns submission included within ***Appendices 1 – 2*** (as required by WG).

NB:

To streamline meeting materials, a 'reading room' has been established in Ibabs. This digital space hosts documents for additional information, not essential for scrutiny or decision-making. Annexes 1 and 2 as described above are available there. Access to the reading room is through the documents/shared folder in Ibabs' main menu. Documents in the reading room will not be posted on the Trust's website with committee papers; however, copies can be provided upon request

Appendix 3

The first table is the total savings delivery, which is then broken down into that being delivered recurringly and that which is non recurrent, in the subsequent two tables.

Welsh Ambulance Services NHS Trust

Savings Performance by Theme 24-25

Reporting Month 12

	Annual	In Month			Cumulative			Forecast		
	Plan	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Apprenticeships	200	17	17	0	200	264	64	200	264	64
Fleet Repair	80	7	0	-7	80	27	-53	80	27	-53
Fuel Efficiencies	249	22	78	56	249	694	445	249	694	445
HEIW CPD Provision	140	12	12	0	140	140	0	140	140	0
Interest Receivable	300	25	45	20	300	771	471	300	771	471
MS Office VAT Rebate	300	10	0	-10	300	0	-300	300	0	-300
Non-pay Local Schemes - Corporate	600	59	73	15	600	397	-203	600	397	-203
Non-pay Local Schemes - Operations	515	41	39	-2	515	442	-73	515	442	-73
Vacancy Management Corporate Teams	2,275	181	194	13	2,275	2,432	157	2,275	2,432	157
Workforce Efficiencies & Transformation	1,062	16	16	0	1,062	1,038	-24	1,062	1,038	-24
Workforce Efficiencies & Transformation Variable	700	57	47	-10	700	633	-67	700	633	-67
Totals	**6,421**	**446**	**521**	**75**	**6,421**	**6,838**	**417**	**6,421**	**6,838**	**417**

Savings Performance by Theme 24-25 - Recurrent

Reporting Month 12

	Annual	In Month			Cumulative			Forecast		
	Plan	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Apprenticeships	0	0	0	0	0	0	0	0	0	0
Fleet Repair	80	7	0	-7	80	27	-53	80	27	-53
Fuel Efficiencies	249	22	78	56	249	694	445	249	694	445
HEIW CPD Provision	140	12	12	0	140	140	0	140	140	0
Interest Receivable	300	25	45	20	300	771	471	300	771	471
MS Office VAT Rebate	0	0	0	0	0	0	0	0	0	0
Non-pay Local Schemes - Corporate	600	59	73	15	600	397	-203	600	397	-203
Non-pay Local Schemes - Operations	515	41	39	-2	515	442	-73	515	442	-73
Vacancy Management Corporate Teams	0	0	0	0	0	0	0	0	0	0
Workforce Efficiencies & Transformation	1,062	16	16	0	1,062	1,038	-24	1,062	1,038	-24
Workforce Efficiencies & Transformation Variable	700	57	47	-10	700	633	-67	700	633	-67
Totals	**3,646**	**238**	**310**	**72**	**3,646**	**4,143**	**497**	**3,646**	**4,143**	**497**

Savings Performance by Theme 24-25 - Non Recurrent

Reporting Month 12

	Annual	In Month			Cumulative			Forecast		
	Plan	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Apprenticeships	200	17	17	0	200	264	64	200	264	64
Fleet Repair	0	0	0	0	0	0	0	0	0	0
Fuel Efficiencies	0	0	0	0	0	0	0	0	0	0
HEIW CPD Provision	0	0	0	0	0	0	0	0	0	0
Interest Receivable	0	0	0	0	0	0	0	0	0	0
MS Office VAT Rebate	300	10	0	-10	300	0	-300	300	0	-300
Non-pay Local Schemes - Corporate	0	0	0	0	0	0	0	0	0	0
Non-pay Local Schemes - Operations	0	0	0	0	0	0	0	0	0	0
Vacancy Management Corporate Teams	2,275	181	194	13	2,275	2,432	157	2,275	2,432	157
Workforce Efficiencies & Transformation	0	0	0	0	0	0	0	0	0	0
Workforce Efficiencies & Transformation Variable	0	0	0	0	0	0	0	0	0	0
Totals	**2,775**	**208**	**211**	**3**	**2,775**	**2,696**	**-79**	**2,775**	**2,696**	**-79**

Please note figures are rounded to the nearest whole number

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

AGENDA ITEM No	**7**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**2**

Integrated Medium Term Plan (IMTP) Delivery/Assurance End of year report

MEETING	Finance & Performance Committee
DATE	20 May 2025
EXECUTIVE	Rachel Marsh - Executive Director of Strategy, Planning and Performance
AUTHOR	Alexander Crawford - Assistant Director of Planning & Transformation Heather Holden, Head of Transformation Deborah Kingsbury, Senior Planning & Performance Business Partner
CONTACT	alexander.crawford2@wales.nhs.uk

EXECUTIVE SUMMARY

The purpose of this paper is to provide the Committee with an end of year position for IMTP delivery and assurance for 2024/25 (year 1 of the 2024-27 IMTP).

This paper provides a position for the Clinical Model Transformation (CMT) programme Directorate-led IMTP portfolio, and Ministerial (now Cabinet Secretary) Priorities set by Welsh Government.

It also provides an assessment against the 'what good looks like' outcomes statements set out in the 2024-27 IMTP.

RECOMMENDED:

That the Committee

1. **Notes** the progress in identifying 'what good looks like' through the continuing development of high-level outcomes measures;
2. **Notes** the CMT programme end of year position;
3. **Notes** the Directorate-led IMTP end of year position;
4. **Notes** the end of year position for the Cabinet Secretary's priorities set out in the 2024-27 planning framework;
5. **Advises** of any further assurance needed for the Board.

KEY ISSUES/IMPLICATIONS
The WAST IMTP for 2024-27 was approved by Trust Board on 28 March 2024 and submitted to Welsh Government the same day. Welsh Government approved the IMTP subject to accountability conditions on 9 August 2024. The accountability conditions set out the following: • Continue with the development of the clinical model, liaising with wider services including health boards, to provide the evidence base and impact expected; • Continue to derisk the financial assumptions in the plan to secure the organisation's position; and • Ensure delivery is maintained against the commitments within the plan, including ensuring the availability of the detail behind the plan is available if needed. This report will set out in detail how the Clinical Model Transformation programme delivered on our commitment to refreshing the current clinical model and how the wider IMTP is has been through a directorate led approach. The IMTP set out a break-even position with a savings target in excess of £6m which was achieved by year end. **Clinical Model Transformation (CMT) Programme** The Clinical Model Transformation (CMT) programme continues to progress, with notable advancements in digitising programme management. A centralised MS365 solution now houses all core controls, supported by a new interactive Programme Portal and the development of workstream-specific gateways. FY25/26 plans are being built in MS Project, aligned to IMTP deliverables, and initial work is underway to automate reporting through Power BI. Key deliverables are nearing completion, including the Clinical Services Model Information Pack, updated Service Model Blueprint, and patient personas, which are being finalised ahead of CMT Board submission. Benefits realisation activities have also advanced, with logic-benefits mapping completed and draft scorecards prepared for Board endorsement, prior to wider consultation and refinement. Impact assessments remain a core assurance function, with QIAs for several workstreams already approved and others progressing through governance. The programme-level EQIA is ready for CMT Board review, and the final workstream QIA is currently in development. A recent health check has also been initiated to assess audit readiness, with findings to inform updates to the programme management plan. The programme remains **YELLOW** (cautionary) due to ongoing challenges related to documentation and workload pressures arising from the pace of change. **Directorate-led IMTP Portfolio** The Planning Team continues to work with Directorates to ensure assurance through directorate plans to the CEO and Strategic Transformation Board (STB), enabling a structured approach to planning through the Integrated Strategic Planning and Development Group (ISPD). Work has

progressed to digitise Directorate plans with the aim to commence reporting through MS365 applications by Q2 2025/26.

The assurance report in Appendix 1 sets out the end of Q4 position. A number of deliverables at directorate level remain **AMBER** (in progress, off track) with some deliverables having rolled over into the 2025-28 IMTP. However, there are a number of key pieces of work **COMPLETE** and progress on track (**GREEN**) in a number of areas where delivery is across multiple years of the plan.

Appendix 2 sets out how we are progressing against ministerial priorities set out in the last NHS Planning Framework.

Outcomes measures

This report has drawn on available data from the MIQPR and through directorate level monitoring where available. Detailed information for each area of the IMTP that has 'what good looks like' statements is contained within appendix 1. The following visual gives an overview of progress of the plan in terms of the outcomes set out in the IMTP 2024/25.

What Good Looks Like Direction of Travel (2024/25)				
Area/Metric	Negative Directional Trend	23/24 Base Figure	Positive Directional Trend	Target (=100%)
NHS 111 Wales				
111 Abandonment Rate	70.3%	6.6%		5%
111 Patient Satisfaction Rate		55.9%	12.5%	90%
Consultations Closed with No Further Follow Up		47,843	54.9%	95,686
111 Website Hits		5,255,996	54.1%	5,781,596
111 Completed Symptom Checkers		152,321	34%	167,553
Emergency Medical Services (999)				
Red 8-Minute Target	10.9%	50.3%		65%
Reduce Unmet Demand/Cancellations	6.7%	118,631		59,316
Consult & Close		13.8%	28.1%	17%
See & Treat	2.9%	45,969		91,938
Rosc Rates		19.2%	15.5%	25%
Ambulance Care				
Renal Journey Times		74.4%	100%	70%
Oncology Journey Times		70.4%	100%	70%
Discharge & Transfer Journey Times	33.1%	82.3%		95%
On the Day Cancellations	3.9%	12.7%		5%
Patient Satisfaction Rate		86.7%	7.3%	95%
Our People				
Sickness Absence		8.54%	28.4%	6%
Staff Turnover Rate		8.73%	17.9%	7%
Staff Engagement Scores		65.8%	13.1%	75%

The graphic focuses on 'What Good Looks Like' for 2024/25, based on data up to the end of February 2025, and then 'What will be Different' (noting that this has been changed mid-year). It concentrates not only on new initiatives or processes that are yet to be implemented, but also on how we are progressing against existing targets and ambitions.

NB this differs in format from the previous quarterly report and the version in the IMTP. We aim to bring through a more visually accessible version in reporting for 2025/26.

The 2025/26 IMTP includes updated 'what good looks like' statements and associated metrics.

Commitments to our people

It has been a commitment within our IMTP to address three key issues based on feedback we have received through engagement with staff and volunteers, surveys and TU relationships. By year end we had made the following progress:

- **Shift overruns:** a task and finish group has been set up collaboratively with trade union partners, with workshops in Q4 focussed on what further actions are within WAST's gift to address overruns. Two key initiatives were identified and are being further explored. Additionally, there is a list of other identified issues that need to be addressed, as this remains a commitment into 2025/26.
- **Digital Experience:** this year, we have laid key foundations to improve the digital experience for staff and align with our People & Culture and Digital Plans. Infrastructure work is underway with DHCW to enable Microsoft Hello and begin to deliver a simplified single sign-on experience. We have launched a 150-person pilot of Microsoft Copilot to explore the benefits of Artificial Intelligence (AI) and begun mapping opportunities to automate manual processes across the organisation. Early exploratory work on our Smart Station concept has progressed and will move to a business case stage. We have also completed the migration of our reporting into Power BI, in order to deliver more accessible and actionable insights. These efforts are supported by a growing Digital Skills plan to build confidence and capability across our workforce.
- **Flexible working:** following extensive work and the implementation of legislation, we see flexible working as a commitment we are now delivering on and will undertake a review of All Wales policy and its impact on WAST.

Given that we have delivered on flexible working, a commitment was added to the 2025-28 IMTP, **1:1 conversations.** Through Our WAST Way, regular 1:1 conversations will be embedded to address staff challenges, enhance motivation and wellbeing, and build a supportive work environment through open dialogue and joint problem-solving.

Forward assurance plan in 2025/26

Cycles of business for Strategic Transformation Board through CMT programme and ISPD have been developed for reporting into the Committee and Trust Board. Both CMT and ISPD are developing digitised mechanisms to support programme and directorate-led IMTP delivery using Microsoft suite of applications available to the Trust. This may result in a change in format of reporting. However, the general approach will remain as in 2024/25 with updates against the CMT programme, directorate-led updates and against ministerial templates. This year we will be reporting against new ministerial priorities:

- Prevention
- Timely access to care – this incorporates urgent & emergency as well as planned care
- Mental health access
- Community capacity
- Women's health

Strategy Planning & Performance directorate is continuing to develop outcomes monitoring of the 'what good looks like' statements and working with directorate leads to ensure data is available against each statement to demonstrate progress in terms of the outcomes set out in the plan.

REPORT APPROVAL ROUTE
Strategic Transformation Board (STB) 24 February 2025

REPORT APPENDICES
Appendix 1 – IMTP Delivery Assurance Report **Appendix 2 - Assurance against the Cabinet Secretary's priorities 2024/25**

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

Appendix 1 - IMTP Delivery Assurance Report

SITUATION

1. The purpose of this paper is to provide the Committee with an end of year position for IMTP delivery and assurance for 2024/25 (year 1 of the 2024-27 IMTP).

2. This paper provides a position for the Clinical Model Transformation (CMT) programme Directorate-led IMTP portfolio, and Ministerial (now Cabinet Secretary) Priorities set by Welsh Government.

3. It also provides an assessment against the 'what good looks like' outcomes statements set out in the 2024-27 IMTP.

BACKGROUND

Clinical Model Transformation (CMT) Programme Management Progress Update and Next Steps

4. The programme continues to mature in its approach, with further progress made in digitising our programme management approach. All core programme controls – including risks, issues, and decisions – have been migrated to a centralised MS365 solution. An interactive Programme Portal has been launched, with workstream-specific gateways currently in development. FY25/26 workstream plans are also being built in MS Project, aligned to IMTP deliverables, providing a digitised and transparent foundation for delivery. Work is ongoing to test and refine this solution, including the development of standard operating procedures for project managers. The team is also exploring the use of Power BI to automate elements of programme reporting, beginning with risk and issue management as the first use case.

5. Key deliverables such as the Clinical Services Model Information Pack and an updated Service Model Blueprint are nearing completion, with final revisions underway ahead of wider circulation. The development of patient personas is also progressing well, with final edits being agreed with SROs before submission to the CMT Board for approval.

6. Significant progress has been made in the area of benefits realisation. Logic-benefits mapping for each workstream has been completed, providing a technical foundation to define meaningful, measurable benefits at the workstream level. Version one of the scorecards has been developed and is on the agenda for endorsement by the CMT Board. Subject to approval, a consultation period will commence to refine the scorecards further with input from workstream SROs and key stakeholders, prior to final approval and development by the Insights & Data Services (IDS) team.

7. Quality and equality impact assessments remain integral to programme assurance. QIAs for the Digital Front-End and Urgent Community Response workstreams have been approved, while assessments for Remote Integrated Care and revisions to Emergency Response (v9) are progressing through governance. The programme-level EQIA is also ready and scheduled for CMT Board approval. The Health Transport QIA is the final assessment under development, following the recent April workshop.

8. In support of audit readiness, a programme health check has been initiated. The findings, including any gaps in documentation or areas for improvement, will be addressed through updates to the programme management plan to ensure robust governance and oversight are maintained.

9. From a management perspective, the overall status of the programme remains **YELLOW** (cautionary) due to ongoing challenges related to documentation and workload pressures arising from the pace of change.

ASSESSMENT

Clinical Model Transformation (CMT) Workstream and Enabling Working Group Updates

CORE CLINICAL MODEL TRANFORMATION (CMT) WORKSTREAMS	
DIGITAL FRONT-END	**↔ Green**
On Track: The implementation of a Virtual Assistant for the NHS 111 Wales website is progressing well, with preparations underway to ensure readiness for live deployment. Security Assessment and Data Protection Impact Assessment (DPIA) approvals are scheduled for the upcoming Project Group Meeting in May. Following strong staff engagement during the CEO Roadshow, over sixty name suggestions were received for the Virtual Assistant. A shortlist will be published on Siren, allowing staff to vote for their preferred options before a final decision is made by the Project Group. The Capital Funding Group is set to review funding for the Online Symptom Checker on 14th May 2025, with expectations of approval. Funding pathways continue to be explored within the Project Group to ensure alignment and readiness. Pending funding approval, the proposal will move to the Trust Board on 29th May 2025 for authorisation to procure a web-based Call Prioritisation Streaming Service (CPSS). This will mark a significant progress point in the transformation of our digital front-end, enabling us to better integrate the 111.Wales website through alignment with our 111-telephony service. In early April, a meeting between WAST and Welsh Government explored Digital Front-End opportunities. A phased approach was proposed with Phase 1 focusing on foundational infrastructure, followed by Phase 2 unlocking new capabilities to support the six goals strategy and collaborate on urgent and emergency care policy developments. Project documentation continues to evolve, with digitalisation of the Digital Front-End Workstream SharePoint Site complete and recent approval of the Quality Impact Assessment (QIA) by the Clinical Quality Governance Group (CQGG) on 14th April 2025.	

EMERGENCY RESPONSE	↔ Green

On Track: As we continue advancing the Rapid Clinical Screening and Call Flow Prioritisation programme, key milestones are being achieved to enhance emergency response accuracy, data transparency, and operational efficiency.

The integration of Telephony Power BI reporting is now fully embedded as business as usual, supporting improved oversight and decision-making. Alongside this, AQM Reporting is progressing in collaboration with the Insights & Data Team and will further our ability to evaluate the impact of Rapid Clinical Screening.

Currently, the team is focused on the forthcoming implementation of newly defined call categories, including Purple (Arrest), Red (Emergency), and Maroon (RCS0), and we are pleased to confirm that we are on track to meet Welsh Government expectations of the 1st July 2025 for official implementation.

The project group has done considerable work to define quality and performance measures aligned to the newly defined categories and the formal Data Definition documents are undergoing final governance review before being submitted to the CMT Board in May for formal endorsement. Project governance continues to strengthen with updates to the Quality Impact Assessment (QIA) progressing, and ongoing development of the overall project plan to ensure alignment with safety and quality standards.

URGENT COMMUNITY RESPONSE	↔ Green

On Track: Considerable progress has been made across the Urgent Community Response (UCR) workstream, with a focus on enhancing operational efficiency and strengthening service delivery. The UCR Service Specification is now complete and has been formally approved, marking a key milestone in defining the framework for future service advancements.

The Mental Health Response Vehicle (MHRV) remains operational, with an evaluation now underway to assess its impact using available data. ITV Wales recently featured the service on the 6 o'clock news (22nd April 2025), providing the public with an insightful look at how WAST develops personalised services to meet population needs. An SBAR will be considered by the CMT Board in May to request a recruitment of a third Mental Health Practitioner to resolve some staffing challenges related to the MHRV.

In Cardiff and Vale, the APPNAV service is now operating extended hours, providing coverage until 02:30. Meanwhile, the APPNAV for Aneurin Bevan is set to go live in early May, marking a significant milestone—with all seven Health Board areas soon having an operational APPNAV resource.

APP recruitment remains a priority, with an active advert for Advanced Paramedic Practitioners (APPs) within Palliative Care in Cardiff and Vale, supporting continued expansion. However, the Advanced Clinical Practice Delivery Group has reported its status as **'Yellow' (cautionary)** as a decision is required on the proposed increase in APP FTE for FY26/27. This is currently being considered, but is impacting recruitment timelines, placements, and location planning.

Outcomes: Turning the dial

In the IMTP we set out what good would look like for 999 callers over the next 3 years. These workstreams within the Clinical Model Transformation more or less cover what is currently the traditional 999 response, and the IMTP set out that the following metrics would determine the positive impacts of our plan:

- 65% red target
- Reducing unmet demand by half
- Doubling the number of patients safely managed at home or in the community
- An increase in ROSC rates

What Good Looks Like Direction of Travel (2024/25)				
Area/Metric	Negative Directional Trend	23/24 Base Figure	Positive Directional Trend	Target (=100%)
Emergency Medical Services (999)				
Red 8-Minute Target	10.9%	50.3%		65%
Reduce Unmet Demand/Cancellations	6.7%	118,631		59,316
Consult & Close		13.8%	28.1%	17%
See & Treat	2.9%	45,969		91,938
Rosc Rates		19.2%	15.5%	25%

The Committee is able to scrutinise this data in more depth in the MIQPR.

REMOTE INTEGRATED CARE — ↑ Green

On Track: Building on the positive evaluation of the Winter Desk Initiative, a proposal is now in development to outline next steps. The initiative, presented at various CMT Project Groups, Clinical and Quality Governance Group, and Operational Forum, demonstrated the successful application of the Call Prioritisation Streaming System (CPSS) for 999-originating calls and strengthening these findings, and building on this success, remains a key priority.

Following the well-received evaluation of Remote Monitoring Solutions within the community, work is progressing to establish clear metrics for measuring the operationalisation of the new Care Planning function. A series of workshops are planned to evaluate the full impact of remote care planners, ensuring informed decision-making and service optimisation.

Additionally, Remote Integrated Care Plans have now been developed and approved, backed by a structured delivery framework and a robust reporting system. These enhancements will drive continuous improvement and oversight, reinforcing the commitment to responsive, data-driven care solutions.

Outcomes: Turning the dial

In the IMTP we set out what good would look like for 111 callers over the next 3 years. The RICS workstream within the Clinical Model Transformation more or less cover what is currently the 111 response (noting that the CSD element of Integrated Care is covered above), and the IMTP set out that the following metrics would determine the positive impacts of our plan:

- 111 Call Abandonment Rate
- Improved patient satisfaction
- Increase in calls closed with no follow up required
- Increased proportion of next steps booked for the patient

What Good Looks Like Direction of Travel (2024/25)				
Area/Metric	Negative Directional Trend	23/24 Base Figure	Positive Directional Trend	Target (=100%)
NHS 111 Wales				
111 Abandonment Rate	70.3%	6.6%		5%
111 Patient Satisfaction Rate		55.9%	12.5%	90%
Consultations Closed with No Further Follow Up		47,843	54.9%	95,686
111 Website Hits		5,255,996	54.1%	5,781,596
111 Completed Symptom Checkers		152,321	34%	167,553

The Committee is able to scrutinise this data in more depth in the MIQPR.

HEALTH TRANSPORT — ↑ Green

On Track: Following the agreement of the Health Transport definition, a workshop was held on 11th April to determine patient criteria and journey processes, ensuring clarity on planned journey outcomes based on a Remote Integrated Care (RICS) assessment.

The patient suitability criteria and process flows have now been established, shaping the following key initiatives:

- A proof of concept will explore transport options for patients who meet Clinical Support Desk (CSD) Taxi Standard Operating Procedure (SOP) criteria but are currently unsuitable due to mobility concerns. The scope may be expanded to include all taxi-suitable patients, subject to data review.
- The development of transport pathways across health boards, ensuring alignment with RICS assessment outcomes.
- An assessment of the feasibility of patient transport to planned care following a face-to-face assessment, mirroring GP referral processes.

These initiatives, alongside the Transfer & Discharge Project, will be taken forward under the leadership of the Health Transport Workstream Board. Next steps will include establishment of relevant Task & Finish groups to begin data analysis and inform future developments.

Outcomes: Turning the dial

In the IMTP we set out what good would look like for users of Ambulance Care services. Whilst the programme for Health Transport continues to develop and whilst commissioners and WAST work to develop a new vision for non-emergency transport and Ambulance Care services, operational improvements and some of the IMTP delivery actions have contirbuted to the following metrics:

- Timeliness
- Fewer on the day cancellations
- Inter-site transfers provided within the time required
- Increased patient satisfaction

What Good Looks Like Direction of Travel (2024/25)				
Area/Metric	Negative Directional Trend	23/24 Base Figure	Positive Directional Trend	Target (=100%)
Ambulance Care				
Renal Journey Times		74.4%	100%	70%
Oncology Journey Times		70.4%	100%	70%
Discharge & Transfer Journey Times	33.1%	82.3%		95%
On the Day Cancellations	3.9%	12.7%		5%
Patient Satisfaction Rate		86.7%	7.3%	95%

The Committee is able to scrutinise this data in more depth in the MIQPR.

CHANGE ENABLING WORKING GROUPS	
QUALITY & PERFORMANCE METRICS	**↓ Yellow**

Yellow (cautionary status) overall: The CMT Metrics Workstream has made significant progress in several key areas while also identifying and addressing various challenges. The definitions for Purple (Arrest), Red (Emergency), and Maroon (RCS0) have been approved with minor clarifications, and further work on monitoring and assurance metrics is underway, with expectations for approval by CQGG on 12th May.

Draft workstream scorecards have also been developed and are central to our approach to benefits management across the programme. The scorecards have been informed by the development of technical 'Logic Benefits Maps' and will be shared with the CMT Board in May for consideration. Following CMT Board endorsement we will commence more detailed work with workstream SROs to finalise benefit measures and will commence dashboard development.

To manage capacity challenges, the workstream continues to collaboratively prioritise incoming IDS requests, with several meetings during April to review and agree priorities with Executive Leadership. However, the ability to manage competing and changing priorities and the capacity to deliver these continues to present the greatest risk. It is expected that this will be addressed through the additional IDS investment agreed via the IMTP 25/28, however continued collaborative prioritisation of the IDS workplan will provide some mitigation whilst additional resource is recruited.

The CMT independent evaluation procurement was out to tender during April, with shortlisting taking place in early May.

CHANGE MANAGEMENT	↔ Yellow

Yellow (cautionary status) overall: The Board was alerted to ongoing challenges regarding the availability of Senior Responsible Officers (SROs) to attend workstream meetings. Alternative approaches are being explored to identify barriers and improve engagement. A proposal to repurpose the Transformation Delivery Network (TDN) has been shared, aiming to broaden participation to include all those with an interest in the transformation agenda. This revised model would be chaired by Strategy, Planning and Performance (SP&P), with updates provided by SROs. Feedback from workstream members is currently being gathered.

The development of the next internal communications output is underway, featuring talking head videos with workstream SROs. In addition, the CMT prioritised Change Management on the agenda for May.

PARTNERSHIPS & ENGAGEMENT	↔ Green

On Track: Engagement with priority clinical stakeholders has continued throughout Q4, including targeted sessions with All Wales Medical Directors, Associate Medical Directors, and National Clinical Leads for Urgent Care. Preparations are underway to engage with National Clinical Directors and Directors of Primary Care, while thematic analysis of stakeholder feedback has

commenced, with outputs to be shared in due course. Planning has also begun for the next phase of broader system stakeholder engagement, as outlined in the Programme Engagement Plan.

The Board was assured that regular contact is being maintained with key leaders at Llais. The Chief Operating Officer of Llais continues to attend Trust Board meetings, and feedback to date remains positive. While no concerns have been raised, active dialogue is ongoing to ensure continued confidence in the Trust's engagement approach.

Directorate-led IMTP Delivery & Assurance Approach

10. IMTP deliverables outside the scope of the Clinical Model Transformation programme are managed through Directorate Plans or bespoke programmes noting that some actions may still require cross-directorate working.

11. Existing Directorate Business Meetings are utilised, and assurance provided to the STB and onward to the Committee and Board.

12. This process is facilitated by the Integrated Strategic Planning & Development Group (ISPD), with summary updates from Directorates to the group. This will also support with the cycle of strategic planning. Updates by exception will subsequently be incorporated into quarterly reports to STB, providing status updates on the IMTP deliverables and escalating any key risks/issues or achievements.

13. The current update in this paper is the end of quarter 4, year end position.

14. Directorate led IMTP deliverables below are set out against each of our strategic objectives.

SO1 Providing the right care or advice, in the right place, every time

IMTP Objective	IMTP Action/ Deliverable	Q4 RAG Status	Year End Position	Summary
High quality, immediate or timely on scene assessment, care and conveyance where needed	Fully roll out CHARU	**Complete**	**Transition to core business**	• UHP at 94% nationally, 1% off 95% target • External recruitment completed; secondment opportunities being considered for remaining gaps
Excellent clinical leadership	New remote clinical assessment service clinical leadership team	**Yellow**	**Will roll over to 25/26**	• In process of recruiting clinical navigators and locality manager
Rapid call answering, initial triage and onward referral	Demand & capacity review for activity originating in 111	**Green**	**Review to be completed**	• Demand and capacity review, tender process completed, contract award being made • Further re-roster deliverables in 25/26 IMTP following completion of the review
A flexible, user centred Non Emergency Patient Transport Service with the right capacity in place to meet demand	Complete NEPTS roster review and commence benefits realisation	**Yellow**	**Will roll over into 25/26**	• Significant progress but longer timescale to implement, project established, engagement underway • To be delivered by end of Q2 25/26
	Develop and implement an enhanced oncology joint plan with partners	**Green**	**Will roll over into Q1 25/26**	• Will roll over into Q1 25/26 • Significant work with cancer centre liaison to develop national checklist to maximise service delivery
	Reduce cancellations through system redesign with health boards	**Green**	**Further phases in 25/26**	• Text messaging options developed, two-way messaging gone live Mid Feb. • Further phases to SMS messaging in 25/26 which will contribute to reduction in cancellations
	Implement a revised Liaison Service Model	**Green**	**Completed**	• Engagement sessions in February/March

IMTP Objective	IMTP Action/ Deliverable	Q4 RAG Status	Year End Position	Summary
A dedicated and timely transfer & discharge service supporting HBs with their transformation agendas	Plan for 24/7 major trauma desk & transfer clinical hub (subject to funding)	**Yellow**	**Will roll over to 25/26**	• Business case being developed • Consideration as part of future model development
A high quality, safe service with improved patient experience	Quality assurance mechanism for external providers further enhanced	**Complete**	**Transition to core business**	• Annual inspections now programmed in with quarterly reporting in place.

SO2 Enabling our people to be the best they can be

IMTP Objective	IMTP Action/ Deliverable	Q4 RAG Status	Year End Position	Summary
Capability	Ongoing work; People Development Plan, People Management Essentials and PADR check ins	**Green**	**Continual development and implementation**	• Further focus on PADRs in 25/26 plan. • Continual development and implementation of people development plan, embedding into organisation
Capacity	Delivery of Strategic Workforce Plan	**Complete**	**Action plan will roll over into 25/26**	• Plan was presented at People and Culture Committee where it was endorsed • Action plan for implementing is included within 25/26 IMTP
	Ongoing work; Health & Wellbeing Plan, Retention Work Plan, e Timesheets	**Green**	**Delivery in 25/26**	• Ongoing work progressing towards Q4 deadlines, albeit there may be some delay on e timesheets due to sickness of key staff working on delivery

IMTP Objective	IMTP Action/ Deliverable	Q4 RAG Status	Year End Position	Summary
Culture	Expand Culture Champions and Change Network	**Green**	**Ongoing into 25/26**	• Ongoing work continuous into IMTP for 25/25 • Development of a culture toolkit currently on hold whilst developing Our WAST Way
	Ongoing work; Allyship & Bystander training, Employee offer, Culture Champions & Change Network, impact of culture toolkit	**Complete**	**Transition to core business**	

In the IMTP we set out what good would look like for Our People, by monitoring the following metrics:

- Sickness absence below 6%
- Turnover rates falling
- Engagement rates (measured for example by NHS Staff Survey completion)

What Good Looks Like Direction of Travel (2024/25)				
Area/Metric	Negative Directional Trend	23/24 Base Figure	Positive Directional Trend	Target (=100%)
Our People				
Sickness Absence		8.54%	28.4%	6%
Staff Turnover Rate		8.73%	17.9%	7%
Staff Engagement Scores		65.8%	13.1%	75%

The Committee is able to scrutinise this data in more depth in the MIQPR.

SO3 Being at the forefront of innovation & technology - Digital

IMTP Objective	IMTP Action/ Deliverable	Q4 RAG Status	Year End Position	Summary
Patient access	Video triage calls, deployment and adoption of video triage technology for our CSD & 111 services	**Green**	**Will roll over to 25/26**	• Trialling in Swansea Bay and Hywel Dda, plan for Wrexham • Roll out in plan for 25/26
Rapid progress of technology	Telephony upgrade for 999	**Complete**		• Successfully delivered November 24
	MDVS project conclusion EMS & NEPTS replacement of mobile data terminals & associated hardware/software	**Complete**	**Phase 2 in 25/26**	• Completed Phase 1, closure report completed. • Plan for MDVS Phase 2 Outline Business Case 25/26
Developing & implementing our plans for Environmental Sustainability and Adaption	Delivery of EFAB funded schemes throughout the year	**Green**		• Newtown due for completion mid-March • Tredegar complete • HART premises complete • Pontardawe complete • Fire alams & medical gas storage work complete

IMTP Objective	IMTP Action/ Deliverable	Q4 RAG Status	Year End Position	Summary
Right buildings in the right place, enabling our staff to provide the best and safest care across Wales	Prioritised estates capital schemes delivered through year and across IMTP years	**Green**	**Schemes across IMTP years**	• Further consideration required on planning for Swansea, Llanelli, Newport and Llandrindod Wells in 2024/25 due to AWC funding • Bangor Fleet Workshop – delivery included in 2025-28 IMTP • Llangunnor due for completion by end of March 2025 • Ruthin remains 'urgent attention required' as alternative solutions required • Dolgellau - delivery expected in 2025/26 • Monmouth delivery included 2025-28 IMTP • North Wales CCC relocation works are on track to be completed by end of March 2025 • Thanet House on hold and included in 2025/26 prioritisation
The right fleet in the right place, enabling our staff to provide the best & safest care across Wales	Prioritised fleet capital schemes delivered through year and across IMTP years	**Green**	**Schemes across IMTP years**	• 35x EA vehicles due for conversion and completion in year • 5x HART responder vehicles due for delivery in February 2025 with completion slipping into 2025/26 • 30 x SRVs on track for commissioning into April

The digital plan is key to turning the dial on the following metrics:

- No successful cyber breaches
- Reduced numbers of helpdesk calls and better rate of first call resolution
- Increase in the number of scaled up technology projects
- Increased confidence in using data
- Increased levels of patient and staff satisfaction with digital solutions

Whilst some of this data is available there is further work to update metrics for the 2025/26 IMTP delivery. Some indicators above will be available through committee reports and/or the MIQPR.

SO4 Developing our services in collaboration - Partnerships & Engagement

IMTP Objective	IMTP Action/ Deliverable	Q4 RAG Status	Year End Position	Summary
Meet the requirements of the Wellbeing of Future Generations Act	Delivery of wellbeing objectives published by end of Q4	**Complete**	**Deliverables in 25/26**	• Wellbeing objectives approved and work commenced to identify initiatives supporting delivery.
University Trust Status in collaboration with WG, embracing democratised culture of learning, research and innovation	Academic Partnership priorities updated and published	**Complete**		• Priorities agreed and included in 25 – 28 IMTP
Well place to influence system thinking/ strategy development	Structured engagement commenced with stakeholders & public	**Green**	**Will continue into 25/26**	• Continued ongoing work being worked up alongside CMT development - working in collaboration with strategy and transformation teams

The Engagement Framework and CMT Engagement plan are key to turning the dial on the following metrics:

- Improved reputation scores
- Stakeholder support for our strategic plans
- Increasing number of research projects
- Increased levels of alternative (to core commissioning) funding streams

Whilst some of this data is available there is further work to update metrics for the 2025/26 IMTP delivery.

SO5 Being quality driven and clinically led

IMTP Objective	IMTP Action/ Deliverable	Q4 RAG Status	Year End Position	Summary
Systems that meet the requirements of the Duty of Quality and Duty of Candour	Establish a Quality Improvement Hub	**Amber**	**Will be completed early 25/26**	• Life QI purchased and implemented • Meetings held with Transformation Team to identify opportunities to utilise software for transformation tracking of PDSA test of change data
A culture of quality improvement with robust quality management systems	WAST Quality Plan	**Green**	**Will roll over into early 25/26**	• Quality T&F Group established to support draft content • Governance approval routes identified • Implementation plan in draft
Meaningful engagement and co-production with communities	CIVICA enhancement	**Amber**	**Will roll over into 25/26**	• Report completed • Launched SMS text service • Continue to expand the wider patient experience capture, DPIA being progressed for Information Commissioner approval

We are currently refreshing both the Clinical Plan and the Quality Plan for the Trust. We will seek to turn the dial on the following metrics:

- Duty of Candour compliance
- Increased number of patient outcomes reported
- Increased evidence of meaningful public and patient engagement
- Increased opportunities for out people to progress their clinical practice and career

Whilst some of this data is available there is further work to update metrics for the 2025/26 IMTP delivery. Some indicators above will be available through committee reports and/or the MIQPR.

SO6 Delivering exceptional value

IMTP Objective	IMTP Action/ Deliverable	Q4 RAG Status	Year End Position	Summary
Rapid call answering, initial triage and onward referral	Undertake demand & capacity review	**Green**	**Re-roster in 25/26**	• Been brought back on track to enable re-roster in 25/26
Sustainable savings & efficiencies	Service Review across the Trust completed with recommendations	**Amber**	**Will roll over into 25/26**	• Final report agreed • ELT session in Feb 25 with key areas of work to be delivered in 3 phases in next IMTP 25 -28
Generate income alongside our core commissioned functions	Develop commercial strategy based on outcome of market analysis exercise	**Amber**	**Will roll over into 25/26**	• Recruitment of Head of Commercial unsuccessful, JD being reviewed to re-advertise with commitments to continue to focus on commercial opportunities in 25/26

Well governed

IMTP Objective	IMTP Action/ Deliverable	Q4 RAG Status	Year End Position	Summary
A risk management framework as a key enabler of our long-term strategy & decision making	Implementation of strategic BAF by end of Q3	**Complete**	**Transition to core business**	• Finalised for roll out in 25/26 for transition to core business
	Suite of risk appetite statements implemented and issued	**Complete**	**Transition to core business**	• Sessions in Board Development delivered; transition to core business

	Risk training rolled out & Level 1 training package on ESR	**Complete**	**Transition to core business**	• Design ready to be published on LM365
Strengthen Welsh Language compliance	Toolkit for senior leaders & board developed	**Complete**	**Complete**	• Toolkit included into Welsh Language Policy • Suite of documents included in Board Development Days

RECOMMENDATION

15. That the Committee:

- **Notes** the progress in identifying 'what good looks like' through the continuing development of high-level outcomes measures;
- **Notes** the CMT programme end of year position;
- **Notes** the Directorate-led IMTP end of year position;

Appendix 2

Assurance against the Cabinet Secretary's priorities 2024/25

BACKGROUND

WAST submitted eight templates covering plans against four of the Cabinet Secretary's priorities for NHS Wales. These covered how we engage across community services, provide support to planned care and cancer, but also how we aligned to the Six Goals programme for Urgent and Emergency Care and how we approached our response to patients with mental health needs. In 2024/25 we were to develop a 'Six Goals' delivery plan. Whilst we set out in the templates submitted to WG many areas across the six goals where we can implement change, these are already factored into the scope of the work to develop a future clinical services model, therefore we have tried not to duplicate reporting in the table below.

ASSESSMENT

The following table sets out the key areas for WAST against the priorities, and the milestones to be achieved by the end of Q4. Bold font indicates new progress update. The end of year position does not differ from the interim position reported at the last Committee meeting.

Cabinet Secretary Priority	Area for WAST	Milestones Q1	Milestones Q2	Milestones Q3	Milestones Q4	Progress
Primary and Community Care, with a focus on improving access and shifting resources into primary and community care	111 Skill Mix	• Group established to consider and develop scope for 111 MDT skill mix	• Scoping paper to commissioners	• (Subject to commissioner support) Project initiation & Business Case Developed	• Business case submitted for introducing new roles	• Off track. The paper has not yet been presented to commissioners. • Multi professional skill mix features within 2025-28 IMTP
	111 Pathways	• Dental access improved in 4x health boards by end of Q4 • Strengthened links into primary care / Out of Hours in. Urgent Primary Care Centre access by end of Q4 • Medicines management pathways in place by end of Q4				• Modelling being undertaken for 3 remaining Health Boards to take on dental access pathways • Currently piloting in BCU and C&V direct booking into Urgent Primary Care Centres

Cabinet Secretary Priority	Area for WAST	Milestones Q1	Milestones Q2	Milestones Q3	Milestones Q4	Progress
	999 Pathways: Falls & Frailty	• Level 1 falls - Assessment of the demand & capacity modelling undertaken • Level 2 falls - Undertake evaluation of our existing services	• Presentation of L1 options and benefits • Present evaluation and options for sustainability of L2 services going forward	• Implement new L1 model • Develop and Implement L2 Plan	• Monitor & evaluate impact on delivery • Y2/3 Milestones for expansion of services across Wales	• **Deliverables for falls have been included in 2025-28 IMTP aligned to the National Community Falls framework** • WAST engaged closely with NHS Executive on the National Community Falls Framework, and is attending a National Task Force group of falls leads across NHS Wales. • Health boards are completing baseline assessments and gap analysis; mapping what current community falls response services exist and how these can be accessed. • We have undertaken 24hr level 1 response modelling nationally (on the basis that all falls can be supported at level 1 where clinically appropriate) and we are supporting health boards on understanding demand and where scaling up is required to provide a response across all geographical areas 7/7.
	999 Pathways: Digitised pathways	• Evaluate the effectiveness of the new digital solutions to make referrals to existing pathways and usage	• Develop further opportunity for digital notifications with Welsh portal	• Implementation and roll out	• No milestone for Q4	• A new digital transformation and innovation programme has been set up to manage and prioritise digital workstreams that fall outside the clinical transformation programme – this is progressing
	999 Pathways: Connected Support Cymru (CSC)	• Recruitment of key roles to support CSC delivery (dependent on outcome of business case)	• Engaging with key stakeholders and evaluating overall project data to determine resource	• Development of secondary business case to support sustainable implementation	• Submission of business case • Y2/3 Milestones for expansion of services across Wales	• **CSC is now part of the work to develop remote integrated care in the 2025-28 IMTP** • No further progress on funding requirement to support ongoing CSC development. • Project continues in BCU and remains part of the WAST IMTP and Clinical

Cabinet Secretary Priority	Area for WAST	Milestones Q1	Milestones Q2	Milestones Q3	Milestones Q4	Progress
		• Commenced recruitment of internal volunteers • Testing 'ambulance in a box' in Care Homes in AB & BCU, evaluate and conclude forward plan	requirements moving forward • Commencement of recruitment and on-boarding on external partner organisations and ongoing recruitment and onboarding of internal volunteers • Developing technology enabled care community pathways up until end of Nov; testing in Care Homes in AB & BCU and in patients homes • Evaluate and conclude forward plan	• Develop business case for procurement of technology (subject to funding)		model transformation programme as part of the wider remote clinical service development.
Urgent and Emergency Care, with a focus on delivery of	Goal 2: New 111 System	• Full implementation of new CAS system 30th April	• Realise benefits in line with business case	• Formal benefits realisation report shared with commissioners	• No milestone in Q4	• 111 metrics report being developed for JCC

Cabinet Secretary Priority	Area for WAST	Milestones Q1	Milestones Q2	Milestones Q3	Milestones Q4	Progress
the 6 goals programme		• Decommission old system				
	Goal 2: 111 website & symptom checkers	• Scoping exercise to review requirements of a 111 website – and develop options appraisal accordingly	• Development of business case • Review and develop requirements to improve symptom checkers, with potential requirement for procurement.	• Finalise business case in readiness to Seek approval through organisational BC governance process • Identify approach to improvement of symptom checkers	• Secure funding and commence recruitment of website team as determined within business case process.	• **No additional funding for website team at this stage** • **The procurement process for RoboticsAI's Virtual Assistant is complete, with contracts signed and development in progress.** • A meeting with the current CPSS supplier in December where the high level Symptom Checker Specification was discusses. A high level specification was approved in the DFE Project. The current corporate risk regarding the symptom checkers has been reviewed by ADLT and will now be presented to ELT • The Business Case for the NHS 111 Wales website is at first draft which will be reviewed by the CMT Board. • To ensure clarity on technical requirements, a collaborative meeting between the Digital and Health Informatics teams facilitated the initial drafting of the technical specification for the Content Management System procurement. • Our WAST Network members (made up from the public) and Llais public contacts and members have been invited to take part in a review of the NHS 111 Wales website. This will provide vital feedback on the current website content and usability to inform planned improvements

Cabinet Secretary Priority	Area for WAST	Milestones Q1	Milestones Q2	Milestones Q3	Milestones Q4	Progress
	Goal 2: 111 re-roster	• No Q1 milestone	• Agreement with commissioners to proceed	• Complete procurement process to undertake Demand and capacity review	• Undertake demand and capacity review • Re-roster takes place in year 2	• **Contract live and work being undertaken with strong expectation that we will re-roster in 25/26** • Review of rostering practices. Agreement from commissioners to commence Review of rostering practices. Procurement process ongoing
	Goal 3: • Develop the remote clinical assessment speciality • Develop a fully remote working clinician offer (operations/training/digital) • Develop Pre-Dispatch Outcome Risk Stratification Tools linking CAD & ePCR data • Roll out of new integrated (111/clinical support desk) care model • Connected support Cymru • Extend use of video/ phone consultation • Urgent On-Scene Community Response	• Milestones set out in the programme to deliver the future clinical service model and reporting will be in main body of IMTP assurance report	• Milestones set out in the programme to deliver the future clinical service model and reporting will be in main body of IMTP assurance report	• Milestones set out in the programme to deliver the future clinical service model and reporting will be in main body of IMTP assurance report	• Milestones set out in the programme to deliver the future clinical service model and reporting will be in main body of IMTP assurance report	• These are key deliverables in the Clinical Model Transformation Programme. See assurance report in appendix 1
	SDEC Pathways	• Re-establish ICAPs with Health Boards (subject to JCC commissioning arrangements) • Complete data quality assurance of end destination in CAD to	• Implementation of SDEC criteria across WAST	• Implementation of SDEC criteria across WAST	• Implementation of SDEC criteria across WAST	• This is now under goal 4. WAST is now part of the Goal 4 delivery group and will develop its own 6 goals delivery plan reflecting actions to improve referrals into SDEC from clinicians on scene. However, actions around SDEC activity currently sit with Health Boards within their 6 goals delivery. WAST will continue to engage and respond to requests to work collaboratively to improve uptake of direct referrals

Cabinet Secretary Priority	Area for WAST	Milestones Q1	Milestones Q2	Milestones Q3	Milestones Q4	Progress
		ensure SDEC direct referrals fully captured				
	Goal 4: CHARU	• Complete CHARU recruitment by end Q2 • Improve utilisation rate to modelled benchmark by end Q2 • (work ongoing during Q1)		• Improved staff in post to establishment		• **CHARU UHP in Q4 up to 94% (1% off target) nationally** • **123.7 FTE staff in post against target of 141.4 FTE (91% SIP to establishment)**
	Goal 4: Rural variation	• Complete CHARU recruitment by end Q2 • Continue process of targeted recruitment and process of smoothing i.e. aligning SIP to establishment by end Q2 • Build rurality results from 2023 EMS Demand & Capacity Review by end Q2 • Agree Implementation Plan with commissioners by end Q2		• Continued targeted recruitment in rural areas		• **SIP to establishment in Powys is 90.19% with only 0.8FTE vacancy and 80.37% in Hywel Dda equating to 8.3 FTE vacancies** • Recruitment in rural areas remains challenging, but is monitored regularly and is a focus within WAST. • The Clinical Model Transformation Programme constitutes WASTS's implementation plan for the D&C. The D&C will need to be formally reported to JCC at some point.
	Goal 4: Sickness reduction in EMS and EMSC	• Ongoing continuation of managing attendance and implementation of the health and wellbeing plan throughout year				• **(NB figures are organisation wide) There was a slight increase in overall sickness absence rates between November 2024 and December 2024, rising from 8.06% to 8.69%. Long term absence decreased from 5.95% in November 2024 to 5.56 % in December 2024, while short-term absence increased slightly to 3.14% in December from November 2024 (2.11%).** • Work on managing attendance continues and engagement is ongoing to develop the next iteration of the Trust's Health & Wellbeing Plan
	Goals 5 & 6: Transfer and Discharge model	• Engagement on modelled options for transfer	• Development of reporting against new protocols	• Develop implementation plans dependent on	• Integration of long term developmental plans into	• **Revised plan being developed for inclusion in 2025-28 IMTP, aligned to updated commissioning intentions for**

Cabinet Secretary Priority	Area for WAST	Milestones Q1	Milestones Q2	Milestones Q3	Milestones Q4	Progress
		services with health boards commenced • Implementation of new MTPS protocols within the Computer Aided Dispatch (CAD) system designed to allocate transfer resources more effectively	within the CAD post MTPS implementation • Agree outline service model for further engagement with Health Boards. • Develop business case/principles for All Wales service. • Develop business case for 24/7 Major Trauma Desk following outcome of Gateway 5 review.	outcome of commissioning discussions.	ambulance care service vision. • Develop implementation plans for major trauma desk.	**transfers in EMS and NEPTS commissioning intentions.** • **Project to be reframed in line with commissioning intentions in 2025-28 IMTP** • Final modelling shared with JCC colleagues shows high levels of staffing requirement for a ring fenced all Wales service. • Further options to improve timely access to transfer services and discharge capacity now being considered with JCC in line with its future vision for transport and through the Health Transport workstream of the Clinical Model Transformation Programme.
Planned Care and Cancer, with a focus on reducing the longest waits	Roster review of NEPTS Ambulance Care Assistants	• Continue with NEPTS Demand & Capacity work, in particular, undertake NEPTS transport roster review by end Q3		• Complete NEPTS roster review and start to review benefits.		• **Working parties for re-roster have commenced with full implementation expected Q3 2025/26** • Contract let with third party providers. • Project manager being appointed to lead the work internally, timescales slipped into Q4.
	Enhanced hub for oncology patients	• Establish expected outcomes & principles to develop enhanced oncology service	• Develop action plan to deliver the required change	• Action plan for oncology implemented	• Enhanced hub live	• Significant work with cancer centre liaison to develop national processes to maximise service delivery, continued joint working

Cabinet Secretary Priority	Area for WAST	Milestones Q1	Milestones Q2	Milestones Q3	Milestones Q4	Progress
	Quality assurance of external providers	• No specific milestone in Q1	• Welsh Ambulance Quality Standard award implemented	• No specific milestone in Q3	• Review award and update as required	• Ongoing
Mental Health, including CAMHS, with a focus on delivery of the national programme	Develop and implement a referral pathway for 111 Press 2 teams	• Completion of 111 CAS system implementation to aid improvement in 111 press 2	• New CAS system will provide resolution to Press 2 pathway	• No specific milestone in Q3	•	• CAS implementation complete • Review with health boards effectiveness of press two and where there is opportunity to improve
	Mental Health Response Vehicles	• Collating and presenting evidence from pilot within AB, discussing outcomes and options for further pilots	• Undertake further pilot (pending agreement) • Continuing to engage with national evidence across UK	• Prepare business case dependent on outcomes	•	• See assurance report in appendix 1 – this forms part of the Clinical Transformation Programme
	Right Care Right Person	• Engaging with Police Services in Wales, NHS partners, Local Authorities and third sector providers on changes affecting response to people in crisis	• Assess impact to WAST • Possible update to 2023 EMS Demand & Capacity Review results.	• Develop Business case	•	• Modelling can be undertaken, but requires further clarity on the likely level of activity • No progress on Business Case
	Mental Health Practitioners in CSD	• Assess demand and capacity plan outlining future needs for the team and training	• Share plan with commissioners for further discussion	• Training implemented (subject to cost and funding)	•	• See assurance report in appendix 1 – this forms part of the Clinical Transformation Programme

Cabinet Secretary Priority	Area for WAST	Milestones Q1	Milestones Q2	Milestones Q3	Milestones Q4	Progress
		requirements (as part of overall demand and capacity work for the future clinical service model)				

RECOMMENDATION

That the Committee:

1. **Notes** the progress in identifying 'what good looks like' through the continuing development of high-level outcomes measures;
2. **Notes** the CMT programme end of year position;
3. **Notes** the Directorate-led IMTP end of year position;
4. **Notes** the end of year position for the Cabinet Secretary's priorities set out in the 2024-27 planning framework;
5. **Advises** of any further assurance needed for the Board.

AGENDA ITEM No	8
OPEN	OPEN
No of ANNEXES ATTACHED	1

MONTHLY INTEGRATED QUALITY & PERFORMANCE DASHBOARD – March 2025 / April 2025

MEETING	Finance & Performance Committee (FPC)
DATE	20 May 2025
EXECUTIVE	Rachel Marsh – Executive Director of Strategy, Planning & Performance
AUTHOR	Georgia Tizzard – Commissioning and Performance Officer Melanie O'Connor - Senior Performance Analyst Mark Thomas – Commissioning & Performance Manager Hugh Bennett - Assistant Director, Commissioning & Performance
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EXECUTIVE SUMMARY

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

2. The report aims to provide an integrated view of quality & performance, so is made available to all three committees, to give that overview, with more specific and detailed reports supplementing it. Whilst giving an integrated overview, each slide contains an icon denoting the lead committee for each set of indicators.

3. Data quality issues have been identified and are being addressed within 111, APPs and throughout the quality indicators, with the result that there are a number of Board approved metrics which are not available at this time.

4. The response times for red 8-minute performance was 50.9% in April 2025, with performance marginally increasing compared to March 2025. The Amber 1 median was 1 hour 48 minutes, which was also a slight improvement on the 1 hour 51 minute 12-month average. The Trust knows these extended times (the ideal is 18 minutes) lead to avoidable patient harm. The Trust continues to work on tactical actions within its control to mitigate this risk including maintaining high levels of EA production (91% in March, slightly below the

benchmark) and fully rolling out the CHARU service (87% in March); whilst also undertaking more transformative actions through the Clinical Model Transformation (CMT) Programme.

5. The Trust lost 21,183 hours to handover in April 2025 (30-days). This level of lost capacity is difficult to compensate for, despite all of the actions being taken by the Trust.

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

7. 111 call handling performance has stabilised post-delivery of the new 111 CAS, but the service did not achieve the 5% abandonment rate in April 2025, with performance decreasing to 11.7% from 11.2% in March 2025.

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

9. The Trust continues to focus on its people, with a range of actions in place to improve workplace experience including, for example, reducing shift overruns, whilst also continuing with the more strategic focus on the People & Culture Plan. Sickness absence was 7.35% in March 2025. The IMTP ambition is to reach 6%. The Trust will continue its focus on sickness absence. EMS abstractions rose above the 30% benchmark figure in March 2025 to 33.86%.

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

RECOMMENDATION

FPC is asked to: **Consider** the March 2025/ April 2025 Integrated Quality & Performance Report and actions being taken and determine whether:

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

REPORT APPROVAL ROUTE
N/A

REPORT APPENDICES
Appendix 1 – Top Indicator Dashboard

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

SITUATION

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

2. The report aims to provide an integrated view of quality & performance, so is made available to all three committees, to give that overview, with more specific and detailed reports supplementing it. Whilst giving an integrated overview, each slide contains an icon denoting the lead committee for each set of indicators:-

BACKGROUND

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

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

4. As previously agreed, the metrics which form part of this committee/Board report are updated on an annual basis, to ensure that they continue to represent the best way of tracking progress against the Trust's plans (IMTP) and strategies. The 2024/25 revised metrics have been agreed.

ASSESSMENT

Our Patients – Quality, Safety and Patient Experience

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

6. **999** call answering times improved in March 2025 with the 95th percentile decreasing to 27 seonds, compared to 33 seconds in February 2025. The 65th percentile and median performance remain consistently good, however data quality checks are being undertaken. Work will be undertaken early in Q1 on a demand and capacity analysis of 999 call demand.

7. **111 call answering performance has decreased over recent weeks,** with the call abandonment performance for April 2025 being 11.7%, and still failing to achieve the 5% target. Recruitment has been undertaken to ensure that staff in post reflect the establishment position, and this has seen performance improve, but high sickness levels are having an effect. It should be noted that there is also a reduction in the commissioned level of call handler FTEs in 2024/25 compared to last year (-4%).

8. 111 demand in April 2025 was 1.79% higher than during April 2024. The Trust procured a third party in January 2025 to undertake a collaborative (with commissioners) and independent review of the Trust's 111 call handler rostering practices, including a review of demand levels and required staffing capacity.

9. **111 Clinical response:** clinical ring back times for patients with the highest priority remained above target at 97.5%. Response times for lower priority calls declined, recording 69.6% and 60.9% for P2CT and P3CT respectively. This is consistent with previous years, but needs to be monitored closely over the coming months.

10. **Ambulance Response** (safety / patient experience): the red 8-minute response performance for April 2025 was 50.9%, remaining below the 65% target, but improving slightly compared to March 2025. The Trust is reaching more red patients in 8-minutes, but the denominator (demand) has also grown. The Amber 1 median in March was 1 hour and 48 minutes and the Amber 1 95th percentile was 7 hours 26 minutes. The Clinical Safety Plan and CHARUs will protect red demand, but Amber is where the impact of handover lost hours is felt i.e. there is a strong correlation. These long response times have a known impact on avoidable patient harm. New performance arrangements were announced by

the Cabinet Secretary on 11 March 2025 which will come into effect on the 1st of July 2025 and will see the introduction of new purple arrest and red emergency categories alongside an increased emphasis on improving patient outcomes.

11. Traditionally the main factors which affect response times are demand and capacity (recruitment and lost hours). EMS production has been good, but the lost capacity through handover at hospital remains extremely challenging and largely out of the Trust's control to address. The Trust's main focus is to implement a material change in how it responds to patient demand by evolving its clinical model through the Clinical Model Transformation (CMT) programme, elements of which have been implemented over the winter. Areas of focus include: -

    - Data quality issues have been identified with APPs and these are currently being addressed.
    - Further investment into remote clinical capacity (+28.5 FTEs) and switching on of remote clinical screening (RCS) (completed);
    - Recruiting up to 153 CHARU FTEs (91% UHP achieved in February 2025, benchmark 95%).
    - Further investment in APPs (+32 APPs) (26 FTEs achieved);
    - Development of the remote integrated care service (111 clinicians and CSD clinicians) (initial development completed as part of winter plan);
    - Continued focus on a range of responses that support non-conveyance, where it is clinically safe and appropriate to do so: Connected Support Cymru, mental health response pilot, Falls response etc. (MH pilot live).
    - Formal reporting of the 2023 collaborative and independent EMS Demand & Capacity review (reported to F&P Committee, but not yet formally reported to the JCC).
    - New Purple Arrest and Red Emergency categories (announced on 11 March 2025) with go live planned for 01 July 2025.

12. As above, the extreme level of lost hours to **handover outside Emergency Departments** remains the critical component of long waiting times and patient safety incidents. 21,183 hours were lost during April 2025. Cardiff & Vale's handover lost hours continues to remain comparably much lower, due to an organisational focus within the health board. While some small improvements have been seen in other health boards during 2024, Betsi Cadwaladr health board remains significantly high and above its two-year average figure, with 7,251 hours being lost within the health board during April. WG have re-iterated to health boards the critical importance of improvements in this area. The WG pan-Wales target of no handovers of more than one hour, equates to 7,500 lost hours.

13. **Ambulance Care (Patient Experience)**: Oncology performance in April 2025 was 79.6%, achieving the 70% target. Renal performance improved to 72.8%

which was also above target. Advanced discharge & transfer journey performance however decreased marginally to 75% and remains below its 95% target. Same day discharge & transfer journey performance also dropped below target for the first time since the performance changes were made in April 2023 to 94%. Overall demand for NEPTS continues to increase and is now above pre-pandemic levels. The Trust has a comprehensive Health Transport transformation workstream in place, which includes delivering a range of efficiencies and improvements. The Trust is currently re-rostering NEPTS transport (now started) which will better align available capacity with changing demand patterns (on target). This is proving complex and difficult but will be delivered.

14. **National Reportable Incidents (NRIs) / Concerns Response**: the Trust reported six NRI's to the NHS Executive in March 2025, slightly less than February 2025 (7) and 33 serious patient safety incidents were referred to health boards under the Joint Investigation Framework. In March 2025 complaint response times increased to 55%, compared to the 52% recorded in February 2025, remaining below the 75% target, with cases remaining complex.

15. **Clinical outcomes**: The percentage of suspected stroke patients who are documented as receiving an appropriate stroke care bundle was 91.6% in March 2025, improving but remaining below the 95% performance target. Work is ongoing to improve reporting and compliance through the ePCR system and this improvement is being seen clearly in most of the clinical indicators. The return to spontaneous circulation (ROSC) compliance rate decreased to 19.8% in March 2025 compared to 23.9% in February 2025.

16. The Trust can report on call to door times for Stroke and STEMI patients. For March 2025, these highlight call to hospital door times of two hours and 41 minutes for stroke patients and two hours and forty-eight minutes for STEMI. Clearly these times are too long and are representative of the longer response times for all calls, as a result of the pressures and issues outlined in this report.

17. In April 2025, 5,951 patients **cancelled** their ambulance (this figure excludes patients who refused treatment), and the Trust sent alternative transport due to the application of the Clinical Safety Plan to approximately 71 callers. Both of these figures are a significant reduction on January 2025 levels, however an increase from February 2025 totals. This reduction is likely to be the impact of switching on RCS through the winter. The Trust believes that 50% (of the pre-RCS switch on figure) of this combined number is unmet demand and is likely to be presenting elsewhere in the system. Anecdotal evidence from health boards suggests that as the Trust has switched on RCS and as the level of patient cancellations has dropped, so has the demand presenting elsewhere in the system. Caution is required at this stage though as a longer run of data is required in order to properly evaluate the changes made. The Trust changed its

Clinical Safety Plan in December, removing the "can't send" application, with the option remaining at the strategic commander's discretion in the new plan.

Our People (workforce resourcing, experience, and safety)

18. **Hours Produced**: The Trust produced 126,639 Ambulance Response unit hours during April 2025 and delivered an emergency ambulance unit hours production (UHP) of 93%, remaining below the 95% target.

19. **Response Abstractions:** EMS abstraction levels decreased to 33.86% in March 2025, below the 30% benchmark figure. Response sickness abstractions stood at 7.43% (benchmark 5.99%).

20. **Trust sickness absence:** the Trust's overall sickness percentage was 7.35% in March 2025, an improvement on the 7.93% recorded in February 2025. Actions within the IMTP concentrate on staff well-being with an aim to continue to reduce this level supported by the ten-point plan. The 7.35% is above the 2023/24 IMTP ambition of 6%.

21. **Staff training and PADRs:** PADR rates did not achieve the 85% target in March 2025 but improved slightly to 82.38%. Compliance for Statutory and Mandatory training increased slightly to 87.96% and continues to achieve the 85% target.

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

Finance & Value

23. **Financial Balance**: the reported outturn performance at Month 12 is a surplus of £70k and the Trust achieved both its External Financing Limit and its Capital Expenditure Limit.

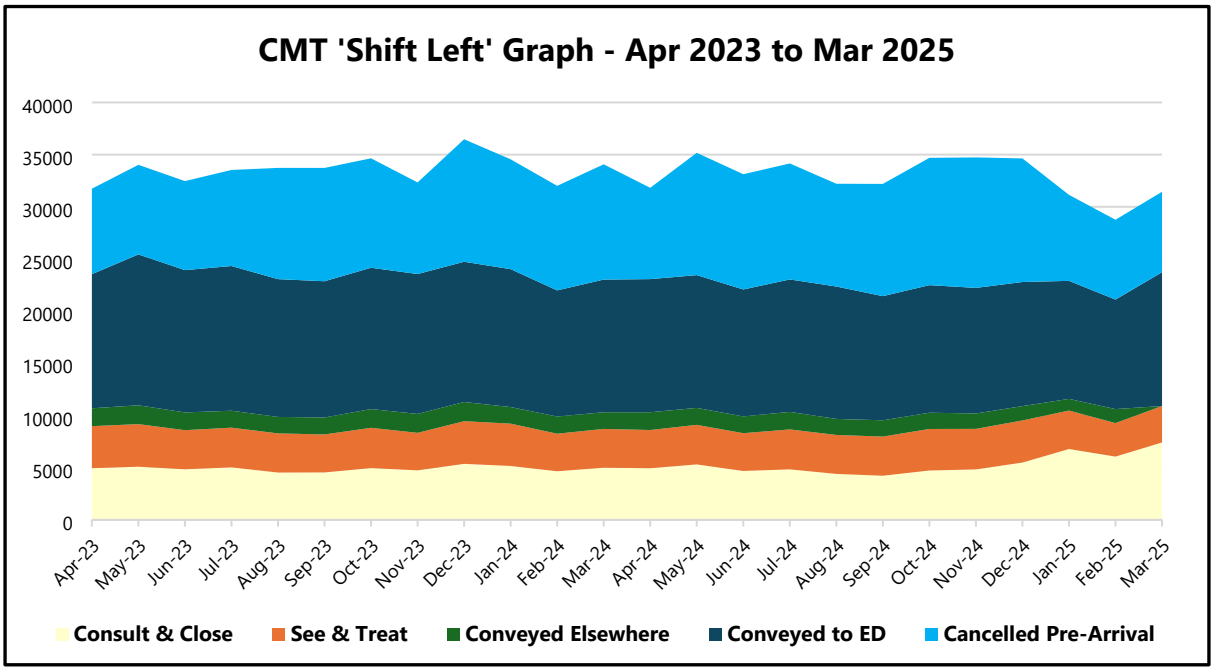
Partnerships & System Contribution

24. We are not able to report on the consult & close rates as the 111 contribution is not available due to issues with system changes within the 111 CAS system. The IMTP ambition (and Welsh Government target) remains 17% at this point in time. The Trust is currently validating new data in this area. A one-off Insight & Data Services consult & close graph indicates that the Trust is now achieving a consult & close rate of +20%. IDS have developed a new consult & close definition is Executive approve and is now with commissioners for sign off before formal reporting can restart.

Summary

25. The indicators used at this high-level highlight that 111 has been resilient during the winter months, more so than in in previous years. For the 999-emergency pathway, the Trust produced good metrics on what it can control e.g. production, abstractions etc. and managed to turn on new elements of its clinical model transformation programme, which appears to be having a positive effect. However, hospital handover lost hours have increased and remain extreme. These levels give further imperative to continuing with the clinical model transformation. NEPTS performance was stable, with the Trust about to re-roster NEPTS transport.

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



RECOMMENDATIONS

FPC is asked to: **Consider** the March 2025/April 2025 Integrated Quality & Performance Report and actions being taken and determine whether:

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

FPC Appendix 1

New Metrics
NHS 111 Website hits & outcomes Online Services (Standards 39-43) – English & Welsh
Measure the number of Community First Responders being deployed and hours produced
#NOF Call to door times and amount of time a falls patient is on the floor prior to treatment
Survival rates for Cardiac Arrest patients that are attended by time
Number of patients taken to minor injuries and referred
Accurate APP conveyance numbers by Type
APP Navigator
Increased reporting on patient outcome measures
111 Direct Steps - booking straight in
Alternative transport recalibration
EMS Taxi Utilisation
Purple Response Rates and numbers
Red Response Rates and numbers
Emerg Response Rates and numbers
Mental Health Response Vehicle conveyance rates
Clinician time on call
Clinician calls per hours
RCS Time to answer
RICS Call back times for all 3 categories
Pathway referrals from RICS
Jobs per hour and per shift for all EMS types and conveyances. Cancelled by patient/hospital handover times
Recall rates – patient deterioration
RICS and Community response surveys (tbc)
Health Transport (tbc)

Welsh Ambulance Services University NHS Trust

Monthly Integrated Quality & Performance Report

March 2025 /April 2025

Annex 1 – Top Indicator Dashboard

GIG CYMRU NHS WALES

Ymddiriedolaeth Brifysgol GIG
Gwasanaethau Ambiwlans Cymru

Welsh Ambulance Services
University NHS Trust

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

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by Commissioning & Performance Team

Section 1: Monthly Indicators / Top Indicator Dashboard

Top Monthly Indicators	Target 2024/25	Mar-25	Apr-25	2 Year Average	RAG
Our Patients					
Timeliness Indicators					
NHS111 Call Handling Abandonment Rates	< 5%	11.2%	11.7%	8.5%	R
111 Clinical Triage Call Back Time (P1)	90%	97.5%	N/A	97.9%	G
999 Call Answer Times 95th Percentile	00:06	00:27	N/A	00:20	R
999 Red Response within 8 minutes	65%	50.3%	50.9%	49.6%	R
999 Amber 1 Median	00:18	01:53	01:48	01:32	R
Oncology Journeys arriving within 45 mins and up to 15 minutes after appointment time	70%	74.8%	79.6%	73.0%	G
Advanced Discharge & Transfer journeys collected less than 60 minutes after booked time (NEPTS)	90%	78.2%	75.1%	79.7%	R
Clinical Outcomes / Quality Indicators					
Return of Spontaneous Circulation (ROSC)	Increasing Trend	19.8%	N/A	19.7%	G
Stroke Patients with Appropriate Care	95%	91.6%	N/A	82.0%	A
Stroke Call to Hospital Door Times	Reduction Trend	02:41	N/A	02:25	A
ST-Elevation Myocardial Infarction (STEMI) with Appropriate Care	95%	70.0%	N/A	53.2%	R
National Reportable Incidents reports (NRI)		6	N/A	4	
Can't Send & Cancelled by Patient Volumes	Reduction Trend	6,431	6,433	8,686	G
Concerns Response within 30 Days	75%	55.0%	N/A	52.3%	R
Enactment of the Duty of Candour Total		6	N/A	5	

Top Monthly Indicators	Target 2024/25	Mar-25	Apr-25	2 Year Average	RAG
Health & Well-being					
Sickness Absence *(all staff)*	6.0%	7.35%	N/A	7.84%	R
Mental Health Absence Rates	Reduction Trend	2.31%	N/A	2.32%	R
Staff Turnover Rate	Reduction Trend	8.42%	N/A	8.50%	G
Statutory & Mandatory Training	>85%	87.96%	N/A	77.79%	G
PADR/Medical Appraisal	>85%	82.38%	N/A	72.96%	A
Number of Shift Overruns	Reduction Trend	3,839	3,773	3,681	R
Inclusion & Engagement / Culture					
NEPTS % of Total Calls Answered in Welsh	Increasing Trend	1.90%	2.30%	1.8%	G
Value					
Financial balance - annual expenditure YTD as % of budget expenditure YTD	100%	100%	N/A	100%	G
EMS Utilisation Metric (CHARU)	Increasing Trend	30.7%	29.4%	28%	G
Average Jobs per Shift (All Vehicles)	Increasing Trend	2.56	2.64	2.35	A
NEPTS on the Day Cancellations	Reduction Trend	12.9%	12.9%	13%	R
Partnerships / System Contribution					
Inverting the Triangle					
Successful Consult & Close Outcome	17.0%	N/A	N/A	13.1%	
% Of Total Conveyances taken to a Service Other Than a Type One Emergency Department	Increasing Trend	10.48%	N/A	11.3%	R
Number of Handover Lost Hours	7,500	21,852	21,183	21,785	R
NHS111					
NHS111 Dental Calls	Increasing Trend	N/A	N/A	7,137	
Consult & Close Volumes by NHS111	Increasing Trend	N/A	N/A	962	

In-Month RAG Indicates =

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

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

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

TBD: Status cannot be calculated (To Be Determined)

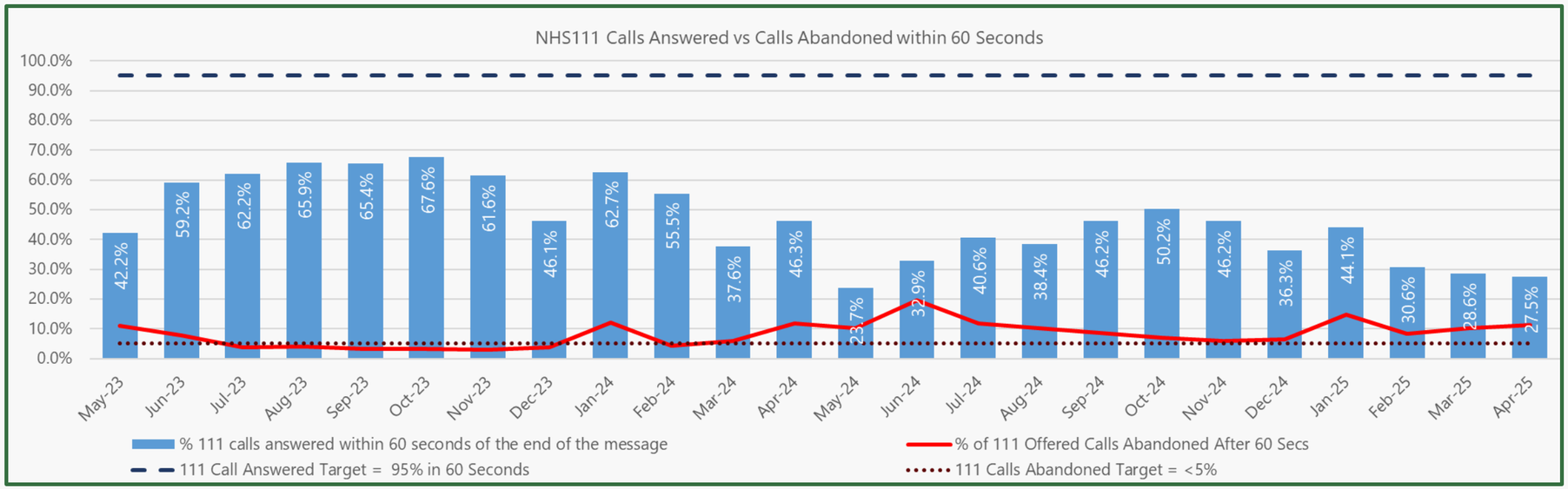
Our Patients: Quality, Patient Safety & Experience
111 Call Answering/Abandoned Performance Indicators

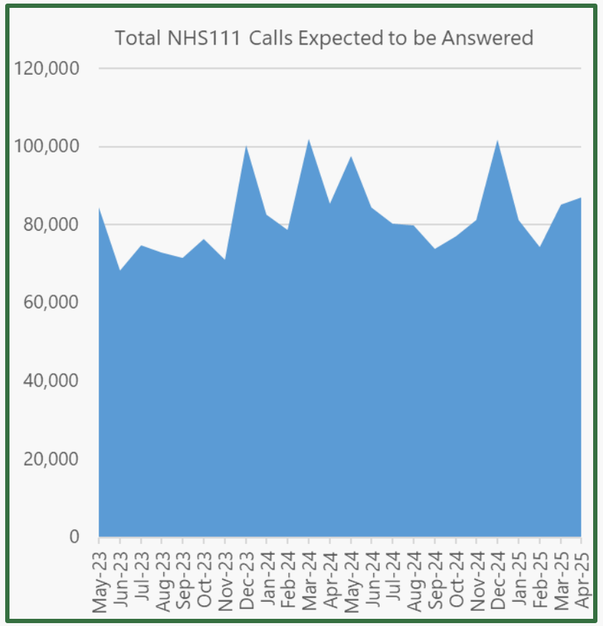
(Responsible Officer: Lee Brooks)

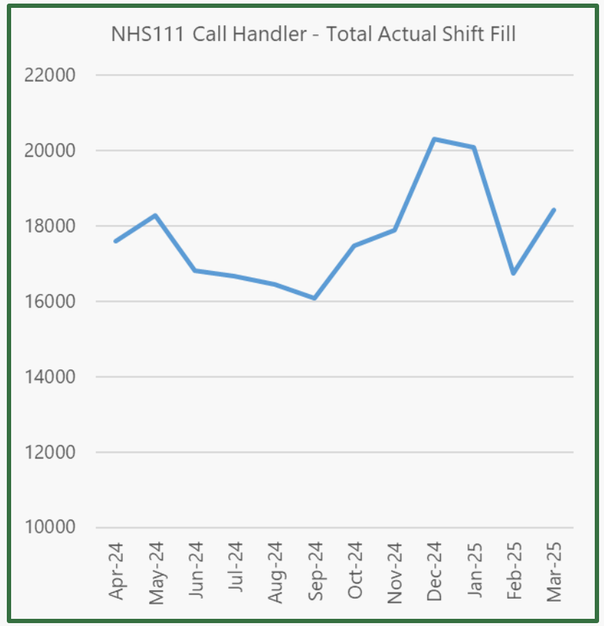
Abandonment Rate R

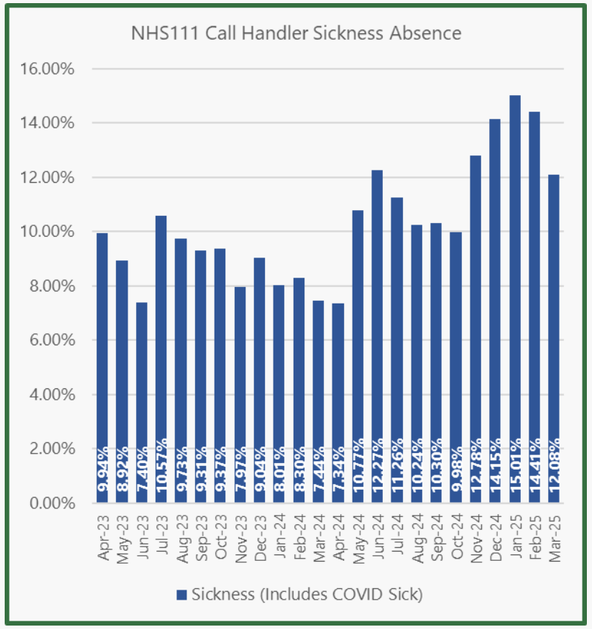
FPC

Influencing Factors – Demand and Call Handling Hours Produced









Analysis

The 111-call abandonment rate increased slightly to 11.7% in April 2025 from 11.2% in March 2025. The percentage of 111 calls answered within 60 seconds decreased, from 28.6% in March 2025 to 27.5% in April 2025 and continues to remain significantly below the 95% target.

Following a decline in performance during the middle part of 2024, due mainly to the introduction of the new 111CAS system, which went live on 30th April 2024, performance did improve during the latter months of 2024, however March and April 2025 have seen a further dip in performance levels. This follows a similar pattern to the last few years, which has seen demand increase during April. This is at a time when UHP capacity for call handlers has reduced slightly, compared to January 2025 and abstraction levels have increased to over 35%.

Remedial Plans and Actions

Key actions include:

- Actions have been undertaken to try and improve the call handling position across the Winter and Spring months with record levels of resourcing seen in December 2024 as well as opportunities for further bolstering including overtime, bank and managers/supervisors also re-aligned to call handling.
- A focus on realising the benefits of the new 111CAS;
- A 111-re-roster pre-work review (underway) that takes account of the increased demand the Trust is seeing; what levels of performance commissioners want and the mix of capacity and efficiencies to achieve this.
- The 111-re-roster project is also considered a key response to improving sickness levels i.e. more workable patterns.

Expected Performance Trajectory

We might expect to see an improvement in performance in the spring, traditionally a period with lower demand and sickness..

Our Patients: Quality, Safety & Patient Experience
111 Clinical Assessment Start Time Performance Indicators

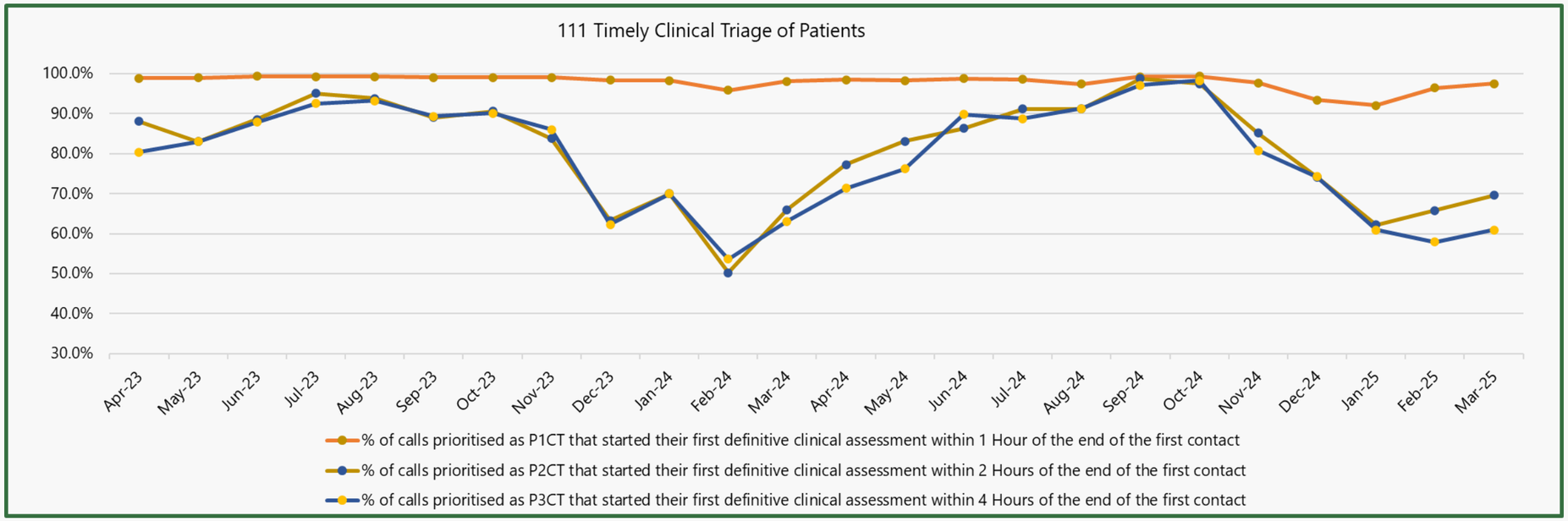
(Responsible Officer: Lee Brooks)

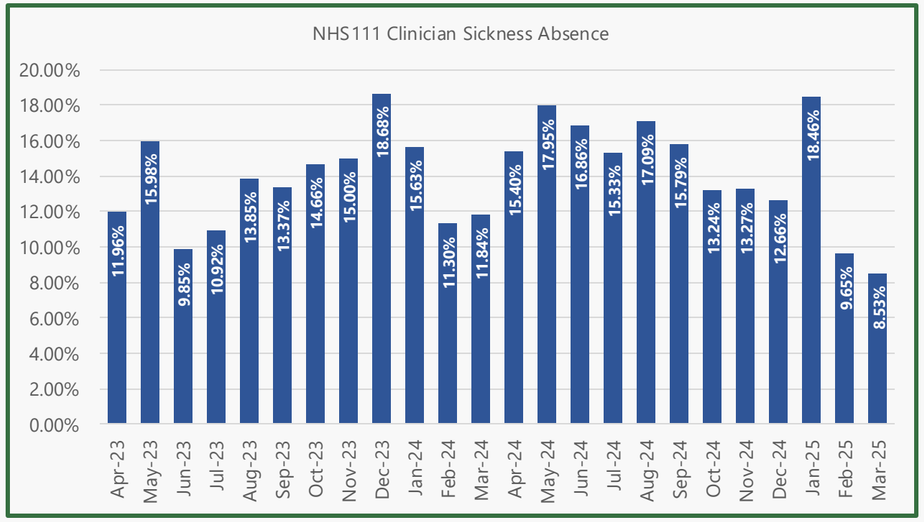
P1CT G

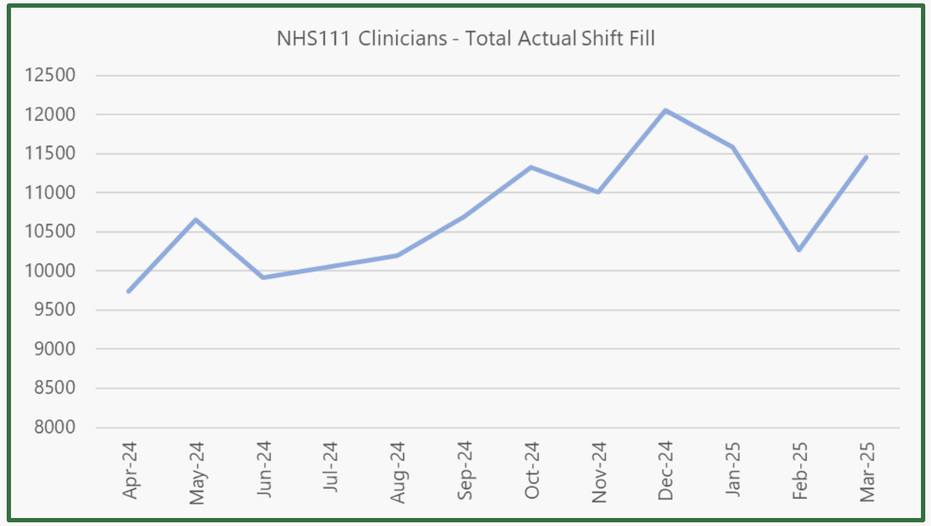
FPC

Influencing Factors – Demand and Clinical Hours Produced

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







Analysis

The highest priority calls, P1CT, achieved the 90% target, recording 97.5% in March 2025.

Ring back times for lower category calls did decline between October 2024 and January 2025, linked to a higher-than-average level of clinician sickness absence and an increase in demand, but we have seen an improvement over the past two months. If following a similar pattern to last year it is anticipated that these times will improve further over the next few months.

Numbers of clinician hours produced increased last month, rising from 10,268 hours in February 2025 to 11460 hours in March 2025. Clinician sickness absence during March 2025 was 8.53%.

Remedial Plans and Actions

The key actions include:

- A focus on delivering the benefits of the new 111CAS.
- Recruitment up to commissioned levels of clinicians
- A review to determine appropriate levels of capacity to meet increasing demand, including rostering practice (review now live).
- This review also considered key to improving clinician sickness absence along with exploring rotation, as part of the Strategic Workforce Plan.

Expected Performance Trajectory

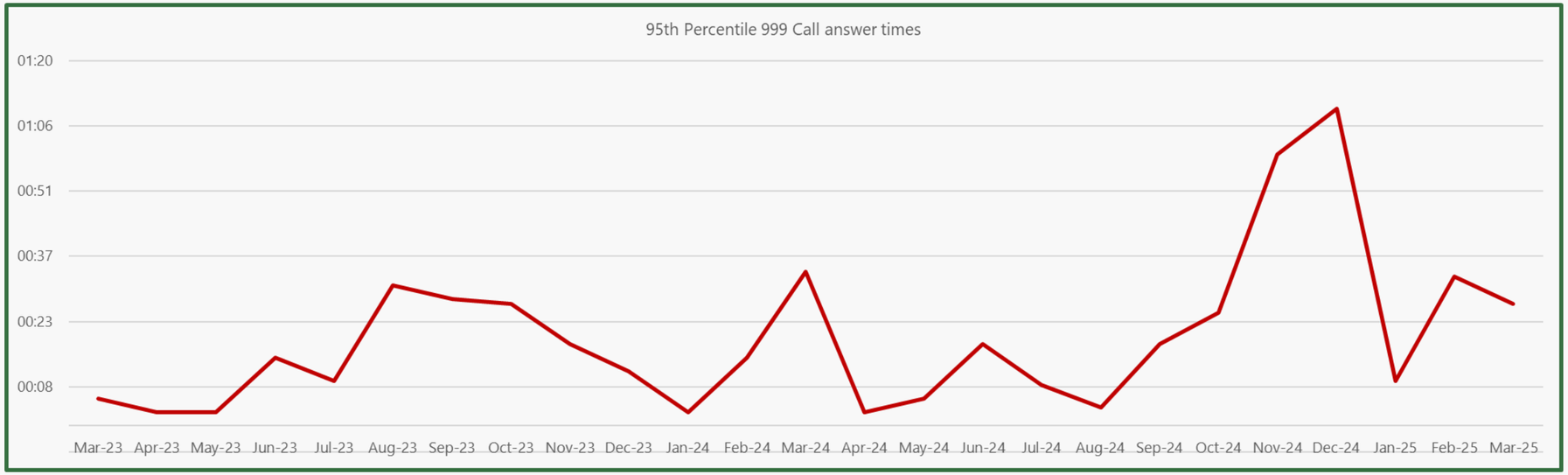
The new 111CAS will bring performance benefits. Initial approach to performance prediction developed, but further work being undertaken to refine the accuracy of the predicter.

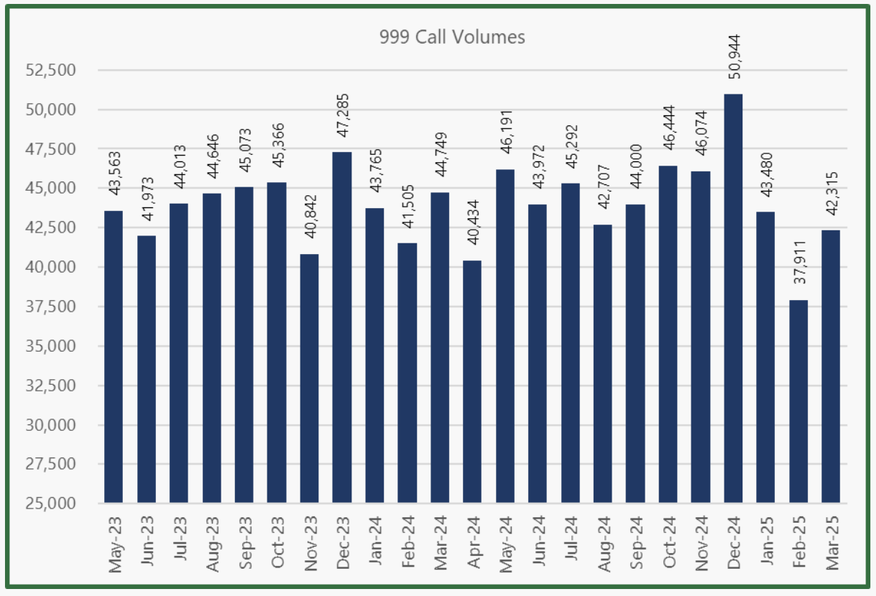
Our Patients: Quality, Safety & Patient Experience
999 Call Performance Indicators

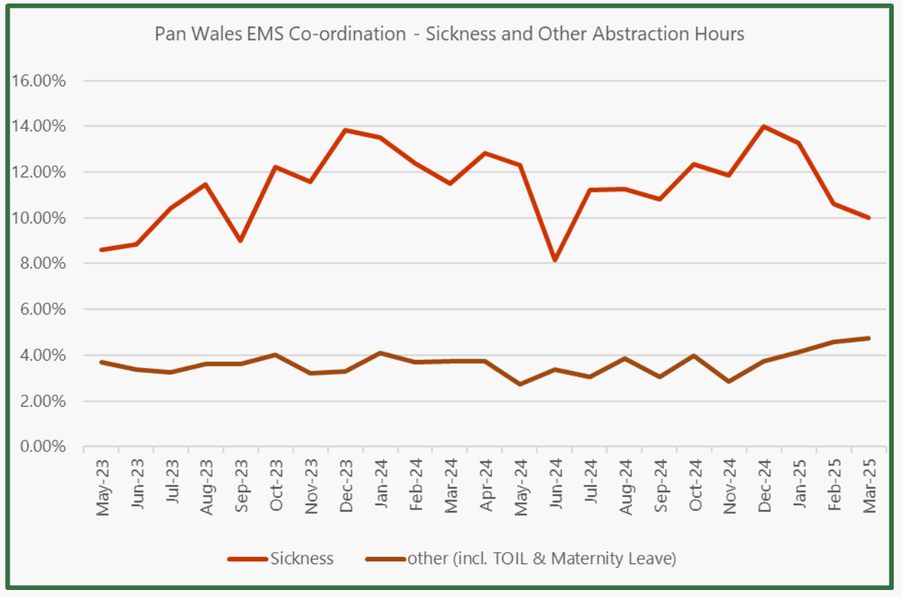
(Responsible Officer: Lee Brooks)

R FPC CI

Influencing Factors – Demand and Hours Produced







Analysis

The 95th percentile 999 call answering performance decreased to 27 seconds in March 2025 and failed to achieve the 6 second target; however, the median call answer time for the 999-service has been consistently good at 2 seconds (October 2024). However, due to the migration of the 999-telephony service, data quality checks are being undertaken for further 2024 data.

There was an increase in demand in March 2025 to 42,315 calls from 37,911 in February 2025.

Sickness levels saw a slight improvement, reducing from 10.62% in February 2025 to 9.99% in March 2025.

Remedial Plans and Actions

- Will continue to overrecruit for the next few months (as approved by the ADO and the EDoOps) which will also support potential losses from the Bryn Tirion move to Ty Elwy.
- Further recruitment is underway in North, and 3 cohorts started by the end of the fiscal year.
- Work is ongoing to identify what is contributing to high sickness via the Managing attendance at work and attrition via the recruitment and selection processes.

A transformation programme concluded:

- **Roster Review.** A dispatch roster review for Allocators and Dispatchers. Complete.
- **Boundary changes.** Realignment of dispatch boundaries to balance workload and pressures for individual dispatch teams. Complete.
- **Broader Ways of Working**. This project is looked to create efficiency, effectiveness and improved productivity through a review of processes and procedures as well as providing consistency and reduction in variation across centres. Complete.

Expected Performance Trajectory

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

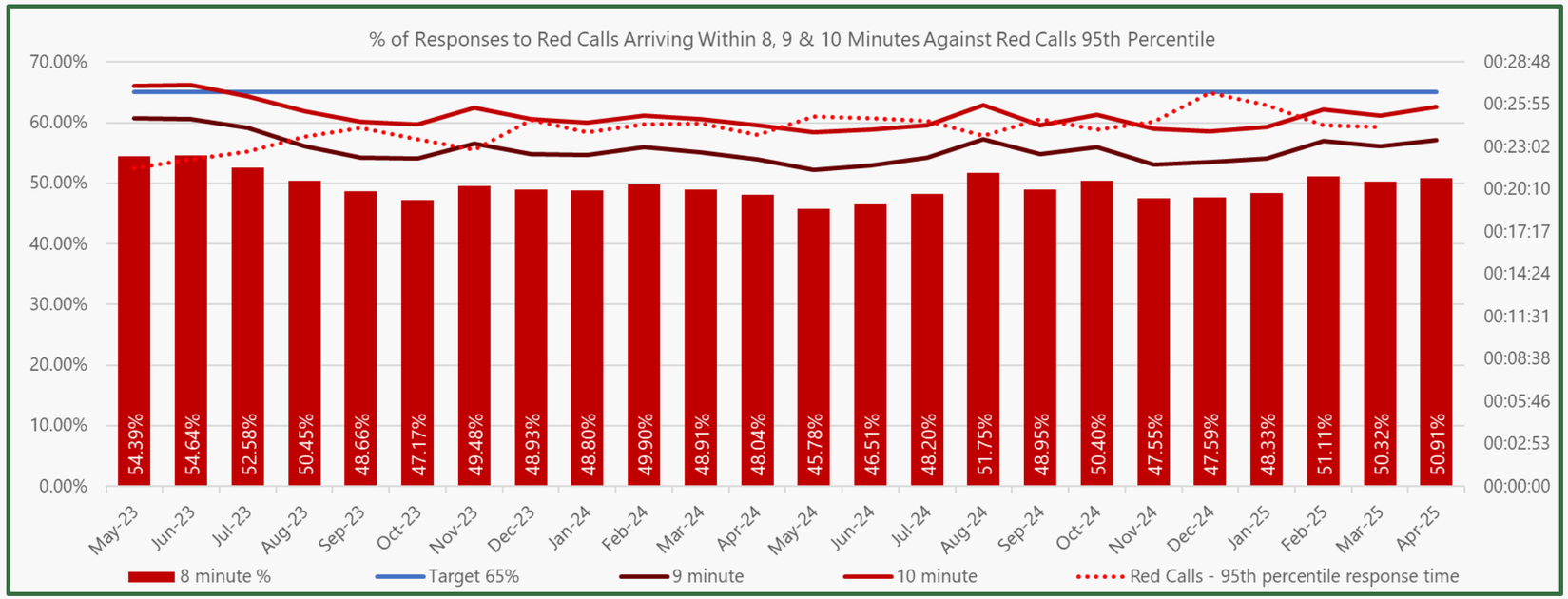
Our Patients: Quality, Safety & Patient Experience
Red Performance Indicators

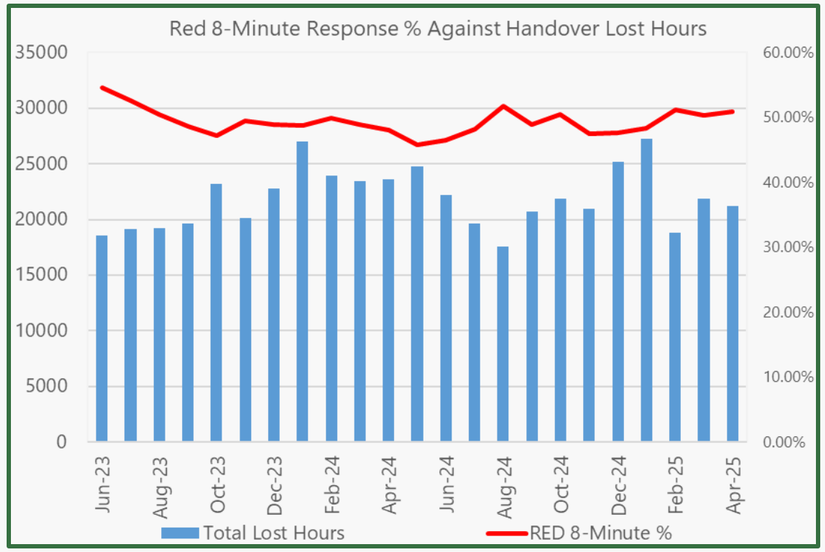
Influencing Factors – Demand, Hours Produced and Hours Lost

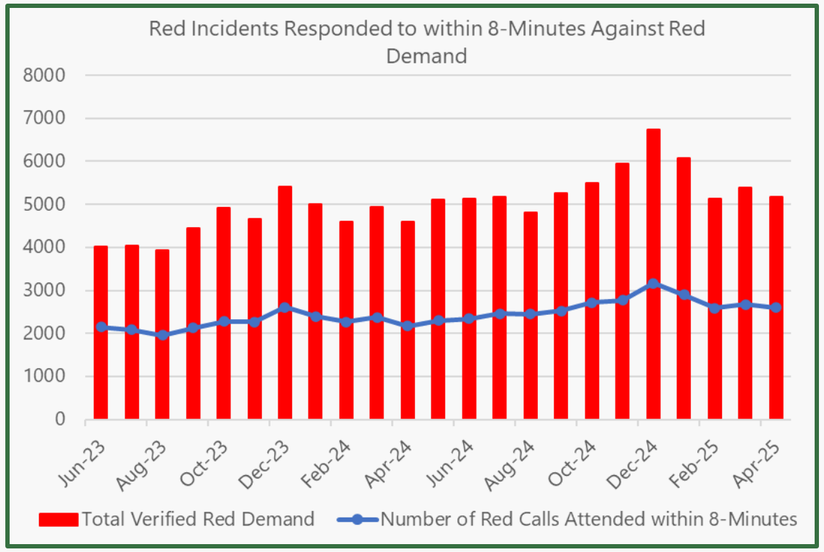
(Responsible Officer: Lee Brooks)

8 Min
R

QUEST
FPC
CI







Analysis

Red 8-minute performance improved slightly in April 2025 to 50.9% from 50.3% in March 2025, but remained below the 65% target.

Red 10-minute performance for April 2025 was 62.6%, which is marginally above the 2-year average (61.1%).

One of the main determinants is **red demand**, which has **increased** over the last few years, with red demand in April 2025 being 12.5% higher than that seen in April 2024. As red demand has increased, so too has the number of red incidents responded to within 8-minutes, with the figure for April 2025 of 2600, being 19.5% higher than the figure for April 2024, i.e. the Trust is reaching more red calls in 8-minutes, but the denominator is also increasing.

The lower left graph demonstrates the correlation between overall Red performance and **hospital handover lost hours**, which shows that as handover rates decrease, so red performance improves. There were 21,183 lost hours during April 2025.

Remedial Plans and Actions

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

- To maintain commissioned establishment in post levels overall: the Trust remains close to achieving its 95% UHP benchmark in March with 91% UHP (all resources);
- Full roll out of the Cymru High Acuity Response Unit (CHARU): the Trust achieved its highest ever CHARU UHP in January;
- The deployment of rapid clinical screening, as outlined in our IMTP (the Trust achieved this); and

Expected Performance Trajectory

On the 11th March 2025 the Cabinet Secretary for Health & Social Care announced that the current Red category will be replaced with a new arrest category and emergency category from 01 July 2025, with the focus moving to measures of the chain of survival and patient outcomes i.e. saving lives, rather than a hit/miss time target.

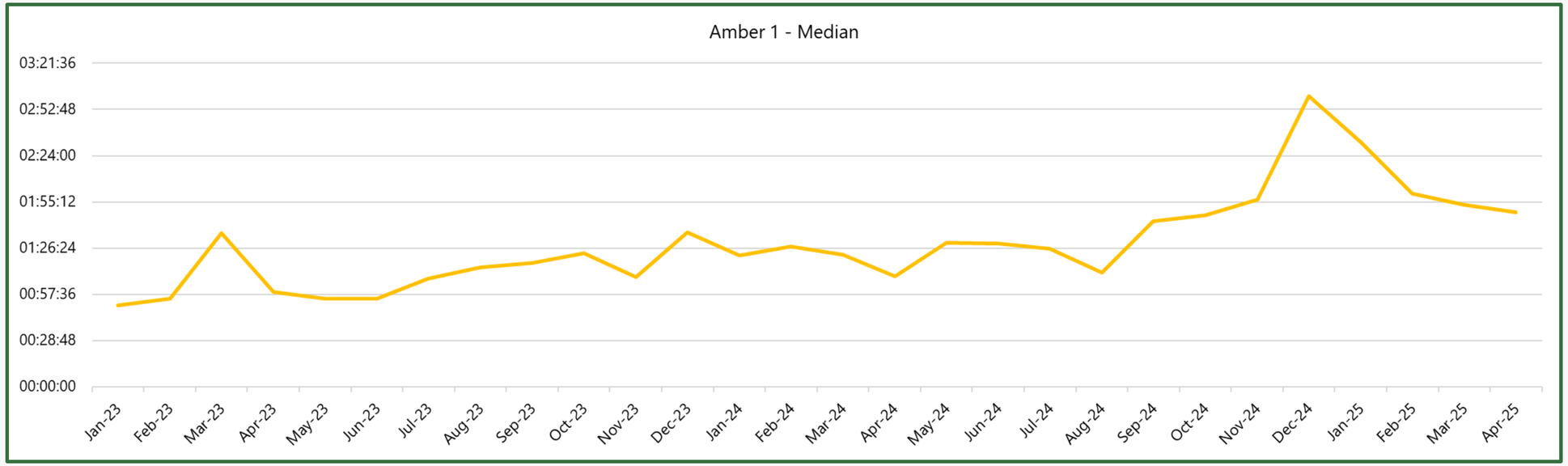
Our Patients: Quality, Safety & Patient Experience
Amber Performance Indicators

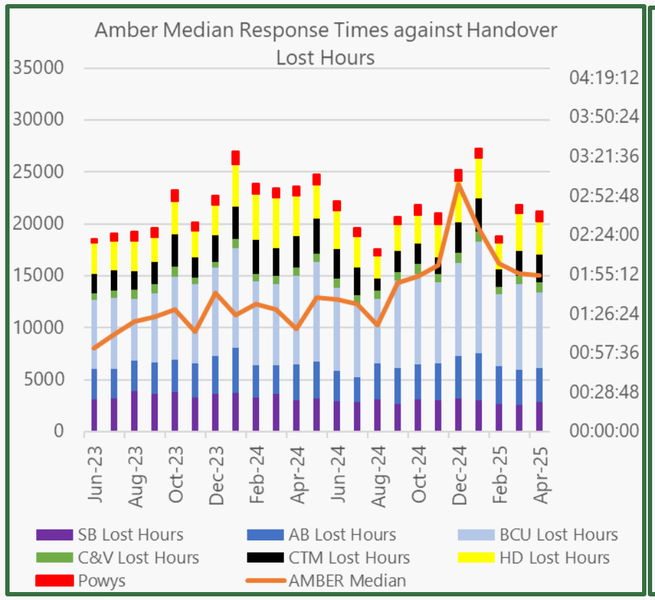
(Responsible Officer: Lee Brooks)

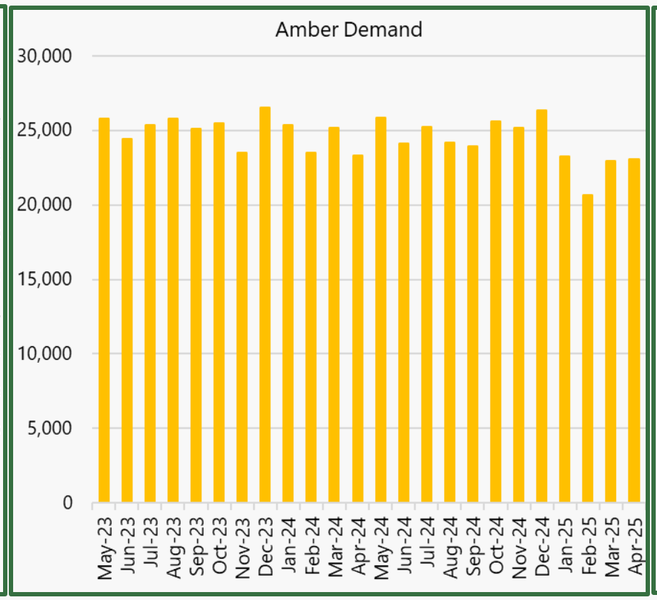
R

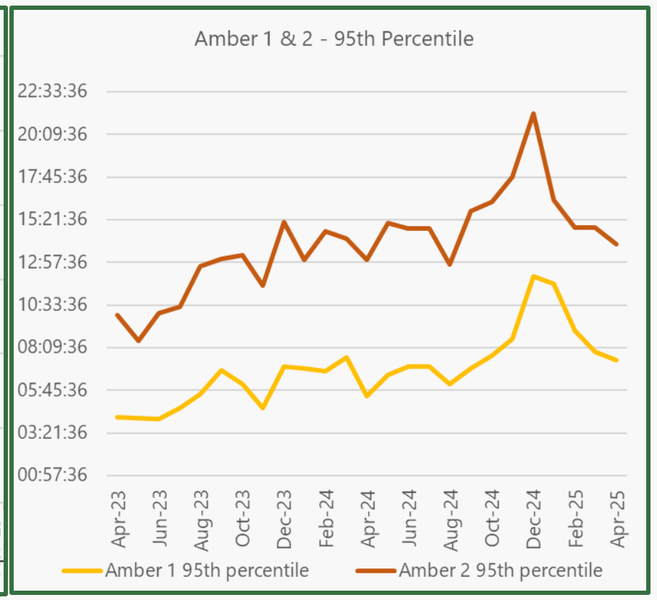
FPC CI QUEST

Influencing Factors – Demand, Hours Produced and Hours Lost









Analysis

The Amber 1 median performance time decreased during April 2025 to 1 hour and 48 minutes compared to 1 hour 53 minutes in March 2025. The ideal Amber 1 median response time remains at 18 minutes.

The Amber 1 95th percentile also decreased during April 2025 to 7 hours 26 minutes, down from 7 hours 53 minutes in March 2025. This time remains far too long and remains above the 2-year average figure of 7 hours 02 minutes.

As with Red, there is a strong correlation between Amber performance and lost hours due to handover delays.

Remedial Plans and Actions

The actions being taken are largely the same as those related to Red performance on the previous slide. A Welsh Government review of Amber response times is due to start imminently.

Expected Performance Trajectory

The Trust's commissioned level of production (its rosters) is designed to cope with 6,000 hours of handover lost hours. Unless there is a material reduction in handover lost hours and a transformation of the 999 emergency ambulance pathways, the Trust will continue to see long amber waits and avoidable patient harm. Trust expecting to join a WG led meeting on how handover can be reduced to the 6,000 level.

Our Patients: Quality, Safety & Patient Experience

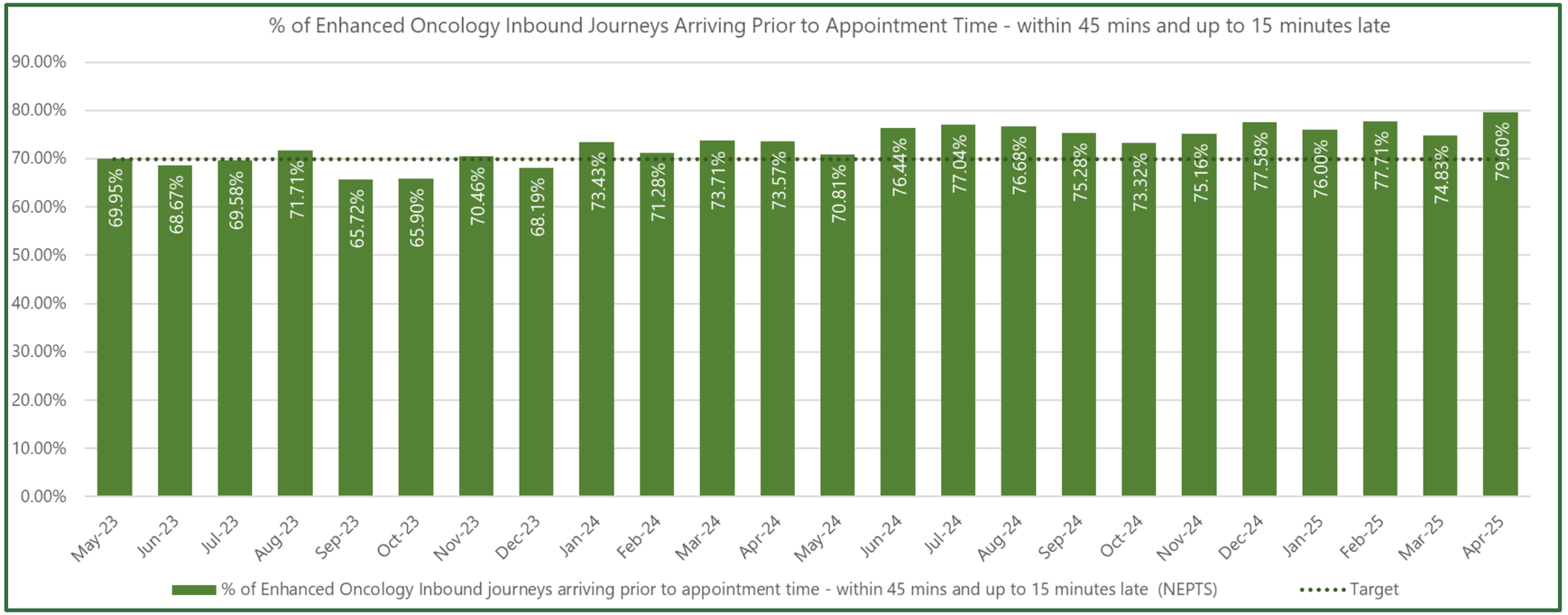
Patient Experience – Influencing Ambulance Care Indicators

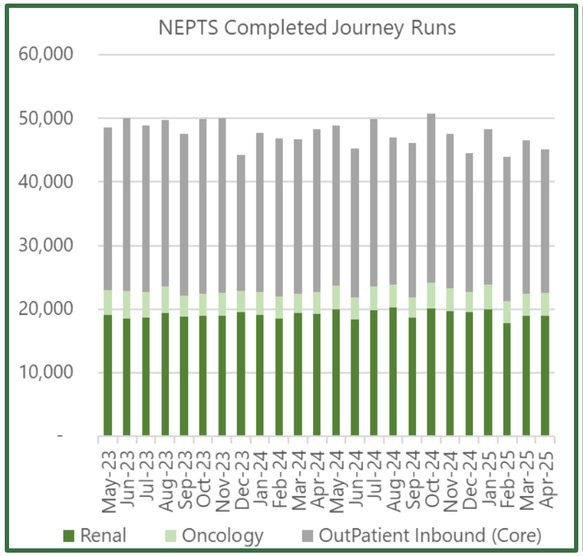
(Responsible Officer: Lee Brooks)

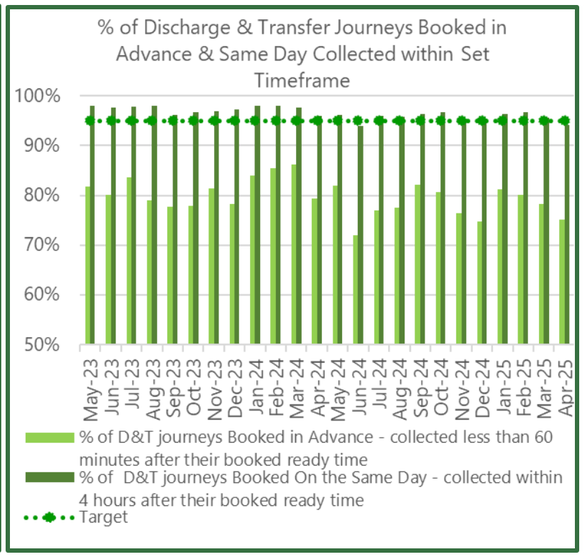
D&T	Oncology	Welsh Calls
R	G	G

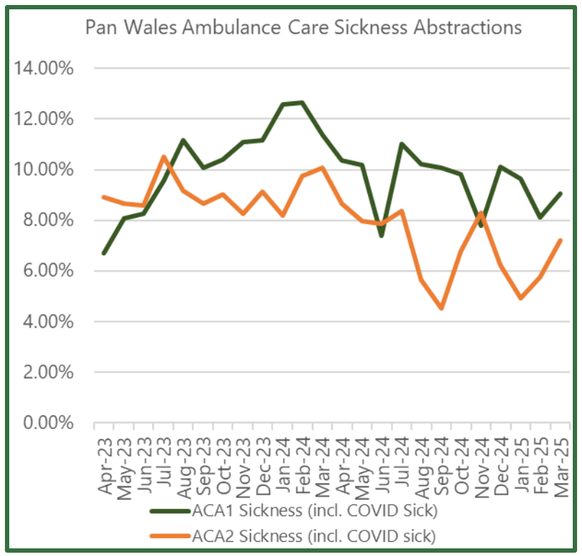
FPC

CI









Analysis

79.60% of enhanced Oncology journeys arrived within 45 minutes prior and up to 15 minutes late of their appointment time in April 2025, once again achieving the 70% target. Oncology performance continues to be an area of focus for the service, and we continue to invest both time and resources on these journeys.

Discharge and Transfer journeys booked in advance and collected less than 60 minutes after their appointment decreased in April 2025 to 75% and remains below the 95% target. Discharge and Transfer journeys booked on the same day also failed to reach the 95% target in April 2025, achieving 94%. The lowest percentage since before the performance targets changed in April 2023.

Enhanced Renal journeys minimally decreased from 73.74% in March 2025 to 72.81%, however therefore achieving the agreed performance standard of 70% for only the fourth time since September 2024.

Call volumes answered decreased to 14,469 calls during April 2025, down from 16,389 in March 2025; however, the average speed of call answering increased from 7 minutes 52 seconds to 11 minutes 7 seconds.

ACA1 sickness remains above the 5.99% target, at 9.04% in March 2025. ACA2 sickness has risen above the target increasing to 7.22% in March 2025.

Remedial Plans and Actions

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

New rosters keys have been finalised based on updated demand with the roster review now commenced.

Enhanced sickness monitoring has been implemented at the ADO/HoS level and all long term and complex cases are being reviewed regularly.

Expected Performance Trajectory

The re-roster, which will take six months to deliver will enable the Trust to reach more patients within the current resource envelope

Our Patients: Quality, Safety & Patient Experience
Clinical Indicators

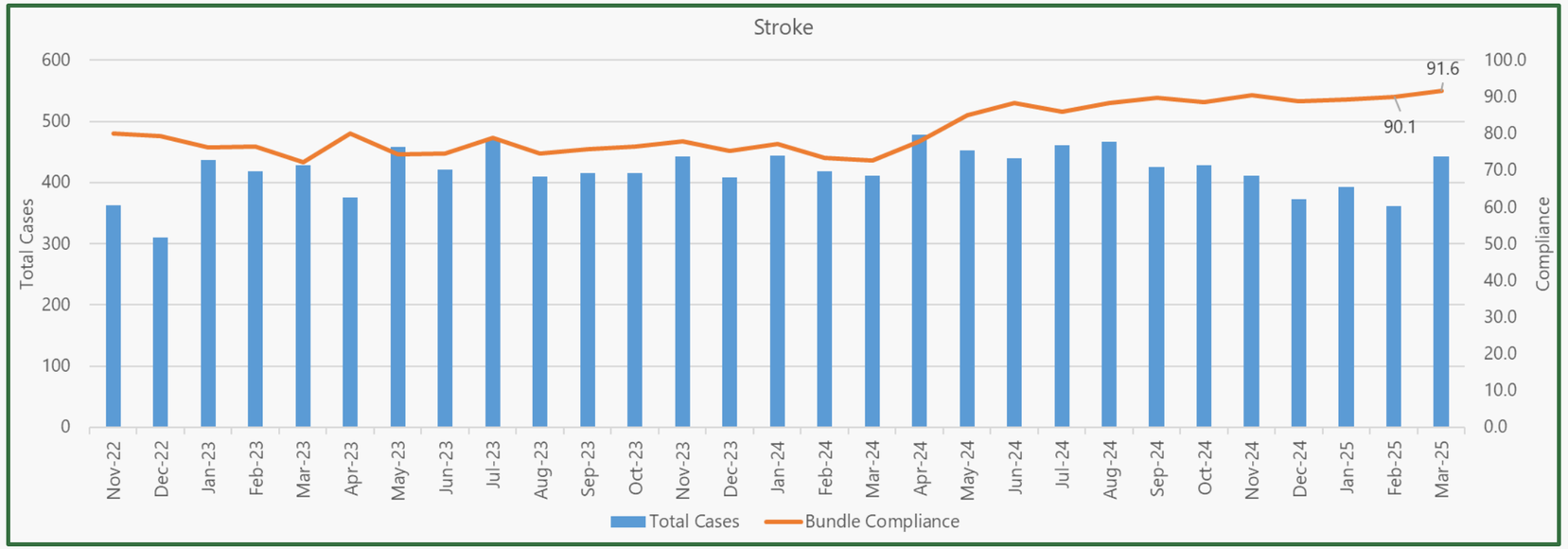
Return of Spontaneous Circulation, Suspected Stroke Patients with Appropriate Care, ST-elevation myocardial infarction (STEMI) with Appropriate Care

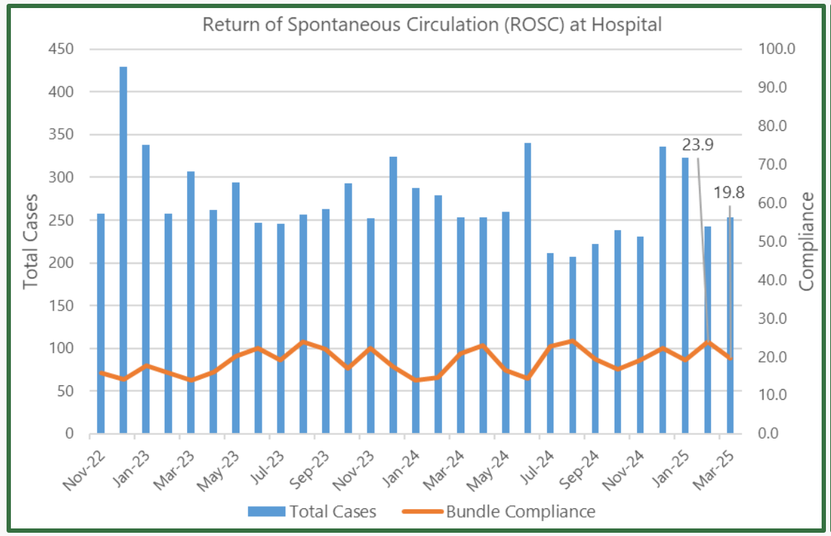
Stroke	ROSC	STEMI
A	G	R

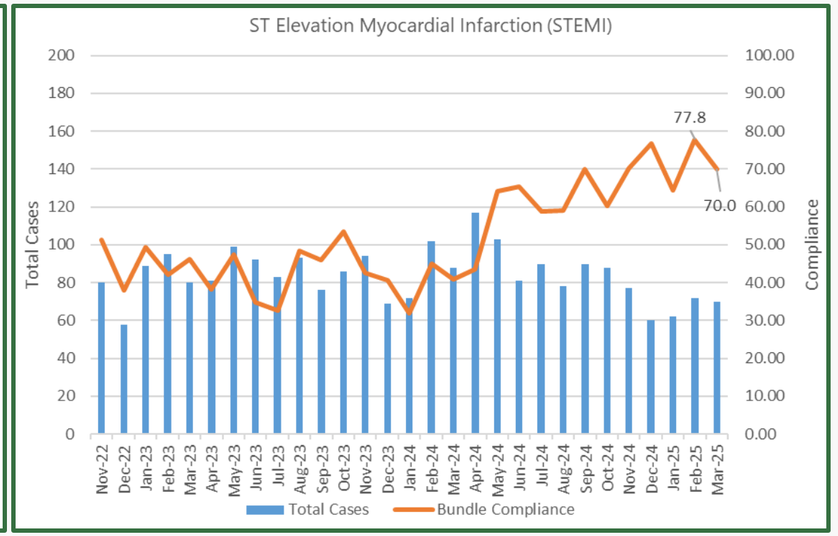
Self-Assessment: Strength of Internal Control: Moderate

QUEST

(Responsible Officer: Andy Swinburn)







Analysis

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

Stroke – 91.6%, a slight increase from 90.% in February 2025. There is a close correlation between documenting FAST (a test to detect symptoms of stroke) and care bundle compliance.

STEMI (heart attack) – 70%, a decrease from 77.8% in February 2025. There has been a decrease in documenting all criteria in Q1, particularly in the pain score and analgesia components. The number of cases remained low (70) therefore, increasing the volatility of the compliance data so this could be natural variance.

Return of Spontaneous Circulation at hospital (from cardiac arrest) – 19.76%, a decrease from 23.9% in February 2025. 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. Months since have continued to see higher numbers of cases in this indicator.

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 2025, the impact will be monitored by the Clinical Intelligence & Assurance Group.

Our Patients: Quality, Safety & Patient Experience
Clinical Indicators

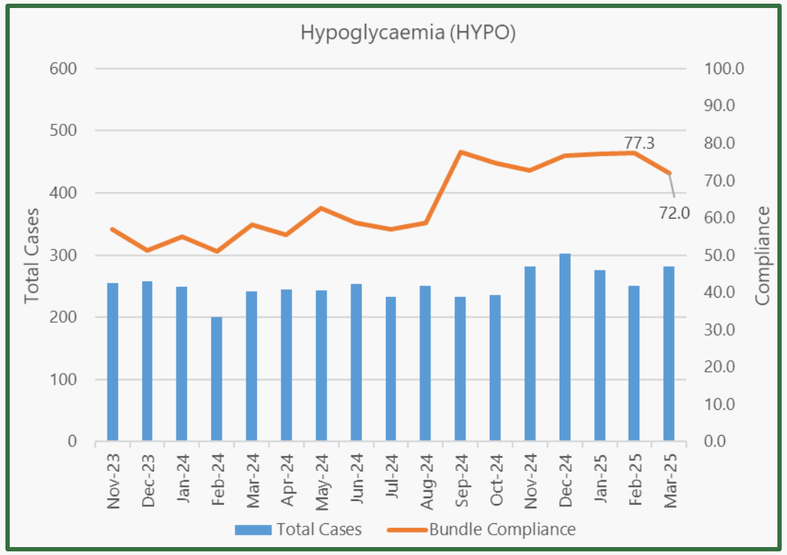
Hypoglycaemia, Fractured Neck of Femur (#NOF) and Time-Based metrics (Stroke & STEMI)

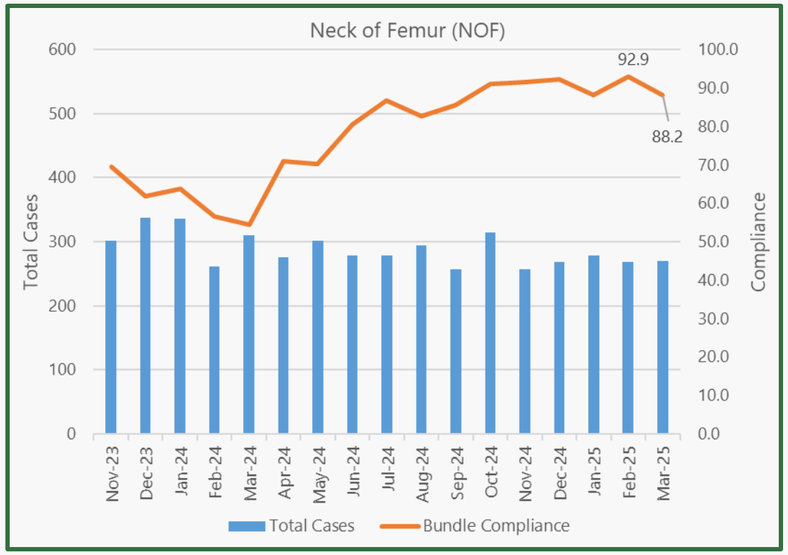
(Responsible Officer: Andy Swinburn)

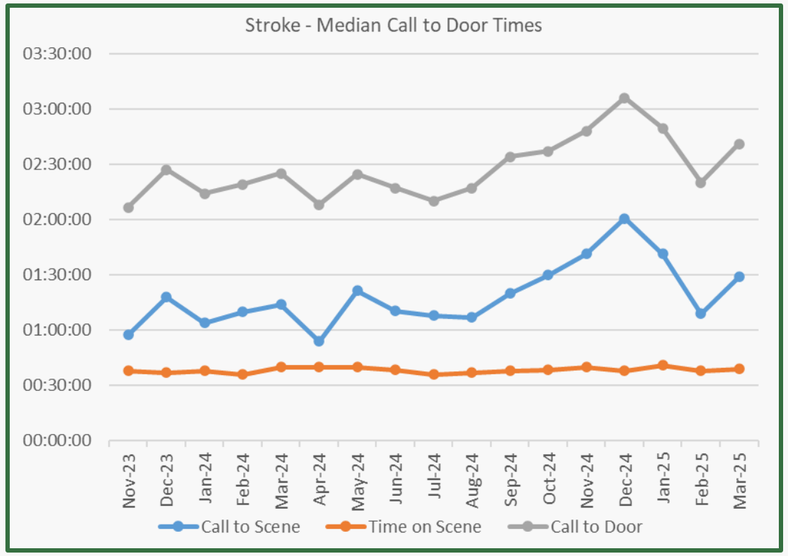
Call to Door
A

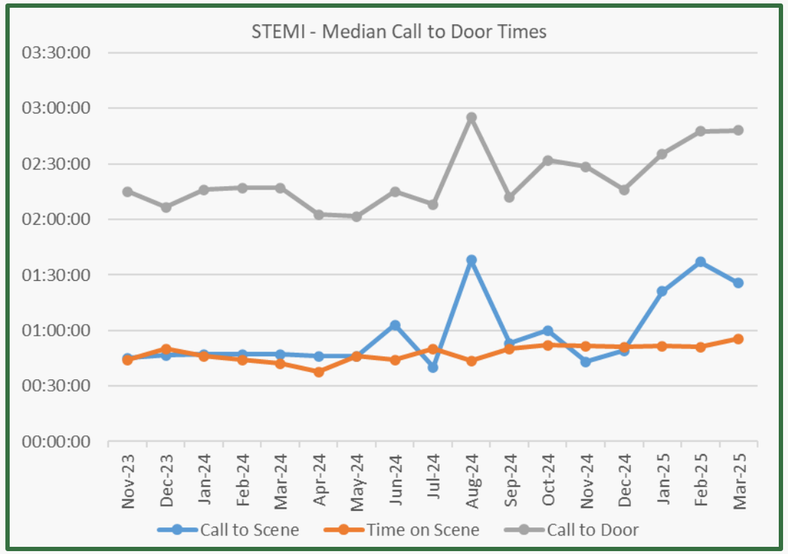
Self-Assessment: Strength of Internal Control: Moderate

QUEST









Analysis

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

Hypoglycaemia (diabetic patients with low blood glucose) – 72%, a decrease from 77.3% % in February. Compliance has remained quite static but dropping slightly in Q3, although with a slight increase in the number of cases from 251 (Feb 24) to 282 for March. This is likely to be within the natural variation.

Fractured Neck of Femur (hip fracture) – 88.2%, a slight decrease from 92.9% in February. Only a slight increase in compliance this can be attributed to a decrease in the documenting analgesia and vital signs elements.

Call to door times for Stroke and STEMI – Although call to door times extended for STEMI during Q1, the corresponding report for stroke improved with the changes both being attributed to the call to door element of the call cycle. There have been changes in the clinical model in this period and more analysis over an extended period will be required to understand the underlying trend and route cause of this.

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.

Expected Performance Trajectory

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

Our Patients: Quality, Safety & Patient Experience
Patient National Reportable Incidents & Patient Concerns
Responses Indicators

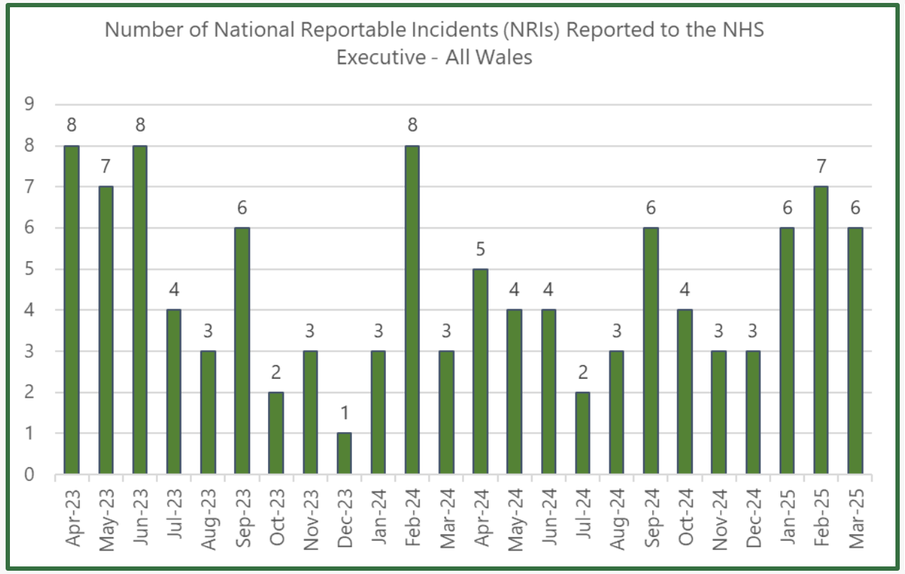
(Responsible Officer: Liam Williams)

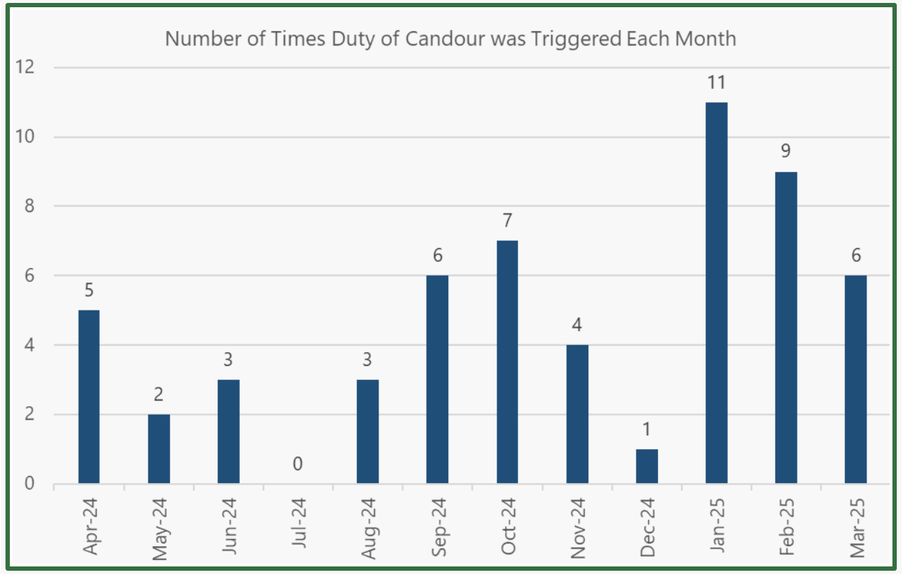
Concerns.
R

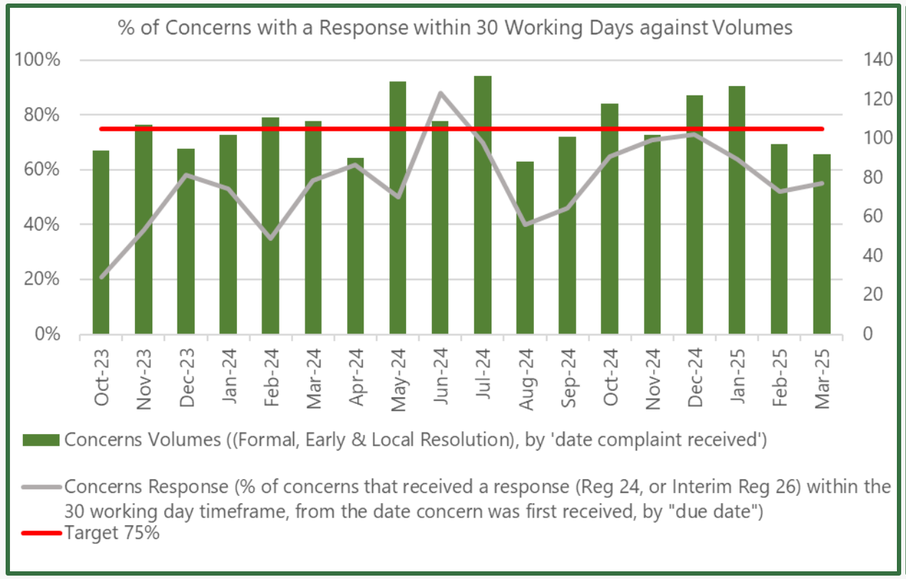
Self-Assessment: Strength of Internal Control: Moderate

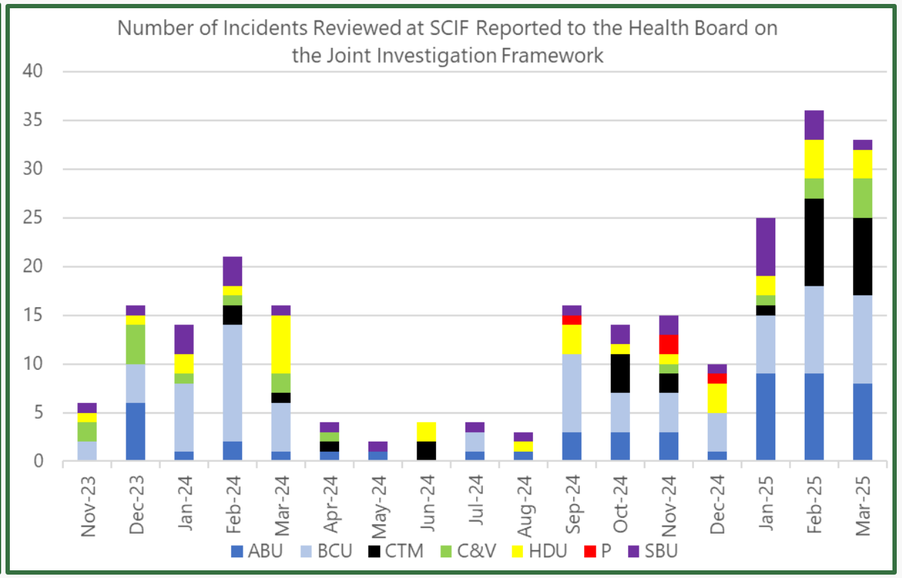
QUEST

Health & Care Standard
Health - Safe Care / Timely Care









Analysis

Compliance with the 30 working day complaints target has improved slightly on last month, however, continues to reflect the challenges associated with increased pressures across the organisation during the winter period. Open complaint volumes have also continued to grow. Challenges in obtaining critical information to complete investigations in relation to information from Clinical Support Desk (CSD) remain.

The number of NRIs reported shows a demonstrable 'winter peak' following a period of Critical Incident declaration and sustained high levels of operational activity. The Trust continues to develop maturity in identifying Moderate harm incidents that trigger the statutory Duty of Candour, in addition to those which meet the threshold for NRI reporting.

Historically high volumes of incidents are being shared with Health Boards under joint investigation arrangements.

Remedial Plans and Actions

- Ongoing monitoring of national incident reporting, enactment of the Duty of Candour and Complaints performance is monitored by team leads on a regular basis.
- All teams are working to achieve national timescales and a benchmarking position comparative to other NHS Wales organisations as visible in the national Quality and Safety dashboard, Beacon.

Expected Performance Trajectory

Operational frontline focus over the winter period is likely to continue to influence complaints performance over coming months. Cross directorate teams continue to work together to expedite the required information wherever possible to conclude investigations, and provide short-, medium- and long-term solutions.

**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*

NRI & Concerns Data source: Datix / Longest Waits Data Source: Report Manager

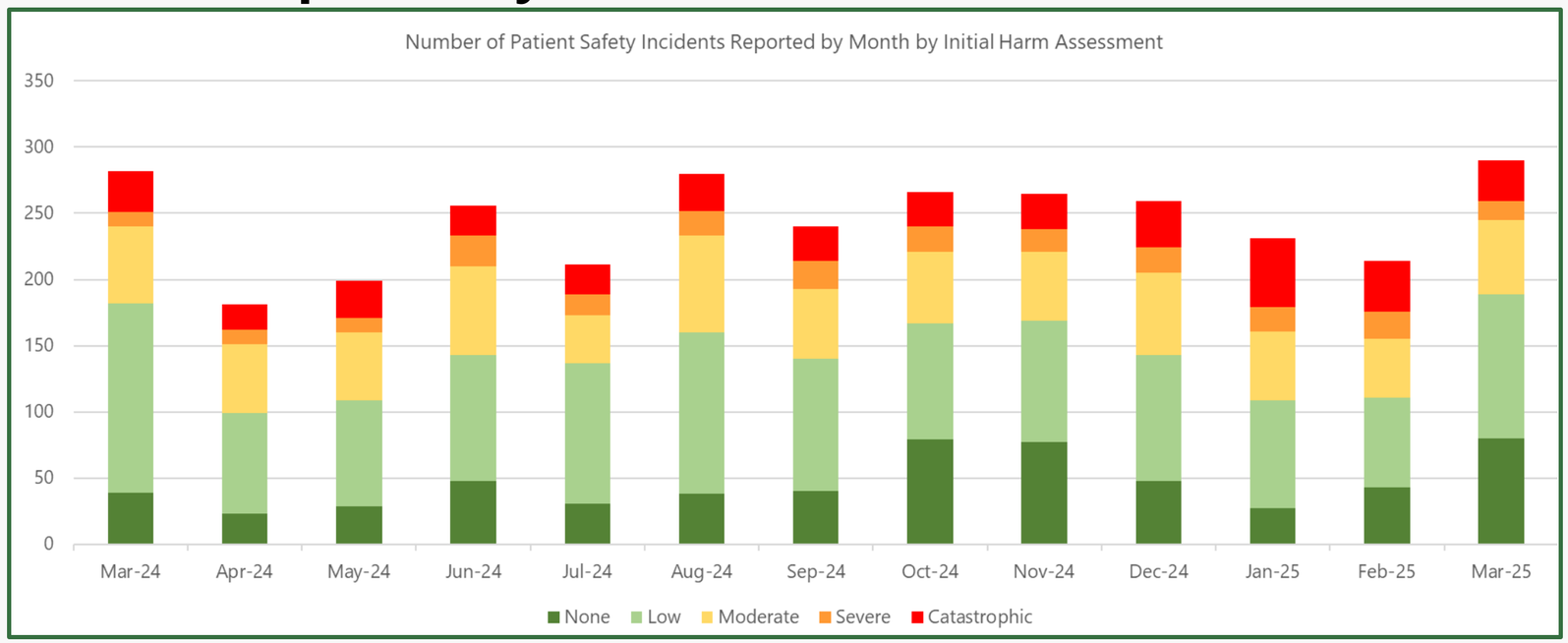
Our Patients: Quality, Safety & Patient Experience
Patient & People Safety Indicators

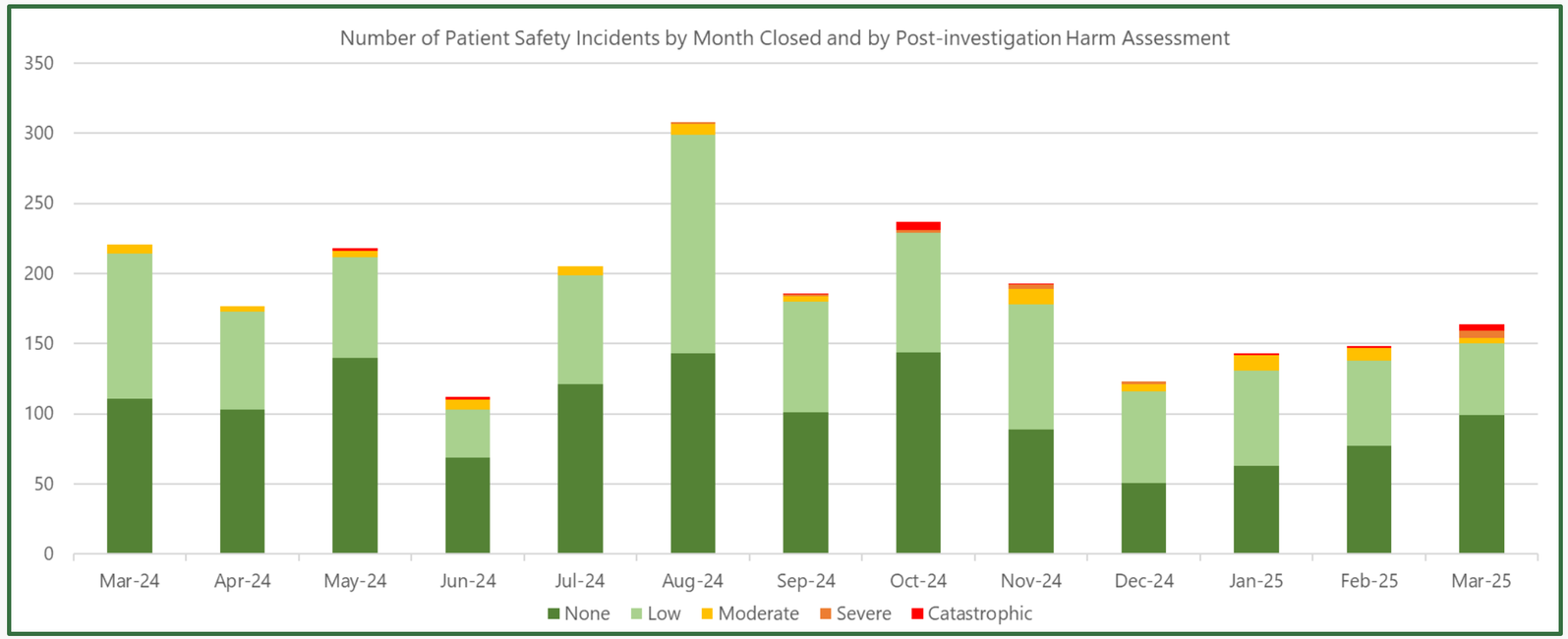
(Responsible Officer: Liam Williams)

Self-Assessment: Strength of Internal Control: Moderate

QUEST

Health & Care Standard
Health – Safe Care





Analysis

Incident reporting volumes have increased since last month to a level comparable to March 2024. Near miss reporting is being encouraged during daily operational meetings to ensure we learn from all opportunities. Closed incidents continue to demonstrate that validated levels of severe or catastrophic harm remain consistently low. NRI's that have been closed with the NHS Executive Wales have improved during the last month.

Monthly volumes should be interpreted with caution as incidents can be duplicated on the system (for example two crews submitting the same incident); however, the introduction of the Rejection SOP by the Quality Team has reduced the risk of duplication. Incident volumes include those reported internally by WAST staff, but also those reported by Health Board colleagues about WAST services or care.

Harm levels for March 2025 were: -

- No harm or hazard - 80
- Low - 109
- Moderate - 56
- Severe harm - 14
- Catastrophic/Death - 31

Remedial Plans and Actions

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

Expected Performance Trajectory

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

Data source: Datix

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

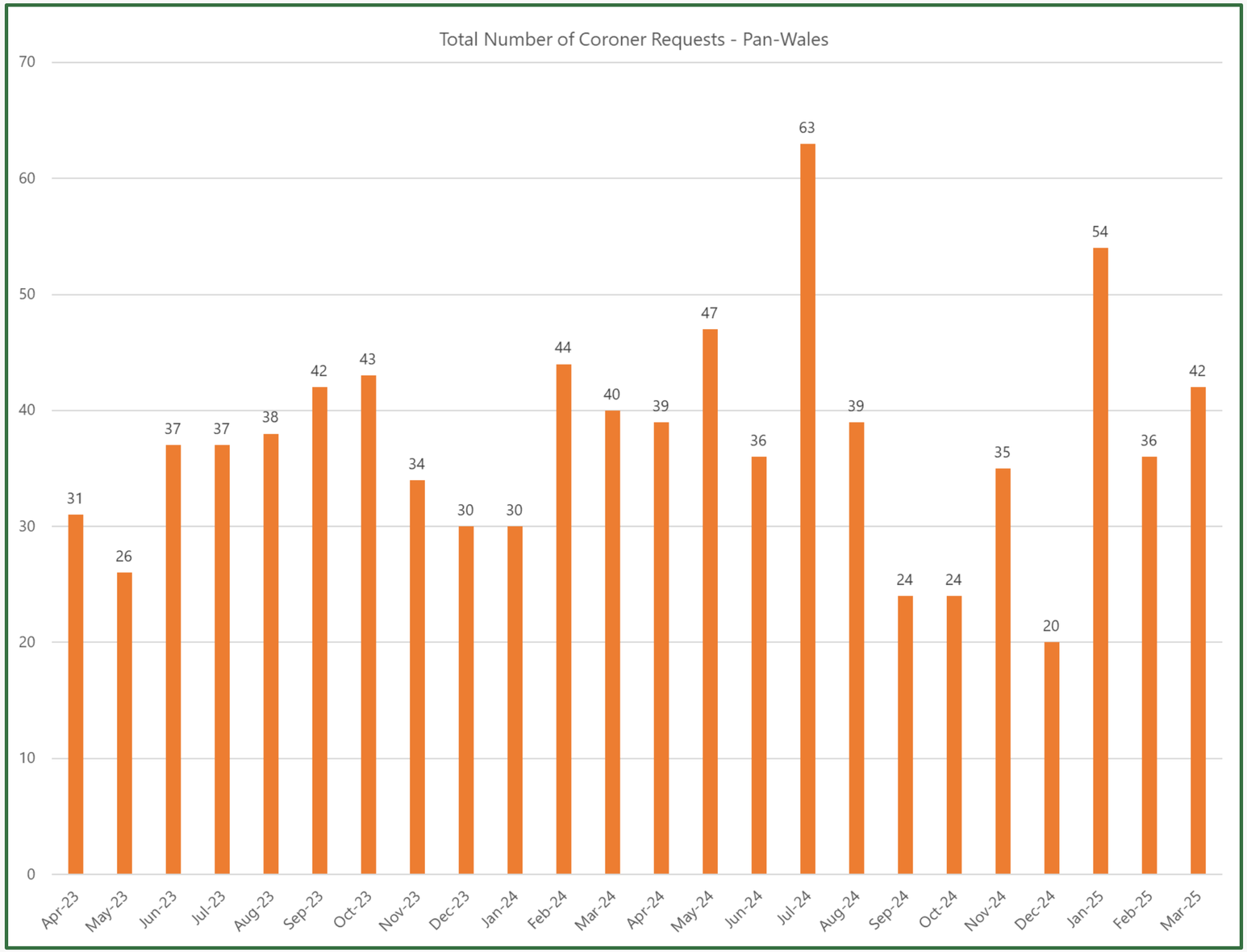
(Responsible Officer: Liam Williams)

Coroners Self-Assessment: Strength of Internal Control: Moderate

Mortality Self-Assessment: Strength of Internal Control: Moderate

QUEST

Health & Care Standard
Health – Safe Care



Mortality Reviews Data source: Internal Web Application

Analysis

The number of coroner approaches continues to bring a high level of activity to the Trust. Inquest cases continue to present with increased complexity and large numbers of statements and witnesses being called. It is noticeable that many requests are accompanied by short timescales. Challenges to meet deadlines, in particular those in relation to EMSC with Clinical Support Desk involvement, continue to require extension of deadlines.

The Trust continues to mature its Learning from Mortality approaches, through a quarterly meeting on thematic learning, weekly triage of Medical Examiner referrals and fortnightly learning panels for Medical Examiner feedback.

Mortality - Following the publication in May 2024 of the All-Wales Learning from Mortality Reviews Model Framework (Second Edition) (the Framework), the Trust has established an effective clinical governance structure to discharge all 5 levels of the Framework.

226 referrals were received from the MES between 1st October 2024 and 31st March 2025. Cases are triaged promptly at Level 1 with 26 cases have been triaged as requiring further review and investigation under the PTR guidance. Level 2 Medical Examiner Learning Panels will now run at increased frequency to address cases awaiting review.

There is a decreasing number of Medical Examiner referrals since April 2024 which is believed to be due to relational work undertaken with other health bodies to reduce the duplication of cases.

Remedial Plans and Actions

- Additional temporary resource in the Legal Services team is supporting the management of inquest coordination and activity across the Trust.
- Operations Quality have provided estimated completion dates for coronial deadlines, which will provide some assurance and expectations of completion dates to the coroner.

Expected Performance Trajectory

Coroner activity will continue to be monitored and delays in statement gathering escalated and prioritised internally as appropriate.

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

(Responsible Officers: Jonny Sammut & Liam Williams)

Health & Care Standard
Health – Safe Care

Self-Assessment: Strength of Internal Control: Strong

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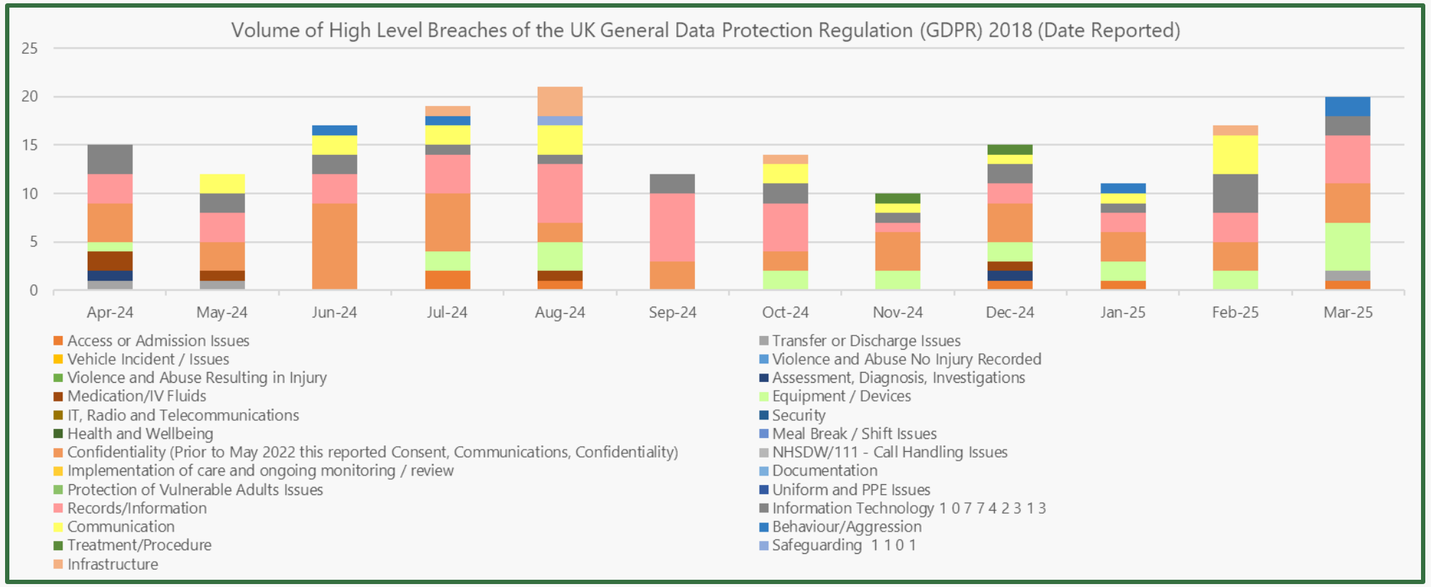
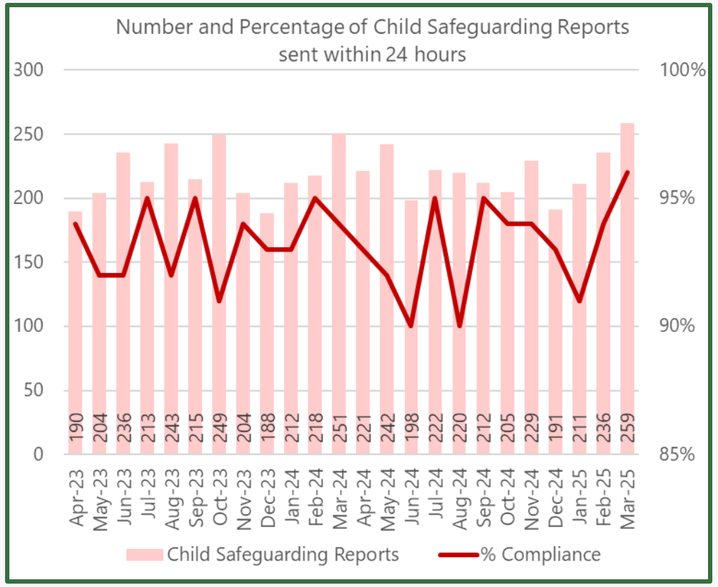
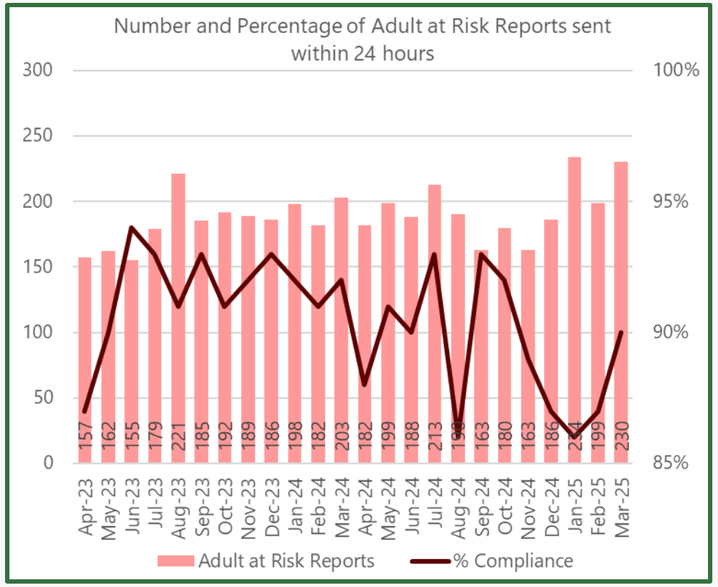






Analysis

Safeguarding: In March 2025 WAST colleagues submitted a total of 230 Adult at Risk Reports, 90% of these were processed within 24 hours. Whilst the Trust does not report on Adult Need for Care & Support reports (wellbeing); 719 reports were shared with local authorities across Wales during this reporting period. There were 259 Child Safeguarding Reports submitted in March 2025, 96% of these were processed within 24 hours.

Data Governance: In March 2025, there were 20 information governance (IG) related incidents reported on Datix Cymru categorised as an Information Governance (IG) breach. Of these 20 breaches, 5 related to Equipment / Devices, 5 Records/Information, 4 IG/Confidentiality, 2 IT, 2 Behaviour/Aggression, 1 Access/Admission, and 1 Transfer/Discharge.

Public Engagement: During March, PECI attended 34 community engagement opportunities, engaging with approx. 430 people. This included attending Newport 50+ Forum, a Women's Health event hosted by BCU Health Board, a BME Young People's Group hosted by EYST, Swansea LGBTQ+ Forum and Barry Veterans Group.

Remedial Plans and Actions

Safeguarding: The Trust manages all safeguarding reports digitally via Doc-works Scribe and regular monitoring of the system by the Safeguarding Team provides a means to identify any problems with delayed reports with appropriate action taken to support WAST colleagues. Only minimal paper safeguarding reports are now received, they are used as a back-up.

Data Governance: During the reporting period, of the 20-information governance related incidents reported on Datix, no incidents were reported to the Information Commissioner's Office (ICO). The IG Team continues to monitor, and review reported incidents where applicable.

Public Engagement: Community involvement and engagement with patients/public forms an integral part of the Trust's strategic transformation ambitions to deliver value-based healthcare evaluated against service users' experiences and health outcomes. The PECI Team will continue to engage in an ongoing dialogue with the public on what they think could be done to improve services.

Expected Performance Trajectory

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

Data Governance: The IG Toolkit submission was completed on 31st March 2025.

Public Engagement: All feedback received is shared with relevant Teams and Managers and continues to be used to influence ongoing service improvement. Patient experience and community engagement information is now shared weekly at the Senior Quality Team meeting.

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

Safeguarding Data source: Doc Works

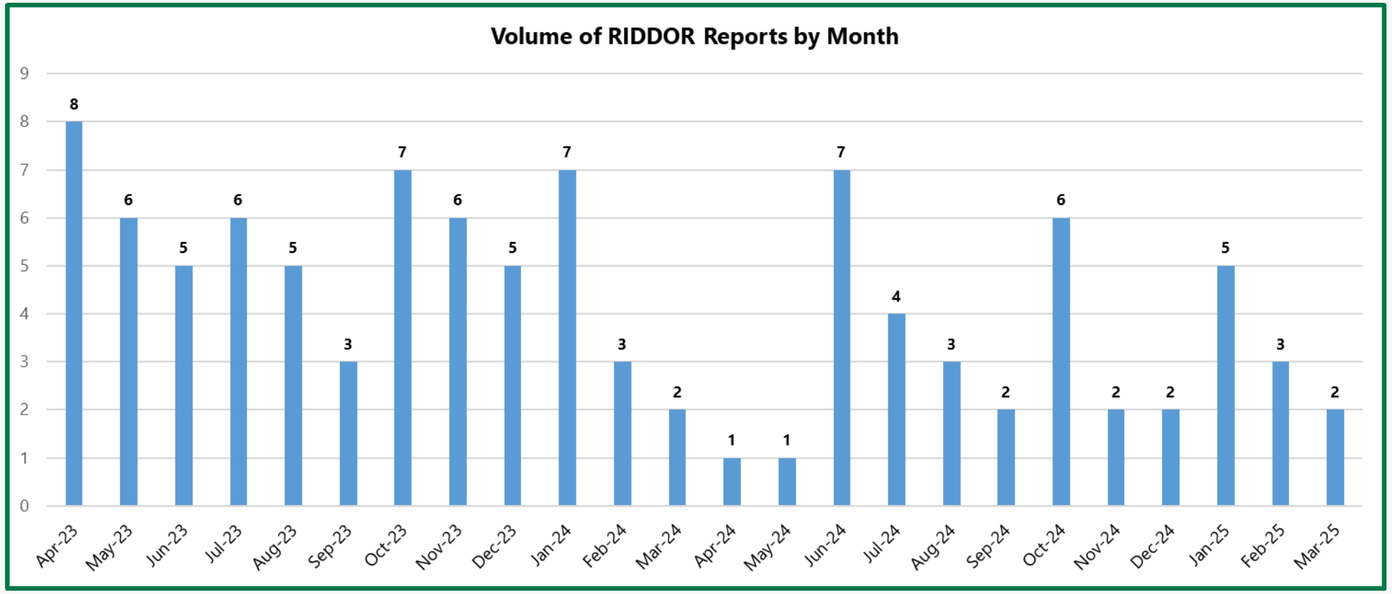
Our Patients: Quality, Safety & Patient Experience
Health & Safety (RIDDORS) Indicators

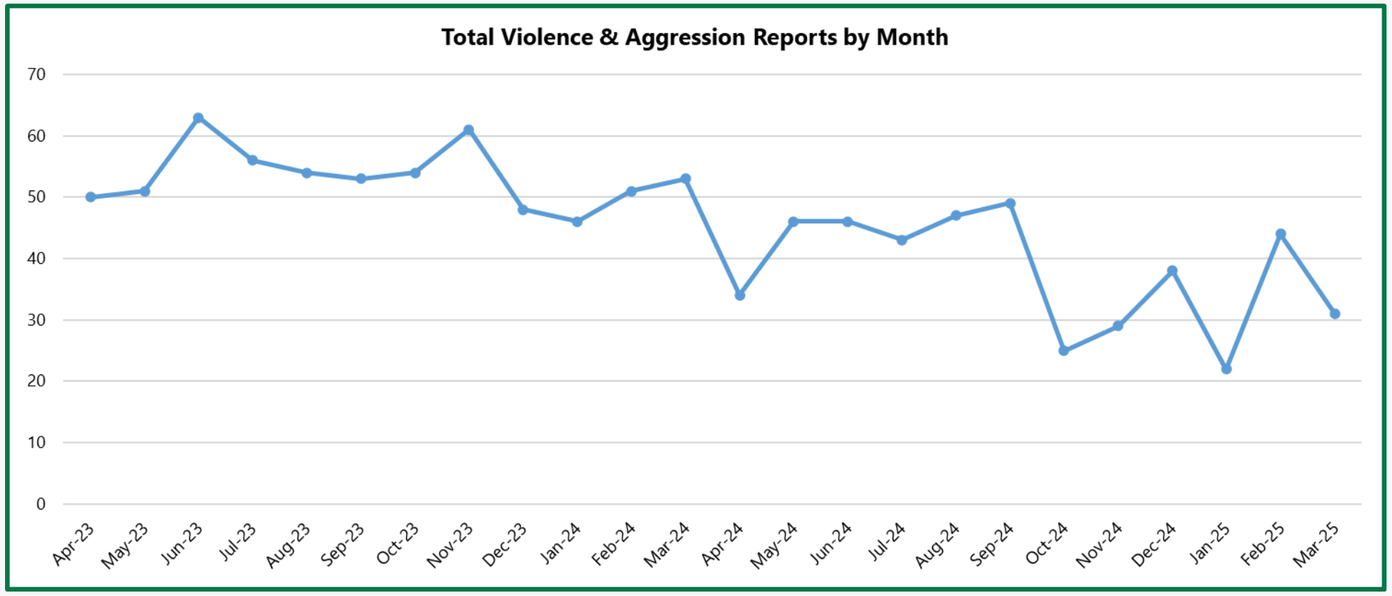
(Responsible Officer: Liam Williams)

Self-Assessment: Strength of Internal Control: Moderate

PCC

Health & Care Standard
Health – Safe Care





Analysis

RIDDOR: There were 2 incidents requiring reporting under RIDDOR during March 2025.Both were for an injuries requiring over 7 days of work

100% of the RIDDOR's were submitted within the HSE reporting timelines due to good working relationships with the H&S and Operational Teams.

1 over 7- day injury was due to fall over patients' items left at place of treatment
1 over 7-day injury was to staff members patella due to stepping on even ground.

Violence and Aggression: A total of 31 incidents have been reported of V&A in March.
6 Physical Assaults on staff were reported during the month with 25 incidents of verbal abuse
6 incidents were reported as Moderate in harm and 15 noted as low harm with 1 case being reported as causing severe harm.

The number of verbal assault incidents increased significantly during the month with aggressive and threatening behaviour accounting for 25 of the 31 incidents.

- The number of V&A incidents reported in March has decreased with 31 incidents for the month compared to 44 for the previous month.
- Toolbox talks, raising awareness of case management support are taking place across the Region by the V&A Team to support staff and raise awareness.
- Verbal abuse continues to be the major category of reporting received with aggressive and threatening behaviour toward staff still at high levels.

Remedial Plans and Actions

RIDDOR: A weekly Datix incident meeting is being used to identify RIDDOR reportable incidents and assign a Safety Advisor to assist with the investigation and reporting to the HSE.

Violence and Aggression: V&A incident causation is being trended to identify the suitability of recording incidents in response to the volume of low harm and no harm incidents to with the aim of undertaking suitable investigations and providing sufficient support for staff members affected.
Of note is a number of staff on staff reported incidents
The team continue working with the Clinical Support Desk to explore mechanisms to better protect staff by use of Community Behavioural Orders via the Patient Care Plans.

Expected Performance Trajectory

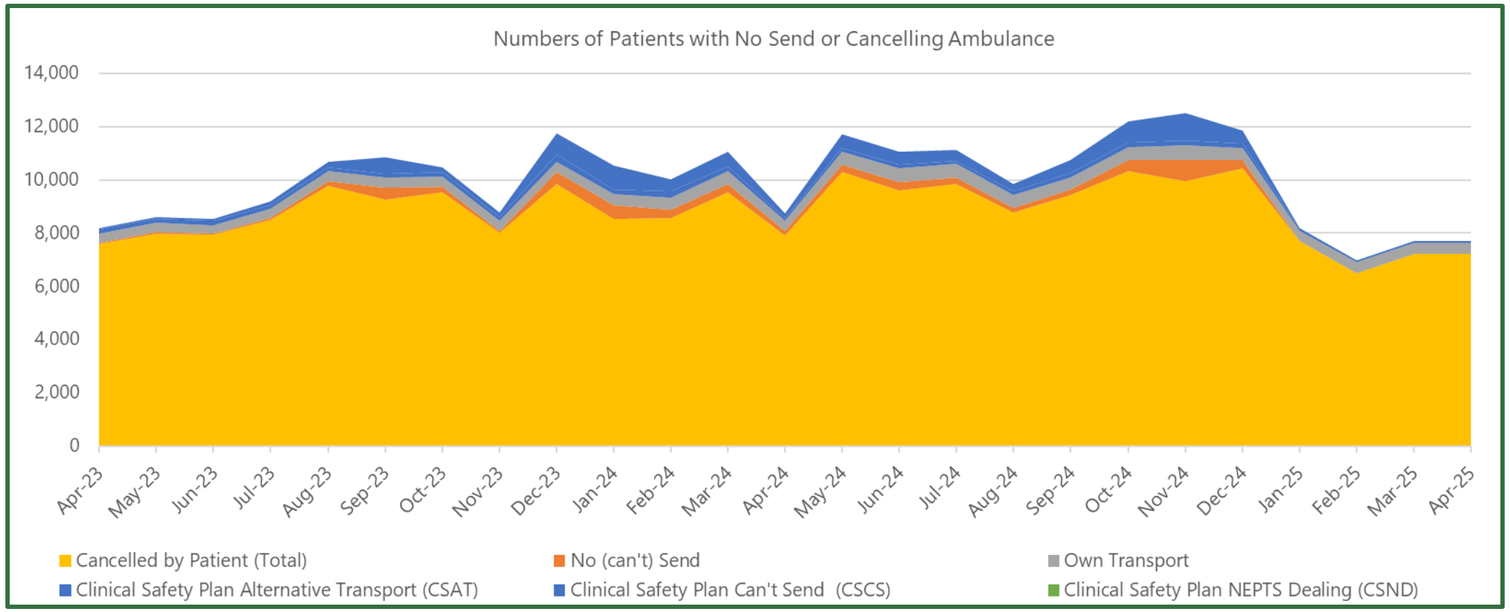
RIDDOR: As the weather improves over the coming months there us expected to be a lower number of slip and trip incidents reported due to improvement in ground conditions at patient properties.

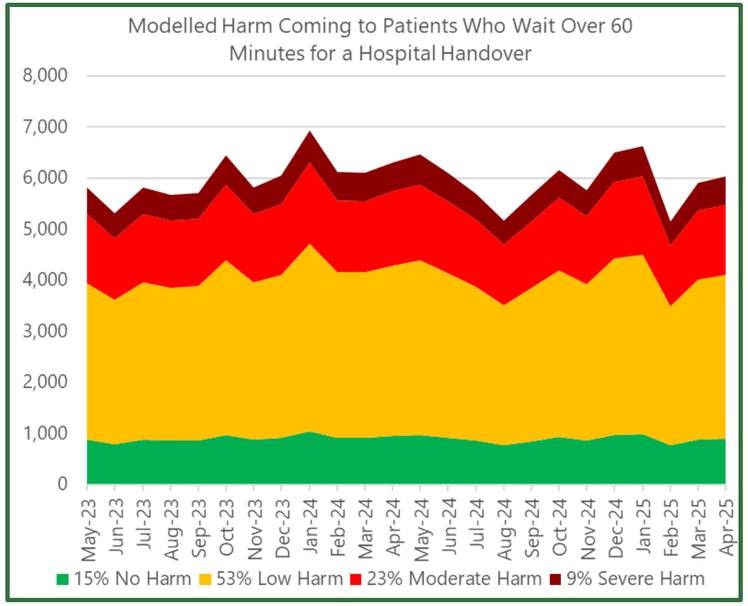
Violence and Aggression: The number of verbal assaults is expected to rise over the coming months as staff become more confident in the support provided by the V&A team.

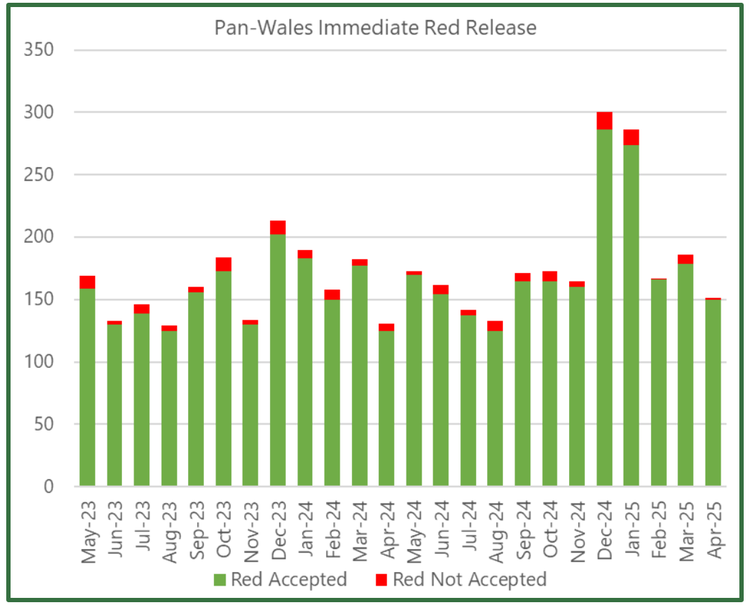
Data source: Datix

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

(Responsible Officer: Andy Swinburn) G QUEST







Analysis

In April 2025, 71 ambulances were stopped due to Clinical Safety Plan alternative transport (CSPT). In addition, 7,232 ambulances were cancelled by patients (including patients refusing treatment at scene) a minimal increase from the 7,229 in March 2025. There has been a downward trend in patient cancellations since December 2024 which the Trust believes is connected to the implementation of Rapid Clinical Screening.

There were 712 requests made to Health Board EDs for immediate release of Red or Amber 1 calls in April 2025. Of these 150 were accepted and released in the Red category, with 1 not being accepted and 192 ambulances were released to respond to Amber 1 calls, but 369 were not.

The graph in the bottom left shows the level of patient harm during April 2025. Of the 6,025 patients who waited outside an ED for over an hour to be handed over to the care of the hospital, the Trust could assume that 15% (903 patients) would experience no harm, 53% (3,193 patients) would experience low harm, 23% (1,385 patients) would experience moderate harm and 9% (542 patients) would experience severe harm.

In April 2025 CSP levels for the Trust were:

Remedial Plans and Actions

Red immediate release is monitored weekly by the Chief Executive and reported through to Health Board CEOs with the expectation that there are no declines for Red Release from any of the 7 Health Boards. All health boards have agreed to this measure. Integrated Commissioning Action Plan (ICAP) meetings had been paused as the Trust moves into the new commissioning arrangements with new arrangements expected from Q1. The NHS Wales Performance Delivery framework 2024/25 has a target of no handovers of more than one hour, this equates to 7,500 hours of handover lost hours.

Expected Performance Trajectory

The Trust continues to monitor CSP levels both daily through the ODU and weekly through the Weekly Operations Performance Meeting and mitigations are actioned to reduce the impact on the Trust's ability to respond to demand. See also slides on Red performance and Amber performance, in particular, remedial actions.

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

Our Patients: Quality, Safety & Patient Experience
Patient Experience Surveys

(Responsible Officer: Liam Williams)

Self-Assessment: Strength of Internal Control: Moderate

PCC

Health & Care Standard
Health – Safe Care

March 2025		
NEPTS (238 responses)	Benchmark	Score
How long did you wait for your transport to take you home after your appointment.	85	88
Were you happy with the transport you received?	85	96
999 (7 responses)	Benchmark	Score
The 999-call taker who answered your call was reassuring.	85	75
The 999-call taker who answered your call explained what was going to happen next.	85	100
You felt confident in the call taker ability to manage your call and provide appropriate advice.	85	75
The length of time I waited for an ambulance to arrive was acceptable.	85	83
111 (10 responses)	Benchmark	Score
Do you feel your call to 111 Wales was helpful?	85	35
Did you follow the advice given to you by NHS 111 Wales?	85	100
Would you consider using NHS 111 Wales again?	85	25
WAST Overall - Friends & Family Test How was your overall experience with the service today?	Ranked from very poor to very good.	
○ Ambulance care	91.75% Good	5.15% Poor
○ Integrated Care (NHS 111 Wales Telephone line only)	0.00% Good	75.00% Poor
○ EMS (including CSD)	50.00% Good	33.33% Poor
○ NHS 111 Wales Online	50.00% Good	28.57% Poor
	* Where totals above do not add up to 100%, this is because a 'Do Not Know' answer was given, these are excluded from overall total.	

Analysis

Within the NEPTs survey the response provided did not hit the benchmark in relation to the question 'How long did you wait for your transport to take you home after your appointment, while the question 'Were you happy with the transport your received', came out above the 85-benchmark figure (n=96).

In the 999 survey 'The length of time waited for an ambulance to arrive was acceptable' question failed to meets its target. Whilst within 111 survey the only question to achieve its 85-benchmark was 'Did you follow the advice given by NHS 111 Wales?'

Response rates to the 999 and 111 surveys remain low and it's acknowledged that these do not reflect an entirely representative picture based on overall call volumes.

Engagement and survey outcomes remain largely consistent and tell us that people continue to be very concerned about response times in the community and frustrated at hospital handover delays. 111 callers have told us that they experienced long waits for call backs. NEPTS users told us that overall, they continue to be happy with the transport they receive but experience delays when waiting for their transport home following their appointment.

Remedial Plans and Actions

We continue to make available 4 core Patient Experience surveys, covering the Trust's main service delivery areas:
999 EMS Response (incorporating CSD)
Ambulance Care (NEPTS)
NHS 111 Wales Telephony
NHS 111 Wales Online

A DPIA to allow distribution of surveys to patients via SMS Texting is currently with the IG Team and we expect this to be submitted to the ICO for approval imminently.

We continue to work closely with the Trust's Falls Improvement Lead to deliver a targeted survey looking at the experiences of people who are responded to by either a Level 1 or Level 2 falls responder. Plans are in place to duplicate this method of survey delivery with patients attended to by a CWR Volunteer.

We continue to engage with the Once for Wales Programme Board who have updated the 'All Wales Patient Experience Question Set' and 'People's Experience Framework'. The Framework and new questions have now been formally released by Welsh Government alongside an updated Welsh Health Circular.

Expected Performance Trajectory

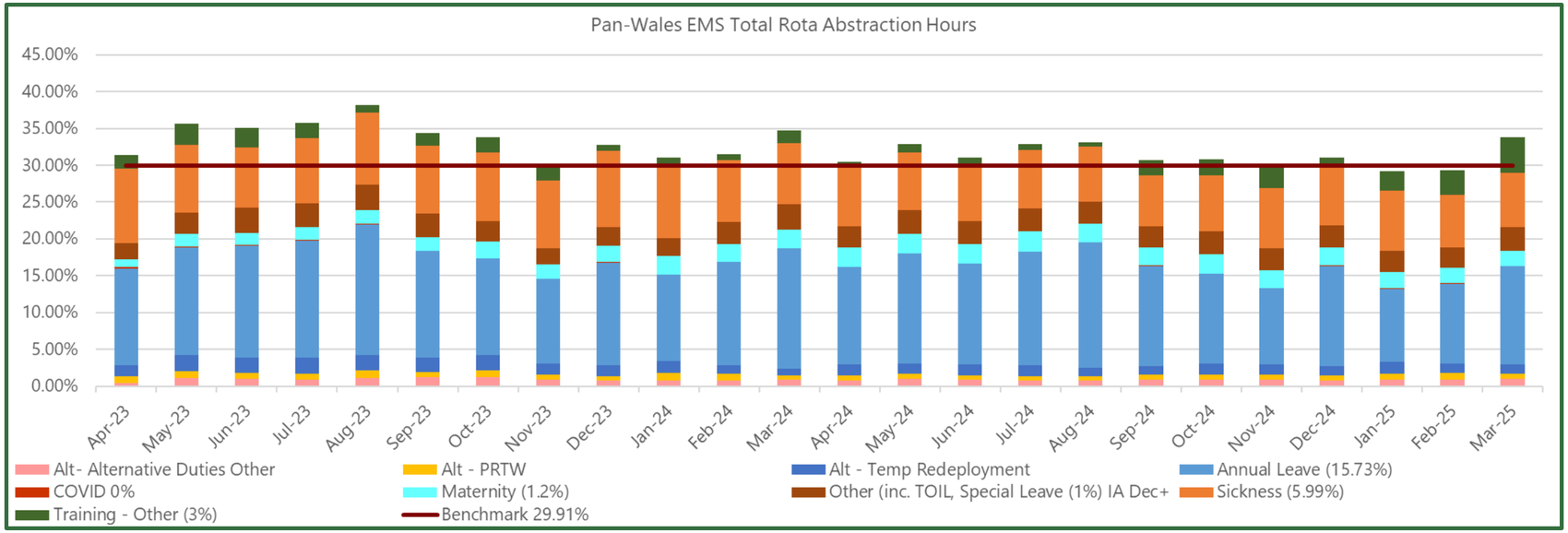
An overall aim of increasing visibility of experience surveys and maximising opportunities to capture patient experience data.

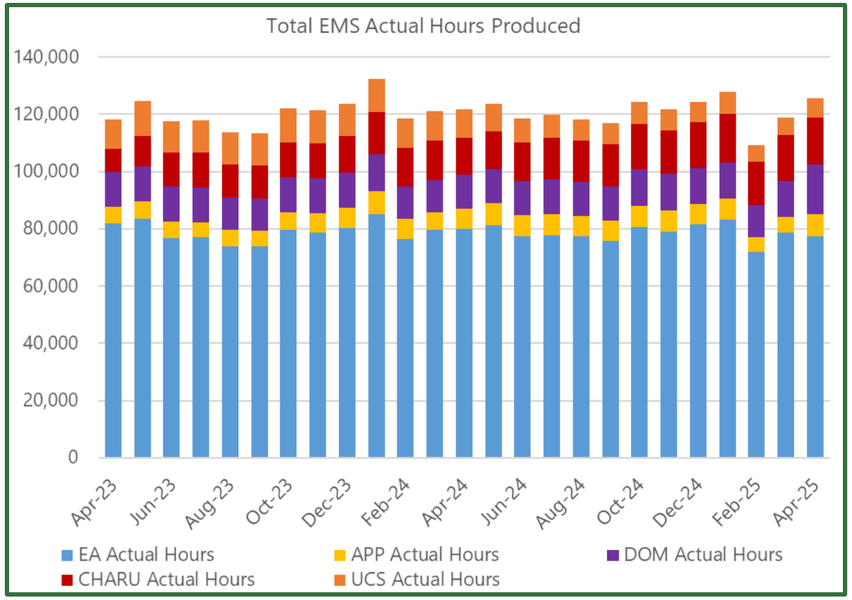
Our People
Capacity - Ambulance Abstractions and Production Indicators

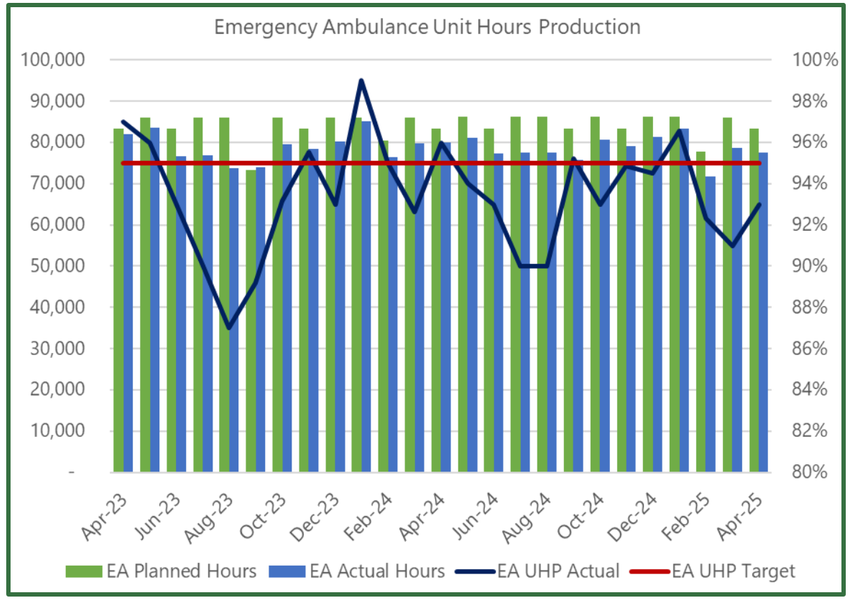
(Responsible Officer: Lee Brooks)

EA Production	Abstractions
A	R

CI PCC FPC







Analysis

The total EMS hours produced is a key metric for patient safety. The Trust produced 125,639 hours during April 2025, an increase compared to the 121,578 hours produced during April 2024. The Trust is delivering good levels of production.

As shown in the top graph, monthly abstractions from the rosters are key to managing the number of hours the Trust has produced, as are the total number of staff in post. March 2025, saw a total EMS abstractions (excluding Induction Training) of 33.86%. This was an increase on the 29.36% recorded in February 2025 and does not achieve the 29.91% benchmark. The highest proportion of abstractions was due to annual leave at 13.31% followed by sickness at 7.43%.

Emergency Ambulance Unit Hours Production (UHP) achieved 93% in April 2025 which equated to 77,470 Actual Hours.

In April 2025 CHARU UHP was 91% against the full roll out requirement. The second highest UHP in the last four months.

Remedial Plans and Actions

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

Expected Performance Trajectory

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

Our People
Capacity - Sickness Absence Indicators

(Responsible Officer: Angela Lewis)

Mental Health R

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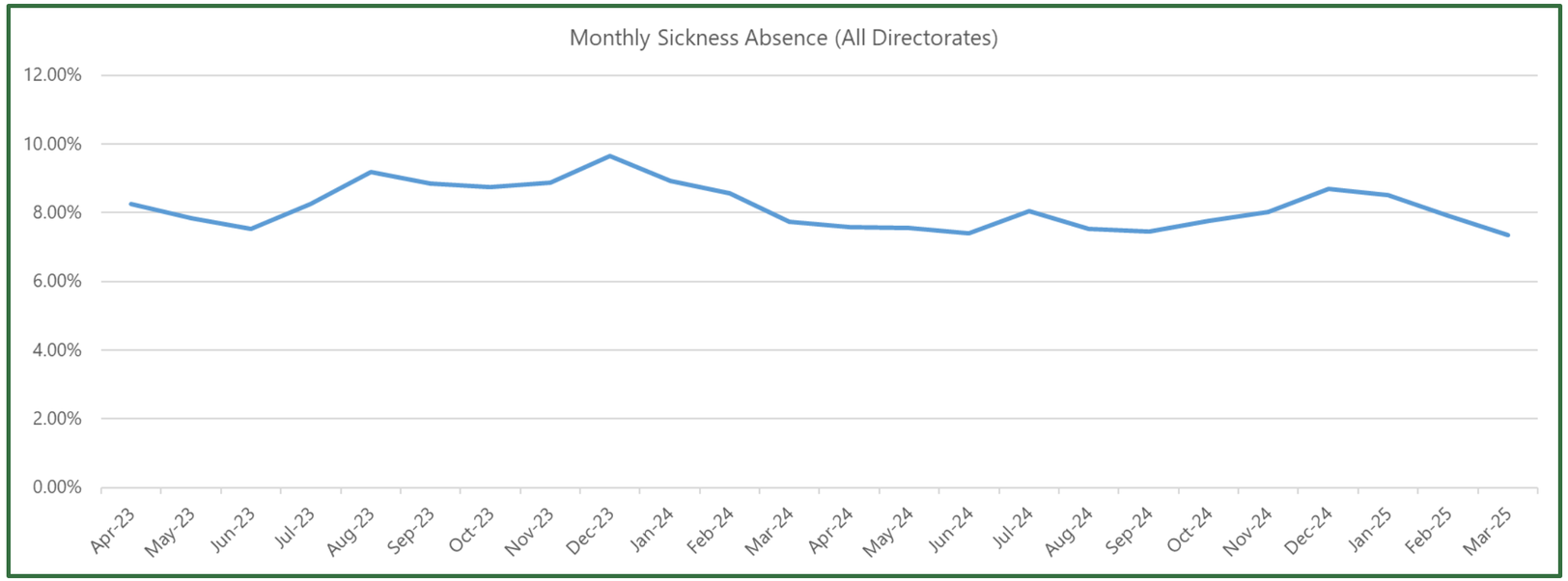
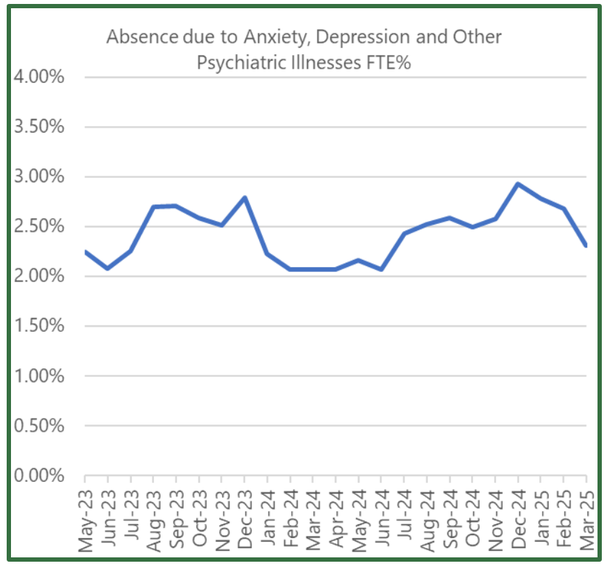
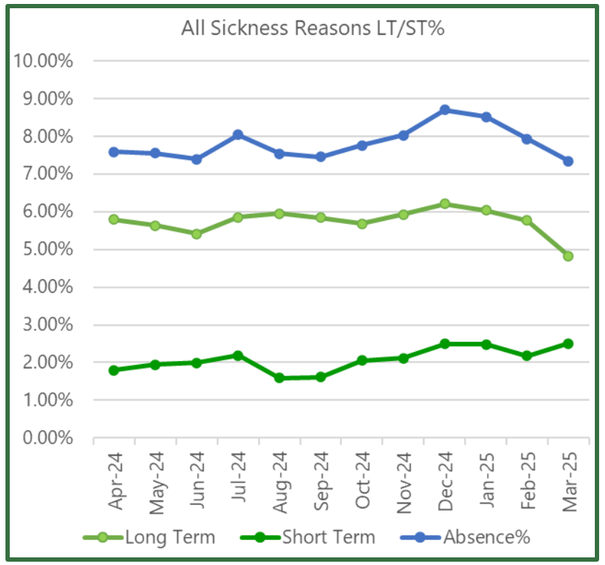




Average working days lost per FTE (Annual)	
17.84	days
Single month Absence %	
7.35%	
Long Term	**Short Term**
4.83%	2.51%
Mental Health	**Other MSK**
(S10 Stress/Anxiety)	(excluding Back)
2.31%	0.73%



Analysis

There was a slight decrease in overall sickness absence rates between February 2025 and March 2025, dropping from 7.93% to 7.35%. Long term absence decreased from 5.77% in February 2025 to 4.83 % in March 2025, while short-term absence increased slightly to 2.51% in March 2025 from February 2025 (2.17%).

The highest reasons for absence in March 2025 were Anxiety/ Stress/ Depression, other musculoskeletal problems, Gastrointestinal problems and injury fracture. Absence due to Mental Health decreased slightly for the fourth consecutive month from 2.68% in February 2025 to 2.31% in March 2025.

55 OH management referrals were received in March compared to 166 in February. The self-referral portal on Opas G2 continues to prove popular and has helped streamline the service, 12 self-referrals were received in March. In March we received a total of 72 Wellbeing referrals; 29 wellbeing management referrals, 7 self-referrals and 36 walk–in referrals.

For the 2024/25 Flu campaign, 1,423 flu vaccines were administered by our WAST OH / Peer Vaccinators. 1,035 were given to WAST employed staff with 250 WAST staff also confirming they have received the flu vaccine elsewhere i.e. GP / Pharmacy, therefore, 28.93% of the WAST workforce were vaccinated. A further 277 WAST staff have completed our Microsoft Form to state they wish to opt-out from having the flu vaccine this year.

Remedial Plans and Actions

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

Expected Performance Trajectory

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

March 2025

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

Our People
Capacity – Staff Turnover

(Responsible Officer: Angela Lewis)

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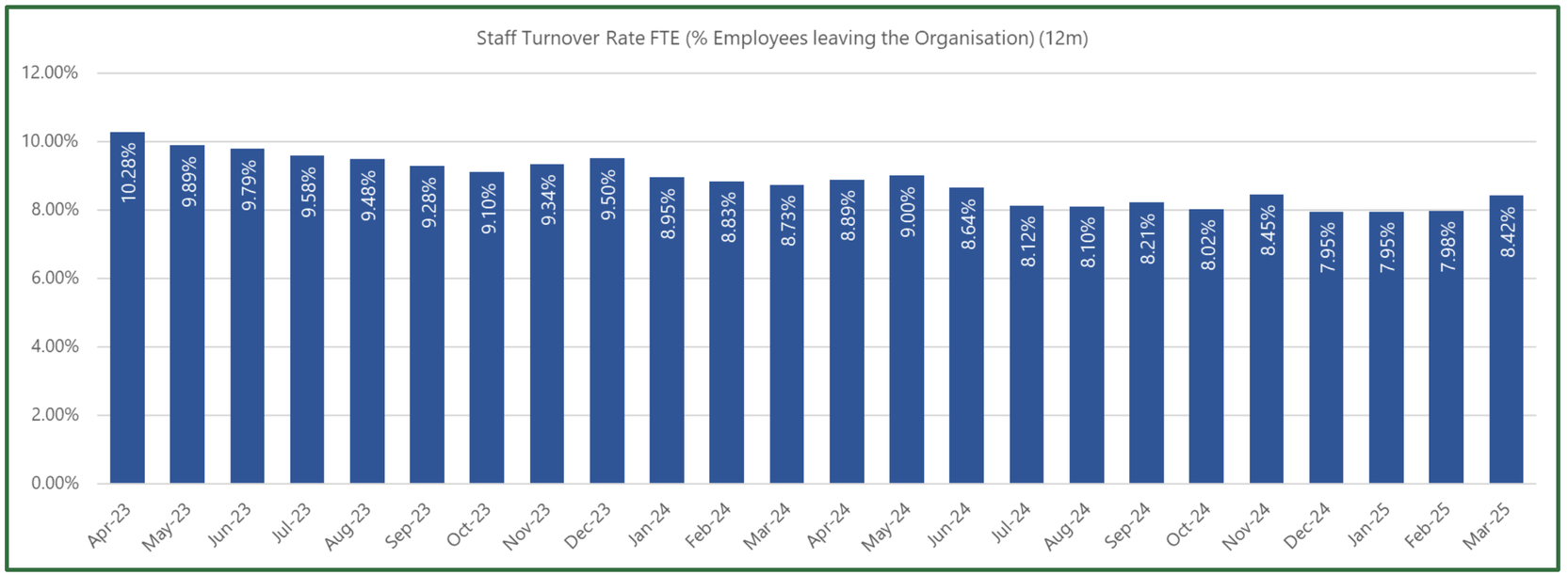

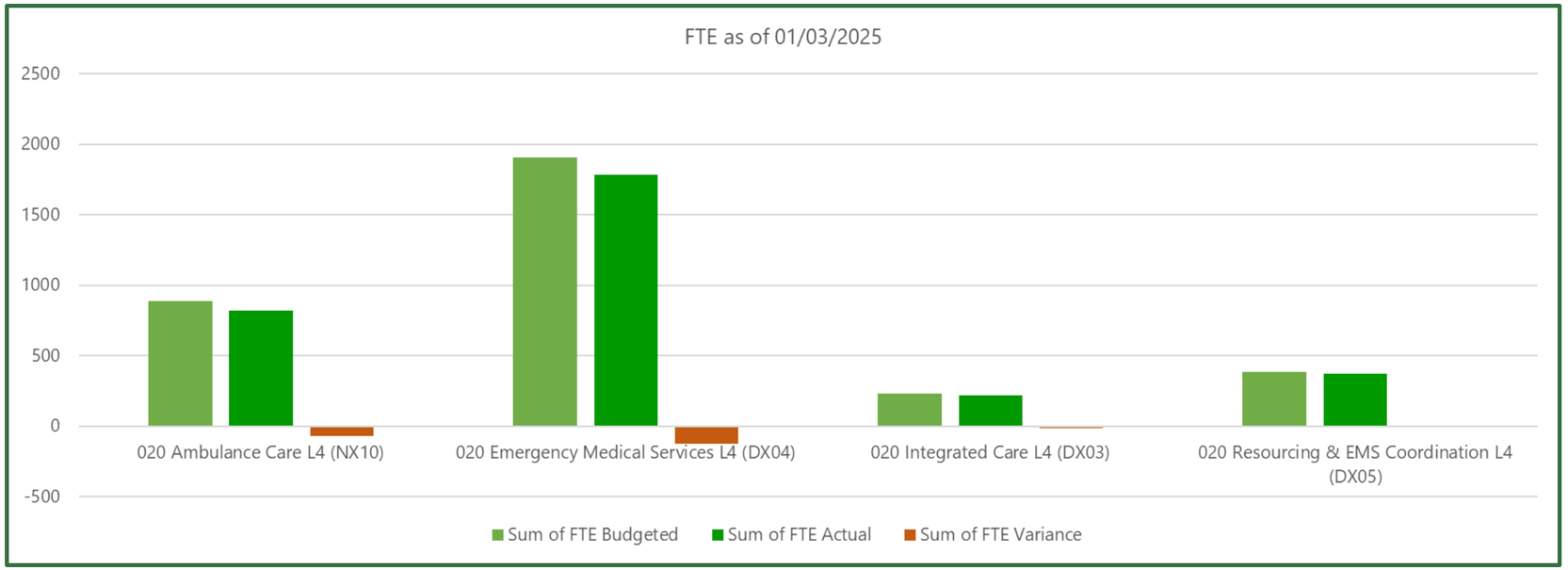

Analysis

Staff turnover rates in March 2025 were 8.42%, increasing from 7.98% in February 2025. March saw 52 leavers (43.97 FTE). Turnover trends are being monitored. Currently it has been noted that in January & February months a peak occurs predominately due to retirements. This was compensated by 42 joiners (41.35 FTE). Of those leaving, the group with the greatest number were Ambulance Care Assistants or Patient Transport Drivers (12 people), Technicians (11 people), Staff Nurse (5 people) and Paramedic (5 people).

Occupational Health continue to meet national KPIs set by the All-Wales Occupational Health standards and scope of practice, i.e., regarding turnaround times for referrals the national KPI states: The 1st offered appointment date will be within 29 calendar days of the date referral received. KPI that this is achieved 80% of the time.
Our waiting times have fluctuated over the past months, this has been due to staff changes and staff sickness. The current waiting time for management referral is 6.41 days.
Staff are currently waiting approx. 14.85 days for pre- employment screenings from date of this has been due to submission to first offered appointment.

Remedial Plans and Actions

- The team continue to work closely with Civica to improve the system, including a text reminder service for appointments and awaiting access to visual diaries.
- The Wellbeing team continue to support colleagues and managers by attending regular meetings, providing targeted support and facilitating drop-in sessions for colleagues.
- Team members from OH/Wellbeing/TRiM continue to promote our services via Siren, outstation visits and drop-in clinics. We regularly give presentations to newly recruited staff to highlight and promote the Occupational Health & Wellbeing service.
- Our Head of Workplace Wellbeing offers psychological consultation to managers and People Services for sensitive and complex situations (e.g., suicide risk, long-term sickness regarding mental ill health).

Expected Performance Trajectory

The team continue to review the Occupational Health and Wellbeing provision, so that we ensure that services/interventions offered are relevant, appropriate, and up to date, our focus is on continuous improvement.

Our People
Capability - PADR and Training Rates Indicators

(Responsible Officer: Angela Lewis)

PADR: A

Stat & Mand: G

CI

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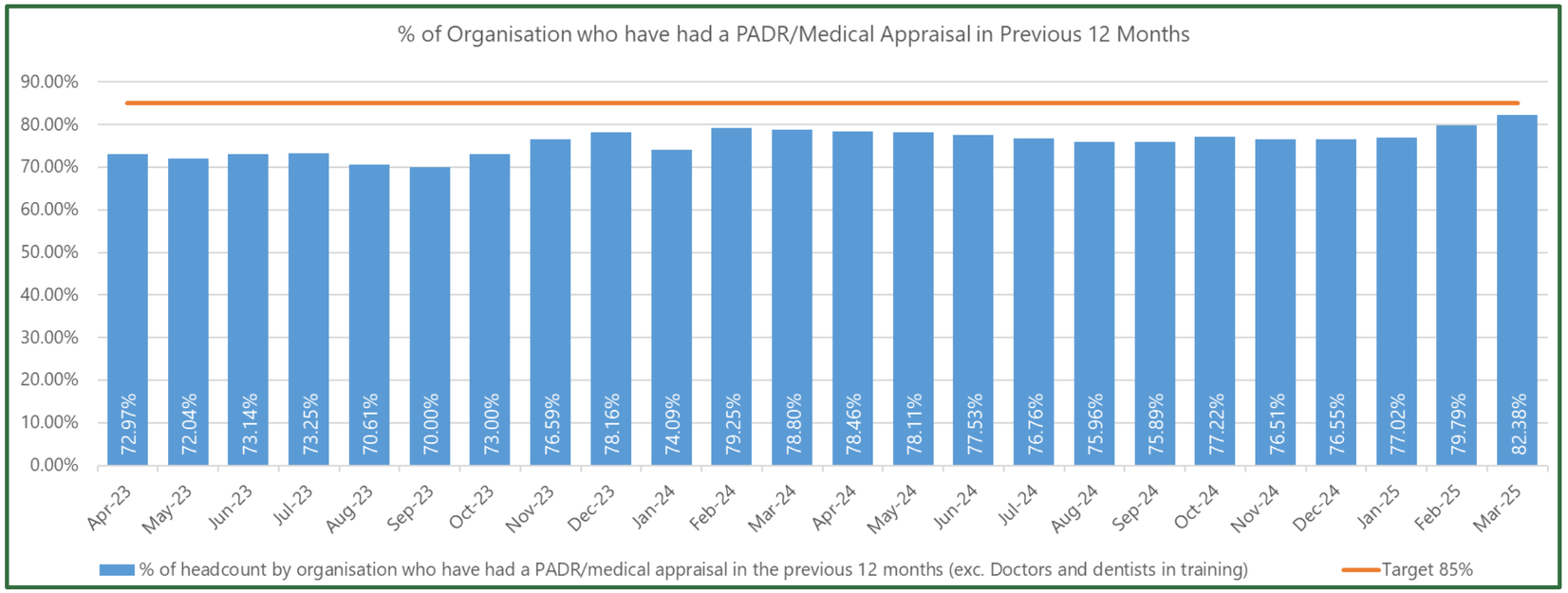
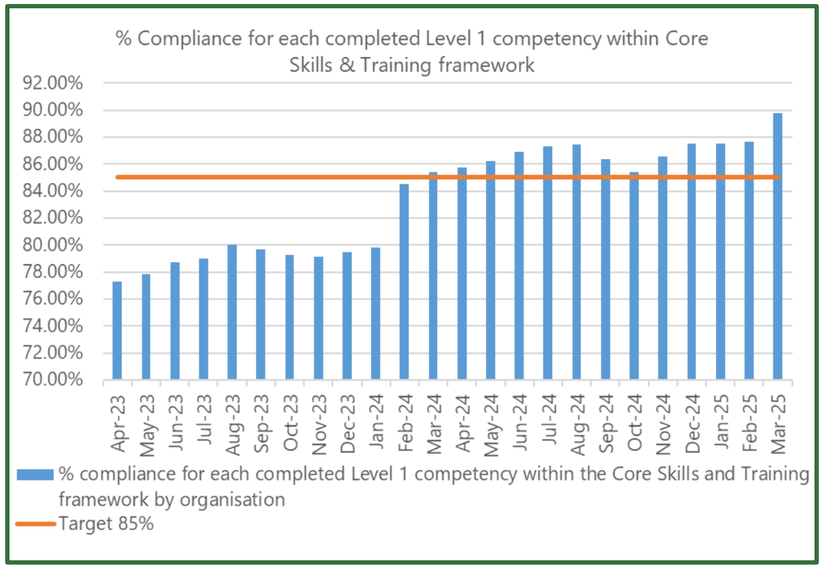
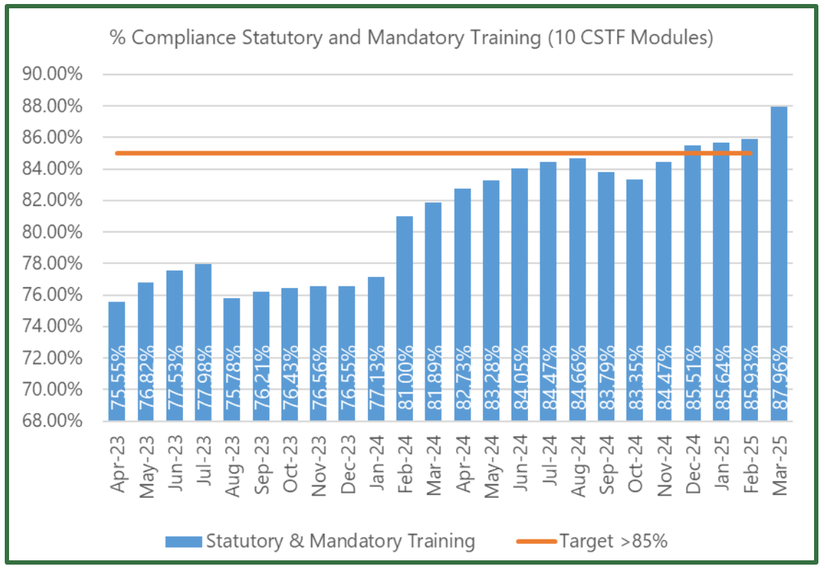
Health & Care Standard Health – Staff & Resources

Self-Assessment: Strength of Internal Control: Strong







Analysis

PADR rates minimally increased from 79.79% in February 2025 to 82.38% in March 2025 and is close the 85% target. Over the reporting period this target has only been achieved once, in December 2022.

In March 2025 Statutory & Mandatory Training rates reported a combined compliance of 87.96% exceeding the 85% target for the fourth consecutive month. However, only Dementia Awareness (98.13%), Moving & Handling (95.67%) and Safeguarding Adults (97.94%), achieved the 85% target. Equality & Diversity (82.32%), Information Governance (79.20%), Fire Safety (77.16%), Paul Ridd (75.94%), Fraud Awareness (75.71%), Violence Against Women, Domestic Abuse & Sexual Violence (73.58%) and Welsh Language Awareness (70.79%) all remain below this target.

There are currently 19 Statutory and Mandatory courses that NHS employees must complete in their employment. These are listed in the table:

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

Remedial Plans and Actions

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

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

Expected Performance Trajectory

Performance is improving as compliance has risen.

Data source: ESR

Our People
Health and Well-being – Shift Overruns

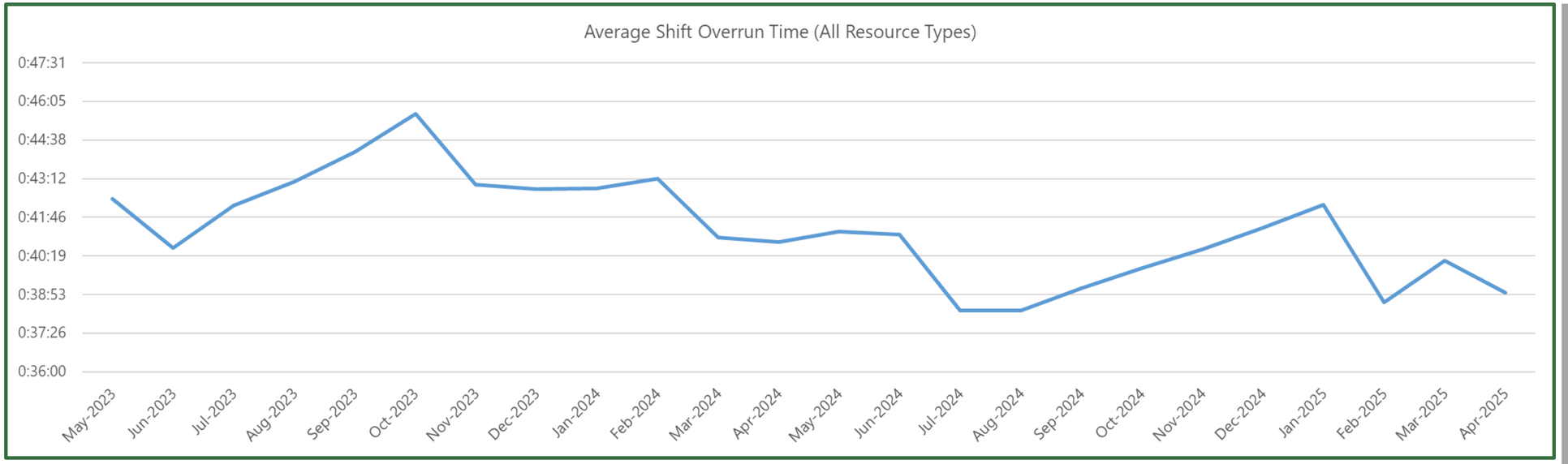
(Responsible Officer: Angela Lewis)

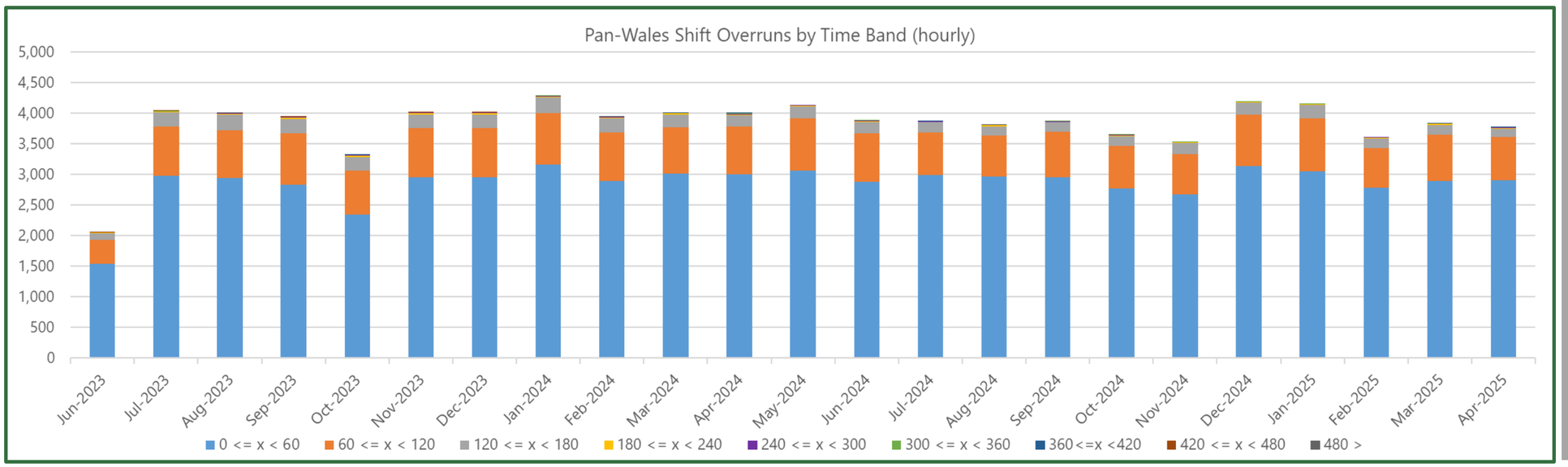
Overruns
R

CI

PCC

FPC





Analysis

There were 3,773 shift overruns during April 2025.

The average overrun figure for April 2025 was 38 minutes and 58 seconds, a minimal decrease from March 2025 (00:40:08). The trend continues to be downward over the past two years.

The highest volume of shift overruns occur within the 0 to 60-minute category, accounting for 75.8% of the total. 19.3% fall within the 61 to 120-minute category, 4.4% in the 121 to 180-minute category, 0.3% in the 181 to 240-minute category and 0.2% in the 241 minutes and over category.

Remedial Plans and Actions

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

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

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

Expected Performance Trajectory

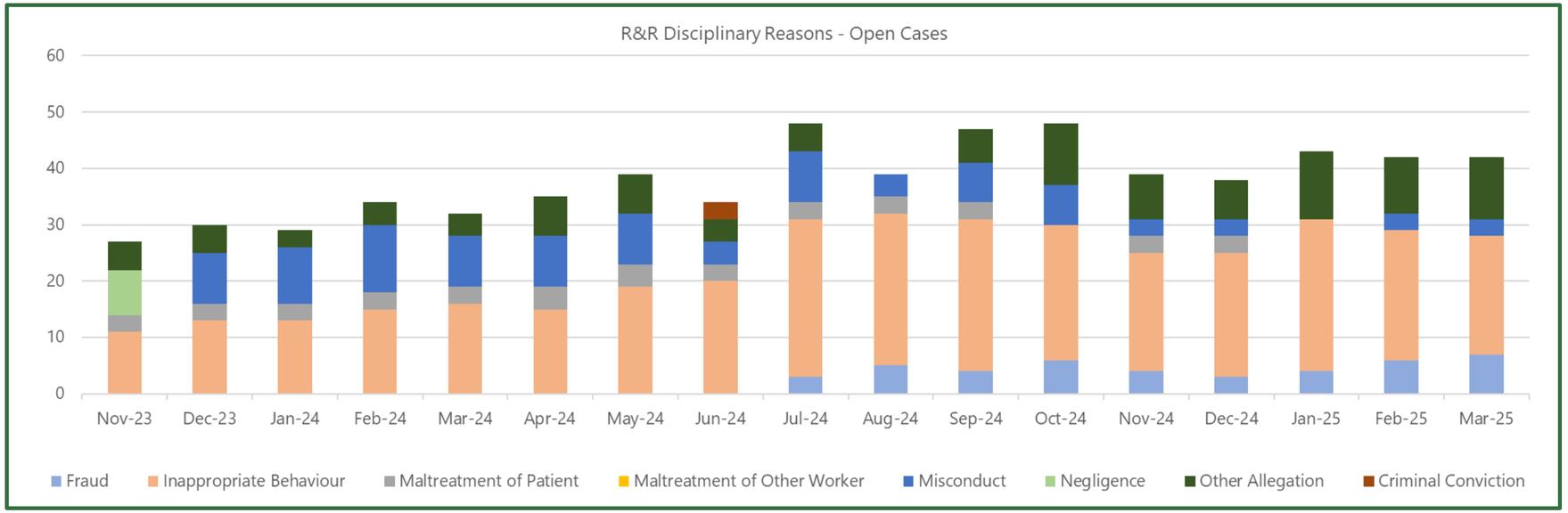
Overruns correlate with handover lost hours and may continue to increase.

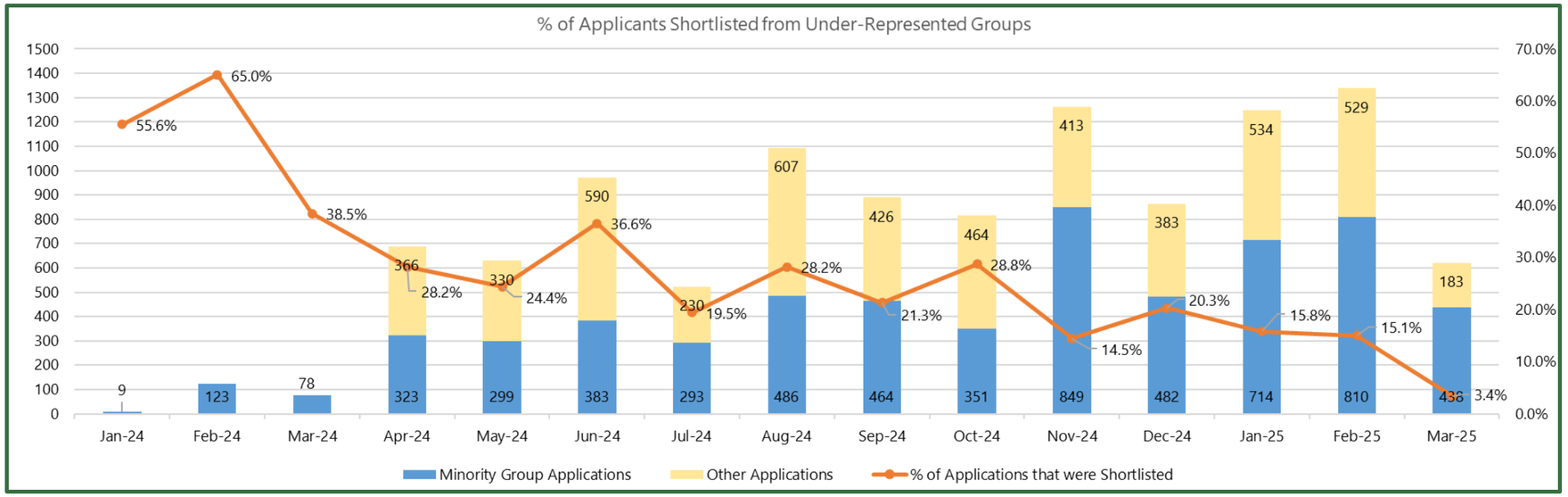
Our People
Culture – Number of R&R Disciplinary Hearings and Number of Applicants Shortlisted from Under-Represented Groups

(Responsible Officer: Angela Lewis)

Self-Assessment: Strength of Internal Control: Moderate

PCC





Analysis

There were 42 open formal disciplinary cases recorded at the end of March 2025, which remains consistent with the previous month. Of these Disciplinary cases, the majority are again due to allegations of inappropriate behaviour, followed by fraud.

There were 14 open formal Respect and Resolution cases submitted by employees in March 2025, two less than the 16 February 2025. These are a mixture of both Respect and Resolution Grievances and Dignity at work.

The bottom graph shows that in March 2025, 621 job applications were processed, and 32 interviews planned.

Of the 621applications, a total of 438 were from under-represented groups with 328 in the category of Ethnicity, 74 within Disability and 36 identifying within Sexual Orientation.

In March 2025, 3.4% (n=15) of all applications from under-represented groups made it through shortlisting and were invited for interview. This was a decrease from the 15.% in February 2025.

Remedial Plans and Actions

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

Applications: The inclusive recruitment work is ongoing to develop targeted recruitment campaigns and events. Two workshops have taken place to recruit for Black, Asian and Ethnically diverse applicants into our digital roles and work is ongoing on how to expand this to other areas such as Graduate Paramedics. Unconscious bias training for the managers that will be involved in their recruitment is underway.

Expected Performance Trajectory

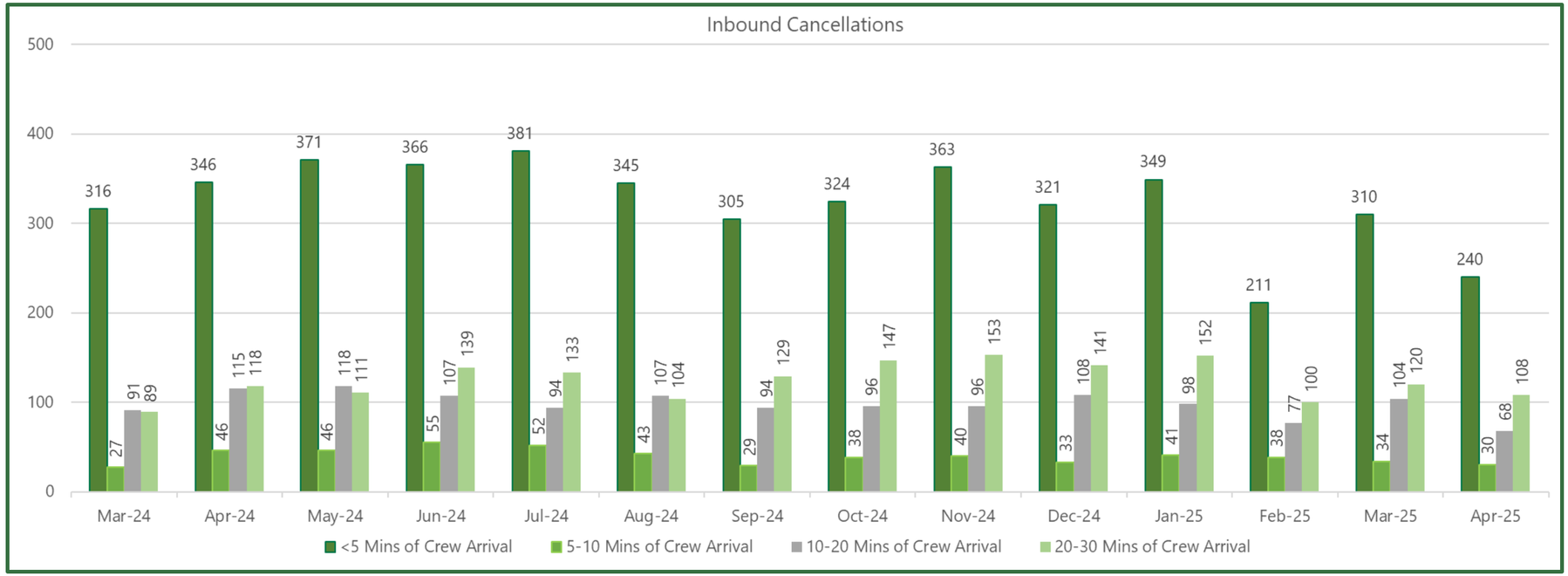
Continue to monitor levels, no trajectory for this measure.

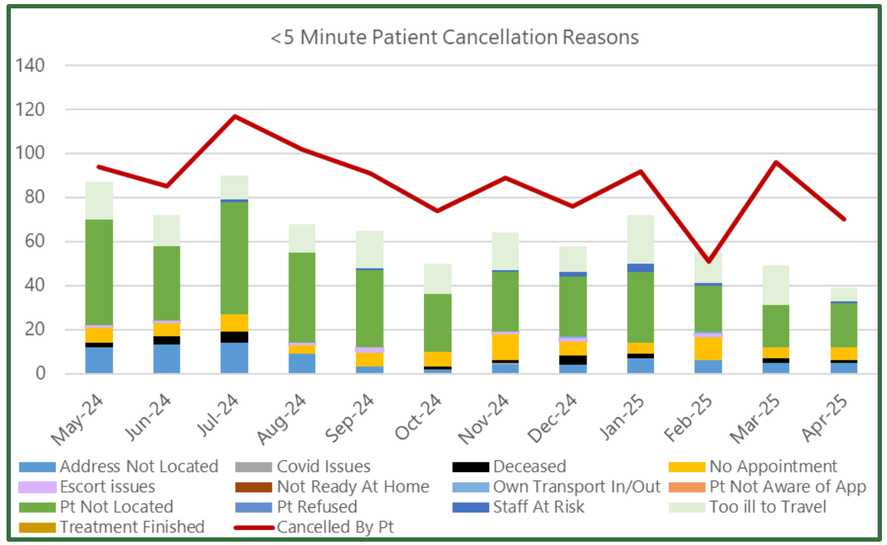
Finance, Resources and Value
Value: Ambulance Care Indicators

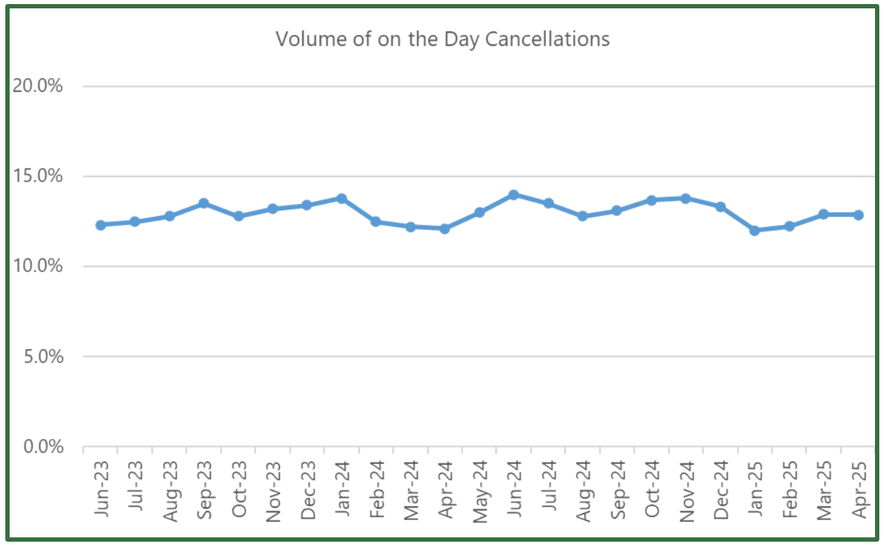
(Responsible Officer: Lee Brooks)

Cancellations
R

FPC







Analysis

Inbound cancellations of 5 minutes or less of the crew arrival time saw a decrease in April 2025 to 240, compared to 310 in March 2025. The total number of cancellations within 30 minutes also decreased from 568 in March 2025 to 446 in April 2025.

In April 2025 there were 70 travel bookings cancelled by patients (including via SMS), decreasing from 96 in March 2025.

The other top reasons for less than 5-minute cancellations included: 20 patients not located, 6 unwell/too ill to travel, 6 no appointment and 5 address not located.

Same day cancellations remained consistent in April with March at 12.9%.

Remedial Plans and Actions

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

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

Expected Performance Trajectory

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

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

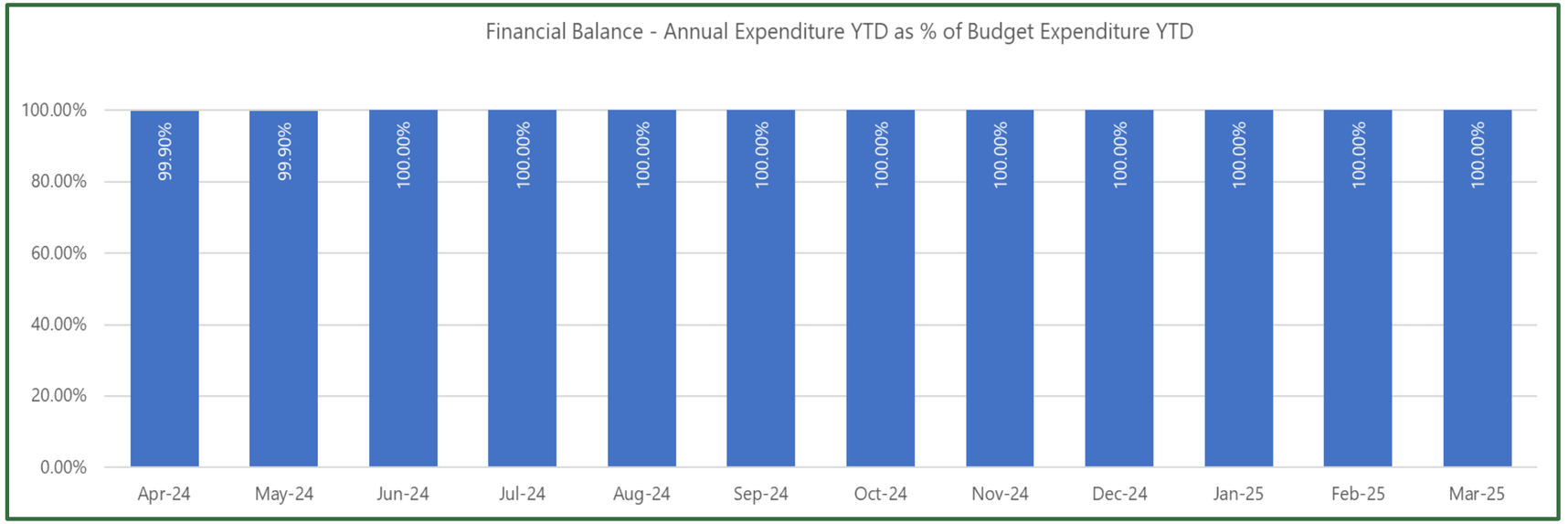
**Please note that MDTs do not appear to provide specific cancellation reasons for either inbound or outbound journeys. There are at present multiple and duplicated reasons both crews, control and the liaison desk can select.*

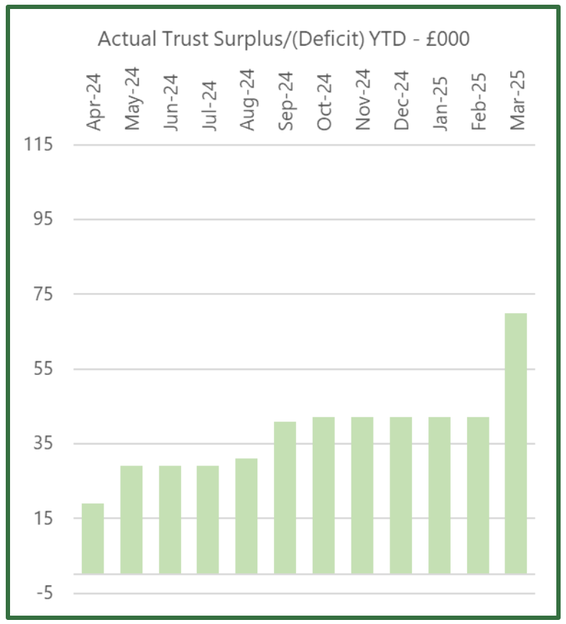
Finance, Resources and Value
Value - Finance Indicators

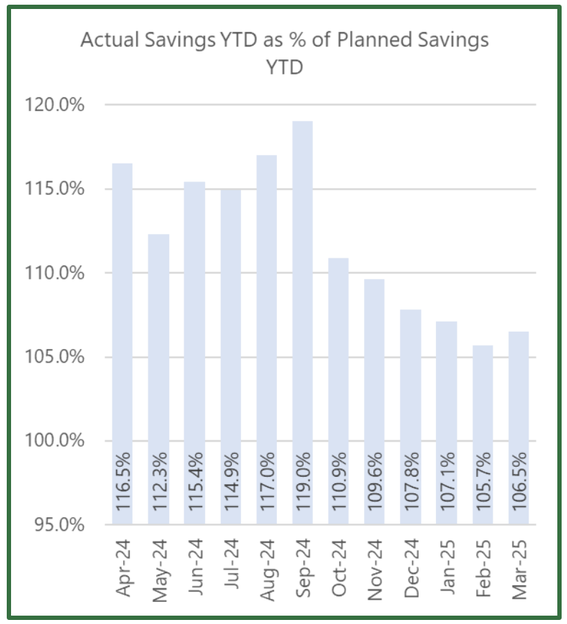
(Responsible Officer: Chris Turley)

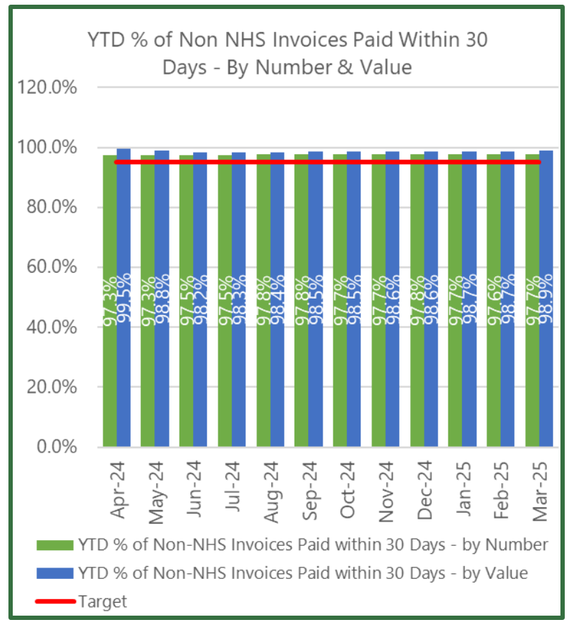
G

FPC









Analysis

The reported outturn performance at Month 12 is a surplus of £70k.

For Month 12 the Trust is reporting planned savings of £6.421m and actual savings of £6.838m (an achievement rate of 106.5%).

The Trust's cumulative performance against PSPP as at Month 12 is 97.7% against a target of 95%.

At Month 12 the Trust achieved both its External Financing Limit and its Capital Expenditure Limit.

Remedial Plans and Actions

There is no remedial plan required given the Trust closed the year with a small surplus of £70k (subject to audit); however, key areas of focus in future years include:-

- Undertaking a review of commercial opportunities for income generation (Report being considered by FSP group).
- A continued focus on the Trust's financial sustainability programme.
- Improved governance for Value Based Health Care, with a particular focus on benchmarking; and
- An improved approach to benefits realisation

Expected Performance Trajectory

The month 12 / year end position was a small surplus of £70k (subject to audit)

Finance, Resources and Value
EMS Utilisation & Average Job/Shift Times

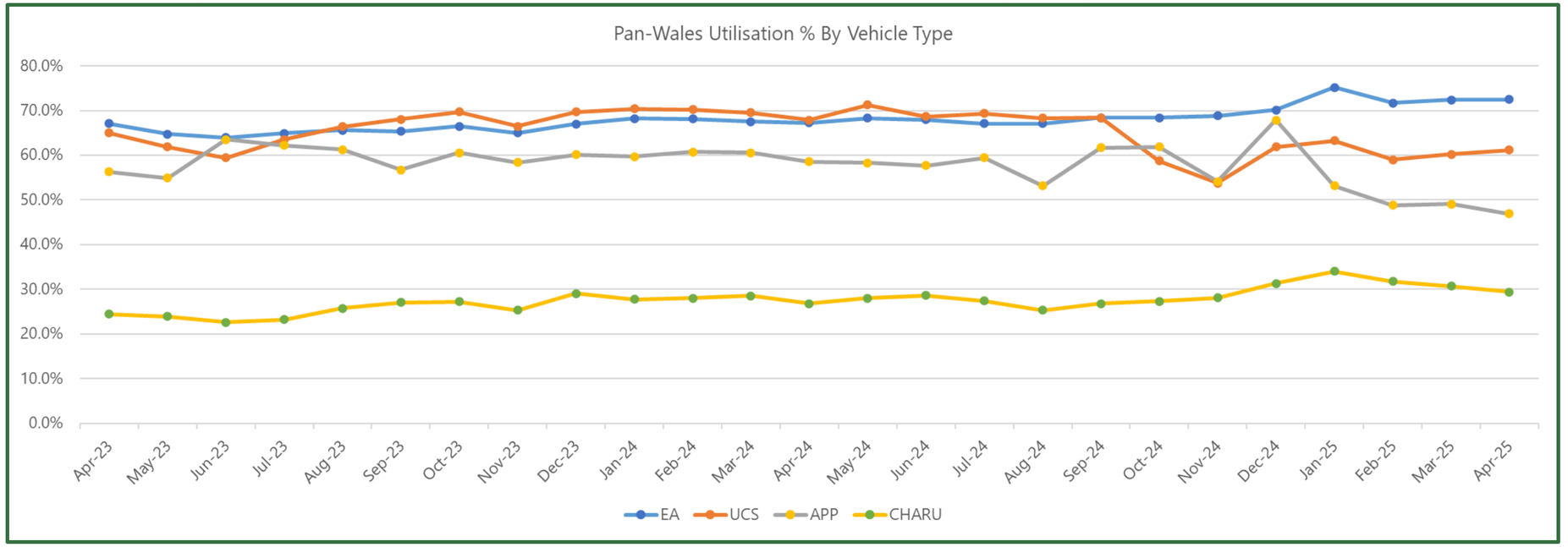
(Responsible Officer: Lee Brooks)

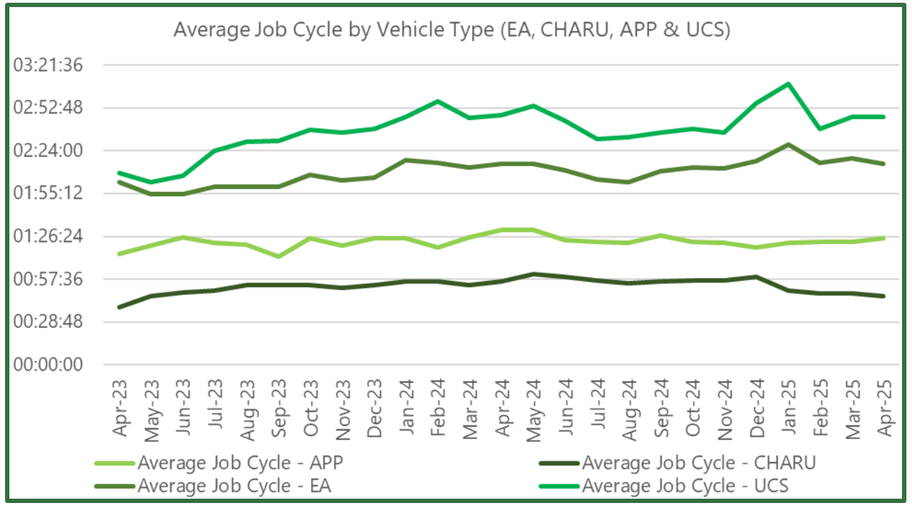
Jobs Per Shift: A

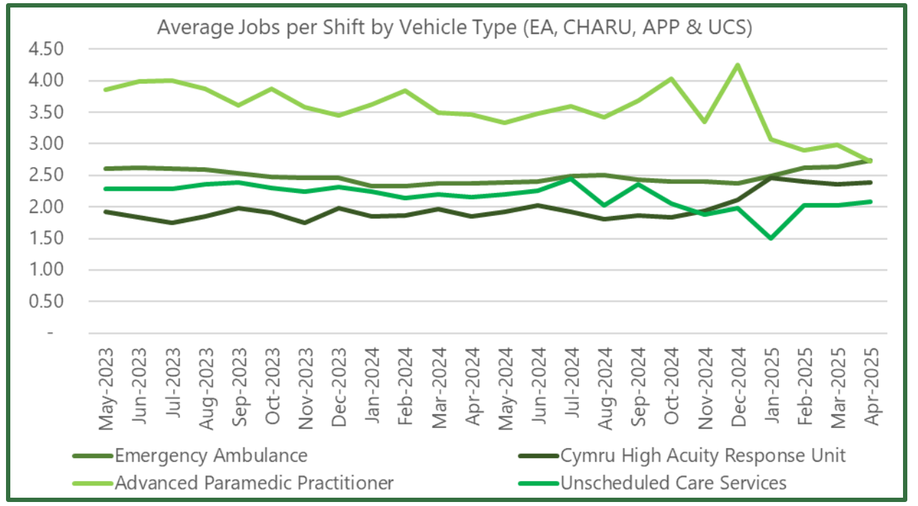
CHARU Utilisation: G

FPC

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







Analysis

Pan Wales Utilisation metrics in April 2025 were 63.7% for all vehicles types, a decrease from 64.4% in March 2025. EA saw the highest rate during the month at 72.5%, returning to the upward trend seen over the past year. The optimal utilisation rate for EAs needs to be lower so that they are free to respond to incoming calls.

As demonstrated in the bottom left graph, the average job cycle increased in April 2025 for EAs (2 hours 15 minutes) and APPs (1 hour 25 minutes). UCS (2 hours 47 minutes) remained the same as the previous month: however, CHARU minimally increased (46 minutes).

Overall average jobs per shift was 2.64 in April 2025, a minimal increase from March 2025 (2.56). EAs averaged 2.74 jobs per shift and UCS crews 2.08. This is lower than what would be ideal and a product of handover delays.

APPs attended on average 2.73 jobs per shift and CHARU's 2.39. However, both sets of data are under review.

Remedial Plans and Actions

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

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

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

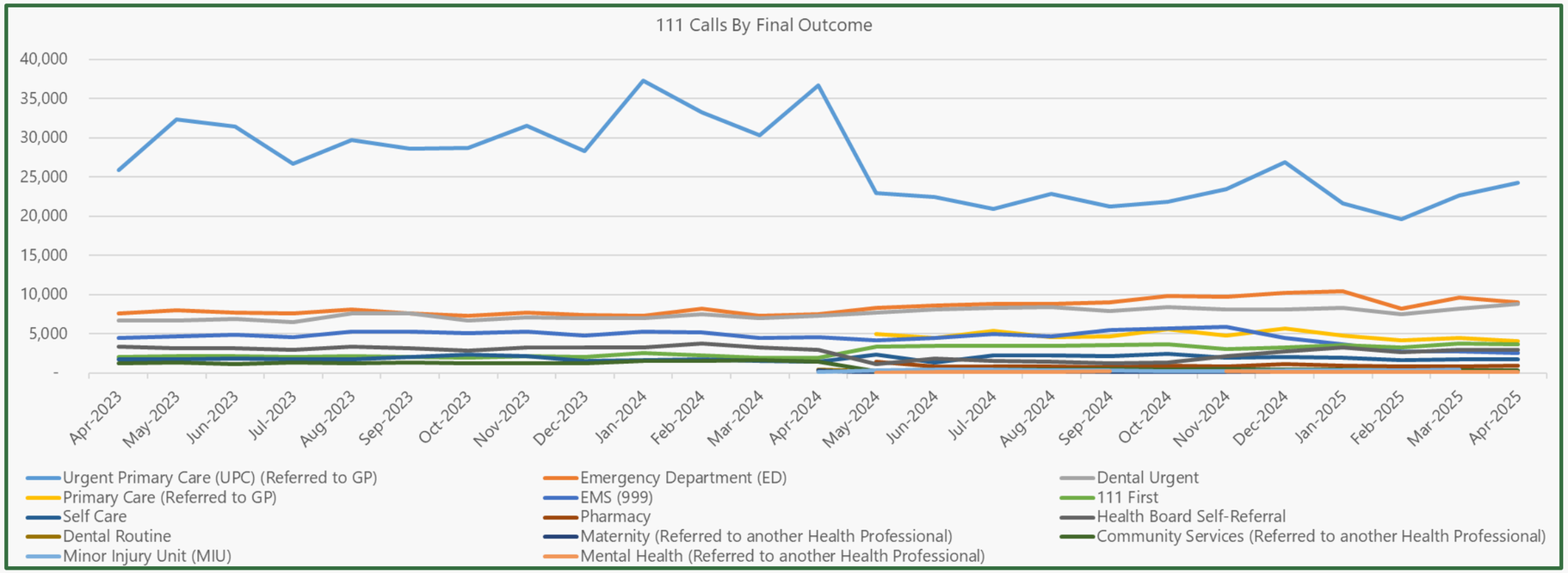
Expected Performance Trajectory

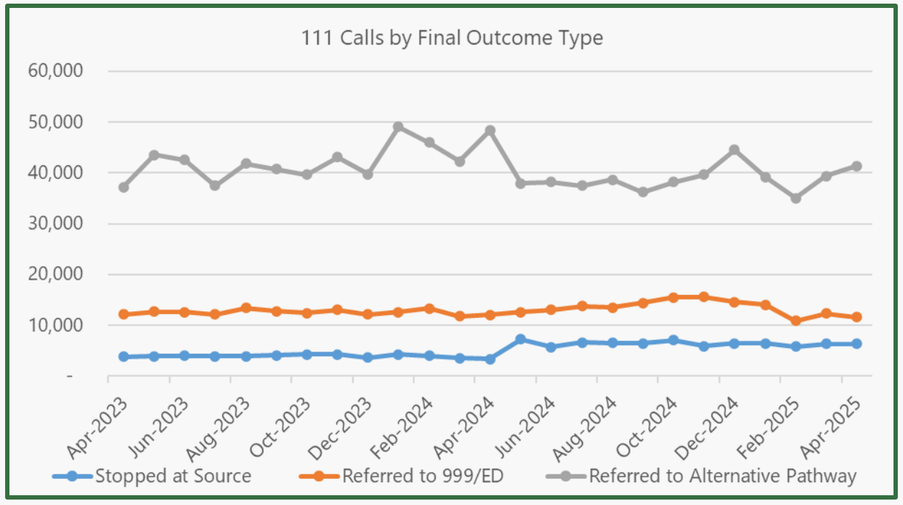
The Trust's ability to reduce the high utilisation rates for EAs and UCS is a product of handover, which it does not control. The Trust would expect an increase in CHARU utilisation and a decrease in EA utilisation during 2025/26 linked to the remedial actions identified above.

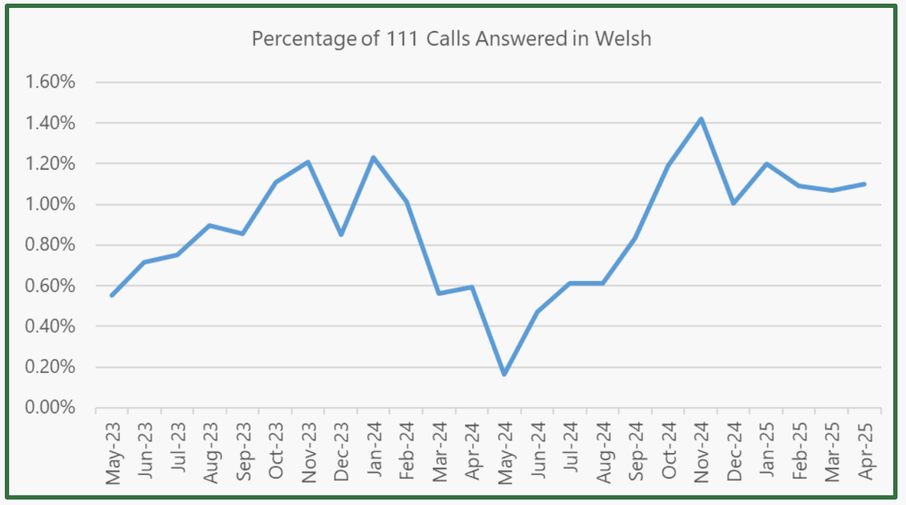
Partnerships / System Contribution
NHS111 Hand Off Metrics and NHS111 Consult & Close Indicators

(Responsible Officer: Lee Brooks)

Influencing Factors – Demand and Clinical Hours Produced







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

Analysis

During April 2025, 59,345 calls were allocated into the 14 categories displayed in the graph opposite; an increase compared to the 58,114 seen during March 2025. However, data quality issues continue within 111 reporting which are currently being addressed.

Calls Referred to a General Practitioner (handover of care) continued to be the top outcome for NHS111 accounting for 35.24% of all calls during April 2025, but there has been a material drop since the implementation of the new 111CAS system.

As the bottom left graph highlights, in April 2025, 6,344 calls were 'Stopped at Source', with no onward referral, a slight decrease from 6,363 in March 2025. 11,615 calls were referred to 999/ED in April 2025.

The percentage of 111 calls answered in Welsh increased slightly from 1.07% in March 2025 to 1.10% in April 2025. This equated to 55.4% of all 111 calls being offered in Welsh being answered.

Remedial Plans and Actions

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

Expected Performance Trajectory

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

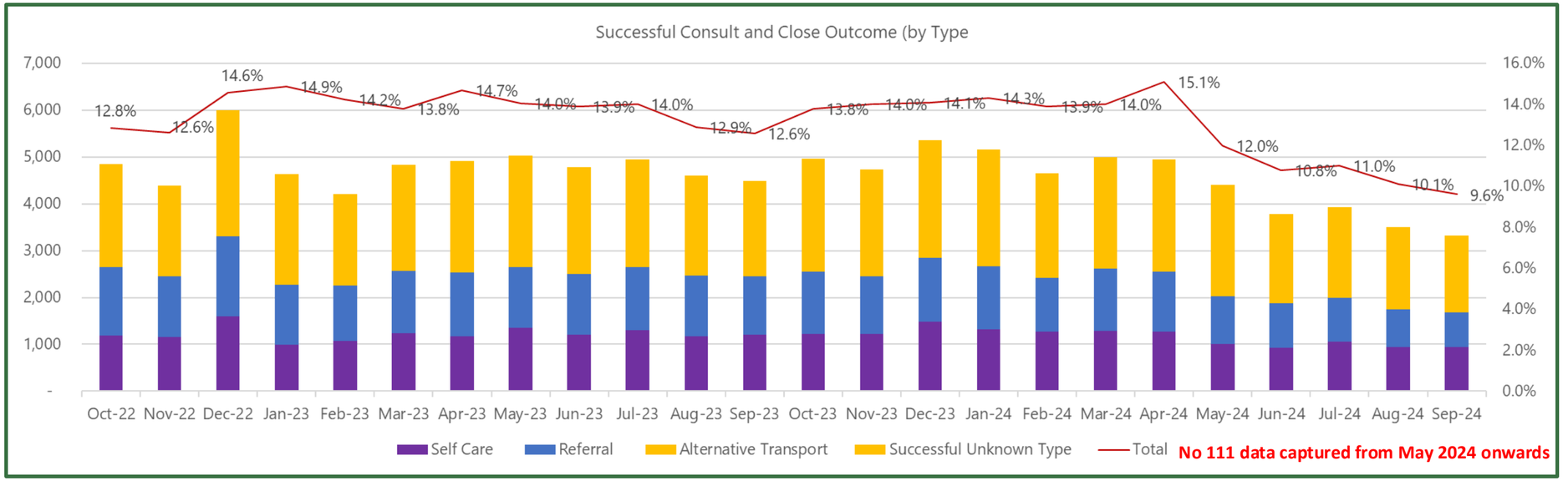
Partnerships / System Contribution
Consult & Close Indicators

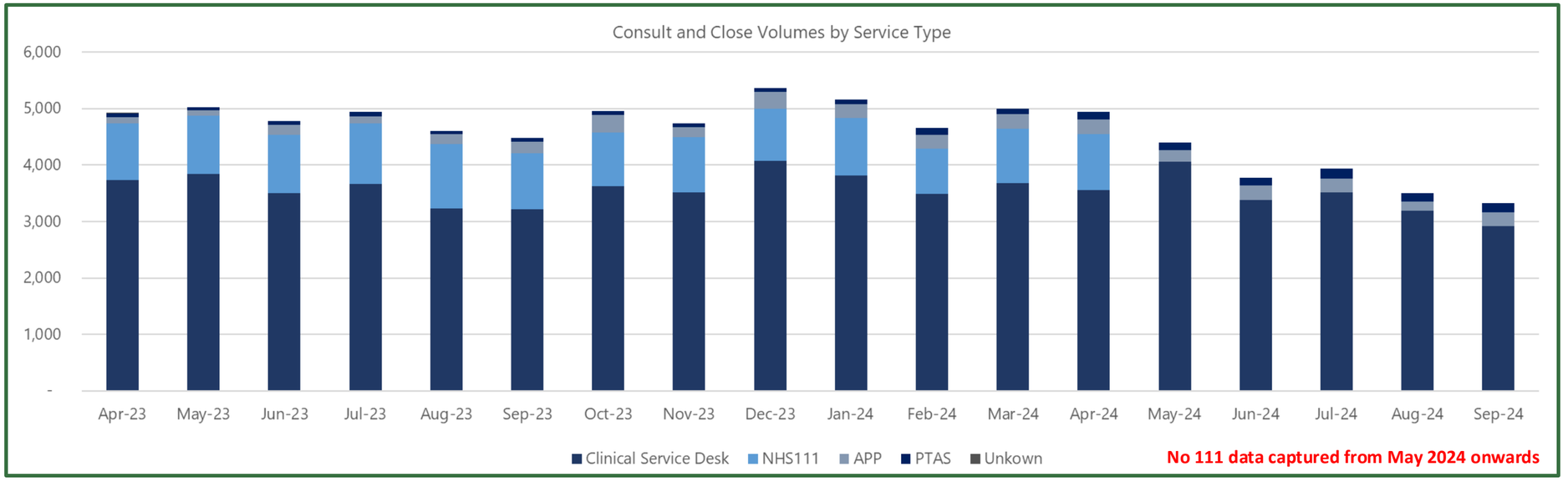
(Responsible Officer: Lee Brooks)

C&C Outcomes

FPC

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





No additional analysis possible given no 111 data is currently available on these metrics.

A revised metric is under development.

See separate patient harm mitigations report to Trust Board.

New metric definition agreed. With commissioners for approval.

A one-off IDS assured graph indicates that the Trust is achieving a +20% consult & close rate.

Partnerships / System Contribution
Conveyance to ED Indicators

(Responsible Officer: Andy Swinburn)

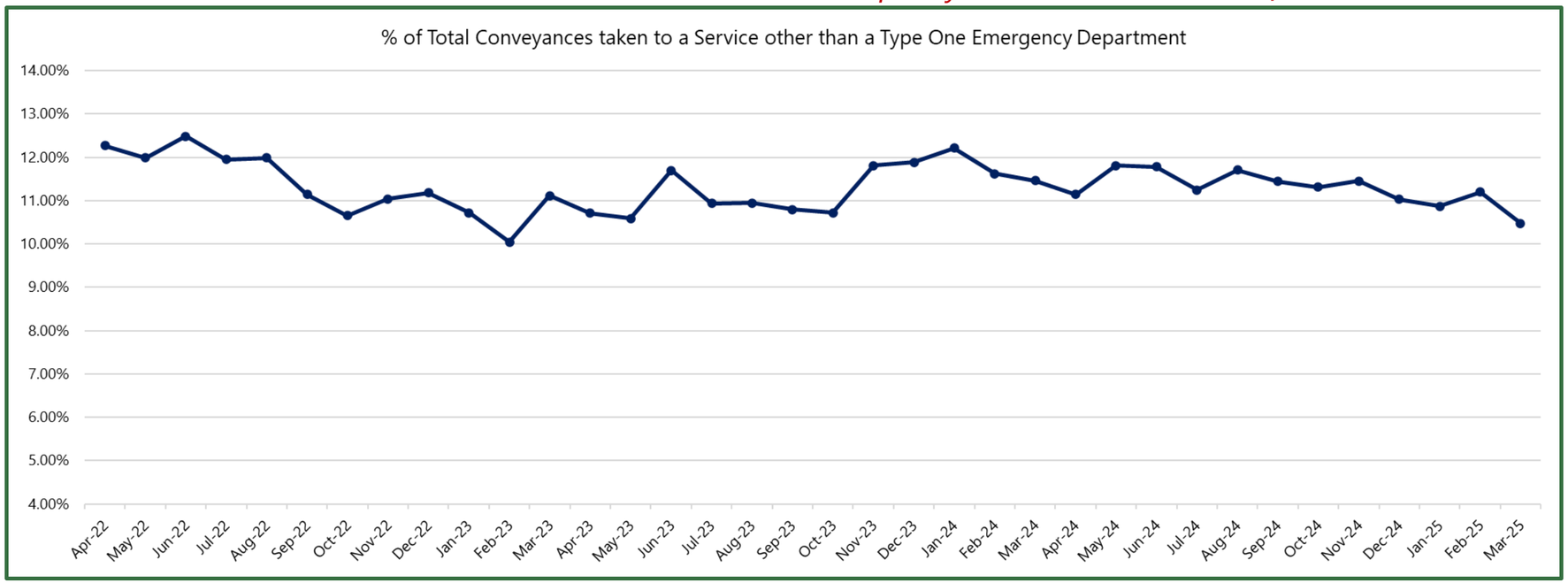
Conveyances

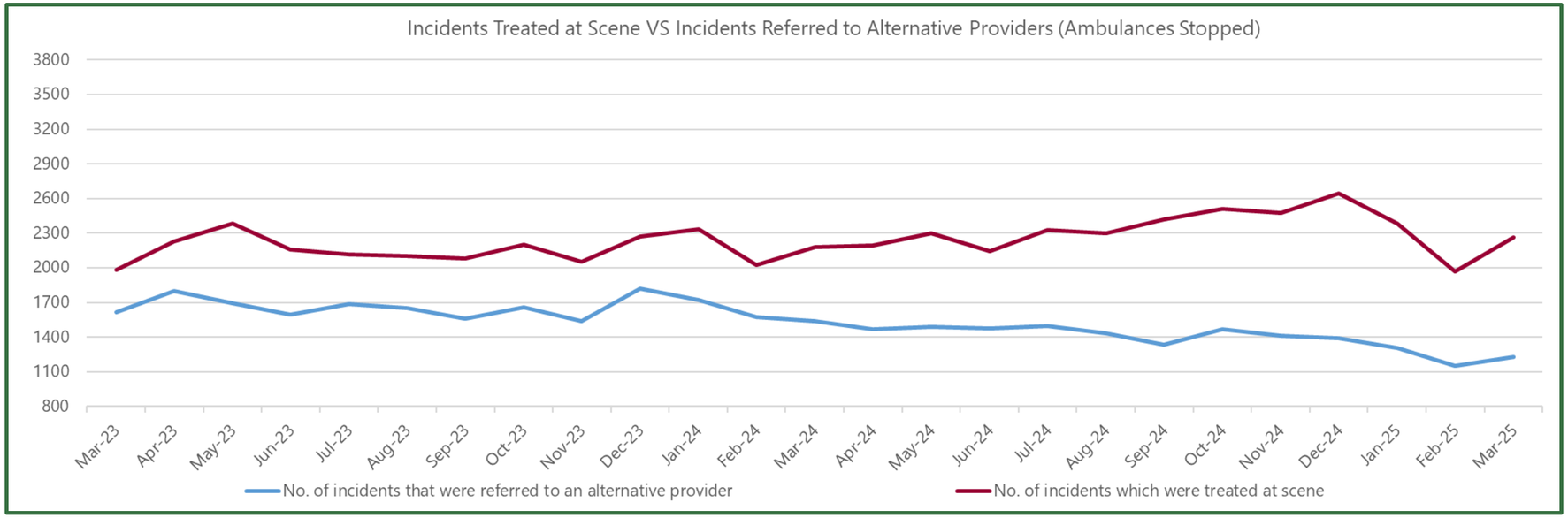
G

FPC

Ministerial Measure

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





Analysis

In March 2025 10.48% of patients (1,343) were conveyed to a service other than a Type One ED, while 38.18% of patients were conveyed to a major ED, as a percentage of verified incidents.

The combined number of incidents treated at scene or referred to alternate providers increased, from 3,124 in February 2025 to 3,494 in March 2025.

The APP conveyance rate was 46.6% in October 2024 and continues to experience a generally increasing trend since March 2023; whilst the DCR table highlights by code the incidents where the preferred response should be an APP (if available). Patients conveyed to SDEC's in October 2024 remained low at 0.14%. No further data is available.

Remedial Plans and Actions

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

Expected Performance Trajectory

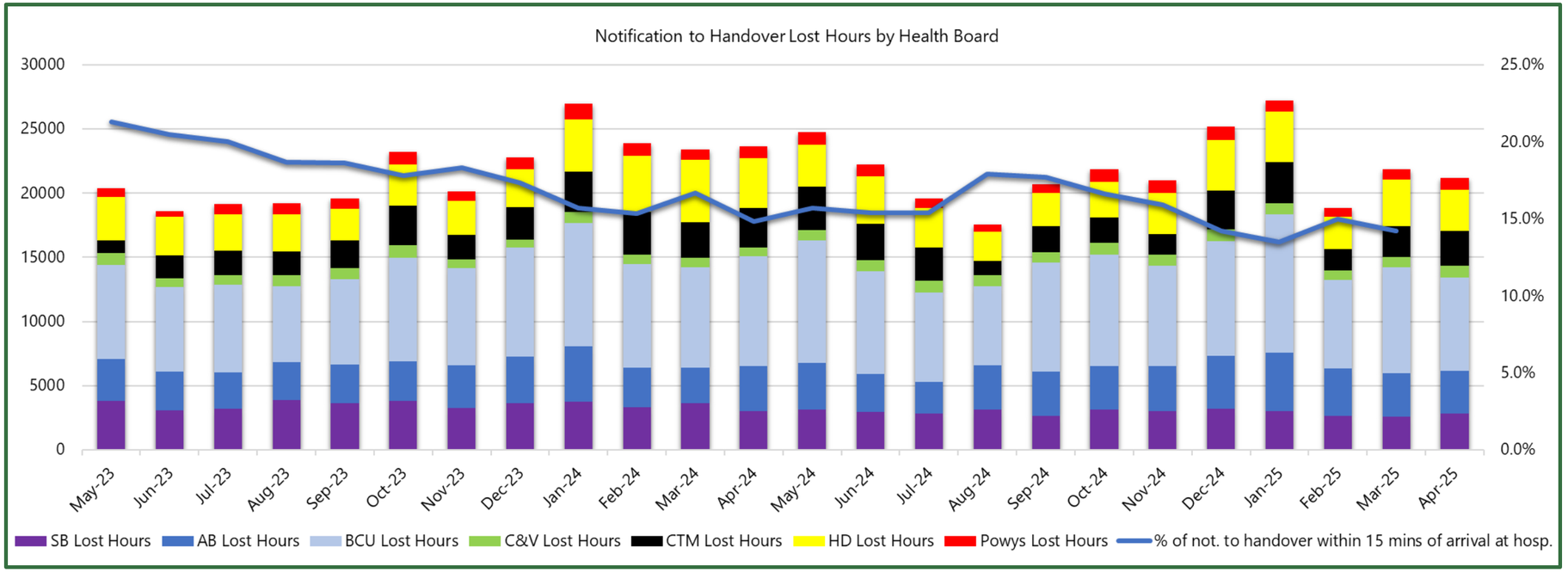
The 2023 EMS Demand & Capacity Review (strategic) models various future states. The modelled scenarios indicate that the Trust will need to evolve its clinical model with health boards also significantly reducing handover e.g. 12,000 hours or 7,500 hours, alongside varying levels of investment. Seasonal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

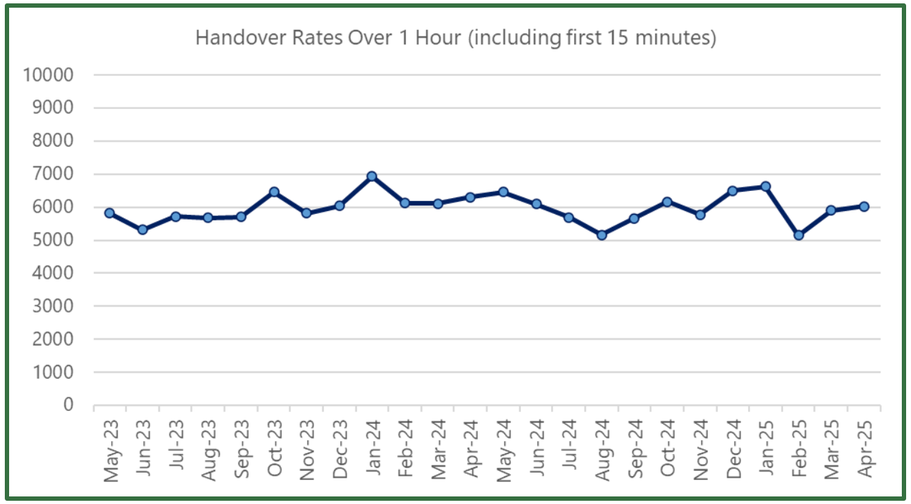
Partnerships / System Contribution
Handover Indicators

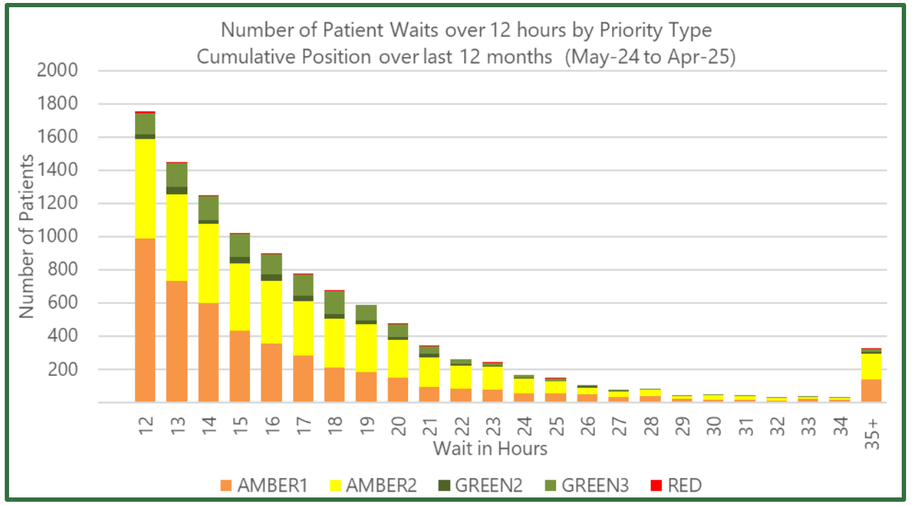
(Responsible Officer: Health Boards)

Lost Hours R

CI QUEST







Analysis

261,945 hours were lost to Notification to Handover, i.e. hospital handover delays, over the last 12 months (May-24 to Apr-25), compared to 260,947 hours over the same timeframe the previous year. There were 21,183 hours lost in April 2025, which is 10.3% lower than the 23,631 hours lost during April 2024.

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

- Grange University Hospital (ABUHB) at 3,169 lost hours
- Morriston Hospital (SBUHB) at 2,791 lost hours
- Ysbyty Maelor Hospital (BCUHB) at 2,578 lost hours
- Ysbyty Gwynedd Hospital (BCUHB) at 2,265 lost hours
- Glan Clwyd Hospital (BCUHB) at 2,246 lost hours

Notification to handover lost hours averaged 706 hours per day during April 2025 (30 days) compared to 705 hours per day (31 days) in March 2025.

In April 2025, the Trust could have responded to approximately 6,682 more patients if handovers were reduced, which highlights the impact these numbers are still having on the service.

In April 2025, 776 patients waited over 12 hours for an ambulance response.

Remedial Plans and Actions

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

Expected Performance Trajectory

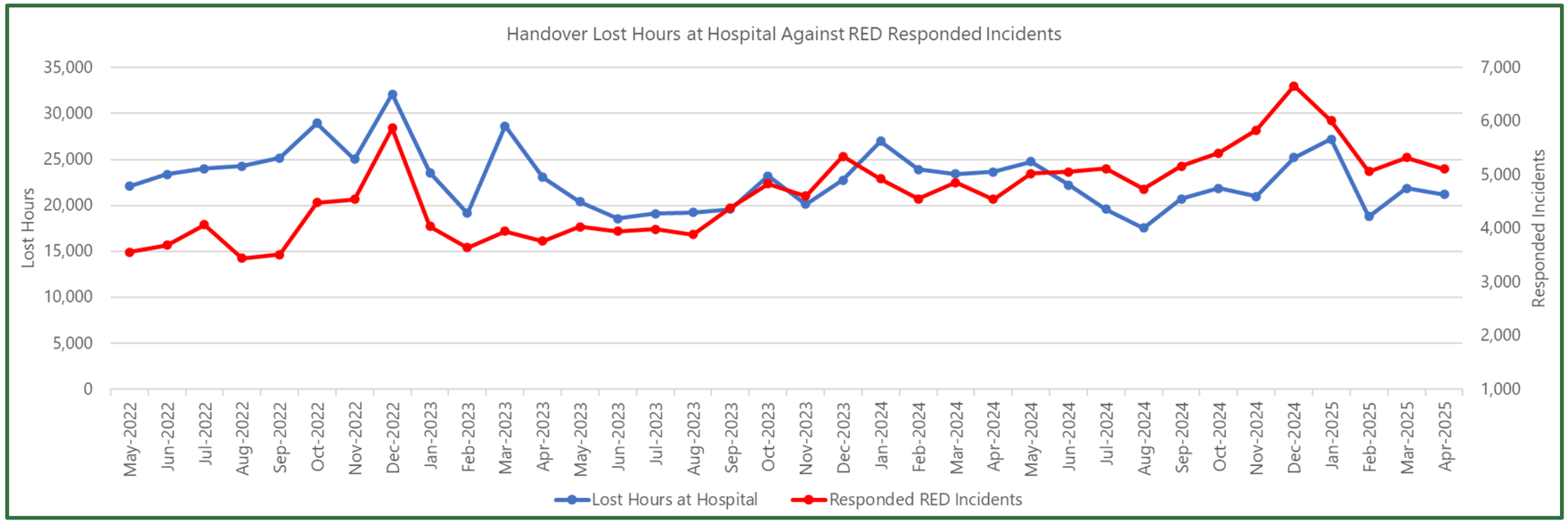
The Welsh Government handover target for 2024/25 is no waits over one hour; this equates to 7,500 hours lost to handover delays per month. There would need to be a 60% reduction in current handover levels for this to be achieved.

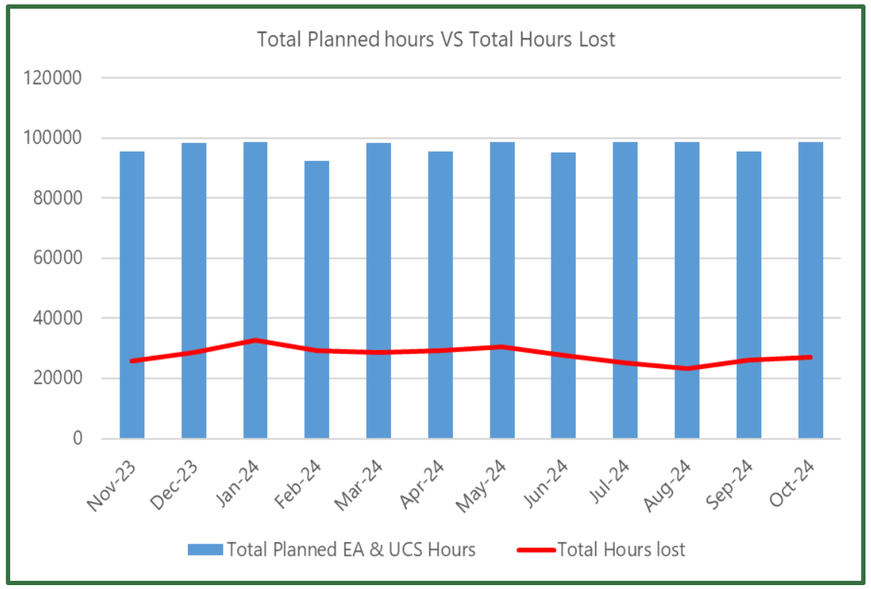
Partnerships / System Contribution

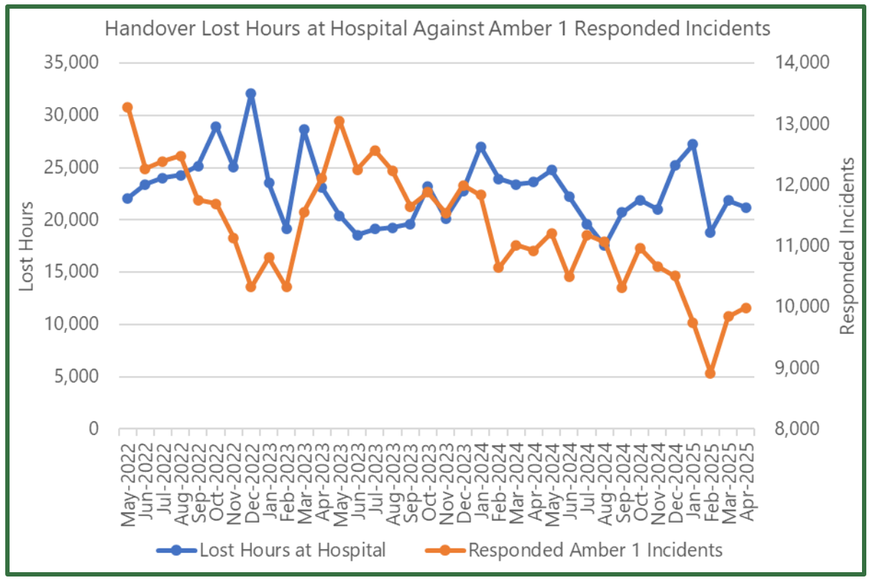
Handover Lost Hours Against Red & Amber 1 Responded Incidents

(Responsible Officer: Health Boards)

CI QUEST







Analysis

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

The bottom right graph illustrates, that there is also a correlation between lost hours increasing and a decrease in the number of Amber 1 incidents being responded to, particularly at times of high demand, such as during December 2022. This is notwithstanding that some of these patients within the Amber 1 category will still be seriously ill.

Remedial Plans and Actions

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

Expected Performance Trajectory

The Welsh Government target is no patient handovers of more than one hour, which equates to 7,500 lost hours a month. The Welsh Government target was to see a 30% reduction in this metric by December 2024. However, this has not been achieved, with the 21,183 hours lost in April 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
111 Abandoned Calls	An offered call is one which has been through the Interactive Voice Response messages and has continued to speak to a Call Handler. There are several options for the caller to self-serve from the options presented in the IVR and a proportion of callers choose these options. An example is to guide the caller to 119 if they wish to speak to someone about a Coronavirus test. Once the caller is placed in the queue for the Call Handler if they hang up, they are counted as "abandoned" as we did not answer the call. The threshold starts at 60 seconds after being placed into the queue as this allows the callers to respond to the messages and options presented as it often takes a short while for the caller to react. Starting the count at 60 seconds provides a picture of abandonment where the caller has chosen not to wait, despite wanting to speak to a Call Handler	**Hours Produced for Emergency Ambulances**	Proportion of hours produced within the calendar month for Emergency Ambulance Vehicles (Target 95%).
111 Patients Called back within 1 hours (P1)	(Welsh Government performance target) which prescribes that 111 has up to 1 hour (longer for lower priory callers) for a 111 Clinician to call the patient to discuss their medical issue. These callers will already have been screened by Call Handlers and received an outcome which needs a conversation with a 111 Clinician. WAST operates a queue and call back method for all Clinical Calls.	**Sickness Absence (all staff)**	Staff sickness volumes as a percentage for all staff employed within the Welsh Ambulance Services NHS Trust.
999 Call Answer Times 95th Percentile	Time taken (in Minutes) to answer 999 emergency calls by call handlers. A percentile (or a centile) is a measure used in statistics indicating the value below which a given percentage of observations in a group of observations fall. For example, the 95th percentile is the value below which 95 percent of the observations may be found.	**Frontline COVID-19 Vaccination Rates**	Volume of frontline (patient facing and non-patient facing) who have received a second COVID-19 vaccination.
999 Red Response within 8 Minutes	Percentage of 999 incidents within the Red (immediately life-threatening) category which received an emergency response at scene within 8 minutes.	**Statutory and Mandatory Training**	Combined percentage of staff who are compliant with required statutory training undertaken by staff where a statutory body has dictated that an organisation must provide training based on legislation and mandatory training which relates to trade-specific training that the employer considers essential or compulsory for a specific job. (A detailed list of these can be found on slide 20).
Red 95th Percentile	Time taken (in minutes) for emergency response to arrive at scene for Red (immediately life-threatening) calls (NB: The 95th percentile is the value below which 95 percent of the observations may be found).	**PADR/Medical Appraisal**	Proportion of staff who have undertaken their annual Performance Appraisal & Development Review (PADR) or Medical Appraisal. This is a process of self-review supported by information gathered from an employees work to reflect on achievements and challerges and identify aspirations and learning needs. It is protected time once a year.
999 Amber 1 95th Percentile	Time taken (in minutes) for emergency response to arrive at scene for Amber 1 calls (other life-threatening emergencies – including cardiac chest pains or stroke). (NB: The 95th percentile is the value below which 95 percent of the observations may be found.	**Ambulance Response FTEs in Post**	Number of Emergency Medical Services, Full Time Equivalent (FTE) staff working for the Welsh Ambulance Services NHS Trust.
Return of Spontaneous Circulation (ROSC)	Percentage of patients for whom Return Of Spontaneous Circulation occurs. This refers to signs of restored circulation (more than occasional gasp, occasional fleeting pulse or arterial waveform) evidenced by breathing, a palpable pulse or a measurable blood pressure.	**Ambulance Care, Integrated Care, Resourcing & EMS Coordination FTEs in Post**	Number of Ambulance Care, Integrated Care, Resourcing & EMS Coordination Full Time Equivalent (FTE) staff working for the Welsh Ambulance Services NHS Trust.
Stroke Patients with Appropriate Care	Proportion of suspected stroke patients who are documented as receiving an appropriate stroke care bundle (a bundle is a group of between three and five specific interventions or processes of caret hat have a greater effect on patient outcomes if done together in a time-limited way ,rather than separately).	**Financial Balance – Annual Expenditure YTD as % of budget Expenditure**	Annual expenditure (Year to Date) as a proportion of budget expenditure.
Acute Coronary Syndrome Patients with Appropriate Care	Proportion of STEMI patients who receive appropriate care. ST segment elevation myocardial infarction - occurs when a coronary artery is totally occluded by a blood clot.	**Duty of Candour**	A notifiable adverse outcome is any incident whereby harm (moderate harm, severe harm and death) is caused, which is unintended or unexpected and that the provision of the health care was or may have been a factor in the service user suffering that outcome.
Renal Journeys arriving within 30 minutes of their appointment (NEPTS)	Proportion of renal journeys which arrive at hospital appointments within 30 minutes (+/-) of their appointment time.	**111 Consult and Close**	Consult and Close refers to the response to 999 callers where an alternative to a scene response has been provided. A cohort of 999 calls are passed to 111 where they are low acuity and the Clinicians in 111 may be able to help the caller with self-care, referral, etc. This is similar to the work of the Clinical Support Desk but for a lower acuity of caller. Where the outcome from the 111 clinical consultation ends in a Consult and Close outcome (self-care, referral, alternative transport) this is captured and forms part of the Trust's Consult and Close reporting. Over 50% of calls passed to 111 in this way are successfully closed without an ambulance response.
Discharge & Transfer journeys collected less than 60 minutes after booked ready time (NEPTS)	Proportion of journeys being discharged from and/or transferred between hospitals which were collected within 60 minutes of the hospital booked ready time.	**999 / 111 Hear and Treat**	Proportion of 999/111 calls which are successfully completed (closed) without dispatching an ambulance vehicle response. This may include advice, self-care or referral to other urgent care services.
National reportable Incidents (NRI)	Volume of patient safety incidents reported in the month which caused or contributed to the unexpected or avoidable death, or severe harm, of one or more patients, staff or members of the public, during NHS funded healthcare.	**% Incidents Conveyed to Major EDs**	Proportion of patients transported to a hospital Emergency Department following initial assessment at scene by a Welsh Ambulance Services NHS Trust Clinician, as a proportion of total verified incidents. (NB: An ED provides a wide range of acute in-patient and out-patient specialist services together with the necessary support systems, which allow emergency admissions, and which usually has an Accident and Emergency Department).
Concerns Response within 30 Days	Proportion of concerns responded to by the complaints team within 30 working days of receiving the concern.	**Number of Handover Lost hours**	Number of hours lost due to turnaround times at EDs taking more than 15 minutes. Transferring the care of a patient from an ambulance to an ED is expected to take no longer than 15 minutes, with a further 15 minutes for ambulance crews to make their vehicle ready for the next call.
EMS Abstraction Rate	The percentage of Emergency Medical Services (EMS) staff unavailable for rostered duties due to reasons, such as: annual leave, sickness, alternative duties, training, other and COVID-19.	**Immediate Release requests**	The number of requests submitted to Health Boards for the immediate release of vehicles at Emergency Departments to release them back into the community to respond to other urgent and life-threatening calls

Appendix 1

The following indicators and points have been identified through the Board Development session on the MIQR and discussions in the Commissioning & Performance Team and with colleagues across the Trust.

Board Development MIQPR Session

A recognition that there was limited capacity either in SP&P or Digital Services at present to do anything very different. Ceri indicated that she would like us to consider how we think we would want reporting to look like in the future, potentially using AI as a tool.	IMTP investment into the Insight & Data Services function's analytical capability, in particular, to support the Clinical Model Transformation Programme. Commissioning & Performance Team's capacity was identified as thin in the Service Review. Executive Director Strategy, Planning & Performance currently reviewing this with her team. AI does offer potential and will form part of the on-going review of capacity in both Insight & Data Services and Commissioning & Performance.
The potential use of PhD and master's students to assist with data analysis was considered as a way to enhance resources. Ceri mentioned to me this morning that perhaps we could also consider the use of charity funds, especially if we link it to being able to monitor and report on patient pathways across systems.	Following discussion, it was raised that previous attempts to use students to assist with analysis did not prove to be a useful option with students possessing the skills but not the knowledge to provide meaningful analysis. See previous point about capacity in the Commissioning & Performance Team. Executive Director SP&P considering further with team.

There were a couple of comments about how to focus on a smaller number of top-level metrics that align with strategic objectives, particularly in the areas of patient care, quality, and performance, but think we will be doing that through the 'what good looks like.	Commissioning & Performance Team are currently considering a reduced number of top-level metrics which will be aligned to "what good looks like work'.
The importance of data literacy among Board members was highlighted to ensure they can interpret the results effectively and scrutinize adequately. Might want to consider a session once a year or something?	Data literacy/training has been identified as an action in the Quality & Performance Management Framework work programme. The proposed action is training for all B7 managers and above through to Board, with the training having two parts a) generic, b) tailored to particular role in the Trust. This is currently programmed as a year 2 IMTP action i.e. 26/27, with planning for it in 25/26.
Data linkage across different health services and the legal challenges in Wales were noted as areas that need improvement for better population health outcomes.	Data linking is a key enabler for the Clinical Model Transformation programme, supporting improved patient outcomes and helping the Trust prove the benefit of remote clinical interventions and community interventions e.g. see & treat. The Trust is currently testing data linking for cardiac arrest data via the National UK Registry. The Trust is also currently testing data with the NHS Executive. Once the data flow is finalised and accurate this approach can be replicated.

There were concerns about the immense volume of data presented in the MIQPR, with suggestions to provide more analysis and narrative rather than just data to avoid information overload. I noted that we had limited capacity to do masses of analysis and I know that's something you'd like to do more of if we could – I think perhaps we could think ourselves about areas where deep dives might be important (I am thinking productivity as an area, as well as 111).	The Trust is a complex organisation with data/analytics being a key enabler of quality and performance. The MIQPR is high level relative to the amount of data being used by the Trust, however, it is acknowledged that it contains a lot of information. The scorecard at the front does provide a one page summary. Deep Dives have been well received by committees before, normally focused on a "hot topic". Productivity would certainly be an area of interest in 2025/26, with some previously internal work undertaken in this space.
The importance of quality assurance in data collection and reporting was discussed, with ongoing efforts to address data quality issues from various sources. This was the first time that NEDs seemed to have noted the ongoing issues and Jayne and Ceri talked to this. In talking to Ceri again this morning, she is quite worried about data quality – Tus had also raised concerns with her about quality of overrun data for example	This is an area that falls under IDS. As above IDS is receiving IMTP investment to increase its capacity. This should help resolve some of the outstanding data quality issues.

<u>Commissioning & Performance Team Review</u>

New Metrics under Consideration	Status

NHS 111 Website hits & outcomes Online Services (Standards 39-43) – English & Welsh	Data currently being developed and to be included once available.
Measure the number of Community First Responders being deployed and hours produced	Data currently being developed and to be included once available.
#NOF Call to door times and amount of time a falls patient is on the floor prior to treatment	Data currently being developed and to be included once available.
Survival rates for Cardiac Arrest patients that are attended by time	Data currently unavailable but is being worked on through the National Registry (see above).
Number of patients taken to minor injuries and referred	Will be included from June 2025.
Accurate APP conveyance numbers by Type	Data currently unavailable, but forms part of the Clinical Model Transformation IDS Plan with additional capacity agreed to support the plan.
APP Navigator	Data currently unavailable, but forms part of the Clinical Model Transformation IDS Plan with additional capacity agreed to support the plan.
111 Increased reporting on patient outcome measures	Will be included from June 2025.
111 Direct Steps - booking straight in	Data currently being developed and to be included once available.
Alternative transport utilisation rates	Will be included from June 2025.

Arrest Response Rates and numbers	Data definitions currently being agreed with the JCC and WG. To be included once available (from 01 July onwards).
Emergency Response Rates and numbers	Data definitions currently being agreed with the JCC and WG. To be included once available (from 01 July onwards).
RCS Time to answer (RCS0-3)	Data definitions currently being agreed with the JCC and WG. To be included once available (from 01 July onwards).
RCS0 Returned to Dispatch Queue (not answered within 60 seconds)	Data definitions currently being agreed with the JCC and WG. To be included once available (from 01 July onwards).
RICS Clinician time on call	Data available, but historic reporting requires further work. High priority, part of Clinical Model Transformation IDS Plan with additional capacity agreed to support the plan.
RICS Clinician calls per hours	Data available, but historic reporting requires further work. High priority, part of Clinical Model Transformation IDS Plan with additional capacity agreed to support the plan.
RCS Time to answer (RCS0-3)	Data available, but historic reporting requires further work. High priority, part of Clinical Model Transformation IDS Plan with additional capacity agreed to support the plan.

RICS Call back times for all 3 categories	Data available, but historic reporting requires further work. High priority, part of Clinical Model Transformation IDS Plan with additional capacity agreed to support the plan.
Pathway referrals from RICS	Data currently being developed and to be included once available.
Mental Health Response Vehicle conveyance rates	Will be included from June 2025.
Jobs per hour and per shift for all EMS types and conveyances.	Will be included from June 2025.
RICS and Community Response Surveys	Data currently being developed and to be included once available.
Health Transport	Data currently being developed and to be included once available.

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

AGENDA ITEM No	**9**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**0**

INFORMATION GOVERNANCE REPORTING

MEETING	Finance & Performance Committee
DATE	20th May 2025
EXECUTIVE	Jonny Sammut, Director of Digital Services / Senior Information Risk Owner
AUTHOR	Leanne Smith, Assistant Director of Digital
CONTACT	leanne.smith4@wales.nhs.uk

EXECUTIVE SUMMARY

1. This report brings to the committee an update on the Information Governance (IG) of the Trust and related areas including information security, records requests & management, Freedom of Information requests, and data quality. Information Governance Highlight Reports are presented monthly to the Information Governance Steering Group (IGSG) chaired by the Trust's Senior Information Risk Owner (Director of Digital Services), supported by the Caldicott Guardian and Data Protection Officer. The IGSG reports via AAA to the Executive Leadership Team (ELT).

2. This paper covers intelligence from the period of March 2025, and the topics discussed at the April meeting of IGSG.

ALERT

3. **DPIA non-compliance:** whilst there has been significant improvement in the number of Data Protection Impact Assessments (DPIAs) which are awaiting review, update or input by the IG team (improvement which has correlated with recent investment and recruitment into the team), there are two recent instances of DPIA non-compliance across the Trust. The instances are where processes either went live or were due to go-live without the IG and Cyber assurances in place. The IG team are working with the process owners to ensure all risks are mitigated and that appropriate assurances will be in place. The IG will also continue to raise awareness of the importance of IG and Cyber assurance prior to systems, tools and processes going live to prevent further non-compliances.

4. **IG Training:** the overall Trust IG training compliance figure as of 31/03/25 was 78.98% which did **not achieve the 85% compliance** requirement, meaning this section of the IG Toolkit ('Training and Awareness') did not meet 'Minimum Expectations' at the time of submission to Welsh Government at the end of the financial year. For individual staff members who are not meeting their mandatory training requirement, they are in breach of their employment Terms & Conditions. The IGSG was informed of the consequences of being below the 85% threshold target (note the target was 75% in the 2023/24 financial year), which include:
    a. The Information Commissioner's Office (ICO – UK regulator) looking unfavourably on WAST, and should a data breach occur, this would be taken into account when considering enforcement action.
    b. That the organisation may not be meeting its obligations under the accountability principle. The accountability principle places a responsibility on organisations to not only comply with the UK GDPR, but that they must also be able to *demonstrate* this. Organisations which cannot demonstrate good data protection practices may be left open to administrative fines (irrespective of a data breach), reputational damage and impact the public's trust in the organisation handling their data.
    c. The UK's Confidentiality Advisory Group (CAG), which process 'section 251' approval for research and non-research projects to utilise confidential patient information, are likely to reject proposals, directly impacting WAST's research and innovation progress.

    This position continues to be escalated to ELT and senior leaders for further support, and more detail can be found in the BAF risk 623.

Highlights

5. **IG Toolkit status:** the Trust achieved all actions in its IG Toolkit Improvement plan for 2024/25, and submitted the IG Toolkit on the 31/03/25, meeting or exceeding the 'Minimum Expectations' in all categories except for the 'Training & Awareness' category (see table below for results, and explanation in paragraph 4 above). The new Toolkit for 2025/26 is now open and an action plan is in development to help meet the standards by the submission date in March 2026.

Category	Outcome
Leadership & Oversight	Expectations Exceeded
Policies and Procedures	Minimum Expectations Met
Training and Awareness	Minimum Expectations Not Met
Individual Rights	Expectations Exceeded
Records of Processing and Lawful Basis	Expectations Exceeded
Contracts and Information Sharing	Minimum Expectations Met
Risks and Data Protection Impact Assessments (DPIAs)	Minimum Expectations Met
Breach Response and Monitoring	Expectations Exceeded
Freedom of Information (FOI) and Environmental Information (EIR)	Expectations Exceeded
Information Security	Minimum Expectations Met
Business Continuity	Expectations Exceeded

6. **information Asset Ownership** a draft Terms of Reference for the establishment of an Information Asset Management group was brought to IGSG for endorsement. The TOR will be finalised as one of the first actions of the IAM group once established, where it will be brought back to IGSG for formal and final approval. The membership now needs to be confirmed, but will initially be made up of a small group of Information Asset Owners and/or Information Asset Administrators, spanning the Trust's most critical systems. The route for reporting of this group will take place between IGSG and ADLT.

7. **FOI report:** there were 31 FOI requests from 1st to 31st January 2025, with 4 not applicable and 1 redirected to the Records Management team. The Trust issued responses to 21 of the 25 requests within the 20-working day timeframe, providing a compliance rate of 84% for January. Due to other priority work, and high demand outstripping available capacity, the February compliance rate was 27.6%. The Corporate Governance team is reviewing the FOI process, and progressing with the implementation of a platform which will help manage FOIs with automation and increased efficiency. The KPI report presented to IGSG is now also tracking the complexity of FOI requests more broadly, including the volume of questions per request, types of questions, and number of directorates involved in supplying parts of the response.

Lowlights

8. **Phishing campaign:** results of a recent phishing campaign further highlighted the importance of the mandatory ESR IG Training module, which includes sections and education on Cyber Security. Additional learning and awareness for Cyber related topics can also be found via the Meta Compliance platform, with a link readily available in the Microsoft Teams interface, and regular email reminders sent to all staff.

RECOMMENDATION: The COMMITTEE are asked to NOTE the contents of paper.

KEY ISSUES/IMPLICATIONS

9. **Risk 623 Failure to comply with Data Protection Legislation:** A risk to Data Protection Compliance was initially on the Corporate Risk Register in April 2024 and has since been received by the Trust Board on several occasions as part of the Board Assurance Framework.

10. **Risk of Physical Security:** The group previously discussed the risk of physical security. At the March meeting, although not discussed, a paper was received detailing progress in articulating and documenting the risk. The draft risk is being progressed through usual risk management cycles.

11. **Freedom of Information Requests:** Failure to meet statutory and legal requirements for FOI requests appears on the Corporate Governance Directorate risk register (ID 182) and is being reviewed, with update provided to IGSG through the IG Highlight report narrative.

REPORT APPROVAL ROUTE

The points presented in this paper are taken from the Information Governance Highlight Reports presented at the 14th April meeting of the Information Governance Steering Group (IGSG), and the resulting AAA presented to ELT.

REPORT APPENDICES

n/a

REPORT CHECKLIST

Confirm that the issues below have been considered and addressed		Confirm that the issues below have been considered and addressed	
EQIA (Inc. Welsh language)	NA	Financial Implications	NA

Environmental/Sustainability	NA	Legal Implications	Y
Estate	NA	Patient Safety/Safeguarding	NA
Ethical Matters	Y	Risks (Inc. Reputational)	Y
Health Improvement	NA	Socio Economic Duty	NA
Health and Safety	NA	TU Partner Consultation	NA

AGENDA ITEM No	**10**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**1**

DIGITAL REPORTING

MEETING	Finance & Performance Committee
DATE	20th May 2025
EXECUTIVE	Jonny Sammut, Director of Digital Services
AUTHOR	Kimberly Abraham, Digital Directorate Support Administrator Aasha Cowey, Assistant Director of Digital Services Leanne Smith, Assistant Director of Digital Services
CONTACT	Aasha.Cowey@wales.nhs.uk Leanne.Smith4@wales.nhs.uk

EXECUTIVE SUMMARY

1. This report brings to the committee updates relating to Data & Analytics, ICT, Digital innovation and transformation projects and programmes, and details progress against the Digital Plan (see **Appendix 1** for the project status report). As the first paper to the committee for the 2025/26 financial year, this report offers highlights and lowlights, and a brief description to introduce each of the Digital deliverables set out in the IMTP and local plan for the year. These descriptions can then be used as reference / glossary in subsequent reporting rounds as a reminder of what each project and commitment aims to achieve, whilst the status will be updated regularly to offer an evolving picture of progress.

Highlights

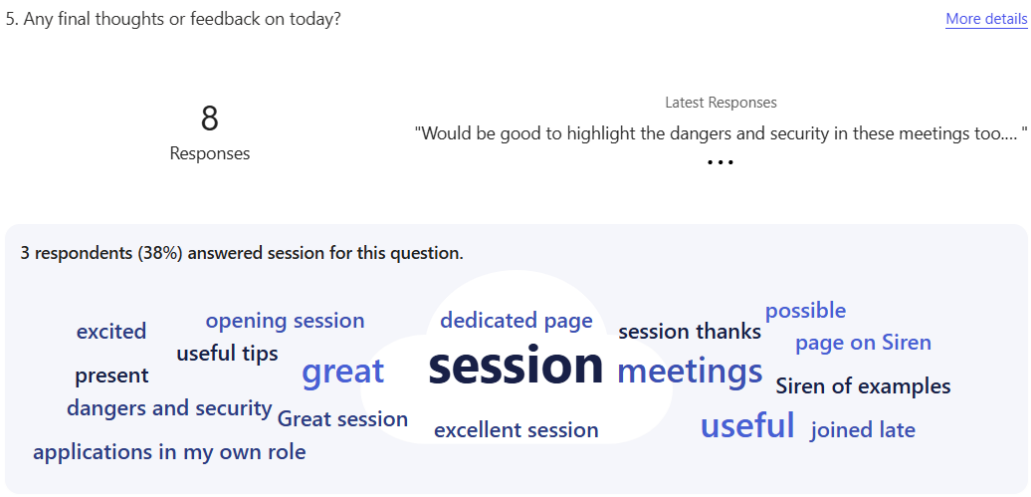
2. **Recruitment** into the new Digital posts following additional investment last year (24/25) is progressing well:
   - All new ICT posts recruited
   - All new Insight & Data Services posts recruited
   - The Operational Communications Programme team is scaled appropriately to deliver the next phase of the Outline Business Case for ESN Phase 2
   - The Innovation & Transformation structure is near finalised and Job Descriptions will now start going through the Recruitment Control Panel
   - Recruitment is ongoing to support the Chief Clinical Information Officer (CCIO) with a Digital Clinical Lead role awaiting go-live of advert and a Digital Clinical Safety Officer JD in review.

3. The scale of work to support the **Clinical Model Transformation** (CMT) has significantly expanded. There is a need to ensure proactive coverage into all CMT workstreams so work can be aligned and properly planned out. There is also an opportunity to 'scale' work across workstreams where possible if or where similar asks are emerging. The work to scope 2025/26 requirements is well underway, and from July an additional page will be included in the accompanying status report (Appendix 1) to show progress of Digital's contribution to the CMT.

4. WAST is to begin using remotely operated **drones** to survey the scenes of hazardous and challenging incidents. These will provide specially trained Hazardous Area Response Team (HART) paramedics with live, aerial footage of incidents, allowing them spot previously unseen dangers. As well as providing live video feeds to the operators on scene, the drones are also capable of relaying the feed to clinicians in the Trust's control rooms, allowing them to monitor, assess and if necessary, provide additional assistance to those on the ground. Recent milestones which have enabled us to get to this point include securing an operational support package, training for HART colleagues (including HART drone pilot with a Civil Aviation Authority accredited certification, DroneDesk, the live stream platforms and provision of enhanced internet connectivity). The live stream can also be shared with partner agencies during multi-agency responses when the nature of the incident requires it. The recent press release (dated 07/05/2025) is also available: Drone use set to take off at the Welsh Ambulance Service - Welsh Ambulance Services University NHS Trust

5. To support a Microsoft Copilot pilot (running to the end of June 2025), **two Copilot pilot "promptathon" and two engagement sessions** have been delivered to support users in getting the most from this Generative-AI tooling. In addition to these sessions, and as part of the pilot, participants have been provided with various resources including a dedicated SharePoint site, a Teams channel area for questions and peer support, and a specific Digital Notice to highlight do's and don'ts. Colleagues are encouraged to regularly complete evaluation forms; the information from these alongside intel gathered via the initial sign-up form, as well as general questions and discussions are shaping our understanding of the value-add use cases and additional needs for colleagues. This work will also help influence our AI policy development. The two promptathons have proven useful and successful:

- Excluding the project team and Microsoft trainers, 32 unique colleagues across WAST attended these sessions and 22 colleagues completed the post-session survey
- The average response to "how would you rate the usefulness of this session" scored highly at 4.5 out of 5
- Participants expressed preferences around future training and support which we will build into our iterative plans
- A word cloud is included below of polled feedback from the sessions



Lowlights

6. As part of our ongoing efforts to improve user productivity and operational flexibility, we propose the removal of existing restrictions that prevent **copy-and-paste functionality** across corporate devices and applications. We recognise that this change introduces an increased risk of data leaving the secure network environment. To mitigate this, it is essential to emphasise that all employees remain personally responsible for ensuring compliance with data protection legislation and internal information governance policies. Any failure to do so will be treated as a breach of policy and may lead to disciplinary action in line with the Trust's procedures. This change will be formally registered as a new data risk and presented to the Information Governance Steering Group (IGSG) for review and oversight. Ongoing monitoring of compliance and any data breaches associated with this change will be reported through the IGSG to ensure governance accountability is maintained.

7. There are ongoing concerns about **capacity**, particularly within the Data & Analytics team (part of Insight & Data Services, IDS, function) who are managing a long-list of CMT related data definition, metric development,

reporting, and evaluation type requests; and within the ICT function, who have been stretched recently whilst supporting significant Estates projects.

IMTP 2025/26 - Digital Contribution & Progress

8. Digital's contribution to WAST's strategy and IMTP is monitored against the 5 pillars of the refreshed Digital Plan (namely: Everyday Essentials; Cyber, Security & Safety; Digital Pioneers; Transformation; and Data, Information and Insight).

9. The list of Digital Contributions for 2025/26 and their progress / status are visible in the Appendix. As this is the first report of the financial year to FPC, a short description of the goal of each of the projects under the 5 pillars is provided here to support understanding of the Digital Contributions visual:

10. Everyday Essentials
    a. **Simplified Sign-On:** aims to remove friction and frustration for staff in using multiple systems and applications on iPads – allowing them to log-in once and avoid multiple username and password inputs for different interfaces. This is likely to be done via the Microsoft Hello product. This will not cover full implementation of 'single sign-on' and is dependent on enabling infrastructure work by DHCW.
    b. **iPad Replacement:** 2725 iPad have been purchased to enable the replacement of devices for frontline EMS staff. Planning work is ongoing and includes the opportunity for staff to purchase their old iPad.
    c. **Automation:** many automated workflows to improve efficiency and free staff up from repetitive and mundane tasks are already in place within the Trust, however, the goal is to craft a plan which will help scale automation delivery with good governance and process wrappers.
    d. **Cloud GRS Replacement:** there is a need to transition to GRS Cloud (delivered as Software as Service) to ensure WAST can benefit from necessary updates (including security) in the future. A GRS SaaS Technical Task and Finish group has already been established.
    e. **eTimesheets:** ICT will continue to support the implementation of e-timesheets. (Linked also to the Cloud GRS Replacement project.)
    f. **999 Servers Replacement:** significant list of hardware (servers and racks) to be replaced to refresh the infrastructure related to 999 CAD and Paramount.
    g. **Windows 11:** standardise all laptops and PCs to run Windows 11 to ensure security, performance and readiness for the future.

11. Cyber, Safety & Security
    a. **AI Safety / Policy:** co-develop a Policy for WAST regarding the procurement, development and implementation of AI technologies, ensuring safe, compliant, ethical and accurate use.
    b. **Smart Stations:** explore what value smart stations could add to WAST, identifying and implementing initiatives that will provide the biggest benefits. A scoping piece of work has taken place to provide a menu of options to explore, including affordability for each option.
    c. **Cyber Improvement:** delivery against the cyber improvement plan continues and is regularly monitored by the Trust. Work is ongoing to review iPad copy and paste capabilities and any potential IG consequences.
    d. **Information Governance Improvement:** aim to produce and implement the next iteration of the IG Toolkit Improvement Plan, based on the 2025/26 IG Toolkit submission criteria. Plans will also extend to IG Compliance deliverables (e.g. see Video Compliance project).
    e. **Video Compliance:** ensure data protection and IG documentation is in place for all video surveillance systems used by the Trust. The CCTV Policy is being reviewed and will be re-published with support from this task & finish group.

12. Digital Pioneers
    a. **Enhanced IVR:** deployment of Enhanced IVR to capture key patient details virtually whilst callers are in a queue. Engagement with suppliers has progressed to develop potential costings.
    b. **SMS Functionality:** Phase 2 of development for the SMS functionality in Ambulance Care, supporting asynchronous communication with patients and service users who may wish to confirm, cancel or amend their scheduled transport booking.
    c. **AI Development:** evaluate suitability of Gen-AI tooling for Corporate and administrative use cases, and define ambition statement for broader AI usage / development by WAST. (See also separate AI Policy project).
    d. **Innovation Lab:** engage on, design, and implement the digital innovation labs. These should enable exploration of new ideas with ambition to test and scale the right ideas rapidly. Engagement has taken place at various forums (including recent CEO Roadshows).

13. Transformation

a. **CAD Replacements:** preparations for a CAD procurement in future years, commence conversations with Operations to understand requirements.
b. **ESN Phase 2:** outline business case developed for replacement of critical communications infrastructure (Airwave) which is progressing through Trust governance (see agenda for FPC May 2025).
c. **Drones:** deliver the HART drone project and support HART to become operational with drones for surveying hazardous and challenging incident scenes.
d. **Digital Engagement:** improve engagement between the Digital Directorate and the wider organisation, including raising the profile and awareness of what we do in digital, ensuring that learning and adoption needs are met, and that colleagues can contribute to new developments more easily whilst increasing peer-to-peer support.
e. **ePCR Phase 2:** the current design of ePCR has largely remained unchanged since its introduction in 2021, but significant engagement with users and stakeholders note opportunity to enhance the application and improve the quality of the data captured. The application will be streamlined, duplication removed, contributing towards a reduction in on-scene times from record completion.

14. Data, Information & Insight

a. **Individual Insights:** reporting to be developed to provide insights to individual clinicians about their professional practice, supporting career development conversations.
b. **NDR Programme:** deliverables as agreed with DHCW, relating to WAST's support of the National Data Resource (NDR) Programme; these include: ongoing work to share Out of Hospital Cardiac Arrest data with UK and Welsh registries; utilisation of advanced analytical and data science tooling available on the platform.
c. **Data Skills Enablement:** build data literacy and confidence across WAST workforce, and enable self-serve of insights and intelligence through the PowerBI platform. Continue to develop the top organisational metrics and surface insights in always-on reporting (e.g. MIQPR). Aim to empower staff to make better clinical and operational decisions, understand patterns in data, and how to interpret and apply intelligence accurately.
d. **IDS Improvements:** position the Insight & Data Services team to be able to *proactively* support the strategic direction of WAST and develop a Data Plan to accompany the Digital Plan to ensure WAST data lifecycle and related compliance and governance are fit for the future.

e. **Data collaborations:** supporting the organisation's University Trust Status, contribute to research and innovation with academic and industry partners. Continue to collaborate with NHS Wales partners on innovative data analytics and modelling projects supporting the ambitions of operational efficiency and improved patient outcomes (e.g. via VBHC and PHM initiatives and cross-organisational data linkage).

15. In addition to this list, significant work has been delivered under the Clinical Model Transformation (CMT) programme already in Q1, and the Digital team continue to support ongoing efforts. From the July meeting of FPC, it is anticipated that a fuller list of Digital's CMT-related projects will be available with progress / status updates to accompany this Digital Plan update.

16. Please note the Digital KPIs for Data & Analytics and ICT System updates (usually available in the Appendix) will be refreshed for this new financial year and made available from the July meeting of FPC. We will also look to introduce KPIs for the new Innovation & Transformation and CCIO areas of the Digital Directorate.

RECOMMENDATION: The COMMITTEE is asked to NOTE the contents of the accompanying report and the trends in metrics presented.

KEY ISSUES/IMPLICATIONS
17. The Clinical Model Transformation programme requires significant input from various Digital teams – including those supporting on changes to CAD or other systems, DOS updates, and data, reporting and analytics for the new call flow and categorisation process. The complete requirements for 25/26 and 26/27 remain unknown and while work is progressing to understand this, there is a risk on overall capacity within the directorate. This may lead to reprioritisation of other deliverables within the local Digital plan.

REPORT APPROVAL ROUTE
Reviewed by DLG members 8th May 2025

REPORT APPENDICES
Main report – 'Digital Reporting May 2025 - Metrics'

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

Digital Contribution 25/26

Everyday Essentials

Simplified Sign-on	dependent on DHCW work
iPad Replacement	phase 1 & 2 by Q3 (XL)
Automation / RPA	scale up RPA
Cloud GRS	in planning
eTimesheets	cont. from 24/25
999 servers	CAD & Paramount replacement
Windows 11	50% before Q3

Cyber, Safety & Security

AI Safety / Policy	in planning
Smart Stations	scoping report due Q1
Cyber Improvement	actions as per corporate risk
IG Improvement	actions as per corporate risk
Video Compliance	CCTV policy in review + DPIA

Digital Pioneers

Enhanced IVR	for 111 contact centres by Q4
Patient Messaging	NEPTS SMS phase 2 scale-up
AI Development	Gen-AI pilot evaluation by Q2
Innovation Lab	initial offer by Q3

Transformation

CMT	detail to be reported from July
CAD Replacements	EMS & NEPTS & 111 contracts
ESN Phase 2	business case development
Drones	training in progress
Digital Engagement	scoping in progress
ePCR Phase 2	scoping in progress

Data, Information & Insight

Individual Insights	clinical team structures mapped
NDR Programme	actions as per NDR plan
Skills Enablement	e.g. data literacy + self-serve
IDS Improvements	e.g. Data Plan + Data Science
Collaborations	e.g. with PHW & Research

See IMTP & STB trackers for action & milestone based progress.

RAG and progress based on Directorate Plan
Last updated 08/05/2025

AGENDA ITEM No	**11**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**1**

Environment, Decarbonisation and Sustainability Update – May 2025

MEETING	Finance and Performance Committee
DATE	20th May 2025
EXECUTIVE	Chris Turley - Executive Director of Finance and Corporate Resources
AUTHOR	Jo Williams – Head of Capital Development
CONTACT	Joanne.williams10@wales.nhs.uk

EXECUTIVE SUMMARY

To provide an update on:

- Decarbonisation Programme Board and progress reporting
- Capital Investment – EFAB Funding
- Capital Investment – TEF Funding
- Single Response Vehicle locations and EV charging
- EV rapid charging infrastructure
- EV and infrastructure resources

RECOMMENDATION: The Committee is asked to NOTE this update.

REPORT APPROVAL ROUTE

Capital Management Board – 2nd May 2025 – to note
F&PC – 20th May 2025 – to note

REPORT APPENDICES

Qualitative Report submission – 15th April 2025

REPORT CHECKLIST

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

WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST

Finance and Performance Committee

Environment, Decarbonisation & Sustainability Update

May 2025

SITUATION

1. This paper presents the Finance and Performance Committee with an update on the work being undertaken in support of the Trust's Environment, Decarbonisation and Sustainability work programme.

2. It also provides an update on the detailed reporting against the Trust's Decarbonisation Action Plan.

BACKGROUND

3. WAST has produced a Decarbonisation Action Plan (DAP) in response to the Welsh Government NHS Wales Decarbonisation Strategic Delivery Plan (*NHSW-DSDP*).

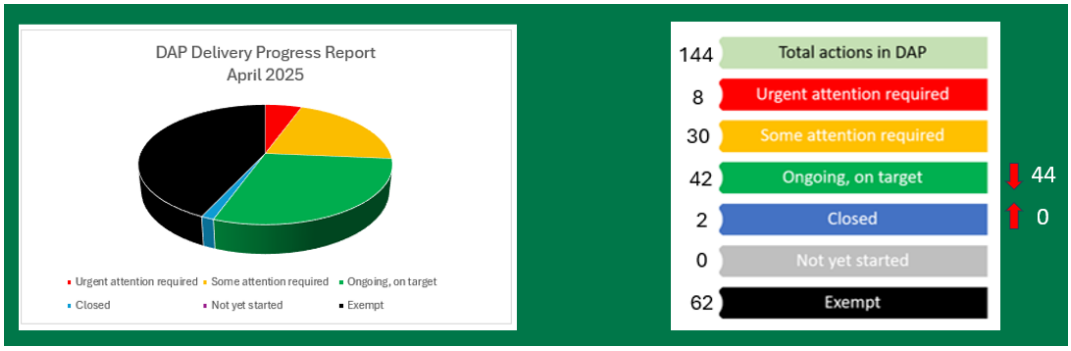
4. The plan has a range of actions which frame the Trust's decarbonisation response and spans all directorates across the Trust. It is vital that all areas of the Trust take ownership for the plan and that work across a potentially complex range of actions is organised appropriately to monitor and demonstrate progress.

ASSESSMENT

Decarbonisation Programme Board and progress reporting

5. The Decarbonisation Programme Board met on 28th April 2025 and considered updates on reporting via the DAP and to Welsh Government, capital investment – TEF funding, SRV implementation and EV infrastructure, and EV and infrastructure resource planning.

6. The team continues to monitor the DAP. The charts below indicate the current status of the DAP.



7. The latest Decarbonisation Co-ordination Reporting (DCR) submission was made to NWSSP on 7th April 2025 with the Qualitative Report submitted to Welsh Government by 15th April 2025; the two have a degree of duplication, and so link closely together. To note, the Qualitative Report submission (attached at ***Appendix 1***) also now includes Adaptation Planning aspects which are being managed for the Trust by ADLT, and which it is probably fair to say is currently in its infancy.

Capital Investment – EFAB Funding

8. At this point in the year, delivery of the WG Estates and Facilities Advisory Board (EFAB) schemes for 2024/25 is complete. As previously noted, the Trust was awarded a proportionally significant amount of the total funding available, with a 30% contribution by WAST from within its discretionary capital funding.

9. Final outcomes of each of the EFAB schemes are noted below.

- **Newtown Ambulance Station**– Three new roofs with a 26.5kW solar PV installed, 7Kw EV Charger has been installed, new kitchens installed in both admin and operational building. Infra-red heating panels installed throughout building, 3 renewable energy storage heaters installed in crew area for evening use.

- **Tredegar Ambulance Station** – Works included installation of a 17.5kW solar PV system, replacement of low carbon heating throughout the station via an air source heat pump, infra-red heaters installed in MRD garage and point of use hot water incorporated throughout to reduce energy demands.

- **HART** – Works included partial re roof, to ensure a secure building envelope, installation of a 36kW solar PV system, installation of an office area within the storeroom, which provides a compliant workspace for the stores person, alongside reducing the heating needs of the area, from the whole uninsulated storeroom to the insulated workspace.

- **Pontardawe Ambulance Station** – Works included a complete reconfiguration & refurbishment to make the building more fit for purpose, 9kW Solar PV

system installed, replacement of the natural gas boiler heating to a low carbon heating system and thermal battery hot water

Fire alarms and medical gas storage – this scheme has now also been completed.

10. The delivery of schemes under the EFAB funding scheme was project managed by the Capital Development and Estates Teams and overseen by the Decarbonisation Programme Board.

Capital Investment – TEF Funding

11. In 2025/26 a Targeted Estates Fund (TEF) has been made available to all NHS Wales, across 6 categories to a total value of £40m per year for 2 years (2025/26 and 2026/27).

12. The Trust bid against six schemes and have been awarded funding for three, as outlined within the tables below.

		REQUESTED						FUNDING CONFIRMED			
		Funding source		WAST				Funding source		WAST	Total scheme
Priority	Scheme	Decarbonisation	Infrastructure	contribution	Total scheme value	Delivery year	STATUS	Decarbonisation	Infrastructure	contribution	value
1	Abergavenny	385,000	210,000	255,000	850,000	2025/26	SUPPORTED	385,000	210,000	255,000	850,000
2	Rhyl	157,000	361,865	222,585	741,450	2026/27	SUPPORTED	158,000	362,000	222,585	742,585
3	HART heating	109,620	NA	46,980	156,600	2025/26	SUPPORTED	110,000	NA	46,980	156,980

	2025/26	2026/27	TOTAL CONTRIBUTIONS
DECARBONISATION	495,000	158,000	653,000
INFRASTRUCTURE	210,000	362,000	572,000
WAST	301,980	222,585	524,565

13. The Capital Development Team will lead on the implementation of the schemes, which are comprised of the following:
    - **Abergavenny Ambulance Station** (£850k)
        - Reconfiguration of internal layout
        - Upgrade to staff welfare facilities
        - Replacement of heating system to low carbon solution
        - Re-roof and PV system
        - EV charging

    - **HART** (£156k) –replacement of current heating system with a low carbon solution – air source heat pump and radiant heating

- **Rhyl Ambulance Station** (in 2026/27) (£742k)
    - Reconfiguration of internal layout
    - Upgrade to staff welfare facilities
    - Replacement of heating system to low carbon solution
    - Installation of PV solar energy
    - EV charging (possibly rapid charging)

Single Response Vehicle (SRV) specification design

14. It has been agreed with local Operational teams that the 20 hybrid SRVs currently being commissioned from the 2024/25 fleet replacement programme will be provided on a pure replacement basis, and it has been confirmed that the EV charging infrastructure is in place to support this. The 10 full BEV SRV locations also being commissioned from 2024/25 have also been confirmed.

15. The EV and Infrastructure Task and Finish Group is overseeing the implementation of all new hybrid and EV SRVs and is considering the detail of the evaluation process for the full EV SRVs.

16. Confirmation of funding against the 2025/26 Business Justification and Vehicle Procurement Strategy has now been confirmed from Welsh Government. In 2025/26 SRVs will continue to be hybrid, as the evaluation of the BEVs takes place throughout the financial year, but the Trust is looking to BEV vehicles to replace smaller NEPTS vehicles, as well as exploring options for testing new technology within the larger NEPTS vehicles.

17. A dedicated resource will be required to ensure that the programme of works for the implementation has the attention needed, and this cannot be done by the FinCoR and other existing teams in isolation. Work is ongoing to consider the impacts and requirements of this work, with resources initially available to support this in the above approved WG funding.

EV rapid charging infrastructure

18. The team continue to work with BP Chargemaster regarding the installation of rapid charging infrastructure. All three rapid charger installations are now complete. This brings the complement of rapid charging to 5, as follows:
    - Cardiff
    - Wrexham
    - Beacon House
    - Merthyr Tydfil Workshops (x2)

19. Further plans for Welshpool are progressing with installation planned for early in 2025/26. In addition, a number of further sites are being considered, to identify areas for further investment.

20. It should be noted that limitations and challenges still exist with the Distribution Network Operator (DNO) in both timescales for installations (capacity of the network and infrastructure) and the costs of upgrades required to support further EV charging.

EV and infrastructure resources

21. As noted above and within the regular updates, significant progress has been made to develop an EV charging network over the past few years. From a starting position of very little charging capacity in June 2022, the Trust now has a network of **76 EV chargers across 52 sites**. This includes rapid charging.

22. The development work on the EV network has been mainly led by the Capital and Estates Teams, but it is acknowledged that there are close working relationships with the Fleet Team who are responsible for implementing the vehicles, and with other teams such as Operations and Health and Safety. It is recognised that all members of the team are learning about this emerging area of development and much of this work is delivered outside the core scope of individual roles.

23. This has led to a significant change in the way teams work. With uncertain funding routes available, investment to date having been through a range of sources and on a staged basis, and continued future expectations of network expansion, the complexity of this work is increasing.

24. There is step change required in the way in which a network is managed which includes:
    - Monitoring energy use and regular reporting
    - Prevention of inappropriate use
    - Monitoring financial impacts
    - Linking to other systems e.g. renewable energy
    - Management of charger failures

25. Currently there are no dedicated roles within the Trust for the development of the EV network and its monitoring/maintenance, nor for the specific implementation of low emission vehicles within the Trust. In seeking information from other ambulance services and blue light partners, it is recommended that the Trust should consider this as an emerging area requiring resource capacity.

26. The Decarbonisation Programme Board on 28th April considered a range of pressures on current resource, and further work will commence on options for addressing this.

RECOMMENDATION

Finance & Performance Committee is asked to:

- **NOTE** this update

In completing the qualitative review document and providing any additional evidence of your organisation's progress and delivery of your Decarbonisation Action Plan (DAP) and Adaptation Plan the Climate Emergency National Programme Team will be able to make an accurate assessment of your organisations progress and delivery in 2024-25.

The Programme Team reports its assessment to the Climate Emergency Programme Board and shares this with the Cabinet Secretary for Health and Social Care and WG HSC Executive Directors Team. The assessment also feeds into the end of year WG HSC Joint Executive Team meetings held with every organisation and the Programme Team's individual feedback to organisations.

1. General information

Organisation	**Welsh Ambulance Services University NHS Trust**	**Date of Report**	**April 2025**	**Report Prepared By** Name, job title and email	Joanne Williams, Head of Capital Development (decarbonisation section) Alexander Crawford, Assistant Director of Planning and Transformation (adaptation section)

Senior Sponsor (previous title DAP Senior Sponsor) Name, job title and email	**Decarbonisation:** Chris Turley, Executive Director of Finance and Corporate Resources Estelle Hitchon, Director of Partnerships and Engagement (Chair of Decarbonisation Project Board **Adaptation:** Rachel Marsh, Executive Director of Strategy, Planning and Performance	**Finance Allocated to Support Delivery (£s)** Total figure of all funding allocated to support the delivery of your Decarbonisation Action Plan and development of your Adaptation Plan during 2024-25.	**Decarbonisation:** EFAB: £1.2m across 4 projects EV infrastructure: £320k Adaptation: no funding allocation	**FTE Resource allocated to support delivery** Resource specifically allocated to delivery of Decarbonisation Action Plan and development of your Adaptation Plan during 2024-25.	There is 1 WTE (band 6) Project Manager allocated to the whole decarbonisation agenda. The Project Manager is line managed by the Head of Capital Development. Other roles from the FinCoR Team then contribute, but there is no dedicated time allocated. There is no dedicated resource for Adaptation Planning and this will be picked up by Planning and Performance and National Operations.

Qualitative review agreed by/ to be agreed by Include name (of Board or individual), job title or Board title	Hugh Bennett, Assistant Director Commissioning & Performance	**Date agreed**	15 April 2025

Executive Summary of Progress to date
(This section is **optional.** If you wish to add a comment, please limit your words to 250 maximum).

Decarbonisation:

Achievements in 2024/25

- A project was established in 2024/25 to scope the requirements for rapid EV charging across Wales. A pilot installation of 3 x 50Kw units at 3 sites was implemented at Cardiff Ambulance Station, Beacon House, Cwmbran and Wrexham Ambulance Station, building on two already installed at Merthyr Tydfil Fleet Workshop. Additional work is planned for 2025-26.
- Purchase of 10 full electric and 20 PHEV Single Responder Vehicles which will come into service in Q1 of 2025/26.
- The Trust's internal Decarbonisation Programme Board continues to meet on a quarterly basis to oversee the delivery of the DAP and all associated underpinning programme management elements such as workstreams, management of risks, identification of benefits and supporting ongoing programme lessons.

- As a sub-group of the Decarbonisation Programme Board, the Transport Project Board continues to meet on a quarterly basis This group focuses on all transport elements of the DAP including EV, other low emission vehicles, EV charging, cycle and other transport initiatives and the grey fleet/staff vehicles aspects. The group will also be responsible for delivering associated policies and procedures underpinning the safe use of the network.
- The Trust continue to report against the DAP into the DCR team on a biannual basis.
- Successful utilisation of EFAB funding on a range of schemes as outlined below:
  - HART: Renewable energy.
  - Pontardawe: Renewable energy, LED lighting.
  - Newtown: Reroof, PV and EV infrastructure
  - Tredegar: Renewable energy
- For the 2025/26 financial year the Trust has been successful in obtaining funding under the TEF scheme to introduce further decarbonisation workstreams; This work will focus on 2 sites below:
  - HART
  - Abergavenny Ambulance Station

Areas of action

- We continue to focus on discussions with NWSSP around procurement.
- As Pod Point withdrew their support for DC services, including the maintenance and servicing of the chargers once warranties expire, the Trust has had no option but to continue exploring other options for the two 75kW chargers installed in Merthyr Workshops. The Trust has raised this within the National Programme Board and are seeking information on other suppliers.
- It should be acknowledged that WAST is a growing organisation. Whilst the system pressures continue to be felt, there is a need to maximise production hours and resources which encompass staff, fleet and estate provision.
- WAST is progressing with decarbonisation elements wherever possible but additional people and financial resources will be required to do this, including the ability to access emerging technology where possible. The creation of the UK's largest public sector charging network brings with it a need for additional resource to ensure the maintenance and management of this on an ongoing basis. The ability to deliver on this challenging agenda simply will not be possible within existing resources and therefore significant investment is required to enable WAST to deliver on the actions within the strategy.
- WAST has been clear in the support required for EV infrastructure both across its estate and within wider NHS Wales and public service networks.
- We continue to work towards achieving the DAP actions but recognise limitations of a challenging capital programme and wider financial constraints which will limit the ability to prioritise decarbonisation specific schemes. Made more difficult by the National electrical infrastructure issues that limit EV Fast charge progress, and lack of technical resources/R&D in bespoke frontline patient conveyancing vehicle models.

Routes to green including asks of WG

WG is asked to support WAST in several key areas

- Recognition that WAST is the only front-line service delivery organisation explicitly named within the Strategy and support it appropriately
- Limited electrical infrastructure into the country, and the costs associated with electrical infrastructure increases by DNO's ,require a National Strategic Plan to capture all public sector requirements.
- Recognition that 60% of WASTs carbon emission reporting is generated through the procurement process. NWSSP manage this process on behalf of all organisations and further support is needed to make significant progress in this area.

Reporting schedule and requirements:

Progress is to be reported annually at end of year. This form is to be submitted **on 15 April 2025** (covering the period 1 April 2024 to 31 March 2025).
Please provide an update for the reporting period which should focus on providing evidence of your progress and key achievements.

Please attach a copy of or a link to your organisation's climate plans for this review period e.g. Decarbonisation Action Plan, Adaptation Plan.

Completed form to be returned to: hss.performance@gov.wales

2. Decarbonisation

2.1 Decarbonisation Delivery Progress RAG

RAG Rating: The Programme Team in assessing your qualitative review will use the following RAG descriptors to measure and score the organisation's delivery progress against their Decarbonisation Action Plan.

Delivery Progress RAG Rating Guidance: Please use the following measures to assess the delivery progress of your Organisation's Decarbonisation Action Plan (DAP).

Red	Majority of the DAP activity/actions have stalled and are not being delivered. High level risks and issues need to be mitigated to restart progress.
Amber	Majority of the DAP activity/actions are being delivered in part. Progress is slow, and/or delays due to existing low-level issues that need to be mitigated.
Green	DAP activity/actions are being delivered in full, are on track and progressing well within set timescales, budget, and scope.

Provide the RAG status of delivery against Decarbonisation Action Plan.					
Current RAG Status		**Previous RAG Status**		**Reason for current RAG delivery progress**	**Current status is Amber.** We continue to work towards achieving the DAP actions but recognise limitations of a challenging capital programme and wider financial constraints which will limit the ability to prioritise decarbonisation specific schemes further. Progress has been made against some actions this financial year with the EFAB funding received and EV fast charge Infrastructure being installed at multiple sites.

2.2. Decarbonisation Delivery Confidence RAG

Confidence Progress RAG Rating Guidance: Please use the following measures to assess your organisation's overall confidence of contributing towards the NHS collective minimum 16% reduction in emissions by 2025.

Red	Successful delivery of the initiatives/actions appears to be unachievable. There are major issues which at this stage do not appear to be manageable or resolvable.
Amber	Successful delivery appears feasible but significant risks and issues already exist requiring management attention. These appear resolvable at this stage if addressed promptly.
Green	Successful delivery of the initiatives/actions to cost/quality appears highly likely and there are no major outstanding issues that at this stage that appear to threaten delivery.

Provide the RAG status of the organisations overall confidence of delivering a minimum of 16% reduction in emissions by 2025.					
Current RAG Status		**Previous RAG Status**		**Reason for current RAG delivery confidence**	**Current status is Amber.** To note – the 16% target applies across NHS Wales and the public sector. The DAP does not set out an aim to achieve a specific reduction of 16% in emissions by this year. WAST requires support for further funding in support of capital requirements for estate retrofitting where possible to achieve a reduction of carbon emissions. 60% of WASTs carbon emission is generated through procurement process, support is required from NWSSP programme team to make significant progress in this area. Wider EV charging capacity is needed from DNOs and on a national scale, which cannot be done in isolation by WAST. The Trust is taking all possible action within its capability to deliver elements of the DAP which are under its control.

2.3. Decarbonisation Summary of Key Achievements

Summarise your key achievements The NWSSP Decarbonisation Co-ordination Reporting (DCR) Team will provide the Programme Team with your Organisation's Q4 Progress Report. These reports will be considered as part of the annual review on each organisation's progress and delivery of their Decarbonisation Action Plan. Please provide any additional information below not submitted in Q4 report.	
Procurement	Please see WAST DCR Q4 report
Buildings, estates, land use and planning	The Trust has successful utilised EFAB funding on a range of schemes as outlined below: HART: PV system and battery storage, plus EV charging infrastructure Newtown: PV system and battery storage, plus EV charging infrastructure Tredegar: PV system and battery storage Pontardawe: Building envelope upgrade, including insulations and fenestration , alongside installation of LED lighting and an efficient low carbon heating system
Transport	Please see WAST DCR Q4 report
Approach to health care	Please see WAST DCR Q4 report
Additional information	Please include any additional achievements or detail on progress that are not covered by the workstreams listed above.

2.4. Decarbonisation Risks

The NWSSP Decarbonisation Co-ordination Reporting (DCR) Team will provide the Programme Team with your Organisation's high-level risks and mitigation measures, reported alongside Q4 progress report so decarbonisation risks information no longer needs to be submitted within this qualitative reporting template.

3. Adaptation (new for 2024-25)

This is a new section for 2024/25 and reflects the need for organisations to undertake adaptation planning that identifies and responds to the risks and opportunities to health, and health service delivery, from more extreme weather and in particular heat, storms and flooding. The Programme Team appreciate that this work is likely to be at an early stage across all organisations.

Welsh Government's Climate Adaptation Strategy for Wales 2024 contains a specific chapter focused on health and well-being. The Health and Social Care Climate Adaptation Toolkit supports organisations undertake climate risk and opportunity assessments and initiate adaptation planning.

3.1. Adaptation Delivery Progress RAG

RAG Rating: The Programme Team in assessing your qualitative review will use the following RAG descriptors to measure and score the organisation's progress on the development of your Adaptation Plan in readiness for your Board's approval and implementation and monitoring from 1 January 2026.

Delivery Progress RAG Rating Guidance: Please use the following measures to assess the progress on the development of your Adaptation Plan.

Red	Work has not commenced and/or the organisation has not agreed the timescales, budget, and scope to deliver the Adaptation Plan by the end of December 2025.

Amber	Development of the Adaptation Plan has commenced but progress is slow. Low-level issues that need to be mitigated to deliver the Plan by December 2025.
Green	Development of the Adaptation Plan is on track and progressing well within set timescales (by December 2025), budget, and scope.

Provide the RAG status on the development, delivery and implementation of your Adaptation Plan.			
Current RAG Status		**Reason for current RAG delivery progress**	A paper has been presented at Assistant Directors Leadership Team on Adaptation Planning on WAST's approach and way forward to commence work on the risk matrix through to short, medium and long term plans, but no further due to competing priorities for the Adaptation planning lead. However, this is a commitment in our IMTP and will be reinvigorated in Q1 2025/26.

3.2. Summary of Progress on Adaptation Planning

Please include any additional achievements, detail on progress or risks to delivery that are not covered under your Adaptation Plan RAG reason with a particular focus on:

- Actions to undertake climate risk and opportunities assessments in line with the Health and Social Care climate Adaptation Toolkit
- Actions to make existing buildings more resilient to climate change impacts, particularly heat, storms and flooding, and ensure that new buildings are designed to meet future climate challenges.
- Working in collaboration across the health system and wider public sector (including through Public Services Boards) to share best practice, skills and experience with a focus on protecting the most vulnerable and actively addressing inequalities in the communities served.

The Welsh Ambulance Services NHS Trust is keen to make progress in climate adaptation planning to address the climate emergency and to ensure alignment with the Wellbeing of Future Generations Act.

Key activity that we have undertaken to date includes:

- The establishment of a working group to oversee adaptation planning, integrating it across various departments, with the aim of developing a comprehensive adaptation plan. This plan will set out proposed actions to address the climate emergency from an ambulance service perspective and where we need to work with others across Wales. An inaugural meeting on adaptation planning was held, where the concept of adaptation in the context of the climate emergency was defined, and the use of the WG Adaptation toolkit was discussed. A workshop will be planned to further develop the adaptation plan and integrate it into the next IMTP and long-term strategy.

- Engagement with stakeholders, including the Decarbonisation Programme Board and the Assistant Director Leadership Team, has been ongoing to ensure that adaptation planning aligns with the organisation's strategic goals, including the alignment with our newly approved Wellbeing Goals.

4. Background information

The Health and Social Care Climate Emergency National Programme web page sets out the background and key information on how the programme will help the health and social care sector respond to the climate emergency.

Relevant Strategies and Guidance

- Net Zero Wales sets out the actions needed to meet Wales's second carbon budget (2021-2025).
- NHS Wales Decarbonisation Strategic Delivery Plan sets out initiatives to reduce emissions in the NHS
- Adaptation Strategy for Wales sets out the actions being taken now and in the future to respond to climate change.
- The requirement for NHS organisations to ensure that the role as Anchor Institutions is fully exploited, demonstrating their contributions to the climate change agenda and the partnership and collaboration opportunities across sectors that comes with this responsibility is referenced in the NHS Wales Planning Framework 2024-2027.
- Details of how NHS Wales will measure and report performance in health care are referenced in the NHS Wales performance framework 2024 - 2025.

- Best practice and case studies from NHS Organisations can be found on the NHS Confederation website.

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

AGENDA ITEM No	**12**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**1**

INTERNAL AUDIT: ENERGY MANAGEMENT– FEEDBACK FROM ARAC

MEETING	Finance and Performance Committee
DATE	20 May 2025
EXECUTIVE	Trish Mills, Director of Corporate Governance/Board Secretary
AUTHOR	Steve Owen, Corporate Governance Officer
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. The Audit, Risk and Assurance Committee (the ARAC) received and discussed the **Energy Management audit report** at its meeting on 6 March 2025. This report summarises the discussion from this meeting in reference to this report.

2. **Energy Management – Substantial Assurance**. The purpose of this review was to review the risk mitigations and management of energy costs, including the implementation of a new national energy contract. The Trust's impact from the new contract was less significant compared to other organisations. Detailed monitoring reports are used to inform decisions, and renewable energy schemes have been implemented to improve energy efficiency. Three medium-priority findings were raised, including the need for enhanced automation of approvals, reducing estimated reads, and removing non-A-rated small appliances.

3. The committee noted that the Trust is the only ambulance service to have ISO accreditation in this area, reflecting the significant work done by the Estates team.

RECOMMENDATION: The Finance and Performance Committee is asked to note the discussion at the meeting of the ARAC on 6 March 2025, and the assurance that was received following receipt of the Energy Management audit report and agreed management actions.

KEY ISSUES/IMPLICATIONS
Not applicable.

REPORT APPROVAL ROUTE
Not applicable.

REPORT APPENDICES
Not applicable.

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

Estates Assurance - Energy Management

Final Internal Audit Report

2024/25

Welsh Ambulance Services University NHS Trust

Substantial Assurance

Contents

Review Reference	WAS-SSU-2425-20
Fieldwork	December 2024 – January 2025
Executive Sign Off	18 February 2025
Audit Committee	March 2025
Executive Lead	Chris Turley, Director of Finance
Audit Team	Huw Richards, Head of Internal Audit

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

Noting rising costs of energy, effective management and control of energy costs has been risk assessed as an area of potential benefit for audit.

This audit was undertaken in line with the 2024/25 audit plan.

The audit was undertaken to determine the adequacy of, and operational compliance with, the established systems for the management and control of energy consumption within the Trust and also considered other supporting regulatory and procedural requirements.

The audit included a review of both central monitoring and site-based implementation of controls (including sample testing).

Overview

The Welsh Ambulance Trust (WAST) had signed up to the national NHS energy contract, which was managed via the Welsh Energy Group and Welsh Energy Operational Group, which was attended by WAST representatives. WAST had made significant steps toward reducing fossil fuel use within the estate, including investing in an ongoing programme focused on implementing renewable energy sources - including ground source heat pumps and photovoltaic panels.

The move to the new NHS Wales energy contract in 2023 had presented some issues, including difficulties in providing accurate energy forecasts to participating organisations. Recognising the robust data monitoring processes operated at the Trust, the impact of the national issues had not been as significant as seen elsewhere.

Other programmes of improvement have included movement sensor LED lighting, zoned building areas with climate control, and a clear, pragmatic building management policy.

The recording/ monitoring of energy use and management of the invoicing position with the energy provider, were well controlled and the information provided informed decisions related to improving energy efficiency.

The WAST had also been successful in gaining annual reaccreditation of ISO14001 (Environmental Management) and continue to be the only ambulance trust in UK to hold this status.

We have concluded **substantial** assurance in this area. The matters requiring management attention included:

- Approvals did not make use of the Oracle approval hierarchy but instead were completed manually by email,
- In sampled months, 35% of meter readings were estimates, albeit 71% of these were then subsequently manually read within a month.

Full details of matters arising are detailed within the Findings & Agreed Action Plan. The following opportunities for enhancement have been identified that do not impact the overall opinion and are highlighted for management information:

- Legacy small appliances were observed to be in use in the WAST estate that were not A rated, contrary to the Building Management Policy.

Scope & Assurance Summary

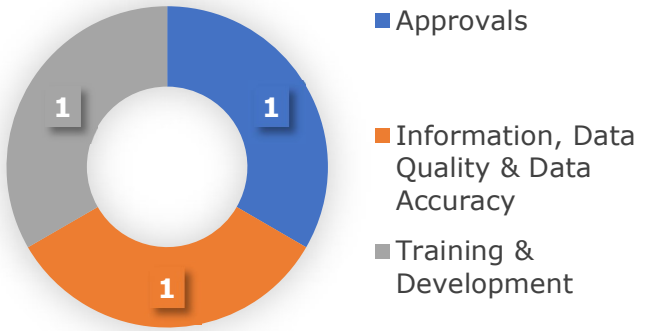
	Objectives	Related Findings	Assurance
1	Governance – To ensure that key roles had been assigned, and responsibilities of key staff were understood. An appropriate forum had been assigned with responsibility and accountability for overseeing Energy efficiency/ consumption.	-	**Substantial**
2	Contracts – Recognising the national contracts in place, to obtain assurance that the Trust obligations under the national contract arrangements were fully understood and applied.		**Substantial**
3	Data Capture – Appropriate systems were in place to capture data on energy consumption in a timely manner.	1	**Reasonable**
4	Data Validation - Adequate checks were undertaken to verify the quality/ reliability of the data - any anomalies were fully investigated.		**Substantial**
5	Monitoring and reporting – Monitoring and reporting arrangements were in place to ensure that anomalies were understood, benchmarking was undertaken where appropriate and resulting action was tracked.		**Substantial**
6	Energy Awareness – Appropriate training for general and key energy staff focused on increasing awareness of obligations. Other initiatives were established to increase awareness e.g. intranet pages.	2	**Reasonable**
7	Payments – energy related billing was verified, authorised, and processed in accordance with contractual payment terms.	3, 4	**Reasonable**
8	Risk Management – Assurance that systems and controls in place to manage energy-related risks, and that there are appropriate arrangements to escalate as appropriate - this includes appropriate risk mitigation strategies.		**Substantial**

Management Actions

0 High Priority

3 Medium Priority

Themes



Risk Types

Financial Loss

Choose an item.

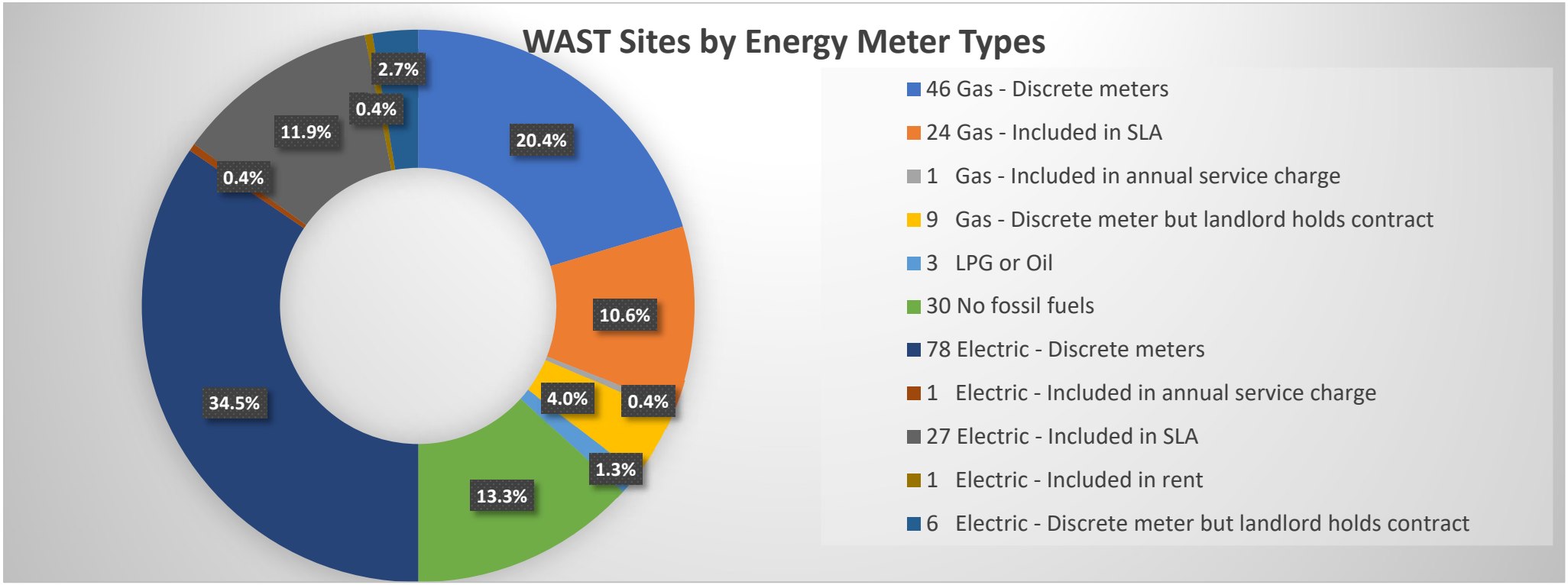
Choose an item.

Choose an item.

Welsh Ambulance Services University NHS Trust, Energy Management - At a Glance

The WAST operates from ambulance stations across the whole of Wales, with a central headquarters based in St Asaph, North Wales and two regional headquarters in South Wales. The service was forecast to use 2,950,676 kWh of Gas, and 2,414,181 NBP of Electric across 2024-25 (a total of £1,013,241).

The service had a total of 124 energy meters, with the remainder either billed to landlord or included in other charges:



Additionally, because of ongoing investment programmes, by March 2025, 19 sites will have Photovoltaic (PV) panels for solar power, and 9 will have Ground Source Heat pumps. More sites will be included in the programme across 2025-26.

Electricity emissions have increased by 15% in the past 12 months. This is not unexpected due to increased numbers of electrically fed heating systems and plug in EV vehicles. This has been offset by 193k kWh of renewable energy generated by PV arrays on Trust premises.

Due to these low carbon heating retrofits and closure of inefficient estate, total heating emissions have reduced by 23%. 35% of the estate no longer use fossil fuels.

Findings & Agreed Action Plan

Objective 1: Governance	Substantial

Overview / Summary of Observations

The WAST had produced a Decarbonisation Action Plan (DAP) in response to the Welsh Government's NHS Wales Decarbonisation Strategic Delivery Plan (NHSW- DSDP). The plan had a range of actions which frame the Trust's decarbonisation response and spans all directorates across the Trust.

A report was submitted to the Welsh Government on 14th April 2024 and feedback was received in June 2024 confirming WG's assessment of the WAST reporting status as Amber which aligned to the self-assessment provided.

On a day-to-day basis the Trust employs an experienced and qualified Sustainability and Environment Manager and Sustainability and Environment Officer, and there were clear process notes relating to recording and reporting of energy use, whilst a reader-friendly Building Management policy outlined pragmatic ways to reduce energy use.

The WAST had also been successful in their annual reaccreditation of ISO14001 (Environmental Management) and continue to be the only ambulance trust in UK to hold this status.

Objective 2: Contracts	Substantial

Overview / Summary of Observations

In October 2023, the Trust entered a new all-Wales NHS energy contract with Crown Commercial Services (CCS), managed by NWSSP: Procurement Services. This change was due to the existing supplier exiting the market, citing volatility since 2021.

In June 2024 NWSSP sent out a summarised PowerPoint showing the trends over the last quarter in energy and sent it to each HB and Trust. The WAST were asked to review their meters and usage, which they did, and confirmed that forecasts appeared reasonable, adjusting for any future changes that were known including new meters. The detailed forecast showed rates and movements, whilst a sustainability report showed movements considering closures of inefficient stations and increased PV installation.

The contracted rates were referred to regularly to ensure invoicing received was accurate and WAST members regularly provide feedback at national forums and provided feedback on the proposed contract renewals.

Objective 3: Data Capture	Reasonable

Overview / Summary of Observations

The WAST has an expansive estate covering a wide geographic area – additionally, a significantly high number of estate sites may also not be manned full-time and/ or have management in attendance full time.

There was a clear policy for capturing meter readings/ energy usage, which were then sent to a central Account Payable email address, where they were collated and submitted to the Energy Supplier as one feed. 35% of submissions sampled were based on an estimated reading. This was clearly linked to the profile of the WAST estate and the requirement to read meters within fixed date ranges.

The non-receipt of readings was monitored and was actively chased – 71% of those estimated readings were subsequently provided as a true/ actual reading to the Energy Supplier within 1 month. Most of the estate's meters were still manually read, and the Trust would benefit from expediating their current work to move existing meters to smart meters, albeit it is understood that they are limited by the capacity of the energy provider to install these.

	Key Findings	Risk & Impact	Agreed Management Action
1	35% of sampled readings were estimated. Although it was noted that these were appropriately chased with 71% of them being submitted within a month, this also represented a risk that invoices may be issued by the energy provider for incorrect values affecting the timing of the cashflow of the Trust. The Trust has advised that: "Monthly updates via WEOG meetings with the energy provider include smart meter/AMR rollout update. WAST are a member of WEOG and participate actively with this meeting. The trusts previous Environment and Sustainability Manager was also in contact with the energy provider's booking team to facilitate progress of this roll out. It however must be noted that WAST has no control over the speed and efficiency of the energy provider's smart meter roll out and can only raise as a concern at WEOG meetings.	That energy usage is incorrectly captured resulting in invoices being issued by the energy provider for incorrect values, affecting the timing of the cashflow of the Trust.	**Agreed Action:** The new Environment and Sustainability Manager, in post March 2025 will be an active participant of WEOG and will endeavour to progress roll out at a quicker pace.

	As there is a procedure in place to ensure that invoices are adjusted to actual reads in a timely manner, therefore the impact on Trust cashflow should be virtually insignificant.”		**Expected Evidence of Implementation:** Minutes of WEOG showing new manager as an attendee and continuing to raise smart meter implementation, if it remains an issue.
		Medium Priority	**Officer:** Head of Estates
	Theme: Information, Data Quality & Data Accuracy	Control Operation	**Target Implementation Date:** 30th June 2025- please note this is the implementation date of the new manager attending WEOG and not installation of a Trust wide AMR/Smart meter project, WAST has little control on that timescale.

Objective 4: Data Validation	Substantial

Overview / Summary of Observations

Meter readings were recorded electronically on a central shared drive on a file which compared month-on-month movements with invoice values and volumes received from energy companies. There were some expected discrepancies due to reading dates and invoice date ranges, however these were ratified and determined as materially appropriate.

Agreed rates charts were also saved electronically on a central shared drive, and these were reconciled periodically to the invoices being received from the energy provider.

During the audit it was possible to review the movements on the invoices to the readings, and the readings taken during site visits to the recoded readings and no anomalies were noted.

Objective 5: Monitoring and Reporting — Substantial

Overview / Summary of Observations

The Trust completed a variety of reporting including:

- granular reporting by meter of all readings vs. invoiced values, and recording whether the reading was estimated, read by the energy provider or read by the Trust,
- recording charted energy information over a 7-year period, which was compared to various external information including the average temperature for the month and other factors to identify where energy use had been unexpected.

The analysis was often used to support decisions such as closures of inefficient sites; but also, to focus and prioritise investment e.g. with photovoltaic panels, trickle chargers, ground source heat pumps and full LED movement sensor lighting.

During site visits it was possible to see the outcome of investments. The application of the building management policy was also tested in site visits which found that windows were predominantly double glazed in older buildings, whilst the South-West headquarters visited was based in a relatively new building, built on Passivhaus principles with sealed windows, climate-controlled air conditioning and Brise Soleil to limit building overheating. Chillers were based in chiller rooms to the exterior of the building with exposed grill facings.

On all visits thermostats were set within guided ranges, and lighting was noted to be movement sensor driven. Doors between zones were kept shut, whilst shutters to ambulance garages had rubber draught excluders and were in good condition.

Ground source heat pump and photovoltaic installations were observed.

Small appliance use was noted in sites visited, and included wall mounted hot water boilers. New appliances were noted to all be 'A' rated. In some areas kettles and fan heaters were observed to be supplementing more energy efficient appliances and some older unrated "household" appliances were noted to be in use: it would be recommended that these are replaced with 'A' rated appliances at the end of their useful life.

Sites were visited at various times and lights were noted to be off in the South-West office outside of core operating hours.

The WAST found benchmarking of data very difficult due to the very differing locational profile of the WAST, but a noticeable difference in the quality and extent of issue logging, which was also shared with the energy provider, noting the issue by meter.

Over time, the resolutions achieved were clear to see, including receipt of credit notes from the energy provider and sustained attempts to resolve longer term issues. Issues had also been escalated via the Welsh Energy Operational Group.

Objective 6: Energy Awareness	Reasonable

Overview / Summary of Observations

A booklet had been provided to staff regarding energy use which contextualised the benefit to the Trust and the environment of steps that could be taken to mitigate and lower emissions, and discussed the requirements of ISO14001 and what individual staff members could do to help the Trust meet the standard.

Some of the topics covered in this awareness exercise included drawing attention to "opening up and closing down" procedures and asked staff to find out what they were and if they were in place, and to not only consider facilities temperatures, but to provide feedback to the estates team.

Links to the Estates portal were provided for readers to find out more about environmental issues.

Evidence was provided during the audit of educational media/ posters created by the WAST for display around the WAST estate. During visits to the South-West headquarters, no posters were observed to have been displayed.

Whilst on an ambulance station visit non-WAST generated posters were noted as being displayed in relation to turning off appliances when not in use, and whilst there was clear evidence amongst staff of energy awareness, the WAST posters were not on display.

	Key Findings	Risk & Impact	Agreed Management Action
2	Educational media created by the WAST to encourage behaviours conducive to good energy management, were not displayed in estate premises sampled. The Trust have advised: "The new Environment and Sustainability Manager starting March 2025, will be tasked with updating current training materials, plus communication materials to encourage reduced use of energy, this will be supported by WAST communications team. As the new manager starts in post March 2025 and requires bedding in time, plus the imminent ISO14001 internal audit requirements, this will be scheduled in for an appropriate time."	Behaviours adopted by the WAST employees are not conducive to efficient energy usage, increasing reputational risk and increasing financial cost to the Trust.	**Agreed Action:** Handover meeting between previous environment and sustainability manager and new environment and sustainability manager booked for 18th March. This handover will include the requirement to address training concerns, and to allow time to develop a comms plan at an appropriate juncture. **Expected Evidence of Implementation:** Email from new Environmental Manager to Communications for support, including some wider comms via internal IT avenues and directorate notices.
	Medium Priority		**Officer:** Head of Estates **Target Implementation Date:** 30th September 2025
	Theme: Training & Development	Control Operation	

Objective 7: Payments	Reasonable

Overview / Summary of Observations

A sample review of invoicing and payments found the process to be well managed and tracked, despite a labour-intensive manual process of approval.

Invoices and credit notes were entered onto Oracle in a timely manner and there was a clear path between the issues log/ agreed actions by the energy provider and the credit notes and receipts which were being received.

In the sample of 9 invoices which were reviewed in detail, the volumes appeared to be reasonable and paid accordingly.

One invoice had been entered onto Oracle system and then removed, whilst another was missing from Oracle entirely. It was unclear what had happened with these two invoices, but both relate to an ambulance station where incorrect invoicing had been provided by the energy supplier since the recent acquisition of the site.

It was noted that WAST Standing Financial Instructions 11.19 'No purchase order, no pay", state that there should be purchase orders for all invoices, however the All of Wales Standing Financial Instructions waiver energy invoices. Whilst Purchase Orders were not therefore required in this case, it would be beneficial for either purchase ordering or the approval hierarchy in Oracle to be utilised to streamline and strengthen the control processes around approvals and coding of energy invoices which was currently subject to an unwieldy manual emailed process.

Whilst the tracking of invoices was noted to be detailed and regularly undertaken, a strategy for a more system driven approach to approvals would be lower risk and would additionally make it easier to identify correct posting to Health Board/ Trust and distributions (nominals) on Oracle. It would also avoid manual coding in most cases. A key finding has been raised in relation to this matter.

Key Findings		Risk & Impact	Agreed Management Action
3	The invoices sampled had been approved for payment manually using emails: • The invoice was sent by the local team to the WAST AP email • The Sustainability and Environment Manager had picked up the invoice and forwarded it to the Sustainability and Environment Officer. • The Sustainability and Environment Officer had coded the invoices on Oracle before confirming they had done so to the Sustainability and Environment Manager. • The Sustainability and Environment Manager had forwarded the approval request to the Assistant Director if over their own authorisation limit. • The Assistant Director had returned the approval to the Sustainability and Environment Manager. • The Sustainability and Environment Manager had forwarded the approval to the WAST AP email address requesting approval. On an uncomplicated single invoice and payment scenario, whilst the payment was not delayed, this had resulted in 9 emails and 8 separate email addresses. A strategy should be considered to use a system driven approach to managing invoicing which would allow an invoice to be more easily matched and coded to the correct Trust and distributions on Oracle and would allow for approvals to be facilitated via a system approval hierarchy linked to the Trust's Scheme of Delegation.	Inefficient processing of invoices and payment resulting in financial loss and risk to reputation	**Agreed Action:** We will review the current energy invoice receipt, approval and payment processing arrangements with a view to streamline current arrangements maximise efficiency. **Expected Evidence of Implementation:** Discussion meeting between Assistant Director and Director of Finance regarding team any required change to approval thresholds and streamlined authorisation process.
		Medium Priority	**Officer:** Head of Estates
	Theme: Approvals	Control Operation	**Target Implementation Date:** 30th June 2025

Objective 8: Risk Management	Substantial

Overview / Summary of Observations

Risks had been adequately raised at the Wales Energy Group or WEOG meetings.

Internally, risks were reflected in the activities of the Environment, Decarbonisation and Sustainability work programme in their Environment, Decarbonisation & Sustainability Update.

A detailed Risk Register was reviewed at each Programme Board meeting and was regularly updated. This Risk Register was also linked to work on the Corporate Risk Register, and the risk that decarbonisation initiatives including those related to delivery of investments schemes such as installation of renewables (e.g. photovoltaics) had been formally adopted at the Corporate Risk Register level and was included in the Board Assurance Framework.

The Environment, Decarbonisation & Sustainability Update was reviewed and approved by:

- Capital Management Board – 23rd August 2024
- Executive Leadership Team – 11th September 2024
- Finance and Performance Committee – 17th September 2024

Appendix A

Assurance Opinion

Substantial

Few matters require attention and are compliance or advisory in nature.

Low impact on residual risk exposure.

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Limited

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Unsatisfactory

Action is required to address the whole control framework in this area.

High impact on residual risk exposure until resolved.

Advisory

Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate.

These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Disclaimer

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Welsh Ambulance Service University NHS Trust, and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of the Welsh Ambulance Service University NHS Trust. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

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

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AGENDA ITEM No	**14**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**4**

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

MEETING	Finance & Performance Committee
DATE	20 May 2025
EXECUTIVE	Trish Mills, Director of Governance / Board Secretary
AUTHOR	Julie Boalch, Assistant Director of Governance & Risk
CONTACT	Julie.Boalch@wales.nhs.uk

EXECUTIVE SUMMARY

1. The purpose of the report is to provide assurance in respect of the management of the Trust's principal risks, specifically the seven 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) in Annex 4.

3. The more detailed description contained within the BAF provides the Committee with an opportunity to review the controls in place against each principal risk and the assurance provided against those controls where applicable. This will assist Members in evaluating current risk ratings supported by the frameworks in Annex 2.

4. Each of the risks have been reviewed during this reporting period in line with the agreed schedule detailed at Annex 3 with continual and dynamic focus on the highest rated risks scoring 15-25. Attention has been given to the risk ratings of each principal risk and the mitigating actions identified and taken to ensure that risks achieve their target score. This is in addition to the standard and regular review of all controls, assurances, and any gaps.

5. All principal risks were presented to the Trust Board on 27 March 2025. These have been reviewed, and recent activity is due to be considered and approved by the Executive Leadership Team on 21 May 2025. There are no material changes foreshadowed.

6. Updates are highlighted in blue on the BAF which show changes to the narrative, mitigating actions, controls, and assurances.

7. **Risk 260** *A significant and sustained cyber-attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems* has

increased in score from 15 (3x5) to 20 (4x5) due to the escalated world conflicts and recent increase in targeted cyber-attacks against NHS organisations.

8. The specific detail and planned mitigations of this risk will be considered in closed session of committee today due to the sensitive and security based nature of these.

9. **Risk 641** *The Trust's inability to implement the learning from all relevant Manchester Arena Inquiry (MAI) recommendations impacting its response to a major incident/mass casualty incident* remains static at a score of 20 (4x5). This risk is taken in open session in full transparency. However, members will note that the actions to address individual recommendations are not included in detail in the BAF extract. This is for reasons of sensitivity and security.

10. **Risks 542** *Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan* at a score of 16 (4x4) continues to be reviewed and remains unchanged, similarly, to **Risk 623** *Failure to comply with Data Protection Legislation* at a score of 15 (3x5).

11. **Risk 594** *The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death* remains unchanged this period and static at a score of 15 (3x5).

12. **Risk 100** *Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience* and **Risk 139** *Failure to Deliver our Statutory Financial Duties in accordance with legislation* remain unchanged at a score of 12 (3x4).in this period.

13. 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 or increased

14. A detailed review, discussion and challenge takes place with the Executive Leadership Team (ELT) and Assistant Director Leadership Team (ADLT) on each of these risks monthly including new risks, changes to scores and those that have achieved target.

RECOMMENDATION:

15. **Members are asked to consider the contents of the report.**

KEY ISSUES/IMPLICATIONS
16. The key issues are set out in the Executive Summary above.
REPORT APPROVAL ROUTE
17. The BAF was considered by: • Assistant Directors Leadership Team (03 February 2025) • Executive Leadership Team (19 February 2025)

- Audit, Risk and Assurance Committee (06 March 2025)
- Trust Board (27 March 2025)

REPORT ANNEXES
• Annex 1 - Summary table describing the Trust's Corporate Risks. • Annex 2 – Scoring Matrix • Annex 3 – Frequency of Risk review • Annex 4 - Board Assurance Framework

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

Annex 1 – Corporate Risk Register Summary

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
260 FPC	A significant and sustained cyber-attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems.	**IF** there is a large-scale cyber-attack on WAST, NHS Wales and interdependent networks which shuts down the IT network and there are insufficient information security arrangements in place **THEN** there is a risk of a significant information security incident **RESULTING IN** a partial or total interruption in WAST's ability to deliver essential services, loss or theft of personal/patient data and patient harm or loss of life	Director of Digital Services	**20 (4x5)** ↑ **15 (3x5)**
641 FPC	The Trust's inability to implement the learning from all relevant Manchester Arena Inquiry (MAI) recommendations impacting its response to a major incident/mass casualty incident	**IF** the Trust has not fully implemented the MAI recommendations AND a major incident or mass casualty incident is declared **THEN** there is a RISK that the Trust's Incident Response will be suboptimal **RESULTING IN** avoidable patient harm and/or death, detriment to staff wellbeing, reputational damage and potentially expose the Trust to legal liability	Executive Director of Operations	**20 (4x4)** →
542 FPC	Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan	**IF** there is a lack of resources and available technology and infrastructure **THEN** there will be a failure to deliver the commitments outlined in the action plan and within the Welsh Government timelines **RESULTING IN** negative environmental and social impacts causing and reputational damage	Executive Director of Finance & Corporate Resources	**16 (4x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
594 FPC	The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death.	**IF** a major incident or mass casualty incident is declared **THEN** there is a risk that the Trust cannot provide its pre-determined attendance as set out in the Incident Response Plan and provide an effective, timely or safe response to patients **RESULTING IN** catastrophic harm (death) and a breach of the Trust's legal obligation as a Category 1 responder under the Civil Contingency Act 2004.	Executive Director of Operations	**15 (3x5)**
623 FPC	Failure to comply with Data Protection Legislation	**IF** the Trust fails to comply with and demonstrate it is meeting the accountability requirements under the Data Protection Act, the UK General Data Protection Regulation (GDPR) and the Common Law Duty of Confidentiality **THEN** the Trust will breach its legal obligations and potentially cause the personal or sensitive data to be compromised, lost, or inappropriately used **RESULTING IN** unauthorised data breaches/loss, financial or compensatory penalties, an increased regulatory scrutiny or enforcement as well as stakeholder mistrust and reputational damage.	Director of Digital Services	**15 (3x5)** →
100 FPC	Failure to persuade JCC/Health Boards about WAST's ambitions	**IF** WAST fails to persuade JCC/Health Boards about WAST ambitions	Executive Director of Strategy	**12 (3x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
	and reach agreement on actions to deliver appropriate levels of patient safety and experience.	**THEN** there is a risk of a delay or failure to receive funding and support **RESULTING IN** a catastrophic impact on services to patients and staff and key outcomes within the IMTP not being delivered	Planning & Performance	
139 FPC	Failure to Deliver our Statutory Financial Duties in accordance with legislation.	**IF** the Trust does: • not achieve financial breakeven and/or • does not meet the planning framework requirements and/or • does not work within the EFL and/or • fails to meet the 95% PSPP target and/or • does not receive an agreement with commissioners on funding (linked to 458) **THEN** there is a risk that the Trust will fail to achieve all its statutory financial obligations and the requirements as set out within the Standing Financial Instructions (SFIs) **RESULTING IN** potential interventions by the regulators, qualified accounts and impact on delivery of services and reputational damage	Executive Director of Finance & Corporate Resources	**8 (2x4)** →

Annex 2 - Risk Scoring Matrix

Consequence:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Safety & Well-being - Patients/ Staff/Public	Minimal injury requiring no/minimal intervention or treatment. No time off work. Physical injury to self/others that requires no treatment or first aid. Minimum psychological impact requiring no support. Low vulnerability to abuse or exploitation - needs no intervention. Category 1 pressure ulcer.	Minor injury or illness, requiring minor intervention. Requires time off work for >3 days Increased hospital stay 1-3 days. Slight physical injury to self/others that may require first aid. Emotional distress requiring minimal intervention. Increased vulnerability to abuse or exploitation, low level intervention. Category 2 pressure ulcer.	oderate injury/professional intervention. Requires time off work 4-14 days. Increased hospital stay 4-15 days. RIDDOR/Agency reportable incident. Impacts on a small number of patients. Physical injury to self/others requiring medical treatment. Psychological distress requiring formal intervention by MH professionals. Vulnerability to abuse or exploitation requiring increased intervention. Category 3 pressure ulcer.	Major injury leading to long-term disability. Requires time off work >14 days. Increased hospital stay >15 days. RIDDOR Reportable. Regulation 4 Specified Injuries to Workers. Patient mismanagement, long-term effects. Significant physical harm to self or others. Significant psychological distress needing specialist intervention. Vulnerability to abuse or exploitation requiring high levels of intervention. Category 4 pressure ulcer.	Incident leading to death. RIDDOR Reportable. Multiple permanent injuries or irreversible health effects. An event which impacts on a large number of patients.
Quality/ Complaints/ Assurance/ Patient Outcomes	Peripheral element of treatment or service suboptimal. Informal complaint/inquiry.	Overall treatment/service suboptimal. Formal complaint (Stage 1). Local resolution. Single failure of internal standards. Minor implications for patient safety. Reduced performance.	Treatment/service has significantly reduced effectiveness. Formal complaint (Stage 2). Escalation. Local resolution (poss. independent review). Repeated failure of internal standards. Major patient safety implications.	Non-compliance with national standards with significant risk to patients. Multiple complaints/independent review. Low achievement of performance/delivery requirements. Critical report.	Totally unacceptable level or quality of treatment/service. Gross failure of patient safety. Inquest/ombudsman/inquiry. Gross failure to meet national standards/requirements.
Workforce/ Organisational Development/ Staffing/ Competence	Short-term low staffing level that temporarily reduces service quality (< 1 day).	Low staffing level that reduces the service quality.	Late delivery of key objective/service due to lack of staff. Unsafe staffing level (>1 day)/competence. Low staff morale. Poor staff attendance for mandatory/key professional training.	Uncertain delivery of key objective/ service due to lack/loss of staff. Unsafe staffing level (>5 days)/competence. Very low staff morale. Significant numbers of staff not attending mandatory/key professional training.	Non-delivery of key objective/service due to loss of several key staff. Ongoing unsafe staffing levels or competence/skill mix. No staff attending mandatory/professional training.
Statutory Duty, Regulation, Mandatory Requirements	No or minimal impact or breach of guidance/statutory duty.	Breach of statutory legislation. Reduced performance levels if unresolved.	Single breach in statutory duty. Challenging external recommendations/improvement notice.	Enforcement action. Multiple breaches in statutory duty. Improvement notices. Low achievement of performance/ delivery requirements. Critical report.	Multiple breaches in statutory duty. Zero performance rating. Prosecution. Severely critical report. Total system change needed.
Adverse Publicity or Reputation	Rumours. Low level negative social media. Potential for public concern.	cal media coverage - short-term reduction in public confidence/trust. ort-term negative social media. blic expectations not met.	Local media coverage - long-term reduction in public confidence & trust. Prolonged negative social media. Reported in local media.	National media coverage <3 days, service well below reasonable public expectation. Prolonged negative social media, reported in national media, long-term reduction in public confidence & trust. Increased scrutiny: inspectorates, regulatory bodies and WG.	National/social media coverage >3 days, service well below reasonable public expectation. Extensive, prolonged social media. MP/MS questions in House/Senedd. Total loss of public confidence/trust. Escalation of scrutiny status by WG.
Business Objectives or Projects	Insignificant cost increase/ schedule slippage.	<5 per cent over project budget. Schedule slippage.	5–10 per cent over project budget. Schedule slippage.	Non-compliance with national targets.10-25 per cent over project budget. Schedule slippage. Key objectives not met.	>25 per cent over project budget. Schedule slippage. Key objectives not met.
Financial Stability & Impact of Litigation	Small loss. Risk of claim remote.	Loss of 0.1–0.25% of budget Claim less than £10,000.	Loss of 0.25–0.5% of budget. Claim(s) between £10,000 and £100,000.	Uncertain delivery of key objective. Loss of 0.5-1.0% of budget. Claim(s) between £100,000 and £1 million. Purchasers failing to pay on time.	Non-delivery of key objective. Loss of >1 per cent of budget. Failure to meet specification. Claim(s) >£1 million. Loss of contract/payment by results.
Service/ Business Interruption	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours. Some disruption manageable by altered operational routine.	Loss/interruption of >1 day. Disruption to a number of operational areas in a location, possible flow to other locations.	Loss/interruption of >1 week. All operational areas of a location compromised, other locations may be affected.	Permanent loss of service or facility. Total shutdown of operations.
Environment/Estate/ Infrastructure	Minimal or no impact on environment/service/property.	Minor impact on environment/ service/property.	Moderate impact on environment/ service/property.	Major impact on environment/ service/property.	Catastrophic impact on environment/service/property.
Health Inequalities/ Equity	Minimal or no impact on attempts to reduce health inequalities/improve health equity.	Minor impact on attempts to reduce health inequalities or lack of clarity on the impact on health equity.	Lack of sufficient information to demonstrate reducing equity gap, no positive impact on health improvement or health equity.	Validated data suggests no improvement in the health of the most disadvantaged, whilst supporting the least disadvantaged, no impact on health improvement and/or equity.	Validated data demonstrates a disproportionate widening of health inequalities, or negative impact on health improvement and/or equity.

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	Frequency:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
1 Highly Unlikely: Will probably never happen/recur	Not for years	1	2	3	4	5
2 Unlikely: Do not expect it to happen/recur but it is possible	At least annually	2	4	6	8	10
3 Likely: It might happen/recur occasionally	At least monthly	3	6	9	12	15
4 Highly Likely: Will probably happen/recur, but not a persisting issue	At least weekly	4	8	12	16	20
5 Almost Certain: Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

Annex 3 - Frequency of Risk Review

Risk Score	Review Frequency	Risk Rating
15 – 25 Red	Review monthly	High
8 – 12 Amber	Review quarterly	Medium
1 – 6 Green	Review every 6 months	Low

Risk ID 260	**Significant and Sustained Cyber Attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems**	**Date of Review:**	**07/02/2025**	**TREND**	**20 (4x5)**
		Date of Next Review:	**07/03/2025**	⬆	

IF there is a large-scale cyber-attack on WAST, NHS Wales and interdependent networks which shuts down the IT network and there are insufficient information security arrangements in place	**THEN** there is a risk of a significant information security incident	**RESULTING IN** a partial or total interruption in WAST's ability to deliver essential services, loss or theft of personal/patient data and patient harm or loss of life

	Likelihood	**Consequence**	**Score**
Inherent	**4**	**5**	**20**
Current	**4**	**5**	**20**
Target	**2**	**5**	**10**

IMTP Deliverable Numbers: 1, 15, 19, 24

EXECUTIVE OWNER	Director of Digital Services	**ASSURANCE COMMITTEE**	Finance and Performance Committee

Risk Commentary

The risk has been fully reviewed in the cycle and the **risk score has increased given escalated tension around various conflicts around the world, the decrease in the relationship between UK and Russia, and Russia's threat to the UK's critical national infrastructure along with the recent increase in targeted cyber-attacks against NHS organisations.** Whilst the Trust and wider NHS Wales organisations have in place several layers of technology to protect the Trust and its information systems, there is still a risk that users will be fooled by phishing emails which are becoming ever more sophisticated. To raise user awareness of cyber threats the Trust ICT department run regular phishing exercises as well as short security training packages, reporting the results and uptake through IGSG and into FPC.

CONTROLS	**ASSURANCES**
	Internal Management (1st Line of Assurance)
1. Appropriate policy and procedures in place for Information/Cyber Security	1. Information Security Policy reviewed every 3 years (currently due for renewal). Incident Policy and Procedure put in place in February 2022 – renewed annually.
2. Trust Business Continuity Procedure and Incident Response Plan	2. Debrief from significant business continuity incidents captured within organisational learning spreadsheet. Governance with respect to this goes through SOTs. Full review of Incident Response plan every 3 years - currently undergoing a partial review. BCPs and BIAs should be reviewed annually by their owners. Annual schedule of testing
3. IT Disaster Recovery Plan	3. Organisation-wide tabletop exercise undertaken in March 2022 with all BC leads and Digital teams.
4. Relevant expertise in Trust with respect to information security	4. Staff undertake relevant training courses e.g., CISSP to increase knowledge and expertise
5. Data Protection Officer in post	5. In job description of Head of ICT
6. Cyber and information security training and awareness	6. Training statistics are available on ESR and from Phish threat module
7. Mandatory Information Governance training which includes GDPR	7. Training statistics reported on by Information Governance department
8. ICT tests and monitoring on networks & servers	8. Any issues would be identified and flagged and actioned
9. Information Governance framework	9. WAST self-assesses its Information Governance Framework against the Welsh Information Governance toolkit.
10. Internal and NHS Wales governance reporting structures in place	10. Internal WAST Information Governance Steering Group & All Wales Information Governance Management Advisory Group (IGMAG) meets quarterly, National Ambulance Information Governance Group (NIAG) meets every 2 weeks, Operational Security and Service Management Board (OSSMB) (national) – daily/weekly meetings and minuted meetings every 2 months. Minutes and actions logs available for meetings.
11. Checks undertaken on inactive user accounts	11. Software in place to run check on inactive accounts as and when
12. Business Continuity exercises	12. Annual schedule of testing
13. Operational ICT controls e.g., penetration testing, firewalls, patching	13. Monthly scans on infrastructure. Penetration testing has occurred for different systems. 2 physical firewalls on networks to monitor traffic. Monthly patching occurs or as and when. 04/08/23 – Exploring procurement of additional penetration tests with the aim of annual testing of all critical systems.
14. Security alerts	14. Daily alerts are received. Anti-virus alerts received as and when threat discovered
15. Cyber/Info Security KPI are reported to senior management and committees	15. Monthly KPI reports now being generated routinely and fed into the Digital Leadership Group, ELT, IGSG and FPC
16. Regular cyber awareness campaigns are conducted	16. Cyber training is provided to staff and regular phishing campaigns are conducted. These are reported as part of the KPI reports
17 IT recovery Plan does include a cyber response	17. Cyber response incorporated into IT Disaster Recovery Plan

Risk ID 260	Significant and Sustained Cyber Attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems	Date of Review:	07/02/2025	TREND	20 (4x5)
		Date of Next Review:	07/03/2025	⬆	

IF there is a large-scale cyber-attack on WAST, NHS Wales and interdependent networks which shuts down the IT network and there are insufficient information security arrangements in place	THEN there is a risk of a significant information security incident	RESULTING IN a partial or total interruption in WAST's ability to deliver essential services, loss or theft of personal/patient data and patient harm or loss of life

	Likelihood	Consequence	Score
Inherent	4	5	20
Current	4	5	20
Target	2	5	10

18. Information Security Policy refreshed and approved.	
19. Suite of business continuity exercises that departments can undertake to test their plans are available via EPRR.	19.
20. The cyber risk is reviewed and monitored	20. The ongoing cyber threat to the organisation is continually monitored using daily comms feeds and automated alerts from various external sources via ICT security team and reported to AD of Digital and DPO. The corporate cyber risk assessment will be reviewed monthly at the Digital Leadership Group informed by the threat and intelligence monitoring and national strategic trends.
21. SIRO in place and ISMS evolving in line with refresh of Trust information Security Policy	**External Independent Assurance** NHS Wales Cyber Response Unit independent view of Network and Information Systems (NIS) Directive compliance within last 4 – 5 months (covering controls 1 -,3 – 11, 13 – 14
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Lack of understanding and compliance with policy and procedures by all staff members, **continued education and awareness as per improvement plan.**	1.
2. Departments do not communicate in a timely manner with Digital Services around putting in new processes, new projects, and procurement and this has a cyber security, information governance and resource impact. **Revised procurement guidance to be disseminated via ADLT.**	

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. **Continued implementation and** development of the Trust Cyber Improvement Plan	Senior ICT Security Specialist	Next checkpoint date **31.01.2025**	Implementation of Cyber Improvement Plan actions ongoing and regularly reported into ICT SMT, DLG, IGSG and FPC.

Risk ID 641	The Trust's inability to implement the learning from all relevant Manchester Arena Inquiry (MAI) recommendations impacting its response to a major incident/mass casualty incident	Date of Review:	16/12/2024	TREND	20 (4x5)
		Date of Next Review:	16/01/2025	➡	

IF the Trust has not fully implemented the MAI recommendations AND a major incident or mass casualty incident is declared	**THEN** there is a RISK that the Trust's Incident Response will be suboptimal	**RESULTING IN** avoidable patient harm and/or death, detriment to staff wellbeing, reputational damage and potentially expose the Trust to legal liability.

	Likelihood	Consequence	Score
Inherent	5	5	25
Current	4	5	20
Target	2	3	6

IMTP Deliverable Numbers:

EXECUTIVE OWNER	Executive Director of Operations	**ASSURANCE COMMITTEE**	Finance & Performance Committee

Risk Commentary

Following the Manchester Arena Incident in May 2017, whereby twenty-two (22) innocent people were sadly killed, and the subsequent Public Inquiry (MAI), ambulance services across the UK have reviewed their ability to respond to a Major Incident. WAST has undertaken its own review and has identified sixty-eight (68) of the MAI recommendations as being pertinent to the ambulance service and/or multi-agency preparedness and response. Once these recommendations have been implemented then the risk will be mitigated to target; however, additional financial resources are required to do this.

As part of the Trust's ongoing commitment to deliver the necessary change against the MAI recommendations, a dedicated team was established in June 2023 to investigate and assure the Board that all necessary organisational processes were in place should an incident occur in Wales. Since the beginning of this project, significant progress has been made in addressing the recommendations (as identified in the 'Controls' section below) and the Trust is better prepared because of the work undertaken to date.

As part of the ongoing work, the Trust has completed a series of investigations and developed a series of 'Capability Reports' to demonstrate and explain where remaining challenges to an anticipated Major Incident could occur. The capability gaps identified are detailed in the below reports, which were shared with the Board, and are supported by a significant base of evidence produced as part of the 'R105' self-review process.

The reports are:

- **R106 Capability Report**
- **Capability to Prepare**
- **Capability to Respond**
- **Capability of Specialist Assets**

The reports identify that a significant proportion of the MAI recommendations remain outstanding, and the Trust is unable to progress these further or fully implement the identified learning without financial support. The reports highlighted what is needed to complete or significantly progress twenty (20) MAI recommendations and forms the basis of the 'Gaps in Controls' and 'Actions' sections. Transitioning these gaps and actions across into the 'Controls' section when achieved will act as a longitudinal method of tracking progress of completion against the MAI recommendations, and the associated risk reduction as this occurs. If the Trust is unable to implement the MAI recommendations fully, there remains a risk to the public, the organisation, and commissioners in the event of a mass casualty incident.

This Board Assurance Framework (BAF) extract is supported by a more detailed appendix of itemised actions required to permit greater scrutiny of remaining gaps and actions, as well as a detailed repository of control measures that have been successfully implemented.

CONTROLS	**ASSURANCES**
	Internal Management (1st Line of Assurance)
1. Forty-four (44) of the pertinent MAI Recommendations have been implemented into WAST practice through the work undertaken to date.	1. MAI recommendations that have been marked as implemented by the EPRR MAI Project are authorised and ratified by Operations Senior Leadership Team and cascaded via the approved governance route (AAA) to ELT and Trust Board. This forms a documented governance route for rationale for completion and details of this are recorded in the EPRR share drive alongside evidence of compliance. Additional details of assurance are provided in the annex to this Corporate Risk. Ongoing monitoring and assurance of lessons learned is captured through BAU processes and the established debriefing/lessons learned process such as the Organisational Learning Spreadsheet.
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Four (4) outstanding MAI Recommendations, identified as pertinent to WAST by the self-assessment, require action against to implement the associated learning **(REF: MAI recommendations 1, 26, 88, 111).** These are not included in the R106 funding request.	1. Work is progressing against these recommendations as part of the ongoing MAI project. It is anticipated that these recommendations can be implemented without additional financial support. Regular updates on these four recommendations are provided through the regular 'touch point' meetings with EPRR HoS, ADO for National Operations & ED of Ops, with periodic updates to SLT that are then cascaded via the approved governance route.

Risk ID 641	The Trust's inability to implement the learning from all relevant Manchester Arena Inquiry (MAI) recommendations impacting its response to a major incident/mass casualty incident	Date of Review:	16/12/2024	TREND	20 (4x5)
		Date of Next Review:	16/01/2025	➡	

IF the Trust has not fully implemented the MAI recommendations AND a major incident or mass casualty incident is declared	**THEN** there is a RISK that the Trust's Incident Response will be suboptimal	**RESULTING IN** avoidable patient harm and/or death, detriment to staff wellbeing, reputational damage and potentially expose the Trust to legal liability.

	Likelihood	Consequence	Score
Inherent	5	5	25
Current	4	5	20
Target	2	3	6

2. Twenty (20) outstanding MAI Recommendations that have been submitted to Trust commissioners via the 'R106' process as requiring financial support to implement the learning **(REF: MAI recommendations 16, 17, 20, 23, 24, 25, 50, 53, 71, 84, 85, 86, 87, 92, 105, 106, 108, 109, 117, 124).**	2. The outstanding recommendations are not able to be implemented independently by WAST and may remain unresolved until such time that additional financial resources and practical arrangements are in place to support this work. Trust commissioners have been notified of this via the formal R106 submission completed in August 2024.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Implement the learning relating to forty-eight (48) recommendations identified in the MAI report as pertinent for WAST **(REF: Outstanding MAI recommendations 1, 26, 88, 111).**	Assistant Director of Operations, National Operations & Support	March 2025	This programme of work is underway, with nearly all recommendations completed. 4 recommendations remain outstanding, with a plan in place to implement all these recommendations.
2. Submit evidence to Commissioners demonstrating that additional funding is required to implement a further twenty (20) recommendations identified in the MAI report **(REF: MAI recommendation R106).**	Assistant Director of Operations, National Operations & Support	March 2025	A formal submission of requirements has been submitted to commissioners for consideration and approval. Commissioners have been engaged with since early 2024 to raise awareness and facilitate early discussion. The Trust is awaiting a formal response to the submission.
3. Implement the necessary amendments to Trust infrastructure, resourcing level and equipment required to address the remaining recommendations once funding has been made available. (**REF: MAI recommendations 16, 17, 20, 23, 24, 25, 50, 53, 71, 84, 85, 86, 87, 92, 105, 106, 108, 109, 117, 124).**	Assistant Director of Operations, National Operations & Support	March 2029	An assortment of 20 proposals rests with commissioners at present. As these proposals are funded, capabilities gaps will be addressed and an associated reduction in the risk score can be expected. Some of these proposals may take several years to implement (e.g. a North Wales HART Unit) which is reflected in the target date. Other proposals could be accomplished in a much shorter timeframe if funded. Once the implementation of infrastructure, resourcing and equipment has occurred, WAST will either be compliant with the MAI recommendations, or, in some circumstances, may need to undertake further work to integrate the MAI learning into practice (e.g. once the EPRR Training & Exercising Team have established, they will then need to provide sufficient levels of exercising to comply with the exercising-related MAI recs).

Risk ID 542	Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan	Date of Review:	27/01/2025	TREND	16 (4x4)
		Date of Next Review:	27/02/2025	➡	

IF there is a lack of resources and available technology and infrastructure	**THEN** there will be a failure to deliver the commitments outlined in the action plan and within the Welsh Government timelines	**RESULTING IN** negative environmental and social impacts causing reputational damage

	Likelihood	Consequence	Score
Inherent	5	4	20
Current	4	4	16
Target	2	4	8

IMTP Deliverable Numbers: 17, 18, 33

EXECUTIVE OWNER	Executive Director of Finance and Corporate Resources	**ASSURANCE COMMITTEE**	Finance and Performance Committee

Risk Commentary

Challenges continue around resources and technology, and currently there is not an ability to reduce this score. Decarbonisation Programme Board **continue to** meet. Noting some progress on positive movement to actions within the DAP. **Recent progress is focussing on implementation of PHEV and BEV SRVs**.

CONTROLS	**ASSURANCES**
	Internal Management (1st Line of Assurance)
1. Oversight of implementation and delivery of Decarbonisation project and monitoring of action plan at Decarbonisation Programme Board and Capital Management Board	1. Regular meetings of the Decarbonisation Programme Board quarterly. Requirements of the Decarbonisation project have been presented to the Trust Board & Finance and Performance Committee. Challenges of the project have also been highlighted. Report goes regularly to FPC and then onto Trust Board
2. Capital and Estates directorate lead support – Director of Finance (DOF)	2. Regular briefings to DOF
3. Partnership working via Communications/Stakeholder liaison group with NHS Wales, Welsh Government and other bodies to gain support and knowledge- with the anticipation of working in collaboration.	3. Sharing of knowledge via partnership working through various forums is documented in minutes of meetings held. Requirements also form part of the action plan
4. Approach changed for heating/lighting/energy systems to become more energy efficient- replacing old inefficient plant with more sustainable technology such as natural gas boilers for air source heat pumps	4. (i) Estate Survey undertaken every 5 years. This is a 6-facet survey to understand where the back log is and the requirements for energy systems. (ii) Approved Estates SOP (iii) Estate Retrofit Guide and framework used to prepare schemes
5. Changing procurement practices for fleet, Estates, equipment, supplies, and ICT to reduce emissions	5. Fleet SOP shows move to ULEV vehicles. BJC 2024/25 details intention for move to EV for smaller and support vehicles
6. Board Development sessions with respect to Decarbonisation to raise awareness of decarbonisation requirements, additional sessions will be required.	6. Board Development session occurred on 8th November 2021 – presentation slides are available.
7. Finance & Performance Committee has oversight of decarbonisation project, decarbonisation to become a standard agenda item.	7. (i) Routine updates at every other FPC meeting (3 times a year) (ii) Annual report (which includes a Sustainability section) is approved by the Finance & Performance Committee
8. KPIs with respect to energy transmissions are communicated to Estates team annually by sustainability manager	8. KPIs to Estates team includes energy use at all WAST managed buildings
9. ISO14001 accreditation in place	9. ISO14001 – Annual audits are undertaken against the accreditation. Environmental Coordinators act as champions in the organisation.
10. Environment Strategy in place	10. Environment strategy has been approved by the Trust Board. This covers the next 5 years
11. Programme Board Risk Register	11. Programme Risk Register reviewed at every Decarbonisation Programme Board meeting
12. Reporting to WG via DCR reporting, qualitative, and quantitative reports and emissions reporting	12. Submissions to WG – quarterly DCR reporting. Annual qualitative and quantitative reporting
13. Membership of National Programme Board (WG), Transport Task and Finish Group and BELP Project Board	13. Minutes and papers of meeting
	External - Independent Assurance: • Sustainability section in Annual Report audited by Internal Audit. Annual audits by BSI on accreditation
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Establishment of further workstreams to address a Programme Plan to support strategy requirements	
2. Ability to deliver on EV infrastructure plan including electrical capacity issues for the purposes of electronic charging points for vehicles	

Risk ID 542	Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan	Date of Review:	27/01/2025	TREND	16 (4x4)
		Date of Next Review:	27/02/2025	➡	

IF there is a lack of resources and available technology and infrastructure	**THEN** there will be a failure to deliver the commitments outlined in the action plan and within the Welsh Government timelines	**RESULTING IN** negative environmental and social impacts causing reputational damage

	Likelihood	Consequence	Score
Inherent	5	4	20
Current	4	4	16
Target	2	4	8

3. Procurement of an electronic fleet of vehicles – this is not currently possible for anything other than a car/van (limited)
4. Resources to be able to deliver extent of DAP – work ongoing to establish actions required and potential cost impacts. Note detailed schemes are challenging to work up without appropriate resource which in turn allow for realistic financial estimates to be made about cost.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Establishment of potential further workstreams to address a Programme Plan to support strategy requirements: Consider further workstreams required in support of delivering DAP actions, including grouping of similar actions	Capital Development and Estates Team	Not needed. Action closed.	Workstreams were set up to manage delivery of the EFAB projects and the transport element (Transport Project Board). Links are also made into ongoing work to develop the IMTP and develop longer term strategies e.g. Fleet Vehicle Procurement Strategy 2025 – 30.
2. Ability to deliver on EV infrastructure plan including electrical capacity issues for the purposes of electronic charging points for vehicles: develop an investment strategy/prioritised list of sites where further EV charging is required. Will need further investment.	Decarbonisation Programme Board	March 2025 (in line with the IA recommendation action)	**Actions taken in line with investment provided to implement rapid charging by end of March 2025 at a small number of sites. Confirmed adequate charging provision for the replacement of 20 x PHEV and 10 x BEV in March/April 2025.**
3. Procurement of an electronic fleet of vehicles – this is not currently possible for anything other than a car/van (limited): development of specifications for vehicles considering achievable and safe ULEV options where possible. NOTE: will be dependent on confirmation of 2024/25 BJC funding	Fleet Team	March 2025	**Position remains that only vans can currently be purchased. This will be delivered by March/April 2025.**
4. NED support ended April 2022: A new NED will need to be nominated to champion this risk/project at Trust Board level	Director of Corporate Governance / Board Secretary	**Not being progressed**	To be further discussed with relevant Directors**. It is unlikely that a NED Champion role will be allocated in the near future.**
5. Resources to be able to deliver extent of DAP – work ongoing to establish actions required and potential cost impacts. Note detailed schemes are challenging to work up without appropriate resource which in turn allow for realistic financial estimates to be made about cost: Development of an investment requirements schedule (also aligned to IA recommendations). Contribute resources to support the Decarbonisation Strategy action plan	Director of Finance & Corporate Resources	31.03.25	**Discussions ongoing regarding enhanced resource requirements to implement low carbon emission vehicles. Targeted Estate Fund (TEF) bids being developed by 31st Jan 2025.**

RISK ID 594	The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death	Date of Review:	22/01/2025	TREND	15 (3x5)
		Date of Next Review:	22/02/2025	➡	

				Likelihood	Consequence	Score
IF a major incident or mass casualty incident is declared	**THEN** there is a risk that the Trust cannot provide its pre-determined attendance as set out in the Incident Response Plan and provide an effective, timely or safe response to patients due to vehicles not being released from hospital sites	**RESULTING IN** catastrophic harm (death) and a breach of the Trust's legal obligation as a Category 1 responder under the Civil Contingency Act 2004	**Inherent**	4	5	20
			Current	3	5	15
			Target	2	5	10

IMTP Deliverable Numbers: 1, 5, 6, 7,14, 15, 24

EXECUTIVE OWNER	Director of Operations	ASSURANCE COMMITTEE	Finance & Performance Committee

Risk Commentary Q1 2024/2025

The challenges across the unscheduled care system**.** Handover lost hours in **November were 20,993 and December were 25,199.** There is a direct correlation with ambulance availability and high levels of resources unavailable due to protracted waits at hospital E.Ds. Several incidents declared have failed to provide sufficient on the ground assurance that vehicles would be released. Health Boards have declined to incorporate testing of vehicle release into a recent mass casualty exercise. Further, a recent workshop undertaken by the EPRR team as part of the Manchester Arena Inquiry assurance process which has tested our ability to fulfil the PDA in North and South Wales, both in and out of hours, has confirmed that we would only meet the PDA in one of these four mass casualty scenarios.

After a thorough review and assessment of Risk 594 within the Corporate Risk Register at SLT on 02/10/2024, we propose reducing the risk score from 20 to 15 (likelihood from 4 to 3) due to the following reasons:

· Mitigation/Controls have been Implemented: We have several controls measures that directly address the identified risk and are content we have exhausted all opportunities for additional controls. These controls are embedded within the corporate risk register.

· Immediate Release Protocol: The revised version of the IR protocol v1.3 has been agreed and shared at COO group and published which has included the release schedule for ambulances at the declaration of an incident as set out below:

·50% of vehicles released within 10 minutes

· 75% of vehicles released within 20 minutes

· 100% of vehicles released within 30 minutes

· Monitoring and Review: We will continue to monitor the risk within the normal governance channels (SOT/SLT/ADLT etc) to ensure that mitigations are still in place and any emerging risks are promptly identified and addressed.

22/01/25 - In light of the critical incident declared earlier this month, a review of the risk scoring is scheduled for this at SLT on 11th February in the first instance and this will be updated following conversations.

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. Immediate release protocol	1. The Immediate Release Protocol is a Nationally agreed NHS Wales protocol. Refusals by Health Boards are Datixed by WAST and compliance report provided weekly to the DG for Health & Social Services. V1.3 has been reviewed, updated and released (August 2024).
2. Resource Escalation Action Plan (REAP)	2. The Senior Leadership Team convenes every Tuesday as the Weekly Performance Meeting to review performance and demand data, and review/assign REAP Levels as appropriate. Dynamic escalation via Strategic Command structure. REAP has undergone an annual review with v4.1 released in November 2023.
3. Regional Escalation Protocol	3. Daily conference calls to agree RES levels in conjunction with Health Boards
4. Incident Response Plan	4. The Incident Response Plan has been ratified via EMT
5. Mutual Aid arrangement with NARU	5. AACE National Policy on mutual aid in place
6. Clinical Safety Plan	6. CSP adopted by EMT and operational; reviewed annually by SLT in December 2023, Version 2.21 of the Clinical Safety Plan was released. The reduction in the demand is the assurance which is dynamically monitored via ODU.
7. Operational Delivery Unit 24/7 cover	7. Shift reports from ODU & ODU Dashboard received by Exec, SOT, and On-Call Team at start/end of shift and cover review at weekly performance meeting
8. In hours and Out of hours command cover	8. Civil Contingency requirement as set out in the Command Policy and Incident Response Plan. Cover review at weekly performance meetings
9. Notification and Escalation Procedure	9. Published procedure in operation, reviewed 3 yearly by SLT
10. Continued escalation of risk to partners and stakeholders	10. Referenced by the Executive Director of Operations in correspondence sent to health board Chief Operating Officers dated 30 March 2023. It was further emphasised at the face-to-face COO Peer Group meeting on 14 April 2023.
	External Independent Assurance N/A
11. CEO letter to Health Boards dated 3 Jan 2023, and DOO letter to Chief Operating Officers dated 30 March 2023 to seek assurance on plans.	11. Acknowledgement and acceptance of risk by HBs and balancing the risk across the whole system. Improvement in handovers in C&VHB and ABUHB. This has been sustained form some months across C&V in a phased programme of improvement with no delays more than 2 hours. Programme of improvement underway in ABUHB commencing at 4-hour

RISK ID 594	The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death	Date of Review:	22/01/2025	TREND	15 (3x5)
		Date of Next Review:	22/02/2025	➡	

IF a major incident or mass casualty incident is declared	THEN there is a risk that the Trust cannot provide its pre-determined attendance as set out in the Incident Response Plan and provide an effective, timely or safe response to patients due to vehicles not being released from hospital sites	RESULTING IN catastrophic harm (death) and a breach of the Trust's legal obligation as a Category 1 responder under the Civil Contingency Act 2004

	Likelihood	Consequence	Score
Inherent	4	5	20
Current	3	5	15
Target	2	5	10

	tolerance with a plan to reduce over time. In other HBs there remains little or no controls with variation in both handovers and risk levels across HBs.
12. Health boards are asked to provide assurance of existing and tested plans to immediately reduce emergency ambulances on incident declaration.	12. All Health Boards responded with assurance of plans except BCU.
13. Multi Agency Exercise to be arranged.	13. This exercise has taken place although Health Boards declined to incorporate vehicle release plans
14. Meeting with Welsh Government to outline this risk; WG agreed to write to HBs seeking assurance from EPRR leads in HBs on the ability to clear EDs and release vehicles. WG agreed to incorporate testing into the forthcoming mass casualty exercise, and a timeframe for vehicle release was proposed by WAST with 30% of vehicles released within 10 minutes of an incident declaration, 50% within 20 minutes and 100% within 40 minutes.	14. WG have confirmed that they have written to HB EPRR leads. Health Board COOs approved the proposals for vehicle release as outlined.
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
Despite the controls listed, the single most limiting factor in providing a pre-determined response in line with the Incident Response Plan is the lost capacity due to hospital handover delays. In this area, WAST has no control. – link to CRR 223 on CRR.	The Trust is not assured that Hospital sites have plans in place that are trained and tested to release ambulances effectively and immediately in the event of an incident declaration.
	Following two incidents (Pembroke Dock Ferry fire on 11th February 2023 and the Swansea gas explosion on 13 March 2023), The Trust is not assured by the effectiveness of assurances given by Health Boards (responses provided following correspondence from WAST CEO – formal returns received from LHBs except BCU). Despite these two incidents being lower-level incident declarations where the pre-determined attendance was met, the experience does not add confidence to the ability to release all resources from hospitals which would support assurance. Further testing of the pre-determined attendance levels has been undertaken as part of the Manchester Arena Inquiry recommendations; This tested the Trust's ability to fulfil the PDA in North Wales and South Wales in the event of a mass casualty scenario both in hours and out of hours. This simulation concluded that in three of these four scenarios, the Trust would be unable to fulfil the PDA. A further declared major incident at Treforest Industrial Estate in December 2023 following an explosion, failed to release resources from Morriston Hospital, Wales's dedicated burns unit (formal debrief still to be conducted).

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Review of Manchester Arena Inquiry	Assistant Director of Operations	March 2025	This programme of work is underway, and a workshop has confirmed that the PDA would be unable to be met in three out of four simulated mass casualty scenarios. The financial case associated with MAI is planned to be familiarised with ELT and JCC during Jan and Feb 2024, with the final outline case to ELT in March 2024. A revised timeline for the governance process for the final MAI reports has been agreed, commencing in May 2024 and finalising at Trust Board the end of July 2024. 01/10/2024 - Progress against the 68 recommendations, directly or through partnership working, that relate to the Trust continues. The Trust has undertaken a detailed review of its provision as part of its obligation under recommendations 105 and 106 and has recently produced an evidence-based series of reports aimed at addressing the identified gaps. This has been supported further by the development of three Quality Impact Assessments that have been approved by the Clinical Quality Governance Group. The work identified 20 recommendations for which there is a financial dependency. The submission to commissioners of the Trust's reports relating to these recommendations has now occurred and the Trust awaits their considered response. The remaining recommendations continue to be progressed, and it is anticipated these will conclude within the next six months. To ensure the continued visibility of these report findings within the Trust, a corporate risk is being developed for inclusion in the Trust's risk register. This will enable the alignment of outstanding MAI recommendations with a clearly defined business-as-usual framework, ensuring proper governance of capability gaps while awaiting financial decisions from commissioners and the implementation of necessary changes.

RISK ID 594	The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death	Date of Review:	22/01/2025	TREND	15 (3x5)
		Date of Next Review:	22/02/2025	➡	

IF a major incident or mass casualty incident is declared	THEN there is a risk that the Trust cannot provide its pre-determined attendance as set out in the Incident Response Plan and provide an effective, timely or safe response to patients due to vehicles not being released from hospital sites	RESULTING IN catastrophic harm (death) and a breach of the Trust's legal obligation as a Category 1 responder under the Civil Contingency Act 2004

	Likelihood	Consequence	Score
Inherent	4	5	20
Current	3	5	15
Target	2	5	10

			Jan 2025 - Progress against the 68 recommendations, directly or through partnership working, that relate to the Trust, continues. We expect to complete all recommendations that do not rely on financial investment by the end of this financial year. To ensure the continued progression and completion of the recommendations with financial dependency (18 recommendations), a corporate risk has been developed for inclusion in the Trust's Corporate Risk Register and Board Assurance Framework. As the risk progresses through the internal governance route, culminating in final approval at Trust Board in January 2025, there is an alignment of the outstanding MAI recommendations with a clearly defined business-as-usual framework, which will support the governance of capability gaps whilst awaiting financial decisions from commissioners and the implementation of necessary changes.
2. Further correspondence to Welsh Government to seek assurance of testing plans following recent mass casualty exercise where Health Boards declined to incorporate vehicle release plans	Assistant Director of Operations	November 2024	Correspondence with Welsh Government remains ongoing. 22/02/2024 - Risk 594 has also been referenced in the context of MAI presentation to Welsh Government (6th Feb 2024). Further follow up will be provided as MAI progresses. Welsh Government has been and will continue to be kept up to date on the developing case, as have the JCC.
3. Request from COO network to share Action cards related to risk	Executive Director of Operations	Q1	May24 – LB will follow up with COO network on the sharing of their action cards to WAST. March 24 – This risk was discussed at both JCC management and in the COO meeting.

Risk ID 623	Failure to comply with Data Protection Legislation	Date of Review:	21/01/2025	TREND	15 (3x5)
		Date of Next Review:	21/02/2025		

IF	THEN	RESULTING IN
the Trust fails to comply with and demonstrate it is meeting the accountability requirements under the Data Protection Act, the UK General Data Protection Regulation (GDPR) and the Common Law Duty of Confidentiality	the Trust will breach its legal obligations and potentially cause the personal or sensitive data to be compromised, lost, or inappropriately used.	unauthorised data breaches/loss, financial or compensatory penalties, an increased regulatory scrutiny or enforcement as well as stakeholder mistrust and reputational damage

	Likelihood	Consequence	Score
Inherent	4	5	20
Current	3	5	15
Target	2	5	10

IMTP Deliverable Numbers: 1, 13, 14, 18, 19

EXECUTIVE OWNER	Director of Digital Services	ASSURANCE COMMITTEE	Finance & Performance Committee

Risk Commentary

The consequences of this risk depend on the worst-case scenario which crosses of a number Domains on the Risk Scoring Matrix e.g. Loss of, or access to mass clinical data, the reputational damage this would cause, subsequent high-level involvement of ICO, Regulatory Body and Government involvement the subsequent fall out, fines and reduction in the level of clinical care. The likelihood would be small NB Just like pandemics. However, there are lower consequences of failure of statutory compliance which would warrant a higher level of likelihood even daily but in this case like near misses they indicate the need for change/improvement to demonstrate managing the risks. Therefore, the consequences will always be 5 but improvements are needed to lower the risk, and should we demonstrate meeting Statutory Requirements even if a serious incident/event/failure arises evidence provided would reduce / mitigate against the consequences.

IIn addition, the Confidentiality Advisory Group (CAG), an independent body advising the Health Research Authority, **recently required** organisations across NHS Wales to demonstrate compliance with legislation via the IG Toolkit **, or risk** requests for using sensitive patient information for research purposes **being rejected–** further resulting in risk to WAST's academic partnerships and reputation, and strategic research endeavours.

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. Data Protection Expertise: **2 x** FTE Data Protection and Compliance Managers (DPCM); 1 FTE Information Governance Officer, **4 x** FTE **in the** Cyber Security **team**	1. Two Data Protection and Compliance Managers were employed on a consultancy basis to provide cover and support backlog clearance (E). Both contractors have now left the organisation (funding ceased for the first in Jun-24, and the contract ended Sep-24 for the second). Two new permanent Data Protection and Compliance Managers have been recruited and are due to start employment with WAST in November 2024, bringing capacity of this skillset up to 3 x FTE.
2. **Permanent** Data Protection Officer	2. Temporary Data Protection Officer **responsibilities held by Head of ICT up to December 2024.** A full-time, permanent DPO has been recruited and the position has been filled since December 2024.
3. Data Protection and Information Governance Policies and Procedures (Incl. DPIAs and Cloud Assessments)	3. **Procedure for auditing Welsh Clinical Portal usage (by WAST staff) updated (Jun24).** Monthly Information Governance Steering Group which includes progress DPC, DSA and DPIA reviews (I) IG Training IG Toolkit (System for providing a level of assurance of compliance (I) Incident Reporting Accountability to ELT Development of reporting (dashboard) which supports IGSG, ELT and Finance & Performance Board Committee for scrutiny.
4. Contracts and agreements: Data processing, Data Sharing and Employment & Consultancy	
5. Register of information assets and data flows (outdated)	
6. Staff training on updated training module (Apr 2023)	
7. Incident Reporting and management (DATIX)	**7. Summary statistics reported monthly via IGSG**
8. NIIAS **(national intelligent integrated audit solution)** for auditing access to personal information **across systems such as CAD and ePCR**	
9. Digital Notices / comms Ongoing (see Siren & recent Lock-screen notices)	**Regular publication of IG related comms:** Lock screen **image** issued 04/24 in relation to WhatsApp and training. This will be refreshed in 06/24. Siren notice drafted for ELT 05/24. **AI Guidance issued 01/25. Cyber & IG procurement guidance drafted for release.**

Risk ID 623	Failure to comply with Data Protection Legislation	Date of Review:	21/01/2025	TREND	15 (3x5)
		Date of Next Review:	21/02/2025	➡	

IF	THEN	RESULTING IN
IF the Trust fails to comply with and demonstrate it is meeting the accountability requirements under the Data Protection Act, the UK General Data Protection Regulation (GDPR) and the Common Law Duty of Confidentiality	THEN the Trust will breach its legal obligations and potentially cause the personal or sensitive data to be compromised, lost, or inappropriately used.	RESULTING IN unauthorised data breaches/loss, financial or compensatory penalties, an increased regulatory scrutiny or enforcement as well as stakeholder mistrust and reputational damage

	Likelihood	Consequence	Score
Inherent	4	5	20
Current	3	5	15
Target	2	5	10

10. Proactive engagement outbound (not inbound to team)

GAPS IN CONTROLS	GAPS IN ASSURANCE
1. **- The third DPCM position has recently become vacant, and recruitment efforts will need to recommence in Spring 2025, however, with 2 x DPCMs in post, this is no longer considered a significant gap in control.**	1. See 21. Further Actions (1)
3. Resource capacity constraints to update, implement or monitor the controls; and lack of engagement by management and staff which either bypass the requirements or stalled engagement.	2. Even with increased capacity without engagement by managers and staff to meet their compliance requirements there will continue to be information reported to IGSG which will demonstrate low levels of assurance i.e. Reports on DPIA log, DSA log, Training Levels, IG Toolkit, and Implementation Plan
4. Personal identifiable information (PII) is being processed or shared with no data processing contracts (DPC) or data sharing agreements (DSA) when legally required; or incomplete DPC or DSA due to stalled engagement.	3. Lack of Data Protection pre procurement controls which form part of Data Protection by Design and Default means that Departments could purchase IT systems, hire document scanning companies, external data consultants and analytical firms and bypass WAST's controls for appropriate due diligence or legislative required controls in managing these risks.
5. New data, or new data processes which have either bypassed the controls or there are no information asset owner and therefore doesn't get on to the asset register or the dataflow is not mapped and creates a weakness in assurance (See 3)	4. Data Protection and Compliance Risks not fully realised. IGSG have approved the establishment of a sub-group to manage activities related to Information Asset Register and Ownership, however, due to vacancies and limited capacity in the IG team, this action will not be able to be progressed until January-25.
6. Currently not meeting levels of IG staff training.	1. Some data errors in ESR reporting for IG mandatory training has been identified, requiring manual effort to calculate Trust- wide compliance percentages.
7. Lack of Data Protection pre procurement controls which form part of Data Protection by Design and Default means that Departments could purchase **non-compliant** IT systems.	
8. The Confidentiality Advisory Group (CAG) notified WAST (via DHCW) in June 24 that for organisations with a 23-24 IG Toolkit outcome of "standards not met", any CAG approvals for research & non-research requests are likely to be rejected unless the organisations' IG Toolkit Improvement Action Plan can be met and evidenced by Nov 24 (instead of the original target date for this plan of Mar 25)..	8. The Confidentiality Advisory Group (CAG) required WAST to submit an IG Toolkit Improvement Action Plan (via DHCW) with adjusted timelines to show a path to a "minimum standards met" position by Nov 24. The Improvement Action Plan has been adjusted and shared, and internal stakeholders notified. This will be managed by ADLT and monitored via IGSG**. The Improvement Plan Actions were met by the Nov 24 deadline, satisfying the requirements of the CAG. This is no longer a gap in Controls / Assurance.**

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Recruitment of Data Protection and Compliance Manager(s)	Leanne Smith	Q2 2024/25	Two candidates expected in post November 2024. **Action complete – 2 new DPCMs in post since November 2024. Now included in Controls.**
2. Seeking funding to recruit/upskill/resource DPO who will encourage engagement**.** Additional funding into Digital for 24/25 allowed a permanent DPO position to be created within the structure.	Jonny Sammut	Q3 2024/25	JD evaluated and translated. Awaiting approval by Recruitment Control Panel to commence recruitment. Expected Recruitment and in post Q4 24/25. **Action complete – permanent DPO in position since December 2024. Now included in Controls.**
3. Ensure compliance with the appropriate IG level training across all Directorate and Departments a. Demonstrate a regular series of comms on IG and DP **- complete** b. Regular monitoring of training compliance through IGSG **– evidence of ongoing** c. Targeted training compliance reporting to line manager on individuals to ensure that 85% target is reached **by March 2025.** d. BAU on Siren training notices and specific guidance or advice	Leanne Smith	Q4 2024/25	Lock screen issued 04/24 in relation to WhatsApp and training. This will be refreshed in 06/24. Siren notice drafted for ELT 05/24. **AI guidance issued 01/25. Cyber & IG procurement guidance in development. Evidence that regular comms is being published, and so action complete, and assurances added to Controls.** IG training compliance still below 85% target **required to be evidenced by March 2025.** An Action Plan for training has been

Risk ID 623	Failure to comply with Data Protection Legislation		Date of Review:	21/01/2025	TREND	15 (3x5)
			Date of Next Review:	21/02/2025		

IF the Trust fails to comply with and demonstrate it is meeting the accountability requirements under the Data Protection Act, the UK General Data Protection Regulation (GDPR) and the Common Law Duty of Confidentiality	THEN the Trust will breach its legal obligations and potentially cause the personal or sensitive data to be compromised, lost, or inappropriately used.	RESULTING IN unauthorised data breaches/loss, financial or compensatory penalties, an increased regulatory scrutiny or enforcement as well as stakeholder mistrust and reputational damage		Likelihood	Consequence	Score
			Inherent	4	5	20
			Current	3	5	15
			Target	2	5	10

			created, and a training needs analysis being progressed with L&D team. Procedures, such as audit of Welsh Clinical Portal usage, has been updated. Paper to ADLT Jun24 seeking support for increased awareness & training compliance Direct contact to individuals who have been non-compliant for a significant period of time, with escalation through their line management structures as required.
4. Report on physical security to IGSG – working with fleet and estates team	Leanne Smith and Aled Williams	Q2 2024/25	Reporting to IGSG and FPC. **A risk has been drafted by members of IGSG, but action plan to be developed in collaboration with Fleet & Estates.**
5. Assurance of "standards met" for all IG Toolkit requirements: gain support of all Directorates' leadership to complete the IG Toolkit Improvement Action Plan and ensure compliance for the 24-25 IG Toolkit submission	Leanne Smith	Nov24 for IG Toolkit Improvement Action Plan (with evidence to CAG) **- complete** **Next deadline is March for 24/25 submission**	Paper to ADLT Jun24 seeking support for completion of the IG Toolkit improvement action plan. To ensure no impact to CAG approvals for WAST research, this improvement action plan must now be met and evidenced by Nov24. **The improvement plan actions resulting from the "standards not met" results of the 23/24 IG Toolkit submission were met ahead of the Nov24 deadline to assure CAG, however, to meet the requirements of the 24/25 IG Toolkit submission, further improvement work is required before the Mar25 deadline.**

Risk ID 100	Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience	Date of Review:	21/01/2025	TREND	12 (3x4)
		Date of Next Review:	21/04/2025		

IF WAST fails to persuade JCC/Health Boards about WAST ambitions	**THEN** there is a risk of a delay or failure to receive funding and support	**RESULTING IN** a catastrophic impact on services to patients & staff and key outcomes in the IMTP not being delivered

	Likelihood	Consequence	Score
Inherent	4	4	16
Current	3	4	12
Target	2	4	8

IMTP Deliverable Numbers: 7, 9, 11, 12, 14, 15, 20, 24, 25, 32

EXECUTIVE OWNER	Executive Director of Strategy, Planning & Performance	**ASSURANCE COMMITTEE**	Finance and Performance Committee

Risk Commentary

From the 01 April 2024 111, emergency ambulance and Ambulance Care are all commissioned by the Joint Commissioning Committee (JCC). This is viewed as a positive development by the Trust, supporting the development of an organisational ambition.

The ambition is appropriate levels of patient safety and good working conditions for our staff across the 111 pathway, emergency ambulance care pathway and Ambulance Care pathway. Clearly neither of these are currently being achieved in the emergency ambulance care pathway as evidenced by the long waits, shift overruns and volume of concerns and reportable incidents. The Trust is currently commissioned on the assumption of 6,000 hours of handover lost hours, with current levels at 26,000 (Jan-24). The JCC had an ambition to achieve 12,000 handover lost hours by the beginning of quarter four 2023/24, which has not been achieved, but even if it was achieved, it would still be double what the EMS rosters are predicated on. The Trust is now looking to recruit up to the modelled 153 CHARU FTEs and connected to this focus on CHARU productivity. CHARU UHP in **December** 2024 was 8**9**%, which is the highest it has achieved, and it is now seeking to close the remaining gap through the recruitment of fully qualified paramedics. Similarly, the Trust has made the decision (delivered) to recruit another intake of APPs, an additional 16 FTEs, but this is also being funded through internal movements, with a planned temporary relief gap to fund these. A further funded 32 APPs are being recruited in 2024/25 along with 2**8** FTEs to **EMSC (clinical navigators)**. The 111-call abandonment rate **has stabilised post 111 CAS go live, as the Trust has recovered it call handler staff in post to establishment**. Ambulance Care performance is stable.

The JCC **is now becoming more established. Current areas of focus for the JCC (in relation to WAST) include: a scrutiny exercise on the Trust's MAI submission, consideration of the Future Vision for NEPTS and the Ambulance Measure Review led by Welsh Government. The Trust has received the JCC draft commissioning intentions 25/26 for 111, 999 and NEPTS. These are broadly supportive of the Trust's ambitions, but the financial pressures within NHS Wales that there is unlikely to be any investment by the JCC in 25/26 in support of the Trust's ambitions.**

CONTROLS	**ASSURANCES**
	Internal & External Management (1st Line of Assurance)
1. JCC/WAST Forward Plan for EMS and NEPTS in place and monitored at JCC meetings	1. Minutes of meetings and a standard agenda item
2. JCC and its 2 sub-committees established as a forum to discuss WAST's strategy (sub-committees currently under review as part of move into JCC).	2. Minutes of meetings and a standard agenda item
3. Weekly catch up between Interim Director of 111 & Ambulance Commissioning /CEO	3. Meetings are diarised every week
4. Collaboration between JCC and WAST on specific projects e.g.	4. Representatives are co-opted onto meetings and frequency is between 3–6 weeks. Set agendas with NCCU reps co-opted.
5. Monthly CASC Quality and Delivery Meeting established (currently paused as part of move into JCC).	5. Formal meeting with agendas, minutes, and action logs available.
6. Patient Safety information e.g. Appendix B incidents, weekly/monthly patient safety reports produced	6. These reports supplied to Director of Quality and Nursing in Health Boards and other senior stakeholder's fortnightly
7. Commissioning intentions.	7. In year progress reported each quarter to the relevant commissioning meeting and 24/25 commissioning intentions approved for 111 Wales and expected to be approved by Mar-24 JCC (approved).
8. Governance arrangements for 111 commissioning: 111 Board, 111 Commissioning Board + 111 DAG etc.	8. Minutes of meetings and a standard agenda item
	External Management (1st Line of Assurance) 1. Plans go to every bi-monthly meeting 2. Meet bi-monthly and agendas, minutes and action logs available
GAPS IN CONTROLS	**GAPS IN ASSURANCE**

Risk ID 100	Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience	Date of Review:	21/01/2025	TREND	12 (3x4)
		Date of Next Review:	21/04/2025		

IF WAST fails to persuade JCC/Health Boards about WAST ambitions	**THEN** there is a risk of a delay or failure to receive funding and support	**RESULTING IN** a catastrophic impact on services to patients & staff and key outcomes in the IMTP not being delivered

	Likelihood	Consequence	Score
Inherent	4	4	16
Current	3	4	12
Target	2	4	8

1. JCC remit is wider than just ambulances and will reduce the agenda time dedicated to WAST's three patient pathways.	1. A shorter provider brief will go to the JCC with more detailed discussions taking place at its sub-committees.
2. Governance coordination between the JCC) and WAST to be improved.	2. Identified need for a governance meeting between JCC and WAST to manage the overall commissioner/provider interface. Actioned, but has lapsed due to capacity and resourcing in NCCU team. This will be further reviewed as the JCC goes live in April-24 (period of transition likely to extend through Q1). This has lapsed at this time, but request to re-establish it sent to commissioners.
3. WAST's ability to influence hospital handover delays (this is outside of the Trust's control and a Health Board responsibility)	3. Ministerial direction on handover reduction with significant pressure being applied to health boards through the NHS Leadership Board and NHS Executive accountability arrangements. The Welsh Government target is no waits > one hour, which equates to 7,000 lost hours.
4. Funding does not flow in a manner to balance demand with capacity (outside of WAST's control)	4. Strategic demand and capacity review being undertaken with output due to be reported to JCC in Q2 2024/25, with initial findings already shared. On advice from the CASC, formally reporting the findings of the review has been re-programmed into Q2 2024/25, for the new JCC. JCC dates to be determined.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Agree and influence JCC/Health Boards that sufficient funding to be provided to WAST	CEO WAST	**As part of 25/26 budget setting process in Q4 this year (18/03/25 F&P Committee)**	26.06.24 Funding for a 32 FTE APPs secured for 2024/25 and 23.2 FTEs into Integrated Care. 06/08/24 WAST briefing on evolved CRM and 2023 EMS Demand & Capacity Review to JCC Board Development session in Aug-24. **21/01/25 ELT has considered the draft commissioning intentions and responded to the Director of Commissioning.**
2. Agree and influence JCC/Health Board of the need for significant reduction in hospital handover hours	CEO WAST	**IQPD 12/02/25**	26/04/24 This modelling has been further supplemented by modelling the Ministerial target of no handovers of more than one hour. 26/06/24 May-24 levels at 24,000, which is higher than 2023 and concerning as an indicator of the winter the Trust may expect. Trust moving at pace to evolve clinical response model, with Welsh Government full sighted on impact of handover hours on the Trust. **21/01/25 The Trust experienced 26,000 ambulance unit hours lost to hospital handover in December 2025, in line with its prediction, but significantly above the WG target of no waits over one hour, which equates to approximately 7,500 hours.**
3. Increased understanding of NEPTS by JCC	Executive Director of Strategy Planning and Performance	02/08/23 30/06/24 20/08/24 **21/02/25**	16/04/24 Workshop arranged for April 2024 (completed). 26/06/24 Workshop results reported to newly established Interim Ambulance Commissioning Committee. 06/08/24 The WAST briefing to the JCC Board Development session in Aug-24 includes coverage of five workstreams, one of which is Health Transport, which includes NEPTS and UCS. **21/01/25 Consideration of Future Vision for NEPTS at JCC meeting on 21/02/25**.
4. Governance meeting between NCCU and WAST to manage the commissioner provider interface	Assistant Director Commissioning & Performance	02/08/23 Checkpoint Date	30.09.22 Meeting in place and meeting regularly. 12/01/23 Meetings continue. 02.05.23 These have lapsed due to pressures and sickness absence in the NCCU. HB to reboot, subject to ability of NCCU to undertake. 28.07.23 Availability remains a challenge, but there is regular informal dialogue between WAST and NCCU. 18.01.24 This specific meeting remains lapsed, but the Trust is currently meeting every two weeks with the NCCU on the development of the IMTP. As the Trust moves into the new JCC from 01 April 2024 there will be a further opportunity to address this control. 16/04/24 The new commissioning arrangements are in transition and still quite fluid at the moment. 26/06/24 Request to commissioners to re-establish this meeting. 06/08/24 Meeting now re-established. **21/01/25 Meeting continues to operate.**
5. Develop and roll out the Stakeholder Influencing Plan	Director of Partnerships & Engagement AD Planning & Transformation	Q2 24/25 onwards	15/03/24 This action is captured in Risk 201 on the CRR. The reputation audit being repeated in Q1 will inform the development and roll out of this plan in Q2.

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation	Date of Review:	07/01/2025	TREND	8 (2x4)
		Date of Next Review:	07/04/2025	➡	

IF the Trust does:	THEN there is a risk that	RESULTING IN
• not achieve financial breakeven and/or • does not meet the planning framework requirements and/or • does not work within the EFL and/or • fails to meet the 95% PSPP target and/or • does not receive an agreement with commissioners on funding (linked to 458)	the Trust will fail to achieve all its statutory financial obligations, and the requirements as set out within the Standing Financial Instructions (SFIs)	potential interventions by the regulators, qualified accounts, and impact on delivery of services and reputational damage

	Likelihood	Consequence	Score
Inherent	3	4	12
Current	2	4	8
Target	2	4	8

IMTP Deliverable Numbers: 9, 12, 15, 18, 24, 25, 30, 31, 32

EXECUTIVE OWNER	Executive Director of Finance and Corporate Resources	ASSURANCE COMMITTEE	Finance and Performance Committee

Risk Commentary: Q3 2024/25 The risk has now been further reviewed in conjunction with the level of financial risk detailed in the Trust's financial monitoring returns submitted to WG year to date to Month 9 of the 2024/25 Financial Year. The score is consistent with that of **Qtr. 2 2024/25** due to a presented opening balanced financial plan for 2024/25 and the Month 9 2024/25 financial performance and positive savings delivery. It must be noted though that clear monitoring of a potential financial risk around workforce re-banding of EMT staff **has been mitigated for 2024/25 financial year** the ability to fund / receive income may impact on the delivery of the financial plan for 2025/26. The current challenging financial climate for all public sector organisations may also impact on WAST financial performance especially as the financial year progresses.

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. Financial governance and reporting structures in place	1. Risk is reviewed quarterly at FPC, and a report is submitted bi-monthly to Trust Board
2. Financial policies and procedures in place	
3. Budget management meetings	3. Diarised dates for budget management meetings
4. Regular financial reporting to ADLT, EFG, ELT, FPC and Trust Board in place	4. Diarised dates for EFG and FPC and monthly reports
5. Welsh government reporting	
6. Monthly review of savings targets	6. ADLT monthly review
7. Regular review monitoring and challenge via WAST and CASC quality and delivery meeting with commissioners.	
8. Monthly ICMB (Internal Capital Monitoring Board) meetings to monitor and review progress against capital programme and engagement with WG and capital leads.	8. Diarised dates for ICMB meetings with regular monthly report
9. PSPP monthly reporting and regular engagement with P2P colleagues and periodic Trust Wide communications	9. Regular PSPP communications (Trust wide) on Siren
10. Forecasting of revenue and capital budgets	a) Monthly monitoring returns to ADLT, EFG, ELT and FPC (b) Reliance on available intelligence to inform future forecasting.
11. Business cases and benefits realisation (both revenue and capital)	11. Business cases – scrutiny and approval at senior management team which are submitted to ADLT, ELT, FPC prior to Trust Board for approval as appropriate according to value.
	External Assurances Management (1st Line of Assurance)
	5. Monthly Monitoring Returns to Welsh Government
	7. JCC management meetings. Monthly meetings with DAG for NEPTS.
	8. Bi-monthly Capital CRL meetings with Trust and WG capital leads
	9. Regular P2P meetings diarised (bi-monthly)
	10. Monthly monitoring returns into Welsh Government
	Independent Assurances (3rd Line of Assurance)
	1-10 Internal audit reviews covering
	1-10 External audit reviews
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Lack of formalised service contracts between Commissioner and WAST as a commissioned body	1. None identified.

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation	Date of Review:	07/01/2025	TREND	8 (2x4)
		Date of Next Review:	07/04/2025	➡	

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• not achieve financial breakeven and/or • does not meet the planning framework requirements and/or • does not work within the EFL and/or • fails to meet the 95% PSPP target and/or • does not receive an agreement with commissioners on funding (linked to 458)	the Trust will fail to achieve all its statutory financial obligations, and the requirements as set out within the Standing Financial Instructions (SFIs)	potential interventions by the regulators, qualified accounts, and impact on delivery of services and reputational damage

	Likelihood	Consequence	Score
Inherent	3	4	12
Current	2	4	8
Target	2	4	8

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Continuing negotiations with Commissioners	Director of Finance and Corporate Resources/ Director of Strategy Planning and Performance	31/03/24 31/03/25	In line with the recent WAST financial position and monthly monitoring letter sent to WG, WAST can resource the cost of the EMS staff itself. In addition, discussions continue with commissioners to ensure WAST continue to obtain funds in relation to 111 on a spend and recover basis.
2. Embed a transformative savings plan and ensure organisational buy in	ADLT and Savings subgroup	31/03/24 31/03/25	The Financial Sustainability Program (FSP) continues to be a key vehicle for the Trust to fully identify its savings program. Over delivery was achieved for the 23/24 financial year and the point of strong delivery is further highlighted with the programs ability to fully identify the 24/25 £6.4m savings plan before the start of the financial year.
3. Embed value-based healthcare working through the organisation	Executive Leadership Team and Value Based Healthcare Group	31/03/24 31/03/25	Work to identify the PROMS & PREMS evaluation criteria for Emergency based services via the Value-Based Healthcare working group continues.
4. Foundational economy, Decommissioning, and procurement to mitigate social and economic wellbeing of Wales	Estates, Capital and Fleet Groups, NHS Wales Shared Services Partnership	31/03/24 31/03/25	The organisation utilises the NWSSP Shared Services Procurement framework to ensure contracts tendered provide best value for money while ensuring criteria within the tender docs ask bidders to highlight their ability to serve the aims of FE, Decommissioning, Decarbonisation and social as well as the economic wellbeing of Wales. Ad hoc reports are received from Shared Services on WAST's progress in switching more expenditure to Welsh suppliers to keep the Welsh pound in Wales.

Key - List of Strategic and IMTP objectives

Strategic Objective 1: Providing the right care or advice, in the right place, every time		***BAF risks***
1.	A modern, easily accessible, user-friendly and integrated digital offer	223, 224, 623, 260, 201,163, 424
2.	Rapid (111) call answering, initial triage and onward referral	223, 424
3.	Timely, high quality clinical assessment, advice and referral	223, 224, 424
4.	Seamless transfer of 111 callers to wide range of available pathways	223, 424
5.	Immediate 999 call answering, and efficient and effective dispatch of the right resource	223, 424
6.	High quality, timely, clinical triage, assessment and consultation, with personalised response	223, 424
7.	High quality, immediate or timely on scene assessment, care and conveyance where needed	223, 100, 424
8.	A range of 24/7 pathways available for further assessment or treatment, closer to home	223, 224, 424
9.	A flexible, user-centred Non-Emergency Patient Transport Service with the right capacity in place to meet demand	100,139, 424
10.	A dedicated and timely transfer & discharge service supporting HBs with their transformation agendas	223, 424
11.	A clear vision for Ambulance care services that supports wider health and care transformation	100, 201, 424
12.	A high quality, safe (NEPTS) service with improved patient experience	100, 139, 424
Strategic Objective 2: Enabling our people to be the best they can be		
13.	Culture: • Enhance and strengthen internal capacity for delivering culture change • Develop amplify employee voice to increase employee engagement • Continue the implementation of our compassionate practices approach	160, 558, 623, 201, 163, 424
14.	Capacity: • Implement our Strategic Workforce Plan • Continue to embed a culture of positive attendance management • Continue our focus on 'getting the basics right.'	100, 160, 163, 223, 224, 424, 558, 594, 623
15.	Capability: • Grow and develop our leadership and management capability • Reinforce and promote career pathways and professional development. • Create an environment centred around effective, ongoing conversations ('Check Ins')	100, 139, 160, 223, 224, 260, 594, 424
16.	Strengthen Welsh Language compliance through strong leadership, enabling Welsh language to flourish	201, 424
Strategic Objective 3: Being at the forefront of innovation and technology		
17.	The right buildings in the right place, enabling our staff to provide the best and safest care across Wales	542, 424
18.	The right fleet in the right place, enabling our staff to provide the best and safest care across Wales	139, 542, 623, 424
19.	Develop & agree Digital Plan • Everyday essentials • Security, Safety & Cyber • Digital Pioneers • Transformation • Data, Information & Insight	163, 260, 623, 424
Strategic Objective 4: Developing services in collaboration		
20.	Well-placed to influence system thinking / strategy development	100, 223, 424
21.	Meet the requirements of the Wellbeing of Future Generations Act	558, 424
22.	University Trust Status in collaboration with WG, embracing a 'democratised culture' of learning, research and innovation	160, 163, 223, 224, 424
Strategic Objective 5: Being quality driven and clinically led		
23.	Systems that meet the requirements of the Duty of Quality and Duty of Candour	224, 424
24.	Excellent clinical leadership	100, 139,160, 223, 224, 260, 594, 424
25.	A culture of quality improvement with robust quality management systems	100, 139, 160, 201, 223, 224, 424
26.	High quality Putting Things Right, Safeguarding and Health & Safety systems	160, 224, 558, 424
27.	Meaningful engagement and co-production with communities	223, 224, 424
28.	A risk management framework as a key enabler of our long-term strategy and decision making	No corporate/principal risks
29.	An integrated governance framework	No corporate/principal risks
Strategic Objective 6: Delivering exceptional value		
30.	Sustainable savings & efficiencies	139, 163, 224, 424
31.	Generate income alongside our core commissioned functions	139, 224, 424,
32.	A Value-Based approach across the organisation which is embedded in culture	100, 139, 163, 424
33.	Developing and implementing our plans for Environmental Sustainability and Adaptation	542, 424

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

AGENDA ITEM No	**15**
OPEN or CLOSED	**OPEN**
No of ANNEXES	**1**

AUDIT TRACKER – March 2025 (2024/25 Q4)

MEETING	Finance and Performance Committee (FPC)
DATE	20 May 2025
EXECUTIVE	Trish Mills, Director of Corporate Governance/Board Secretary
AUTHOR	Trish Mills, Director of Corporate Governance/Board Secretary Lisa Trounce, Head of Compliance & Assurance
CONTACT	trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. This paper provides the Committee with the 2024/25 Q4 position with respect to management actions for audits within the purview of this committee.

2. The Audit Handbook notes that it is the responsibility of this committee to:

   - Receive audits in their remit;
   - Monitor management actions to address recommendations; and
   - Scrutinise impact of actions in response to audit recommendations in terms of, for example, quality improvement, the provision of more efficient and effective patient care, improved governance, better use of resources etc.

3. The Audit Tracker has been updated in Quarter 4 2024/25. To manage volume of papers, the tracker has been added to the Ibabs reading room filtered to the actions assigned to this committee for oversight. This digital reading room hosts documents for additional information, not essential for scrutiny or decision-making. Access to the reading room is through the documents/shared folder in Ibabs' main menu. Documents in the reading room will not be posted on the Trust's website with committee papers; however, copies can be provided to those without access to Ibabs upon request.

Internal Audit

4. At the beginning of 2024/25 Quarter 4, there were a total of 40 open internal audit recommendations relevant to the Committee: 14 from 2023/24 (2 of which are reported via the committees closed session), and 26 from 2024/25.

5. Of the 40 open audit recommendations, 24 were due for closure in quarter, and 16 not yet due.

6. By end of quarter, 21 of the 24 (96%) audit recommendations due for closure during Quarter 4 were confirmed as completed. Of those, six recommendations met their original deadlines, with the remaining 15 completed after one or more deadline revisions.

7. New revised deadlines have been proposed for five recommendations which remain open: two from 2023/24 (one on their first revision relating to Records Management Internal Audit, and one on their second revision relating to ICT Contract Management Internal Audit); and three from 2024/25 (on their first revision) all related to the Data Quality Internal Audit.

External Audit

8. At the start of 2024/25 Quarter 4, there were four external audit recommendations (all related to the '*Review of Cost Saving Arrangements*' audit) relevant to the Committee that remained open. Of these four recommendations, only one was due for closure during the quarter, but two were confirmed as completed.

9. There remain two outstanding recommendations, both related to the 2023/24 Audit Wales '*Review of Cost Saving Arrangements*' audit. These two actions are due for closure in June 2025 and August 2025.

Monitoring of 2024/25 Data Quality Internal Audit Recommendations

10. In line with a commission note from the previous meeting, the Committee agreed to proactively monitor the actions generated from the 2024/25 Data Quality Internal Audit over the coming year, via the future Audit Tracker report. As such these recommendations have been drawn out within this report:

10.1 Position at the start of 2024/25 Quarter 4

There were six open recommendations related to the 2024/25 Data Quality Internal Audit. Of these six recommendations: one was due to be completed in January 2025, one in March 2025, and three in April 2025 (one on a first revised date).

10.2 New Revised Dates

New revised dates have been applied to a further three recommendations: one now due in July 2025, another in August 2025, and the last in September 2025.

10.3 Action 03-24/25 ~ Assessing and Improving Digital Literacy

This recommendation was originally due for completion in December 2024. A first revised date of April 2025 was applied previously to allow time for the newly appointed Data Quality experts (joining in March 2025) to explore alternative learning products/modules. The Committee is asked to note that funding may be required. **This recommendation remains open.**

10.4 Action 04-24/25 ~ Information Asset Register

It was recommended that an Information Asset Owners Group be established to develop and maintain the Trust's Information Asset Register, and monitor compliance and efficiency. At the time of audit reporting, both Data Protection Compliance Manager posts were vacant, limiting capacity within the information governance (IG) function to progress this action.

Since then an IG roadmap has been developed to prioritise all strategic compliance and risk-based initiatives. As a result, the Information Asset Owner (IAO) Project was elevated in priority from position 11 to position 4. A draft terms of reference was approved at the April 2025 meeting of the Information Governance Steering Group (IGSG), enabling establishment of the IOA Sub-Group. As the register will not be completed by the original date of April 2025, a revised completion date of September 2025 has been agreed. **This recommendation remains open.**

10.5 Action 05-24/25 ~ Automated Data Quality Tool

The recommendation was for management to consider implementing an automated data quality tool to support automated audit processes, reduce manual effort and enhance data accuracy and consistency. Whilst a full implementation is recognised as a significant digital undertaking, initial efforts have focussed on reviewing existing platform functionality which would offer a minimum viable product.

A gap analysis was planned to make a recommendation to the IGSG. The data engineering team has reviewed existing SQL warehouse tooling available; however, work was paused due to competing priorities, including the Clinical Model Transformation Programme and patient safety intelligence work streams. A revised target completion date of August 2025 has been set to accommodate the team's focus on the Welsh Government requirement for changes to emergency performance reporting, which goes live in July 2025. **This recommendation remains open.**

10.6 Action 08-24/25 ~ Recording and Reporting of Data Quality Incidents

The recommendation was for assurance to be provided regarding the handling and reporting of significant data quality incidents. Following the appointment to two Data Quality experts, representation at the IGSG has

resumed. Large-scale or system level data quality issues are now reported to the group routinely for awareness and support.

Since November 2024, data quality has featured in the IG Highlight Report. This recommendation was completed ahead of the original due date of April 2025 and closed in quarter. **Recommendation closed in quarter.**

10.7 Action 09-24/25 ~ Development and Reporting of Data Quality KPIs

It was recommended that data quality KPIs be developed and reported. A monthly KPI report, which includes a placeholder for data quality metrics, is submitted routinely to the IGSG. Progress on this action was delayed due to extended recruitment timelines for the two Data Quality posts. Both new appointees joined the organisation in March 2025, and a revised date of July 2025 has been set to allow sufficient time for development of appropriate metrics. **This recommendation remains open.**

10.8 Action 10-24/25 ~ Development of a Standard Reporting Template

The recommendation was for a standardised reporting template for data quality matters. With recent investment in the Digital Directorate and the appointment of two new Data Quality experts, work is now progressing toward building a more resilient Data Quality Team. Development of the reporting template has been assigned to the new Data Quality Assurance Manager and is expected to be completed by the first revised date of May 2025. **This recommendation remains open.**

11. The current version of the tracker is now open for Directorate review for actions due in April, May and June 2025. These updates will then be reported to the Committee at its meeting in August 2025.

RECOMMENDATION

12. The Committee is requested to:

(a) Receive assurance on the monitoring of management actions to address recommendations in the Tracker, noting any revised dates for actions.

(b) Note the progress reported against the remaining 2024/25 Data Quality Internal Audit recommendations.

KEY ISSUES/IMPLICATIONS
As set out above.

REPORT APPROVAL ROUTE

2024/25 Q4 Audit Tracker updates presented to the Assistant Directors Leadership Team on the 14 April 2025.

REPORT APPENDICIES
Annex 1 – Tracker 2.0 24-25 Q4 (January-March 2025) - Copy for FPC 200525 (Open) ~ in reading room

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

POLICIES RECOMMENDED FOR COMMITTEE APPROVAL AND ADOPTION

Committee	Finance and Performance Committee	**Date of Meeting**	20th May 2025
Presenting Officer	Trish Mills, Director of Corporate Governance / Board Secretary		

Policy Name	Directorate	EqIA Completed	Date of Policy Group	Date of ADLT*	Points of Note
Information Risk Policy	Digital Services	Completed No Issues	31/01/2025	03/02/2025	FOR APPROVAL

** Effective from mid-December 2024, the Trust's Policy Group transitioned to a sub-group of the Assistant Directors Leadership Group (ADLT), replacing its previous position under the Executive Leadership Team (ELT).*

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

Information Risk Policy

Policy Number:	088	**Version No:**	1.5 Draft	**Supersedes:**	1.0 Published 23/02/2021
Date of Approval:	TBA	**Review Date:**	3 years from date of approval	**Impact Assessments Completed:**	EqIA 06/01/2025
Classification of Document:	Corporate	**Type of Document:**	Policy	**Approved by:**	Finance & Performance Committee
Brief Summary of Document:	The purpose of this policy is to prevent unauthorised access to the Trust's information systems. The policy describes the rules and principles for information risk management for Trust information systems and data holdings.				
Scope:	This Policy applies to all staff that are directly employed by WAST and encompasses Non-Executive Directors, bank staff, volunteers, contractors, and all those that it has legal responsibility for such as students and trainees.				
To be read in conjunction with:	Data Protection Policy Access Control Policy Information Governance Policy Information Security Policy Records Management Policy Confidentiality Code of Conduct Risk Management Policy				
Owning Committee	Finance & Performance Committee				
Policy Lead: **Trade Union Lead:**	Kelly Holding Hugh Parry	**Job Title:**	Data Protection Officer Trade Union Partner		
Executive Director:	Jonathan Sammut	**Job Title:**	Director of Digital Services		

Version Control Sheet

Version	Date	Author	Summary of Changes
0.1	December 2018	Clare Elcock	Creation of document – awaiting timeline for approvals
0.2	September 2019	Craig Garner	Updated to reflect new requirements
0.3	October 2019	Craig Garner	Amended following comments from Task and Finish Group
0.4	October 2019	Julie Boalch	Minor formatting changes
0.5	July 2020	Craig Garner	Review and changes made following Covid-19 and significant period of non-activity due to other priorities
0.6	July 2020	Craig Garner	Changes made following Virtual Task and Finish Group
1.0	September 2020	Craig Garner	Approved via Policy Group following minor amendments
1.0	23/02/2021	Julie Boalch	Approved policy published
1.1	12/12/2024	Kelly Holding	Review and minor amendments: • Front cover updated • Key words added • Impact Assessments Updated • TFG Membership updated • 1 Introduction updated • 2.2 amended to FOI Guidance • 2.7 DPIA Checklist reworded • 6.1.3 Updated to include Cloud Security Assessments and Cyber Assurance Framework (CAF) Assessments • 6.1.5 Paragraph re: Information security incident and Personal Data Breach added • 6.3.2 Third Party Contractual Arrangements strengthened

Version	Date	Author	Summary of Changes
			• Training moved from 7 to 8.8 • 9 Roles and Responsibilities updated • 10 References updated
1.2	16/12/2024	Lisa Trounce	Review and formatting prior to Policy Group meeting on 18/12/2024
1.3	22/01/2025	Lisa Trounce	Review and formatting prior to Policy Group meeting on 31/01/2025
1.4	01/02/2025	Lisa Trounce	Tracked changes accepted, front cover updated, and approval route updated in readiness for onwards travel to ADLT to recommend approval by Committee.
1.5	03/02/2025	Lisa Trounce	Following ADLT approval, policy prepared for onwards travel to Committee for approval

Keywords	Information, Governance, Risk, Assets

Impact Assessment Reviews

Area	Date of Review	Name of Reviewer
Data Protection	12/12/2024	Kelly Holding
EqIA / Welsh Language	21/07/2020	Melfyn Hughes, Hugh Parry, and Task and Finish Group

Task and Finish Group Members

Name	Job Title
James Rowland	Senior ICT Security Specialist
Hugh Parry	Trade Union Partner
Kelly Holding	Data Protection Officer

Policy Approval Route

Meeting Title	Meeting Date	Purpose/Outcome
Virtual Task and Finish Group	September 2019	Approval
Policy Group	20/07/2020	Minor Changes - Discussed and Adopted
Policy Group	29/09/2020	Approved for onward travel following second consultation period.
Trade Union Partners Cell	13/10/2020	Recommended for approval
EMT	23/12/2020	Recommended for approval
Quality, Safety & Patient Experience Committee	23/02/2021	Approval and adoption
Policy Group	31/01/2025	Approved - Recommended for onward travel to ADLT and Committee Approval
Assistant Director Leadership Team	03/02/2025	Approved - Recommended for onward travel to Committee for Approval
Finance and Performance Committee	20/05/2025	For Approval and Adoption

Disclaimer
If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Amb_policies@wales.nhs.uk

Contents

1. INTRODUCTION

1.1 The Welsh Ambulance Services University NHS Trust (the Trust) recognises the importance of information, both in terms of healthcare management of individual patients and the efficient management of services and resources. This is because information is a vital asset that underpins the delivery of high-quality healthcare and many other key service deliverables.

1.2 The Trust therefore has a responsibility to ensure that information is managed appropriately and in accordance with legal requirements, NHS Health and Care Standards, the Caldicott Principles, the Welsh Information (IG) Toolkit, and guidance published by the Information Commissioner's Office (ICO).

1.3 Information Governance (IG) is a framework for handling information confidentially, efficiently and securely, to appropriate legal, ethical and quality standards with the objective of delivering the best possible care and service.

1.4 IG currently includes the following legislation and guidance:

- Data Protection Act 2018;
- UK General Data Protection Regulations 2021;
- Freedom of Information Act 2000 (FOI);
- Environmental Information Regulations 2004;
- Records Management Code of Practice for Health and Social Care 2022;
- Computer Misuse Act 1990;
- Common Law Duty of Confidentiality;
- Copyright, Designs and Patents Act 1988;
- Information Security Management ISO 27001.

1.5 The Trust regards all Patient Identifiable Information (PII) and sensitive information as defined in this policy as confidential information.

1.6 The key statutory requirement for NHS compliance with information risk management principles is the UK General Data Protection Regulation (GDPR) and the Data Protection Act 2018 (DPA). These two pieces of legislation provide a broad framework of general standards that have to be met and considered in conjunction with other legal obligations.

1.7 The above legislation regulates the processing of personal data, which can be held both manually and electronically. It applies to personal information generally, not just to health records, and therefore the same principles apply to records of employees held by employers.

2. POLICY STATEMENT

2.1 The Trust has established a policy framework for information governance, supported by a set of information governance policies and procedures to cover all aspects of information governance aligned to relevant legislation and standards.

2.2 The key information governance policies and protocols are:

Data Protection Policy	This policy sets out how the Trust meets its legal obligations in respect of data protection in order to meet its operational needs and fulfil legal requirements.
Informational Governance Policy	This policy outlines the Trust's intentions and approach to fulfilling its statutory and organisation responsibilities around information governance.
Freedom of Information Guidance	This guidance sets out how the Trust complies with the Freedom of Information Act (FOIA) 2000 and creates openness and transparency of information which is in the public interest.
Records Management Policy	This policy sets out how the Trust manages records through the delivery of standards, guidance and procedures in line with the IG framework.
Information Security Policy	This policy sets out how the Trust complies with stringent legal requirements and provides assurance that data held and processed by the Trust is treated with the highest appropriate standards to keep it safe
Confidentiality Code of Conduct	This code of conduct sets out standards to ensure that patient and staff information is handled fairly, lawfully and as transparent as possible.
CCTV Policy	This policy sets out how the Trust operates and uses Closed Circuit Television and its outputs.
Access Control Policy	This policy sets out the rules and requirements from the Trust with regards to access to information and documented responsibilities.

2.3 The table below explains the terminology used in this policy:

Term	***Meaning / Application***
SHALL	This term is used to state a **Mandatory** requirement of this policy
SHOULD	This term is used to state a **Recommended** requirement of this policy
MAY	This term is used to state an **Optional** requirement

2.4 Information risk is inherent in all administrative and business activities and everyone working for or on behalf of the Trust shall continuously manage information risk.

2.5 The Trust acknowledges that information risk management is an essential element of broader information governance and is an integral part of good management practice.

2.6 The intent is to embed information risk management in a very practical way into business processes/controls and not to impose risk management as an extra requirement.

2.7 A Data Protection Impact Assessment (DPIA) Screening Checklist should be completed for any new projects introducing new information assets, or changes to processes involving personal data. Please refer to the DPIA Procedure for further guidance and information.

3. SCOPE

3.1 The Information Risk policy applies to all staff and partners who have access to Trust information systems or anyone undertaking work on behalf of the Trust.

3.2 This policy is applicable to all areas of the Trust where information is created, used, stored and disposed of and adherence shall be included in all contracts for outsourced or shared services.

3.3 This policy covers all types of Information Assets within the Trust. Examples include but are not limited to:

- Patient, client and service user information;
- Staff information;
- Corporate information.

4. AIM

4.1 Information risk management is a fundamental component of effective information governance and forms part of the Trust's overall risk management framework.

4.2 This policy aims to help identify and manage the Trust's exposure to risk in relation to any information it compiles, stores or utilises in order to:

- Protect the Trust, its staff and patients from all information incidents;
- Provide consistent risk management methodology in which risks shall be identified, considered and addressed in key approval, review and control process;
- Provide assistance to and improve the quality of decision making throughout the Trust;
- Encourage proactive rather than reactive risk management;
- Meet legal and statutory requirements;
- Assist in the safeguarding of Trust information assets;
- Seek to minimise the risk of a serious untoward incident arising from the misuse of personal or sensitive data to an acceptable level.

4.3 This policy should also provide all administrators of information systems with guidance on the principles to inform decisions and achieve positive outcomes for service users and the Trust.

5. OBJECTIVES

5.1 Information risk management is the on-going process of identifying information risks and implementing plans to address them.

5.2 Where information risk management is constrained by time and resources, priority shall be given to information assets that comprise or contain personal/sensitive information about patients or staff.

5.3 The objective of information risk management is not to eliminate risk, but rather to provide the structural means to identify, prioritise and manage the risks involved in all the Trust's activities. It requires a balance between the cost of managing and treating information risks with the anticipated benefits that will be derived.

5.4 All organisations whom the Trust commissions services shall demonstrate that they have comparable controls to manage information risks. Independent contractors are responsible for ensuring compliance with relevant legislation and best practice guidelines as well as the development/management of their own procedural documents.

6. POLICY

6.1 Information Risk Management Process

6.1.1 The Trust shall be particularly careful to protect all data whose release or loss could cause:

- Harm or distress to patients or staff;
- Damage to the Trust's reputation;
- Financial loss or exposure to the Trust;
- Major breakdown in information systems, information security or information integrity causing service disruption or business continuity issues;
- Significant incidents in regulatory non-compliance.

The Trust shall identify, risk assess and manage all such data.

6.1.2 The Trust shall maintain an Information Asset Register (IAR). This register will:

- Be maintained by Information Asset Owners, who shall update the Information Governance team of any new, updated or obsolete assets if and when this happens;
- Be managed by the Information Governance team, who shall:
  - Define the IAR format and methodology;
  - Ensure that all IARs are regularly updated by Information Asset Owners (IAOs);
  - Collate all IARs into one corporate register, ensuring that it mirrors the departmental and divisional registers.

6.1.3 Information risk assessments – either Information Asset Risk Assessments (RAs) and/or Data Protection Impact Assessments (DPIAs), Cloud Security Assessments, and Cyber Assurance Framework (CAF) Assessments shall be performed where applicable for all the Trust's information systems and critical information assets. These shall be carried out:-

- To ensure the availability, confidentiality and integrity of information;
- To plan and implement appropriate mitigation action;
- At the inception of new systems, applications, facilities etc., that may impact the assurance of Trust information or information systems;
- Before enhancements, upgrades and conversions associated with critical systems or applications;
- Whenever one is required under legislation/best practice.

6.1.4 The Trust should undertake information flow mapping exercises and from this exercise identify the information risks regarding its data flows, and any new assets not identified, within the Trust and/or with its delivery partners. This exercise shall be:

- Managed by the Data Protection Officer;
- Undertaken using methodologies and templates issued by the Data Protection Officer.

6.1.5 Information incident reporting shall be in line with the Trust's Adverse Incident Investigation and Learning Policy and shall be reported as soon as possible.

6.1.6 An information security incident is any occurrence that threatens the confidentiality, integrity, or availability of information systems and data. This may include personal data breaches where personal data is affected. Examples of information incidents include:

Category	Examples Include
Loss from or on NHS premises	1. Loss of health record from department 2. Loss of computer from stores
Theft from or on NHS premises	1. Theft of laptop from Trust site 2. Theft of personnel files from department
Loss from outside NHS premises	1. Loss of memory stick at home 2. Loss of health records by courier
Theft from outside NHS premises	1. Theft of laptop from car 2. Theft of mobile device from home
Insecure disposal	1. Sale of computer with un-wiped hard drive 2. Disposal of confidential papers in domestic waste bin
Unauthorised disclosure	1. Sharing of login names and passwords 2. Inappropriate access to health record 3. Computer hacking
Other	1. Non-compliance with Subject Access Request 2. Not completing a DPIA when legally required

6.2 Risk Registers

6.2.1 Where a risk to information is identified, but no incident has occurred the Information Asset Owner shall assess the risk using the organisation's Risk Management Policy, risk procedures and e-risk solution. Information risks shall be owned by the directorate that is the primary user of the asset and will fall into at least one of the following categories:

- **Tolerate the risk** – where the risk is already below the Trust's risk appetite and further treatment is not proportionate
- **Treat the risk** – where the risk is above the Trust's risk appetite but treatment is proportionate; or where the treatment is so simple and cost effective that it is proportionate to treat the risk even though it falls below the Trust's risk appetite
- **Transfer the risk** – where the risk cannot be brought below the Trust's risk appetite with proportionate treatment but a cost-effective option is available to transfer the risk to a third party
- **Terminate the risk** – where the risk cannot be brought below the Trust's risk appetite with proportionate effort/resource and no cost-effective transfer is available
- **Take Opportunity** of the risk – use the risk identified to opportunities to benefit from the uncertainty of the risk.

6.2.2 The Information Asset Owner shall review Medium and Low risks and recommend suitable action.

6.2.3 The Information Governance Steering Group (IGSG) / Senior Information Risk Owner (SIRO) in collaboration with the Information Asset Owner shall review high risks escalated for discussion and action and recommend suitable action.

6.2.4 In the event that the decision is to treat, then additional activities or controls shall be implemented via a Risk Treatment Plan.

6.3 Third Party Contractual Obligations

6.3.1 Formal contracts shall be in place with all third parties where data handling is undertaken. The contract shall, in addition to standard confidentiality and security clauses, contain an indemnity clause.

6.3.2 Confidential information must not be disclosed to or processed by a supplier, service provider, vendor, or contractor, unless due diligence has been undertaken on the proposed third party, assessing their security and compliance status; and a fully executed written contract has been implemented, (and contains UK GDPR compliant clauses in relation to personal data processing). Standalone Confidentiality Agreements are available clauses in relation to personal data processing.)

6.3.3 Standalone Confidentiality Agreements are available where external third parties will be exposed to confidential information, for example, ambulance observer ride-outs, media visits, student placements, and patient network member forums.

7. AUDIT AND MONITORING

7.1 Systems shall be audited and monitored in line with this policy and associated protocol

7.2 The Trust shall have in place arrangements that enable for the monitoring of compliance with this policy. This includes through the following measures:

- Completion of the annual IG Toolkit Assessment which includes assessment of Information Risk practices.

- Bi-annual compliance audits and checks performed on information assets and information risk management practices, including on the maintenance of Information Asset Register, and on the completion of DPIAs (Data Protection Impact Assessments) and / or Cyber and Security Assessments for all the Trust's information systems and critical information assets.

- Regular reporting to the Information Governance Steering Group on information risk matters including high risks escalations for discussion and action.

8. IMPACT ASSESSMENTS

8.1 Equality Impact Assessment

The Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on the grounds of any protected characteristic (Equality Act 2010).

In accordance with the Equality Act 2010, all policies will be subject to an EqIA. This enables resources to be targeted effectively and can help to reduce inequalities. The EqIA is process to find out whether a policy will affect people differently on the basis of their 'protected characteristics': age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion, sex or sexual orientation and if it will affect their human rights.

Evidence gathered at the initial stages, by undertaking an initial screening, will determine the relevance of policies and how they affect people as service users, members of the public and as employees of the Trust and indicate whether or not a full EqIA is required.

As such, an Equality Impact Assessment was undertaken on this policy and it was assessed not to be significant from the perspective of the application of the Equality Act 2010, and that no negative impact on the protected characteristics within the legislation were identified. A copy of the EQIA screening and outcome report can be obtained from the Information Governance Team or Corporate Governance Team who received the documentation as part of the policy approval process.

Equality Impact Assessment forms and procedures for completion as part of policy development are available on the Trust's intranet Policy page under *Supporting Documents.* Further information on the development and value of EqIAs can be found on the Trust's Intranet site and via the following link: www.eiapractice.wales.nhs.uk/home.

8.2 Welsh Language Impact Assessment

Under the The Welsh Language (Wales) Measure 2011 the Trust's Welsh Language Scheme has been replaced by Welsh Language Standards. This means that the Trust, when formulating new policies or reviewing or revising existing policies, is required to assess what effect a policy decision would have on opportunities for persons to use the Welsh language and on treating the Welsh language no less favourably than the English language. Further guidance can be obtained from the Welsh Language Officer.

In order to comply with the Welsh Language Standards and the Trust's Compliance Notice, the Trust is required to publish several policies in Welsh; particularly those that relate to:

- behaviour in the workplace;
- health and well-being at work;
- salaries or workplace benefits;
- performance management;
- absence from work;
- working conditions;
- work patterns

8.3 Environmental Standards and Impact Assessment

This policy will put the relevant requirements in place (such as waste management plan, reduction of CO2 emissions and reduction of carbon footprint) in order to ensure that the Welsh Ambulance Services University NHS Trust's ongoing commitment to reduce its impact on the environment is maintained and to become a more sustainable organisation in line with Trust policy and Environmental Governance System.

8.4 Counter Fraud

Anti-Fraud and Corruption Concerns

The Welsh Ambulance Services University NHS Trust is committed to taking all necessary steps to counter fraud, bribery and corruption within the Trust. Staff should report suspected incidents of fraud and corruption to the Trust Local Counter Fraud Specialist, who will be happy to discuss any issues or concerns. Alternatively staff may contact the confidential NHS Counter Fraud Authority, Fraud and Corruption Reporting line on 0800 028 40 60; or on-line reporting facility Service https://cfa.nhs.uk/report-fraud Fraud investigations may lead to disciplinary action and / or prosecution and civil recovery procedures.

8.5 Records Management

The Welsh Ambulance Services University NHS Trust (WAST) recognises the importance of sound records management arrangements for both clinical and corporate records. The Trusts' records are its corporate memory, providing evidence of actions and decisions and representing a vital asset to support daily functions and operations. Records support policy formation and managerial decision-making, protect the interests of the Trust and the rights of patients, staff and members of the public.

8.6 Information Governance

Information Governance (IG) is an overarching term used to describe all aspects of information management. The Trust and its staff shall ensure that they provide satisfactory assurance to stakeholders as to how the organisation fulfils its statutory and organisational responsibilities in relation to the management of information. It will enable management and staff to make correct decisions, work effectively and comply with relevant legislation and the organisations aims and objectives.

The IG framework ensures that it sets out the high-level principles for confidentiality, integrity and availability of information to promote and build a level of consistency across the Trust.

8.7 Training

8.7.1 Mandatory Information Governance training is provided to all staff on induction and as part of the Trust's ongoing training programme. Specific training shall be arranged through the Information Asset Owners/Administrators of the systems where it is a prerequisite before access is granted to the Information Asset. (e.g. Computer Aided Despatch / Cleric / Electronic Patient Care Record (ePCR)/ Patient Administration Systems etc.)

8.7.2 Training may also be provided to other groups in response to identified needs.

8.7.3 The Trust is committed to providing high quality evidence-based education to an engaged and skilled workforce operating within an organisational culture and framework that enables colleagues to work to the top of their skill set to deliver high quality care and services with competence and confidence. Staff are encouraged to discuss any concerns or queries regarding education and training with a member of the Education and Training Team, by telephoning the Learning & Development Hub on 0300 123 2319 or via email at amb_LDHub@wales.nhs.uk

9. ROLES AND RESPONSIBILITIES

9.1 Trust Board

9.1.1 The Trust Board is collectively responsible for ensuring that the information risk management processes are providing adequate and appropriate information and assurances relating to risks against the Trust's objectives.

9.2 Chief Executive

9.2.1 The Chief Executive is ultimately responsible for the confidentiality and security of patient, staff and corporate information. Implementation of, and compliance with the policy is delegated to the Caldicott Guardian for patient information.

9.3 Director of Digital Services

9.3.1 The Director of Digital is the Trust lead of this Policy and has overall responsibility for the development and regular review of policies within their areas of responsibility.

9.3.2 The Director of Digital is the Trusts Senior Information Risk Owner (SIRO) and has a responsibility to:

- Ensure that the Trust has a robust plan to achieve and monitor the awareness of information security and compliance with Information Governance standards across the Trust and with associated organisations and business partners;
- Take visible steps to support and participate in that plan, and ensuring completion and updating their knowledge. The SIRO shall undertake strategic information risk management training;
- Maintain knowledge and experience of the Trust's business intentions with particular emphasis on the use of and dependency upon internal and external information assets;
- Ensure that the Trust has appropriate Information Asset Owners who understand their roles through appropriate and regular training and awareness, and are supported by the information risk management specialists should they require;
- Sign off annual assessments of performance relating to security issues and shall ensure that Information Asset Owners deliver assurance for their areas of work and information assets for whom they are the named Owner;
- Initiate and oversee an information risk awareness/training programme of work, to communicate the importance and maintain awareness;
- Ensure that good information governance practice is shared throughout the Trust. Maintain good communication with other NHS organisations locally and nationally;
- Oversee the development of an Information Risk Policy and its implementation;
- Take ownership of the risk assessment process for information risk;
- Review and agree action in respect of identified information risks alongside IAOs;
- Ensure that the Trusts approach to information risk is effective in terms of resource commitment and execution and that this is communicated to all staff;
- Provide a focal point for the resolution and/or discussion of information risk issues;
- Ensure the Board is adequately briefed on information risk issues.

9.4 Executive Director of Quality & Nursing / Caldicott Guardian

9.4.1 The Executive Medical Director is the Trust's Caldicott Guardian and has responsibility to:

- Promote clinical governance;
- Actively support work to enable information sharing where appropriate to share;
- Advise on options for lawful and ethical processing of information;
- Represent and champion confidentiality and information sharing requirements as well as issues at senior management level.

9.5 Information Governance Steering Group (IGSG)

9.5.1 The IGSG has a responsibility to:

- Develop and maintain the IG agenda across the Trust;
- Monitor progress against the IG work plans and initiatives;
- Ensure policies and procedures are developed, implemented and reviewed appropriately;
- Review standards and guidance relevant to Information Risk;
- Promote awareness of Information Risk issues;
- Ensure information risks and incidents are identified, logged, actioned and monitored routinely.

9.6 Director of Corporate Governance / Board Secretary

9.6.1 The Director of Corporate Governance / Board Secretary has a responsibility to:

- Ensure organisational procedures and processes are in place to comply with the FOI Act 2000;
- Report the Trusts compliance with the Freedom of Information Act and for reporting Freedom of Information issues to the Board (or equivalent);
- Work closely with the Board/Executive Team in the planning of Board and Committee meetings in which information governance arrangements are often discussed.

9.7 Data Protection Officer

9.7.1 The Trust's Data Protection Officer and has responsibility to:

- Provide information and guidance to the Executive Team and SIRO on the processing of all personal data and any risks associated;
- Oversee the work plan relating to the Information Asset Owners and Information Asset Register;
- Ensure there is a process to co-ordinate and report on any issues in relation to this policy to IGSG.

9.8 Information Security Specialist

9.8.1 The Information Security Specialist has responsibility to:

- Implement the information security agenda whilst coordinating the information security work programme;

- Develop and maintain information security policies and procedures to provide staff with direction and guidance on how to comply with information security requirements;
- Raise awareness and promote information security throughout the Trust.
- Work closely with the Data Protection Officer, Head of ICT, Senior Information Risk Owner (SIRO), Caldicott Guardian and Information Asset Owners (IAOs) to ensure information risk is managed effectively within the organisation.

9.9 Information Governance Manager

9.9.1 The Information Governance Manager has responsibility to:

- Implement the IG agenda whilst coordinating the IG work programme;
- Develop and maintain IG policies and procedures to provide staff with direction and guidance on how to comply with IG requirements;
- Raise awareness and promote IG throughout the Trust;
- Work closely with the Data Protection Officer, Records Services and Archives Manager, Senior Information Risk Owner (SIRO), Caldicott Guardian and Information Asset Owners (IAOs) to ensure information risk is managed effectively within the organisation.

9.10 Records Services and Archives Manager

9.10.1 The Records Services and Archives Manager has responsibility to:

- Establish a proactive and integrated approach to Records Management through creating, developing and maintaining robust and effective strategies, policies, systems and processes that ensure the function is embedded across the Trust;
- Provide specialist knowledge, advice and training around Records Management, including information rights, confidentiality and information security;
- Provide senior management support in the delivery of an effective Records Management Service across the whole Trust;
- Act as the Trust Lead with senior responsibility for raising awareness of Records Management and the associated training and awareness raising across the Trust. This will involve the development and deliverance of relevant training programmes.

9.11 Information Governance Team

9.11.1 The Information Governance Team has responsibility to:

- Assist with the development and completion of Information Risk Assessment and Data Protection Impact Assessments under instruction from the DPO;

- Ensure compliance with data protection legislation when providing advice and guidance to staff and those working on behalf of the Trust;
- Work closely with the Data Protection Officer, Records Services and Archives Manager, Senior Information Risk Owner (SIRO), Caldicott Guardian and Information Asset Owners (IAOs) to ensure information risk is managed effectively within the organisation.

9.12 Information Asset Owners (IAOs)

9.12.1 IAOs have a responsibility to:

- Lead and foster an information security culture which values, protects and uses information for the success of the organisation and benefit of its patients;
- Know what information comprises or is associated with the asset, what enters and leaves it and why;
- Know and authorise who has access to the asset, whether system or information, why they need the access, and ensuring access is monitored;
- Understand and address risk to the asset, whether system or information, and why;
- Ensure that access provided to the asset is on the least privilege basis to satisfy business needs;
- Ensure that the asset is checked regularly and that use remains in line with policy;
- Ensure that their Information Asset register is maintained, updated regularly and supplied to the Information Governance team in order to update the Trust Information Asset Register.
- Approve the information disposal mechanisms for the asset;
- Ensure that a data mapping exercise is carried out for all assets at least annually and that such data maps are provided to the Information Governance team once completed;
- Conduct Data Protection Impact Assessments (DPIAs) for all new projects and upgrades where applicable;
- Ensure the asset is used for the public good, including requests for access from others, with necessary Data Sharing Agreements in place where applicable;
- Notify the IG Team of any changes to existing assets and ensuring that new information assets are added to the asset register and any redundant assets removed.

9.13 Information Asset Administrators (IAAs)

9.13.1 Information Asset Administrators have a responsibility to:

- Manage the information risk of the Asset on behalf of the IAO;
- Inform the IAO of any potential issues or risks with the Asset.

9.14 Line Managers

9.14.1 Line managers have a responsibility to:

- Ensure all current, new and temporary staff are instructed of their IG responsibilities and made aware of this policy in addition to other IG related policies and procedures;
- Ensure staff receive IG training that is appropriate for their role;
- Investigate and take relevant action on any potential breaches of this policy supported by IAO's and the IG Team in line with existing procedures.

9.15 All Staff

9.15.1 All staff have a responsibility to:

- Adhere to the Information Risk Policy and all other IG related policies, procedures, including the Confidentiality Code of Conduct;
- Undertake IG training that is appropriate to their role;
- Adhere to the relevant legislation in relation to information governance;
- Maintain data confidentiality, security and integrity;
- Ensure the operational security of all systems they use and follow established procedures so that there is reduced risk of breach in information security as a result of their actions;
- Raise any concerns in relation to IG with their line manager or the IG Team.

10. REFERENCES

Information Commissioner's Office www.ico.org.uk

Records Management Code of Practice for Health and Social Care 2022

Data Protection Act 2018;

UK General Data Protection Regulations 2021;

Freedom of Information Act 2000 (FOI);

Environmental Information Regulations 2004;

Equality Act 2010;

Computer Misuse Act 1990;

Common Law Duty of Confidentiality;

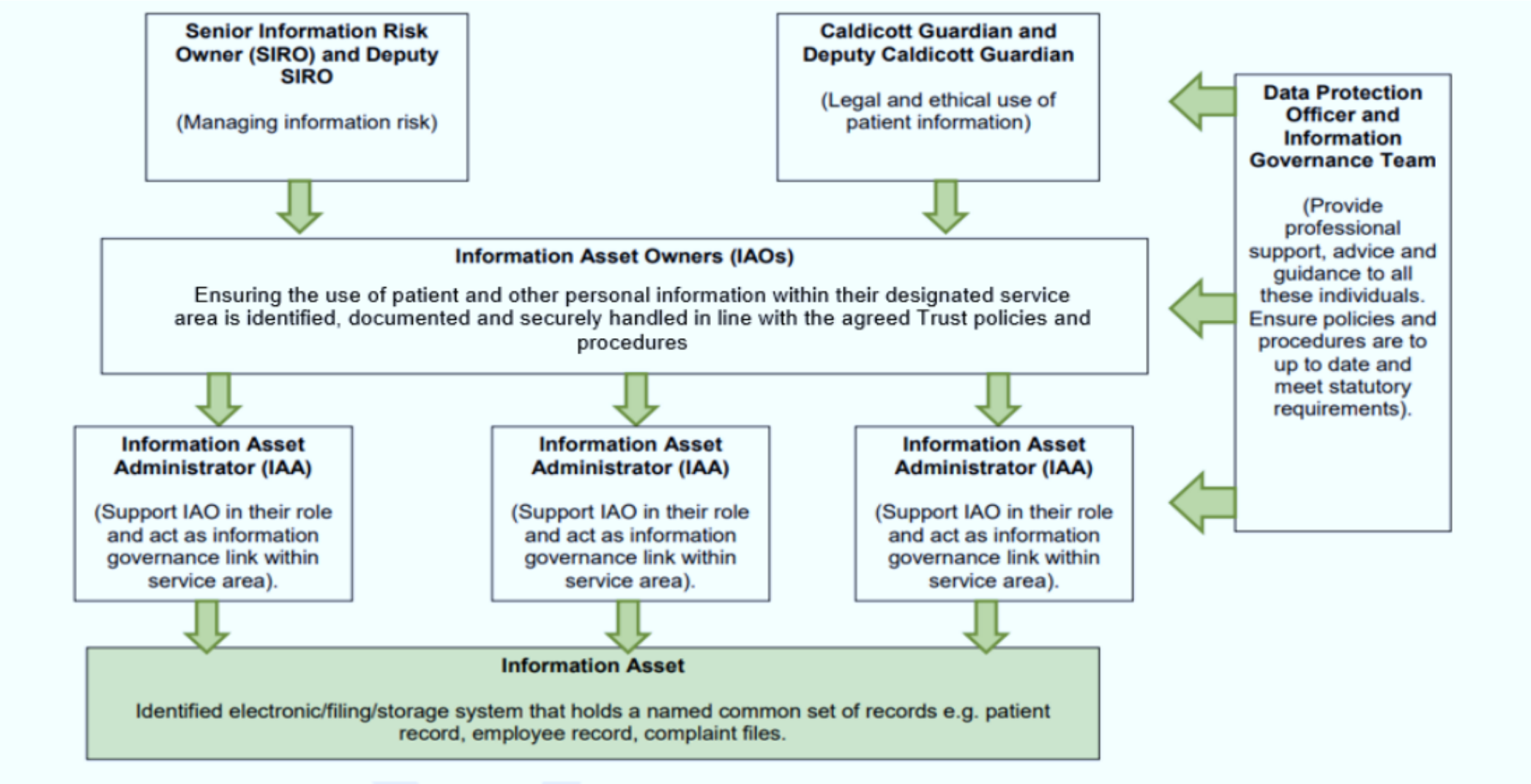
Caldicott Principles;

Information Security Management ISO 27001.

11. APPENDICES

Appendix 1	Responsibility for the Management of Information Assets with the Welsh Ambulance Services University NHS Trust
Appendix 2	Glossary of Terms

APPENDIX 1: RESPONSIBILITY FOR THE MANAGEMENT OF INFORMATION ASSETS WITHIN THE WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST



APPENDIX 2: GLOSSARY OF TERMS

Term	Description
Consequence	The outcome of an event or situation, expressed qualitatively or quantitatively, being a loss, injury, disadvantage or gain. There may be a range of possible outcomes associated with an event.
Impact	The adverse change to the level of business objectives achieved.
Information Security Risk	The potential that a given threat will exploit vulnerabilities of an asset or group of assets and thereby cause harm to the Trust. It is measured in terms of the likelihood of an event and its consequence.
Likelihood	A qualitative description or synonym for probability or frequency.
Risk	Can be defined as the chance that something will happen that will have an adverse impact on the achievement of the Trusts aims and objectives. It is measured in terms of consequence and likelihood.
Risk avoidance	The decision not to become involved in, or action to withdraw from a risk situation.
Risk Communication	The exchange or sharing of information about risk between the decision maker and other stakeholders.
Risk Estimation	The process to assign values to the probability and consequence of a risk
Risk Identification	The process to find, list and characterise elements of risk.
Risk Management	Is concerned with ensuring that risks are recognised and their impact on the Trust is assessed in order that the appropriate resource can be channelled to minimise or eliminate any potential loss.
Risk Management Process	The systematic application of management policies, procedures and practices to the tasks of establishing the context, identifying, analysing, evaluating, treating, monitoring and communicating risk.
Risk Reduction	The action taken to lessen the probability, negative consequence or both, associated with risk.
Risk Retention	The acceptance of the burden of loss or benefit of gain from a particular risk.
Risk Transfer	The sharing with another party the burden or loss or benefit of gain for a risk.
Risk Treatment	The selection and implementation of appropriate options for dealing with risk. Conceptually, treatment options will involve one or a combination of the following five strategies: • Avoid the risk • Reduce the likelihood of occurrence • Reduce the consequences of occurrence • Transfer the risk • Retain/accept the risk

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

AGENDA ITEM No	**17**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**3**

Feedback from Effectiveness Review, Committee Cycle of Business Monitoring Report and 2025/26 Priorities

MEETING	Finance and Performance Committee
DATE	20 May 2025
EXECUTIVE	Trish Mills, Director of Corporate Governance/Board Secretary
AUTHOR	Trish Mills, Director of Corporate Governance/Board Secretary Alex Payne, Corporate Governance Manager
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. The committee discussed its effectiveness on the 18 March 2025. It was agreed at that meeting that it would be necessary to seek agreement of the final committee annual report, terms of reference and cycle of business via Chair's Action. This was completed in early April and ratification of the decision made is now sought.

2. The documents approved by Chair's Action (the final Committee Annual Report for 2024/25 and Committee Terms of Reference 2025/26) are available in the iBabs Reading Room.

3. The results from the Mentimeter survey completed in the meeting on the 18 March are included at **Annex one** for information as well. The results from the Mentimeter were summarised and included in the final committee annual report.

4. The full package of documents from the 2024/25 annual committee effectiveness reviews were presented to the ARAC at its meeting on the 01 May. A verbal update will be provided following the receipt of these documents at the ARAC on the 01 May.

5. The intended changes to operating arrangements for the committee are cited within **Annex two;** however, there are no specific arrangements for the Committee. The majority of the changes are general to all meeting arrangements and / or are components of the Integrated Governance Programme.

6. The committee is asked to discuss and approve its priorities for the 2025/26 financial year. It is suggested that the committee consider no more than two or three priorities for 2025/26. The committee priorities for 2024/25 are cited below: -

    - The development and approval of the Digital Plan;
    - Oversight of the potential commercialisation streams in the Financial Sustainability Programme;
    - Focus on the new elements of its terms of reference relating to Information Governance and Information Security.

7. The cycle of business monitoring report for the committee has been presented for information for quarter one in **Annex three**. There are no issues to raise or escalate to the committee.

RECOMMENDATIONS:

8.

8.1 The committee is asked to ratify the decisions made by Chair's Action effective the 24 April 2025 in relation to the outputs of the annual committee effectiveness review;

8.2 The committee is asked to note the output of the Mentimeter survey held on the 18 February 2025;

8.3 The committee is asked to note the proposed changes to operating arrangements for 2024/25 and the outcome of the meeting of the ARAC on the 01 May;

8.4 The committee is asked to discuss and agree its priorities for the 2025/26;

8.5 The committee is asked to note the cycle of business monitoring report for quarter one of 2025/26.

KEY ISSUES/IMPLICATIONS
Not applicable.

REPORT APPROVAL ROUTE
Not applicable.

REPORT APPENDICES
Annex 1: Mentimeter results from 18 February 2025 Annex 2: Proposed 2024/25 changes to operating arrangements Annex 3: Cycle of business monitoring report – quarter one

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

Annex 1 – FPC Menti Results from March 2025

What would help you as report writers/reviewers/receivers of assurance?

Clarity

Less reports

Concise

Simple language

Clear structure and expectations of requirements so need can be served succinctly and meets expectations

High level executive summary or brief paper overview

use charts

visuals

Less reports

Concise

Streamline key metrics

clear remit for the committee - if a little broad (but perhaps necessary)?

Writing guidance

Agreement to a small number of metrics on which to focus reporting.

Better executive summaries

shorter reports - that clearly draws out key points for readers

Clarity on metrics - preferably in a similar format across all metrics

additional background info could be added as appendices - rather than in body of report?

Annex 1 – FPC Menti Results from March 2025

Are there too many metrics?

Feedback on papers where they don't provide what either the NED or others would like to see

use annexes

concise and focus executive summary

Feedback if papers are not meeting the ned of committee

Annex 1 – FPC Menti Results from March 2025

What works well in this committee?

Hybrid approach

Business is predictable

Pace the meeting moves at!

A lot of business is conducted in a relatively short space of time

good engagement

Balance

Good engagement

Good connected agenda

Structure

Quality of reports

Good debates

Keeps to time usually

Good discussions

Well chaired

Hybrid set up

Good participation

governance supports

more targeted reports - drawing our priorities clearly

Annex 1 – FPC Menti Results from March 2025

What improvements could we make in this committee?

modular approach

Be clearer what should come here

deep dives on occasion

Less duplication

Keep to time slots

Further clarity on some aspects of scrutiny and assurance

Shorter papers

Review frequency of meetings

Clarity on boundaries of merics used for performance

Shorter

Less duplication of what comes here also going to board

Review duplication elsewhere

Evaluations

Potential frequency change of meetings

more time on risk

3 NEDs as quorum

at times; briefer presentations/introductions to the reports/agenda items - allowing more time for debate and discussion

Priority of agenda items first

CHANGES TO OPERATING ARRANGEMENTS 2025/26

Committee	Changes to operating arrangements
Board and all committees	• Further consideration to holding board meetings at venues other than Cardiff in 2025/26. • Introduce progress reports on 'what good looks like' for the strategic objective within committee remits will support the call for more of a strategic focus. • Revised approach to minutes for the board and committees. • Updated board skills mix and align to committees. • Where possible in 2025/26 the introduction of more hybrid meetings. • A reduction in the reporting against the audit tracker will be considered by ARAC in an attempt to reduce volume for committees and increase assurance. • New report front covers and SBAR templates. This includes a short form report which includes a requirement to set out purpose of report and alignment to strategic objectives, wellbeing objectives and health and care quality standards. This will support the desire to use more presentations over SBAR where appropriate • Writing guidance will set out the purpose of executive summaries in an attempt to ensure they are reflective of the comments received by members of this and other committees. • Presentation guidance and support will be provided. • Feedback following meetings on reports – both positive and where there are areas of improvement – are encouraged from committee members. This will ensure we are working towards a continuous improvement in paper length and assurance. • A 'reading room' will be established in Ibabs for documents that members may wish to review for further information, but which are not vital for scrutiny and oversight. • Members were encouraged to pose questions to report writers before meetings and allowing more time for questioning during sessions were suggested to enhance engagement. There is functionality in Ibabs to do this, or directly by email. • Continue with agenda setting meetings and encourage themes for meetings to aid in the flow and triangulation. Members are encouraged to review the agenda both when it is commissioned and closer to the meeting and alert the secretariat if insufficient time has been allocated. Likewise, presenters should ensure they are cognisant of the time allocated which includes time to present and for discussion.

CHANGES TO OPERATING ARRANGEMENTS 2025/26

Committee	Changes to operating arrangements
Finance and Performance Committee	• A board development session on the use of the MIQPR will be held on 24 April 2025, and the annual review of all MIQPR metrics will come through committees in May. • A new finance dashboard is in development and will be considered by the committee in 2025/26.

PAPER	PRE-C'EE FORUM	FREQUENCY	MAY	JUL	SEP	NOV	JAN	MAR	LEAD	PURPOSE	COMMENT/COMPLIANCE
FINANCE AND PERFORMANCE COMMITTEE - CYCLE OF BUSINESS 2025-26											
TERMS OF REFERENCE NOTED IN RED TEXT											
Refreshes of 2030 Delivering Excellence	STB	Ad Hoc							EDSPP	Endorsement	
Refreshes of long term plans	STB	Ad Hoc							EDSPP	Endorsement	
Long term plans organogram	STB	Annually							EDSPP	Assurance	
IMTP for following year	STB/ELT/Board	Annually							EDSPP	Endorsement	Earmarked for potential preliminary discussions n November/January
IMTP Progress Report	STB/Board	Each meeting							EDSPP	Endorsement	
Annual revenue budget	ELT	Annually							EDOF	Endorsement	SFI 4.2.2 - Boards must approve balanced revenue and capital plans before the start of the year
Annual capital budget (closed)	Capital M'ment Board	Annually							EDOF	Endorsement	
Financial report	ELT	Each meeting							EDOF	Assurance	Financial sustainability report may be included in this report or separately throughout the year; year end report May
Year end M12 report (same time as M1 in new year)	ELT	May meeting							EDOF	Assurance	
IMTP financial plan	STB/ELT	Annually							EDOF	Endorsement	
Financial Sustainability Report	TBC	Each meeting							DPC	Assurance	Agreed at 18.09.23 FPC to include quarterly updates on the Financial Sustainability Programme (FSP) for future meetings.
Business cases over £500K	TBC	As required							EDOF	Endorsement	FPC to consider if individual business cases should return for PIR, and if so at what time
Reporting to be developed in 2025/26	TBC	TBC							EDSPP	Assurance	Head of Commercial being appointed in 2025. Reporting to be confimed following appointment.
Value Based Healthcare Report	TBC	Every other meeting							EDQN	Assurance	May: VBH deferred to future meeting, in line with update from LW, EDON.
Review of ASIS	TBC	Bi-annually									
Report on commissioning	TBC	TBC							EDSPP	Assurance	Scope of this element to be developed - see Note 1
QPMF update report	QPMF Steering Group	Bi-annually							EDSPP	Assurance	Assurance on the value of outcomes produced by the framework and effectiveness. Benefits mapping in May 25 then agree regular reportint cycle
Monthly Integrated Quality Performance report	ELT	Each meeting							EDSPP	Assurance	
MIQPR review of metrics	ELT/Board Committees	Annually							EDSPP	Endorsement	KPIs relevant to PCC and Quest reviewed by those Committee in Q4 prior to presentation to FPC
Annual HART KPI report	TBC	Annually							EDO	Assurance	HART Internal Audit Nov 22 recommended annual reporting of HART KPIs which was accepted. See July FPC on HART KPIs
Metrics for digital systems infrastructure	TBC	Three times a year							DD	Assurance	
Commissioning arrangements	ELT	Consider annually							EDSPP	Endorsement	Consider potential annual report to be developed
Demand and capacity reviews	ELT	Ad Hoc							EDSPP	Endorsement	
Estates Condition and Backlog Maintenance Update [EFPMS Data/Re	TBC	Annually							EDOF	Assurance	This was added in as a future requirement (following initial receipt in September 2024) by CorGov.
Decarbonisation Update	Decarb Programme Board	Every other meeting							EDOF		Progress also against WG action plan and Trust Plan; metrics in development. Annually to include update on waste management.
Waste Management Update	Decarb Programme Board	Annually							EDOF	Assurance	Annual update aligned with Internal Audit recommendations. First report in September 2023.
Sustainability Report	Decarb Programme Board	Annually							EDOF	Assurance/Endorse	Annual update - as per Manual for Accounts.
Fire safety annual report	ELT/Board	Annually							EDOF	Assurance	Timing of annual report TBC (annual compliance report was presented in Jan 24). By exception reporting outside cycle.
Fire safety exception report	TBC	Periodically as required							EDOF	Assurance	By exception outside of annual report
WG Annual Emergency Planning Report	ELT/Board	Annually							EDO	Assurance	Report provides for compliance with Civil Contingencies Act 2004; exercises carried out; learning from incidents/exercises/debriefs.
Incident Response Plan Report [closed session]	ELT	Annually							EDO	Assurance	Externally reported - See Note 2
Business Continuity Annual Report	ELT	Annually							EDO	Assurance	See Note 2
Cyber Resilience and Cyber Security Reporting	TBC	TBC							DD	Assurance	Reporting developing in 23/24 - start off at 3 times a year reporting; intention to bring to every meeting if possible.
Information Governance Toolkit	IGSC	Annually							DD	Assurance	
Information Governance Report	IGSC	Each meeting							DD	Assurance	
Policies for review and approval	Policy Group	Ad Hoc							BS	Approval	
Board Assurance Framework	Board	Each meeting							BS	Assurance	
Corporate Risk Register	Board	Each meeting							BS	Assurance	
Audit Recommendation Tracker	ADLT	Each meeting							BS	Assurance	
Audits within purview of Committee	Audit Committee	Ad Hoc							Relevant Director	Assurance	
STANDARD ITEMS											
Quarterly operations update	TBC	Each meeting							EDO	Information/Discussion	Only received in quarter, not at every FPC meeting (if it would otherwise be a duplicate from previous meeting)
GOVERNANCE											
Committee effectiveness review and annual report	Audit/Board	Annually							Board Sec.	Approval	
Review of Terms of Reference	Audit/Board	Annually							Board Sec.	Approval	
Committee cycle of business refresh	N/A	Annually							Board Sec.	Approval	
Committee Cycle of Business review	Audit/Board	Each meeting							Board Sec.	Approval	
Committee Review of Annual Priorities	None	Every other meeting							Chair	Review	
SUB-GROUPS											
Where applicable	N/A	Ad Hoc							N/A	N/A	No sub-committees - but may set up task and finish groups from time to time
PROMPTS											
External Reports	N/A	Ad Hoc							TBC	TBC	

EDOF - Exec Director of Finance and Corporate Resources
EDO - Exec Director of Operations
EDSPP - Exec Director of Strategy, Planning and Performance
DD - Digital Director
BS - Board Secretary
EDQN - Exec Director of Quality and Nursing
DP - Director of People

Key: Pre-agenda setting
- Cycled for each meeting
- Ad hoc item - prompt for agenda setting
- Reporting developing

Key: Post-agenda setting
- Presented as cycled
- Ah hoc / item considered - not programmed
- Item deferred
- Reporting developing

1	**Commissioning**	Review of commissioning standards is the commissioning intentions met as part of IMTP. AQIs published monthly to EASC. Key AQIs included in the 28 KPIs.
2	**Emergency Preparedness**	The Trust is classed as a category one responder under the Civil Contingencies Act (2004) and as a result there is a legislative obligation for us to address 6 key responsibilities, which are - Assess local risks and use this to inform emergency planning - Put in place emergency plans - Put in place Business Continuity Management arrangements - Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency - Share information with other local responders to enhance co-ordination - Co-operate with other local responders to enhance co-ordination and efficiency CCA Part one devolved to Wales. WAST is a category 1 responder under the Civil Contingencies Act (2004) and Regulations (2005). Category 1 responders are required to maintain plans for preventing emergencies; reducing, controlling or mitigating the effects of emergencies in both the response and recovery phases, and has a duty to ensure business continuity plans are in place. Trust is working towards ISO22301 accreditation. Internal Audit on Major Incidents - September 2022 AC - raised F&P review of incident response plan when reviewed next. NHS Emergency Planning Annual Report: return that is signed by JK. Comes to FPC for assurance. One element is assurance the board has received the IRP which FPC does on behalf of the board. WG compile into an All Wales return and in September 2024 the first meeting of the Health Executives for EPRR has been called by WG and likely they will be the primary reviewer of these. Incident Response Plan Report: WG report accompanied by assurance that Incident Response Plan (IRP) in place and approved by ELT. SBAR includes detail of staff training in place, compliance levels, and resourcing for assurance; list of plans that underpin IRP are in date and regularly reviewed. IRP provides guidance and support to commanders on a range of incidents. Taken in closed session due to sensitivities. Business Continuity Annual Report: SBAR to include compliance with CCA 2004 if not included in WG annual report and compliance under policy; list of plans that underpin BCP are in date and regularly reviewed; staff training in place, compliance levels and resourcing for assurance if not included in IRP report above; exercises carried our and planned; learning from incidents/exercises/debriefs.