

Bundle Finance and Performance PUBLIC 21 July 2026

Agenda attachments

Item 00 FPC Agenda 21 July 2026 – Public

0 09:30 – OPENING ITEMS

1 Chair's Welcome, apologies and quorum

2 Declarations of interest

Item 02 Board Member Register of Interests 23 June 2026

3 Minutes of the last meeting held on 19 May 2026

Item 03 2026-05-19 PUBLIC FPC Minutes draft

4 Action Log & matters arising

Item 04 Action Log and Decisions (Public) FPC

4.1 Committee AAA report: 19 May 2026

Item 04.1 Finance and Performance Committee Highlight Report May 2026

4.2 FOR APPROVAL, ASSURANCE AND DISCUSSION

5 09:35 – Operations Quarterly Report Q1 2026/27

Item 05 Operations Quarterly Report Q1 2026-2027

6 09:45 – Financial Performance at Month 2 – 2026/27 / Financial Position for Month 3 – 2026/27

Item 06 Finance Report Month 2 26-27

Item 06 Annex 1 Monitoring Return

Item 06 Annex 2 Monitoring Return Letter

7 10:05 – Financial Sustainability Report

Item 07 Financial Sustainability Programme Governance Group – Finance and Performance Committee – 21 July 2026

8 10:20 – Integrated Medium Term Plan (IMTP) Progress Report

Item 08 IMTP Q1 Delivery & Assurance Update July 2026

Item 08 Annex 1 IMTP Q1 Delivery & Assurance Report

9 10:40 – Monthly Integrated Quality Performance Report (MIQPR) May/June 2026 [TO FOLLOW]

Item 09 MIQPR SBARN FPC May June 2026

Item 09 Annex 1 MIQPR FPC May June 2026

9.1 10:55 – COMFORT BREAK

10 11:10 – Internal Audit Report: Fire Safety

Item 10 Feedback Report from ARAC to FPC Fire Safety

Item 10 Annex 1 Fire Safety Final Internal Audit Report

11 11:20 – Internal Audit Report: Vehicle (Ambulance) Replacement Programme

Item 11 Feedback Report from ARAC to FPC Vehicle (Ambulance) Replacement Programme

Item 11 Annex 1 Vehicle Replacement Programme Final Internal Audit Report

12 11:30 – Internal Audit Reports

Item 12.1 Digital Business Continuity Final Internal Audit Report

Item 12.2 Feedback Report from ARAC to FPC Data Management Practices-Devolved Data

Item 12.2 Data Management Practices Devolved Data Final Internal Audit Report

Item 12.3 Emerging Technology Adoption Final Internal Audit Report

13 11:45 – Digital Reporting July 2026

Item 13 Digital Reporting July 26

Item 13 Annex 1 Digital Reporting July 2026 Metrics

- 14 11:55 – Information Governance Report
Item 14 Information Governance Reporting July 26
- 15 12:05 – Internal Audit Report: High Risk Records Policy
Item 15 Feedback Report ARAC to FPC High Risk Records Policy
Item 15 High Risk Record Policy Final Internal Audit Report
- 16 12:15 – Risk Management Report
Please note document in Reading Room:
– Annex 4 BAF 240226 v1.8
Item 16 Executive Summary Risk Management Report FPC 210726
- 16.1 CONSENT ITEMS There are no consent items
- 16.2 12:25 – CLOSING ITEMS
- 17 Reflections
- 18 Any Other Business
- 19 Date & Time of the next meeting: 15 September 2026

Length of Meeting:		03:00	Agenda Status: AGREED	[PUBLIC] FINANCE AND PERFORMANCE COMMITTEE - 21 July 2026					Deadline for Papers: 10 July 2026	
Time	Mins allotted	Agendum	Title	Format	Item for	Item requested by	Paper prepared by	Item presented by	Colleagues to cc	
OPENING ITEMS										
09:30	00:05	1	Chair's Welcome, apologies and quorum	Verbal	Information	Standing	n/a	Chair	n/a	
		2	Declarations of interest	Verbal	To State Conflicts	Standing	n/a	Chair	n/a	
		3	Minutes of the last meeting held on 19 May 2026 (Confirmation of recording/transcript deletion of previous meeting)	Paper	Approval	Standing	n/a	Chair	n/a	
		4	Action Log & matters arising	Paper	Discussion	Standing	n/a	Chair	n/a	
		4.1	Committee AAA report: 19 May 2026	Paper	Discussion	Standing	n/a	Chair	Trish Mills	
FOR APPROVAL, ASSURANCE AND DISCUSSION										
09:35	00:10	5	Operations Quarterly Report Q1 2026/27	Paper	Assurance	CoB	Ops	Mark Harris [Lee Brooks]	Judith Bryce/Toni-Marie Norman/Sophie Francis	
09:45	00:20	6	Financial Performance at Month 2 - 2026/27 Financial Position for Month 3 - 2026/27	Paper Presentation	Assurance	CoB	FinCor	Chris Turley	Ed Roberts	
10:05	00:15	7	Financial Sustainability Report	Paper	Assurance	CoB	FinCor	Chris Turley	Matt Dugdale/Richard Baxter/Gareth Thomas	
10:20	00:20	8	Integrated Medium Term Plan (IMTP) Progress Report	Paper	Assurance	CoB	SPP	Rachel Marsh	James Houston	
10:40	00:15	9	Monthly Integrated Quality Performance Report (MIQPR) May/June 2026	Paper	Assurance	CoB	SPP	Rachel Marsh	Hugh Bennett, Mark Thomas, Melanie O'Connor	
10:55	00:15	COMFORT BREAK								
11:10	00:10	10	Internal Audit Report: Fire Safety (Reasonable Assurance)	Paper	Assurance	Forward Planner	Digital	Chris Turley [Osian Lloyd]	Lisa Trounce, Osian Lloyd	
11:20	00:10	11	Internal Audit Report: Vehicle (Ambulance) Replacement Programme (Reasonable Assurance)	Paper	Assurance	CoB	Ops	Mark Harris [Lee Brooks] [Osian Lloyd]	Lisa Trounce, Osian Lloyd	
11:30	00:15	12	Internal Audit Reports: 12.1 Digital Business Continuity (Reasonable Assurance) (LS) ** 12.2 Data Management Practices / Devolved Data (Reasonable Assurance) (LS) 12.3 Emerging Technology Adoption (Reasonable Assurance) (LS) ** ** These Internal Audit Reports were not completed in time for the meeting of the Audit Risk and Assurance Committee on 23 June 2026, therefore the committee agreed that the reports would be circulated to members for review outside of the formal meeting cycle, rather than being deferred to the September meeting, hence there is no feedback report from ARAC to FPC.	Paper	Assurance	CoB	Digital	Leanne Smith [Jonny Sammut]/ [Osian Lloyd]	Lisa Trounce, Osian Lloyd	
11:45	00:10	13	Digital Reporting July 2026	Paper	Assurance	CoB	Digital	Leanne Smith [Jonny Sammut]	Leanne Smith	
11:55	00:10	14	Information Governance Report	Paper	Assurance	CoB	Digital	Leanne Smith [Jonny Sammut]	Leanne Smith	
12:05	00:10	15	Internal Audit Report: High Risk Records Policy	Paper	Assurance	CoB	Gov	Mark Harris [Lee Brooks]	n/a	
12:15	00:10	16	Risk Management Report	Paper	Assurance	CoB	Gov	Julie Boalch	n/a	
CONSENT ITEMS There are no consent items										
CLOSING ITEMS										
12:25	00:05	17	Reflections	Verbal	Discussion	Standing	n/a	Chair	n/a	
		18	Any Other Business	Verbal	Discussion	Standing	n/a	Chair	n/a	
		19	Date & Time of the next meeting: 15 September 2026	Verbal	Information	Standing	n/a	Chair	n/a	
12:30	03:00	CLOSE								

LEAD PRESENTERS

Name	Position
Jayne Beeslee	Chair and Non-Executive Director
Julie Boalch	Assistant Director of Corporate Governance and Risk
Lee Brooks	Executive Director of Operations
Mark Harris	Assistant Director of Operations
Rachel Marsh	Deputy Chief Executive
Trish Mills	Director of Corporate Governance/Board Secretary
Jonny Sammut	Director of Digital
Leanne Smith	Deputy Director of Digital
Chris Turley	Executive Director of Finance and Corporate Resources

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended
AHMAD, Umar Afthab DR	Non-Executive Director * Member of the Remuneration Committee * Member of the the Audit, Risk and Assurance Committee * Member of the Quality, Patient Experience and Safety Committee	GP Partner at Plains View Surgery, Nottingham	Financial Interest	2014	
		Primary Care Network Clinical Director for Arrow Health, Nottingham	Financial Interest	2019	
		Non-executive Director (appointed company director) for Primary Integrated Community Services Ltd, Nottingham and small shareholder [Company number 087631361]	Financial Interest	2023 and 2016	
		Owner and company director of Travel Jab Guru Ltd – online medical travel advice [Company number 14685908]	Financial Interest	2023	
		Local Medical Committee Member	Financial Interest	2019	
		Nottingham Integrated Care Board Cardiovascular Disease and Stroke Prevention Clinical Design Authority Lead	Financial Interest	2025	
		Associate Non-executive Director Nottinghamshire University Hospital Trust (non-voting member of the board)	Financial Interest	2024	
BEESLEE, Jayne	Non-Executive Director * Chair of Finance and Performance Committee * Member of the Remuneration Committee * Member of the Remuneration Committee	Employment fro interim assignments via Public Sector Resourcing (an agency) regarding the rev iew of major UK Government programmes (remunerated nex of tax via an umbrella company - Danbro Employment Umbrella Ltd)	Financial Interest	01 October 2023	
		Governor on the Finance and General Purposes Committee of Cardiff and Cale Further Education College	Non-Financial Personal	01 February 2024	
		Fellow Chartered Institute of Persennel and Development	Non-Financial Personal	01 April 2006	
BROOKS, Lee	Executive Director of Operations	Partner employed by Welsh Ambulance Services NHS Trust	Any Other Interest	July 2019	
		Member of the Order of St John	Any Other Interest	01 March 2023	
CURRAN, Peter	Non-Executive Director * Chair of the Audit, Risk and Assurance Committee * Chair of the Charity Committee * Member of the Finance and Performance Committee * Member of the Remuneration Committee	Trustee of Action for Children [1097940]	Position in Charity or Voluntary Organisation	01 February 2021	
		Trustee of Action for Children Pension Board	Position in Charity or Voluntary Organisation	22 May 2023	
		Company Director - Action for Children [04764232]	Directorships	01 February 2021	
		Company Director - Action for Children (Wales) Ltd [10011497]	Directorships	05 April 2022	
		Trustee of National Youth Arts Wales [1170643]	Position in Charity or Voluntary Organisation	06 May 2021	
		Company Director - National Youth Arts Wales [10449512]	Directorships	06 May 2021	
		Chair - Taff Housing Association	Any Other Interest	17 July 2025	
		Member of Governing Body / Independent Member – Kaplan International Colleges UK Ltd [05268303]	Non-Financial Professional	01 March 2024	
		Independent Member - Kaplan Open Learning (inc member of the Audit & Risk Committee)	Directorships	21 March 2024	
DENNIS, Colin	Chair of Trust Board and Non-Executive Director * Chair of Remuneration Committee	Group Chair of South Central Ambulance Service NHS Foundation Trust and South East Coast Ambulance Service NHS Foundation Trust	Directorships	27 March 2026	
		Chair - Green Square Accord (Housing Association)	Position in Charity or Voluntary Organisation	26 March 2024	
		Company Director - LowCarbonLiving Homes Ltd [04207671]	Directorships	26 March 2024	
		Company Director - Green Square Estates Ltd [8719365]	Directorships	26 March 2024	
DURRANT, Penny	Deputy Director of Nursing, Quality and Governance	Nil Declaration		30 May 2026	
EVANS, Bethan	Non-Executive Director * Chair of Quality, Patient Experience & Safety Committee * Member of Finance & Performance Committee * Member of People & Culture Committee * Member of Remuneration Committee	Chief Executive Officer (Employed) at My Choice Healthcare Limited.	Any Other Interest	01 June 2019	
		Non-Executive Board Member at Beacon Housing (Social Housing Organisation Community Benefit Society)	Position in Charity or Voluntary Organisation	01 November 2019	
		Company Director - My Choice Healthcare South Wales Limited	Directorships	11 March 2020	
		Company Director - Moorlands Rehabilitation (Staffordshire) Limited.	Directorships	20 December 2019	
		Company Director - Moorlands Property Ltd	Directorships	16 August 2022	
		Company Director - Springfield (Bargoed) Limited.	Directorships	12 March 2020	
		Company Director - Springfield Property Lettings Ltd	Directorships	16 August 2022	
		Company Director - Homes of Excellence Limited	Directorships	19 March 2021	
		Company Director - Victoria House Care Property Limited	Directorships	05 March 2020	
		Company Director - My Choice Healthcare (Four) Limited	Directorships	27 April 2022	
		Company Director - Luk Ros Property Limited	Directorships	12 March 2020	
		[Previously called Homes of Excellence Healthcare Limited, Company name changed 12.08.2022 - #12513139]	Directorships	12 March 2020	

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended
EVANS, Bethan [continued]	Non-Executive Director * Chair of Quality, Patient Experience & Safety Committee * Member of Finance & Performance Committee * Member of People & Culture Committee * Member of Remuneration Committee	Company Director - Hawthorn Court Property Limited	Directorships	27 April 2022	
		[Previously called My Choice Healthcare (Three) Limited, Company name changed 12.08.2022 - #13371375]	Directorships	27 April 2022	
		Company Director - Ocean Living Property Limited	Directorships	22 July 2022	
		Company Director - Hawthorn Court Care Limited	Directorships	22 July 2022	
		Company Director - Glynconel Property Limited	Directorships	01 July 2022	
		Company Director - My Choice Healthcare (Two) Limited	Directorships	01 July 2022	
		Company Director - Carmarthen Care Limited	Directorships	02 January 2024	
		Company Director - Towy Castle Property Limited	Directorships	01 September 2023	
		Company Director - Glamorgan Care Ltd	Directorships	25 October 2024	
		Company Director - The Mountains Care Ltd	Directorships	09 December 2024	
		Company Director - Alexandra House Care Ltd	Directorships	24 June 2024	
		Company Director - Alexandra House Property Ltd	Directorships	24 June 2024	
		Company Director - My Choice Healthcare Seven Ltd	Directorships	22 October 2024	
		Company Director - Danygraig Property Ltd	Directorships	10 December 2024	
		Company Director - The Mountains Property Ltd	Directorships	09 December 2024	
		Longhope Property Ltd	Directorships	12 February 2026	
		My Choice Healthcare England Ltd	Directorships	26 August 2025	
		My Choice Healthcare Ltd	Directorships	26 August 2025	
HITCHON, Estelle	Director of Partnerships and Engagement	Glynconel Care Ltd	Directorships	16 August 2022	
		Member of Academi Wales Expert Panel	Position in Charity or Voluntary Organisation	15 July 2024	
		Independent Governor (Non-Executive Director), Coleg Sir Gar/Coleg Ceredigion	Non-Financial Personal	01 January 2025	
HUTCHINGS, Hayley	Non-Executive Director * Member of the Remuneration Committee * Member of the Academic Partnership Committee * Member of the People and Culture Committee	Emeritus Professor, Swansea University	Non-Financial Professional	31 May 2025	
		Consultant Advisor to the FASAR Trial, Nottingham Trent University	Financial Interest	25 March 2026	
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	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	
KNEESHAW, Carl	Director of People	Chartered Fellow of Chartered Institute of Personnel and Development	Personal or Departmental Sponsorship	April 2020	
		Fellow of Institute of Leadership	Personal or Departmental Sponsorship	October 2020	
		Safeguarding Lead for local outreach charity, Brunstad Christian Church – Huntworth, Bridgwater, Somerset	Position in Charity or Voluntary Organisation	September 2018	
LEWIS, Angela	Director of Culture Change	Chartered Fellow of the CIPD		2005	
MARSH, Rachel	Deputy Chief Executive/Executive Director of Strategy,	Nil Declaration			
MILLS, Patricia (Trish)	Director of Corporate Governance/ Board Secretary	Nil Declaration			
PARRY, Hugh	Trade Union Partner	Nil Declaration			
ROBERTS, Edward	Interim Finance Director (from 09 September 2025)	Nil Declaration			
ROWAN, Hannah	Non-Executive Director * 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	
		Elected member, The governing body of the church in Wales (Parliament of church in Wales - voting member)	Any Other Interest	01 April 2021	
SAMMUT, Jonathan (Jonny)	Director of Digital Services [appointed 26.09.2023]	Fellow of the British Computer Society – FBCS	Any Other Interest	04 March 2024	
		Federation of Informatics Professionals - Leading Practitioner	Any Other Interest	25 April 2024	
		Chair of BCS Hub Wales	Any Other Interest	20 June 2025	
		Co-opted into the BCS Community Board	Any Other Interest	12 August 2025	11 August 2026
		CHIME (College of Healthcare Information Management Executives) Digital Health Fellowship - UK Cohort 2026	Non-Financial Professional	07 May 2026	
		Working With AI, Not Against It book published commercially and generates royalty income from sales.	Financial Interest	24 February 2026	
SWINBURN, Andrew (Andy)	Executive Director of Paramedicine	Strategic Advisor to College of Paramedics	Any Other Interest	01 January 2020	
TURLEY, Christopher	Executive Director of Finance and Corporate Resources	Nil Declaration			

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



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MINUTES OF THE MEETING OF THE PUBLIC FINANCE AND PERFORMANCE COMMITTEE HELD ON 19 MAY 2026 IN THE CARDIFF MRD AND VIA TEAMS

The meeting started at 09:30

MEMBERS:

Jayne Beeslee	Non-Executive Director and Chair
Peter Curran	Non-Executive Director
Bethan Evans	Non-Executive Director

PRESCRIBED ATTENDEES:

Lee Brooks	Executive Director of Operations
Matthew Dugdale	Assistant Director of Commercial Development
Rachel Marsh	Deputy Chief Executive
Hugh Parry	Trade Union Partner <i>(to 12.40)</i>
Jonny Sammut	Director of Digital
Chris Turley	Executive Director of Finance and Corporate Resources
Damon Turner	Trade Union Partner

ATTENDEES:

Julie Boalch	Assistant Director of Corporate Governance and Risk <i>(deputising for Trish Mills)</i>
Fflur Jones	Performance Auditor, Audit Wales
Osian Lloyd	Head of Internal Audit
Alex Payne	Corporate Governance Manager
AnnaMaria Williams	Corporate Governance Officer (minute-taker)

APOLOGIES:

Carl Kneeshaw	Director of People
Trish Mills	Director of Corporate Governance/Board Secretary
Liam Williams	Executive Director of Quality and Nursing



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OPENING ITEMS

1. CHAIR'S WELCOME, APOLOGIES AND QUORUM

1.1 Apologies were received as set out above. Quorum was confirmed.

2. DECLARATIONS OF INTEREST

2.1 There were no other declarations recorded.

3. MINUTES OF PREVIOUS MEETING 17 MARCH 2026

3.1 The minutes of the public meeting of the Finance and Performance Committee held on 17 March 2026 were received and approved.

4. ACTION LOG AND MATTERS ARISING

4.1.1 The Action Log was reviewed and discussed with updates added to the log.

4.1 AAA HIGHLIGHT REPORT 17 MARCH 2026

4.1.2 The AAA Highlight Report from the meeting held on 17 March 2026 was noted.

ITEMS FOR ASSURANCE, DISCUSSION OR APPROVAL

5. QUARTERLY OPERATIONS UPDATE Q4 2025/26

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

5.1 The committee received the Operations quarterly update for Q4 2025/26.

5.2 Members noted the success of the Falls Desk and asked how the Trust intends to approach continuity of funding for this, beyond the current year. Members were advised that further evaluation will be undertaken in-year, as a longer evidence base showing continuation of effectiveness will strengthen any case for continued financial support. The Trust will continue to engage with Welsh Government and commissioners to sustain the case for funding, aligned to a broader, coordinated national approach to falls.



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The evaluation will help inform decisions about possible reliance on internal prioritisation if external funding is not secured.

The committee received and took assurance from the report.

6. INTERNAL AUDIT REPORT – CAPACITY MANAGEMENT PLAN

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

- 6.1 The committee received and noted the internal audit report and acknowledged that all recommendations made in the report had been accepted and were considered helpful in improving oversight and decision-making, particularly around how cancellations are managed. Work is already underway to implement all recommendations with good confidence in the delivery dates set.
- 6.2 Members noted that the report had been discussed in detail at the Audit, Risk and Assurance Committee (ARAC) and noted the positive report given the high-pressure environments that teams are operating in.

7. RURALITY, INCLUDING OVERRUNS

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

- 7.1 The committee received the paper on rurality, including overruns, and were provided with an overview of the key messages.
- 7.2 Members commented on the high quality of the report and discussed the challenges of recruitment and retention in rural areas, including whether different approaches (for example engaging with universities or new initiatives) could be explored to improve this. Members were assured that alternative recruitment approaches have been considered, such as rotational models to help diversify roles which make rural work more attractive as well as targeted internal recruitment.
- 7.3 Members asked about the use of the 'Handover 45' approach and wider partner engagement, including whether there is an opportunity to share the rurality evidence more widely with system partners to help gain greater traction on the importance of the approach. Members were advised that while improvements from the Handover 45 approach will help significantly, additional work is underway on a new dispatch framework, designed to bring dispatch processes in line with the updated performance and



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categorisation model, which will also support improvements. There has been continued focus on workforce factors such as breaks and overruns, and engagement from NHS Performance and Improvement and Welsh Government.

- 7.4 Members discussed the impact of health board decisions on ambulance operations in rural areas, noting that the Trust is not always involved in strategic decisions that can have a material effect on service delivery and key performance measures, including journey times and additional resource requirements. Assurance was given that the Trust is actively engaged in the relevant planning processes and discussions with health boards, including attendance at meetings and workshops and completion of modelling work to inform proposed changes. It was acknowledged however that some impacts, for example from changes to the location of specialist services, are outside the Trust's control. An action was agreed for the Executive Leadership Team (ELT) to explicitly highlight to the Joint Commissioning Committee (JCC) how external system decisions, particularly service reconfiguration, can impact ambulance performance measures, and to reflect these external factors more clearly in reporting, ensuring this context is clearly understood in commissioner discussions.
- 7.5 Members noted that some of the data in the report was historical and it was agreed that more up-to-date NHS spend data would be sourced and incorporated into the report, to strengthen the report's evidence and to better reflect current funding levels.
- 7.6 Members asked whether there was an agreed reduction level and timeline for shift overruns and whether clearer targets or an improvement trajectory should be set; they were advised that there is no current target for this, with work on the development of the new dispatch framework, supported by a task and finish group, needing to be finalised first. This will allow for better understanding of what level of reduction is achievable and can realistically be delivered.
- 7.7 Members were assured that governance work is ongoing to develop supporting metrics beneath Board level reporting, to ensure committees receive assurance in their areas of focus, such as shift overruns. Members were also assured that shift overruns have been identified as a key indicator for the Trust Board and that the Trust is committed to continuing to monitor and report on this issue.



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- 7.8 The committee discussed the analysis on rural versus urban overruns activity contained in the slides at Appendix 1, and noted the action to work on flexing roster design in more rural stations to encourage recruitment and retention; they noted that the application of Handover 45 is key to the solution and that any change in the level of required rural performance or model to achieve this, would be a decision for the JCC.

8. FINANCIAL REPORT MONTH 12, 2025/26

FINANCIAL POSITION FOR MONTH 1, 2026/27

The papers for this item in relation to the financial performance at month 12, 2025/26 are in the committee pack in iBabs and on the Trust's website, therefore detail of the content is not repeated here.

- 8.1 The committee received the detailed financial position for month 12 2025/26 and were advised that the year-end position has been reported to Welsh Government, with an audit of the draft accounts underway. The draft accounts will be presented to ARAC before being received by Trust Board on 25 June 2026.
- 8.2 Members were advised of a minor adjustment between the reported Month 12 position and the draft accounts, with an £80k surplus reported with an actual surplus of £78k achieved. This was due to a timing issue relating to the notification of pay changes, and although not material, will need to be reflected in the accounts as a post-balance sheet event. Members were further advised that gross savings of £8.556m have been achieved against an £8.5m target and the capital programme has been fully delivered.
- 8.3 Members discussed the report and noted that while overall savings were achieved, this included over-achievement of non-recurrent savings, and a slight under-achievement of recurrent savings, asking whether more recurrent savings will be required in the new financial year and whether this would create additional pressure going forward. Members were assured that non-recurrent savings have already been built into the financial planning assumptions for the new financial year as a cost pressure, with the Trust progressively increasing its focus on achieving recurrent savings going forward.
- 8.4 The committee received an overview of the Month 1 financial position, key assumptions and emerging risks, with a break-even position reported and the savings planned for Month 1 delivered. Members noted the risks with this position, with circumstances already changed since the financial plan was finalised and its dependence on several assumptions including:



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- A Welsh Government funding adjustment of £2.3m, for the Welsh Risk Pool, which has been assumed in the reported position and has been verbally agreed; however, formal confirmation is still pending.
- An emerging cost pressure of increased fuel costs which could create a £1.2m–£1.5m cost increase over the year if sustained at the current rate, and which cannot be covered by any contingency.
- A continuing risk around the savings gap, with £7.8m of savings identified and a remaining residual gap of £1.2m still to be delivered, with an expectation to maximise recurrent savings.
- An overall higher level of risk than typically reported, including emerging medium risks.

8.5 Members asked whether there were any additional or residual risks associated with the Welsh Risk Pool, beyond the stated specific funding assumption; they were assured that the current figure represents the expected position.

8.6 The committee noted and gained assurance in relation to the Month 12 revenue financial position and performance of the Trust as at 31 March 2026, noted the delivery of the 2025/26 savings plan, the capital programme for 2025/26 and the Month 12 Welsh Government monitoring return submission.

9. **COMMERCIAL PLAN**

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

9.1 The committee received the Commercial Plan and acknowledged that this is aligned to the Trust's Integrated Medium-Term Plan (IMTP), and which establishes a structured and values led approach to commercial development, focused on reinvestment in services, workforce and innovation, rather than income generation alone.

9.2 Members welcomed the plan, describing it as a positive step in providing a foundation for developing commercial activity within the Trust and noting the alignment with the its long-term ambitions and strategic objectives. Members discussed the importance of the communications plan in how the initiative is positioned and explained, of measuring success through the positive impact on patients and staff and of balancing risk and ambition. It was noted that the plan is a key mechanism for delivering the Trust's open risk appetite for commercial innovation and responsible growth, and the importance of ongoing visibility and assurance over risks as the plan progresses was emphasised.



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- 9.3 Members asked how partnership activity under the commercial plan would be aligned and coordinated with existing strategic partnership arrangements, particularly to ensure clear roles and avoid overlap; they were assured that existing alignment is already in place, with direct linkage between strategic partnerships and the commercial function. A key priority for the Trust is to develop a clear, formal partnerships framework, so that the organisation is prepared and ready for funding and commercial opportunities, which can be properly assessed within governance boundaries. There is an IMTP deliverable to develop a wider framework of accountability for partnerships, covering different partner types and including commercial partnerships.
- 9.4 Members acknowledged the ambition to develop a self-sustaining commercial function by 2027/28 and confirmed the intention to maintain oversight as implementation progresses, noting that developing meaningful success measures will take time and that the Trust may move from collaboration into competition with some partners.
- 9.5 Members asked how targets will be developed and emphasised the importance of a clear and consistent costing and pricing framework, including transparent treatment of overheads, to ensure credibility and avoid challenge regarding full cost attribution; they were assured that the detail of targets, measures and delivery mechanics will be developed through the delivery phase of the plan, rather than being fully set out at this stage.
- 9.6 Members highlighted the need to balance organisational benefit with local incentives for teams contributing to commercial activity, recognising the risk of disengagement if teams do not see a direct link between their contribution and organisational or local benefit.
- 9.7 An action was agreed for the ELT to propose an appropriate reporting frequency of updates on the Commercial Plan, through the cycle of business, ensuring the committee receives the updates at appropriate key points such as when there has been meaningful progress or where decisions are required.

The committee endorsed the Commercial Plan for 2026-2028.



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10. INTEGRATED MEDIUM-TERM PLAN (IMTP) YEAR END 2025-26

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

- 10.1 The committee received the end-of-year 2025/26 IMTP report, noting progress and the end of year (Q4) position against the 2025/26 IMTP deliverables and future reporting arrangements. Members were assured that delivery against the plan had been positive, with the majority of deliverables either completed, on track or appropriately rolled forward where they formed part of multi-year programmes. Assurance was taken that planned activity had been progressed as intended, with a small number of undelivered items clearly identified in the report.
- 10.2 The committee noted the progress of the Clinical Model Transformation programme (CMT) workstream, including the transition into a new and more mature phase of delivery, the establishment of a benefits realisation workstream, and ongoing work to maximise impact through improvements such as reducing red and orange category demand and strengthening alternative clinical responses. Members noted that change management remained an important area of focus, particularly in light of the pace of programme delivery and the risk of change fatigue and welcomed the renewed emphasis on supporting staff through this.
- 10.3 Members were advised that reporting for 2026-29 has been updated to align deliverables with strategic objectives, supporting improved oversight. The 'what good looks like' measures have been removed from the current IMTP, pending further development through the Trust's strategy refresh. The committee welcomed the 'plans on a page' showing the deliverables aligned to the strategic objectives in an easy-read format.
- 10.4 Members discussed the importance of avoiding duplication between committee and board reporting, while ensuring clear ownership, alignment of metrics and assurance routes, and appropriate handling of areas that do not sit neatly within a single committee remit. Assurance was provided that this work is being progressed through the integrated governance programme, with engagement from committee Chairs, Executive Leads and relevant teams, and that recommendations on future reporting arrangements will be brought forward in due course. Further consideration of these matters would be considered at the Board Development session in June 2026 alongside the forthcoming Good Governance Institute (GGI) report, expected in July 2026, including recommendations on committee remit, information flow and the board's strategic focus.



- 10.5 An action was taken to develop and bring back options for more streamlined, outcome-based IMTP reporting that maintains assurance while avoiding duplication and excessive detail; also, to look further at the governance flow for this reporting and how it should be structured through committees and the board.

11. MONTHLY INTEGRATED QUALITY PERFORMANCE REPORT (MIQPR)

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

- 11.1 The committee received and considered the MIQPR report for March/April 2026 and the actions being taken. Members were advised that a new revised format of reporting will be presented at the Trust Board in May 2026.
- 11.2 The committee heard that call abandonment rates for April 2026 were higher than expected and ring-back times within NHS Wales 111, the Clinical Support Desk and remote clinical assessment services were longer than expected. Assurance was provided that action was being taken through process mapping and benefits realisation work to improve patient flow through new systems, and that additional remote clinicians would be deployed to support improvements across both 111 and 999 pathways.
- 11.3 The committee noted that performance against cardiac arrest response standards remained strong, while turnaround times for red emergency patients were longer than intended. Members were advised that actions being taken are focusing on reducing the number of patients entering the red emergency category inappropriately, as part of the wider benefits realisation programme.
- 11.4 Members asked if targets are being reviewed for 2026/27 and were assured that new, more appropriate targets will be introduced, having already been reviewed through a board development session and with a greater focus on realistic performance expectations, and trajectory thinking.

12. DIGITAL REPORTING MAY 2026

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

- 12.1 The committee received the Digital report, along with an overview of key highlights and areas of focus; they acknowledged the contents of the paper and received assurance on the progress of the Digital Plan activities, IMTP commitments and CMT involvement of the Digital Directorate teams.



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- 12.2 Members discussed the Emergency Services Network (ESN) Phase 2, specifically the Welsh Government decision to separate out the air-to-ground element from the business case, and asked whether this was driven by cost concerns; they were advised that this was due to both financial and wider system considerations, and that the business case will be presented for review through the July meeting cycle.
- 12.3 Members discussed capacity and workforce pressure within the Digital team, noting ongoing recruitment challenges, and asked whether the team is sufficiently resources to meet the competing demands across the digital portfolio. Members were advised that the team is resourced in line with affordability, with no excess capacity. While this enables transformation and growth to continue, it limits the pace of delivery and increasing future demand may require further investment or structural changes.

13. INFORMATION GOVERNANCE REPORT

13.1 INFORMATION GOVERNANCE REPORT TOOLKIT

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

- 13.2 Jonny Sammut introduced both the Information Governance report and the Information Governance Toolkit, noting that this is the Trust's first toolkit submission and confirming that the Trust is now meeting all minimum information governance expectations.
- 13.3 Members noted the key risks and areas requiring action from the report, and received assurance that these risks are recognised, actively managed, and have structured recovery plans in place to address them.
- 13.4 The committee considered the contents of the paper on the progress of the Trust's Information Governance arrangements and related specialist activities for Data Quality, Records Management, Freedom of Information requests and Information Security, and acknowledged the update and outcomes of the 2025/26 Information Governance Toolkit submission.



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14. RISK MANAGEMENT REPORT

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

- 14.1 The committee received the Risk Management and Board Assurance Framework Report and were assured that each risk has been reviewed within this governance cycle, with no material changes to scores. The activity undertaken during this period is due to be considered by the ELT on 27 May 2026.
- 14.2 Members discussed 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* and were assured that outcomes from the independent review commissioned by the JCC was largely supportive of the Trust's position. It was helpful to attend a facilitated meeting with the reviewer, hosted by the JCC, to discuss the small number of areas of divergence. Members were advised that ongoing engagement with commissioners continues, although timelines on the formal outcome and funding remain uncertain. A further focused update will be provided as the position develops.
- 14.3 The Chair requested that a short paper updating on the Manchester Arena Inquiry be provided to the next Finance and Performance Committee meeting.
- 14.4 Lee Brooks updated regarding the High Acuity Response Team (HART); the Trust is preparing to submit a business case for this, covering the South Wales area, to Welsh Government with plans to develop a business case later in the year for a specialist response model in North Wales.
- 14.5 Members discussed risk 139, *Failure to Deliver our Statutory Financial Duties in accordance with legislation* and were advised that this risk score is likely to increase given current financial pressures, reliance on key assumptions that are still emerging and increased overall risk exposure. Work is ongoing to review and update the risk to ensure it accurately reflects the current financial position.
- 14.6 It was confirmed that Risk 542, *Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan*, will be a separate, standalone risk, rather than being reframed as a broader statutory/regulatory compliance risk. Assurance was given that this position has been agreed and discussed with the Director of Corporate Governance/Board Secretary and ELT, and it was agreed that the relevant action point on the action log can be closed.



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- 14.7 Members queried whether the current score attributed to Risk 542 appropriately reflects its relative significance when compared with other red risks and sought greater clarity on the rationale for the rating. It was acknowledged that the risk remains under regular executive review to ensure that it remains proportionate in the context of the wider risk landscape and is reflective of what is within the Trust's control. Mitigation remains constrained by capacity and competing priorities, with progress being made on a best endeavours basis.
- 14.8 Members agreed that the ELT will review the score of risk 542 Decarbonisation at their next risk session to ensure that it remains proportionate and reflective of the current position.

15. AUDIT TRACKER 2025-26 Q4 REPORTING

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

- 15.1 The committee received the Audit Tracker report, noting that the report is by exception, highlighting only areas requiring attention. The committee reviewed and scrutinised the current position regarding high priority and limited assurance audit actions that are on their final revised date and ensured there is sufficient assurance in terms of mitigation of associated risks.
- 15.2 Members were advised that there were two open high-priority internal audit actions that are on their final revised dates, which would be considered further in the private board session. Members were advised that there were three open actions from limited assurance audits, also on their second and final revised dates; two are included in the paper and one is to be discussed in private board session.
- 15.3 It was proposed that bringing forward the original audit findings within the report would allow for enhanced reporting giving clearer visibility of how risk levels have changed over time.
- 15.4 An action was taken to confirm the status of Audit Action: 054-24/25 which is past its revised date of 30 April 2026 and provide assurance and a progress update to ARAC.



CONSENT ITEMS

There were no consent items

CLOSING ITEMS

16. REFLECTIONS

- 16.1 The Chair noted that the Fire Safety report had been expected. Members discussed fire safety reporting, noting that an internal audit on fire management will be presented at the next meeting. It was agreed to revert to the annual reporting cycle, subject to the audit outcome.
- 16.2 Members noted the positive and constructive nature of discussions at the meeting, particularly welcoming the commercial plan and the direction of travel it set out. Assurance was taken from continued strong delivery and performance in several areas despite ongoing system pressures, together with the successful closure of the previous year's accounts. The information governance reports provided significant assurance, oversight and management of related risks.
- 16.3 The Chair thanked colleagues for the transparency and candour of reporting, noting that while issues had been openly identified, assurance had also been provided that appropriate plans were in place to address them.

17. ANY OTHER BUSINESS

- 17.1 The Committee were advised of an offer from the Cyber Resilience Unit to provide a briefing on the Cyber Security and Resilience Bill, including its current progress and the implications for organisations in Wales. Members welcomed the opportunity for early sight of forthcoming regulatory changes to help inform the Trust's cyber planning.
- 17.2 An action was taken for a 30 minute briefing session to be arranged with the Cyber Resilience Unit to consider the Cyber Security and Resilience Bill, looking at what it will mean for organisations in Wales.

18. DATE AND TIME OF THE NEXT MEETING

- 20.1 The next meeting will be held on 21 July 2026 at 9:30am

The meeting closed at 12.47

ACTION LOG - CURRENT
FINANCE AND PERFORMANCE COMMITTEE

5/170326	17 March 2026	(5) Finance Report Month 10, 2025/26 and Financial Position for Month 11, 2025/26	Grip and control checklist review/governance route: Trish, Ed, and Carl to review the grip and control checklist following its assessment by the Financial Sustainability Programme Board, and to provide a recommendation on the most appropriate governance route (whether that be the FPC, ARAC, or both) to ensure the Board is properly assured without duplication within the Trust's governance framework.	Trish Mills, Ed Roberts, Carl Kneeshaw	21 July 2026	<u>Update 14 July 2026</u> The financial sustainability programme governance group have reviewed this, noting that many of the controls are already business as usual at the Trust. The group will evidence compliance and any gaps for submission to Welsh Government/Financial Recovery Unit by early September. Confirmation of this will come through either the financial sustainability reporting to FSP or the usual finance report update. <u>Update 11 May 2026</u> Richard Baxter advised that this is on the Financial Sustainability Programme Board agenda for discussion at the June meeting, following conversations between Trish Mills, Carl Kneeshaw and Chris Turley. A recommendation will come back to FPC following the June FSP meeting.	Complete
7.4 -190526	19 May 2026	7. Rurality, including overruns	An action was agreed for the Executive Leadership Team (ELT) to explicitly highlight to the Joint Commissioning Committee how external system decisions, particularly service reconfiguration, can impact ambulance performance measures, and to reflect these external factors more clearly in reporting, ensuring this context is clearly understood in commissioner discussions.	Rachel Marsh	21 July 2026	A verbal update will be provided at the meeting	Open
7.5 -190526	19 May 2026	7. Rurality, including overruns	Members noted that some of the data in the Rurality report was historical and it was agreed that more up-to-date NHS spend data would be sourced and incorporated into the report, to strengthen the report's evidence and to better reflect current funding levels.	Rachel Marsh	21 July 2026	A verbal update will be provided at the meeting	Open
9.7-190526	19 May 2026	9. Commercial Plan	An action was agreed for the Executive team to propose an appropriate reporting frequency of updates on the Commercial Plan, through the cycle of business, ensuring the Committee receives the updates at appropriate key points such as when there has been meaningful progress or where decisions are required.	Rachel Marsh	21 July 2026	<u>Update 14 July 2026</u> FPC will receive assurance by way of the IMTP report on SO3, in particular the deliverable to establish a fully functioning Commercial Function, underpinned by an approved Trust-wide Commercial Plan and delivering at least two sustainable income-generation streams. Any updates over and above that will be provided in November.	Complete
10.6-190526	19 May 2026	10. Integrated Medium Term Plan (IMTP) Year End 2025-26	An action was taken to develop and bring back options for more streamlined, outcome-based IMTP reporting that maintains assurance while avoiding duplication and excessive detail; also, to look further at the governance flow for this reporting and how it should be structured through committees and the board.	Rachel Marsh	21 July 2026	FPC is asked to consider that the revised reporting is on the IMTP from Q1 2026/27	Open
14.3/190526	19 May 2026	14. Risk Management and Board Assurance Framework Report	The Chair requested that a short paper updating on the Manchester Arena Inquiry to come to the next FPC meeting.	Lee Brooks	21 July 2026	<u>Update 21 May 2026</u> Added to the forward planner to be included on the agenda of the FPC meeting on 21 July 2026; private or public agenda to be confirmed nearer the time dependant on outcomes from commissioners	Complete
14.8/190526	19 May 2026	14. Risk Management and Board Assurance Framework Report	Members discussed the scoring of risk 542 Decarbonisation and agreed that the Executive Leadership Team will review the score at their next risk session to ensure that it remains proportionate and reflective of the current position.	Chris Turley/Julie Boalch	21 July 2026	<u>Update 13 July 2026</u> Discussed at ELT on 27/05/2026. Further work will be undertaken in relation to the scoring and will be considered again by the ELT in due course.	Complete
15.5/190526	19 May 2026	15. Audit Tracker 2025-26 Q4 Reporting	An action was taken to confirm the status of Audit Action: 054-24/25 which is past its revised date of 30 April 2026 and provide assurance and a progress update to ARAC.	Julie Boalch	21 July 2026	<u>Update 19 May 2026</u> Lee Brooks confirmed that a flow chart is being developed to fulfil the requirements of this action; it is anticipated this will be signed off at the next Vehicle management group and can then proceed to closure.	Complete
17.2/190526	19 May 2026	17. Any Other Business	An action was taken for a 30-minute briefing session to be arranged with the Cyber Resilience Unit to go through the Cyber Security and Resilience Bill, looking at what it will mean for organisations in Wales.	Jonny Sammut	21 July 2026	<u>Update 28 May 2026</u> Session arranged for 9 Sept 2026	Complete



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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	28 May 2026
Committee Meeting Date	19 May 2026
Chair	Jayne Beeslee

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

Items for board approval:

1. The committee endorsed the Commercial Plan (**Annex 1**), aligned to the Trust's Integrated Medium Term Plan, which establishes a structured and values led approach to commercial development, focussed on reinvestment in services, workforce and innovation, rather than income generation alone. Members received assurance on the governance framework, ethical considerations and application of Value Based Healthcare principles. Members acknowledged the ambition to develop a self-sustaining commercial function by 2027/28 and confirmed the intention to maintain oversight as implementation progresses. Members emphasised the importance of a clear and consistent costing and pricing framework, including transparent treatment of overheads, to ensure credibility and avoid challenge regarding full cost attribution. The importance of a defined reinvestment principle was highlighted, recognising the risk of disengagement if teams do not see a direct link between their contribution and organisational or local benefit, and the need to balance organisational gain with local incentivisation.

ADVISE

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

2. The committee was advised on the forthcoming **Cyber Security and Resilience Bill** and accepted an opportunity for a focused briefing session to outline implications for NHS Wales organisations. Members welcomed further engagement, recognising the increasing importance of cyber resilience within the Trust's overall risk profile and the need for continued visibility, including via the forthcoming audit reporting.
3. Members **reflected positively** on the quality of the discussions and overall assurance received. The committee noted constructive and meaningful debate, particularly on strategic items such as the Commercial Plan, and recognised continued organisational delivery within a challenging



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environment. Specific commendation was given to financial management and year-end delivery and the transparency and candour of reporting, with issues clearly articulated alongside mitigating actions.

ASSURE

(Detail here assurance items the Committee receives)

The following items will also be presented to board at their 28 May 2026 meeting however members may benefit from the following points of discussion from the committee:

Financial Position

4. The committee received the detailed financial position for **month 12 2025/26**. The detail of the paper is not included here as it will be presented separately to board, but members may wish to note:
 - As at M12, a small revenue underspend/surplus of £0.080m was reported, which is the basis for the draft accounts for the 2025/26 financial year (subject to audit).
 - Full delivery of the capital programme.
 - Gross savings of £8.556m have been achieved against a £8.500m target.
5. A breakeven position for **month 1 2025/26** was reported including delivery of planned savings; however, Members noted that there are some risks and fragility with this and its reliant on some key assumptions as follows:
 - Assumption of c.£2.3m additional Welsh Government funding for risk pool pressures, not yet confirmed.
 - Emerging cost pressures, particularly fuel price volatility, not fully anticipated in planning potentially adding material in-year financial pressure.
 - A remaining savings gap (c.£1.2m), requiring continued focus on delivery, with an expectation to maximise recurrent savings.
 - An overall higher level of risk than typically reported, including emerging medium risks.

Integrated Medium Term Plan 2025/26 Delivery Assurance

6. The committee received the **Year End Integrated Medium Term Plan (IMTP) Assurance Report** (supported by detailed appendices), noting a positive overall position on delivery and strong alignment with multi-year priorities. Reporting for 2026-29 has been updated to align deliverables with strategic objectives supporting improved oversight. The evolving nature of the Clinical Model Transformation (CMT) programme, was highlighted including a shift from large-scale milestones to a more mature phase of delivery, strengthened through the benefits realisation approach and more proportionate reporting.



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Performance Metrics

7. The board will receive the new form **Monthly Integrated Quality and Performance Report** (MIQPR) for March/April 2026 at its May meeting; however, of note from the committee's existing reporting were higher than expected 111 call abandonment rates in April, increased clinical call-back times across remote assessment services, with actions underway to increase clinical capacity and improve patient flow. While performance for life-threatening incidents remains strong, pressures in higher acuity demand and system flow continue to impact performance, with further improvement work progressing through the CMT benefits realisation programme. The committee welcomed the ongoing work to refine the MIQPR reporting including that for committees.

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

8. The reasonable assurance **Internal Audit Report** on the **Capacity Management Plan (Ambulance Care)** was received with recommendations focussing on strengthening documentation of decision making in a high demand operational environment.
9. Members received the **Rurality report** describing performance variations between rural and urban areas noting the importance of a clearly defined problem statement with commissioners before identifying further actions. Committee discussed system level factors influencing outcomes, the need for clarity in performance measures and continued engagement on key enablers such as Handover 45 and targeted recruitment approaches.
10. The **Digital Report** was noted including continued digital innovation with constrained capacity relative to demand, with ongoing recruitment and market challenges. Members were assured that while the position has stabilised, future prioritisation and potential investment will be required to sustain delivery.
11. Members noted the **Information Governance** report which provided transparency on key risks, including pressures in records management and Subject Access Request compliance, a backlog of Data Protection Impact Assessments, and issues relating to CCTV governance. Members were assured that these risks are being actively managed, with targeted recovery actions in place, including the establishment of a dedicated recovery cell.
12. Members were assured that the **2025/26 Information Governance Toolkit** was successfully submitted and all minimum standards had been met for the first time. Many standards were rated as exceeded, a significant step forward within a complex NHS landscape of compliance. An action plan is in development for the 2026/27 submission to maintain existing requirements and to address new standards on AI use, data subject complaint processes and an updated Information Asset Register, and DPIAs for AI solutions.
13. The **Operations Quarterly report** was received, with the following of note for the board:
- The **111 rostering review** on track for June, supported by enabling digital developments.
 - Early work on RCS0 pre-alert functionality has identified capacity trade-offs within clinical navigation, and further work is underway to better understand and optimise resource requirements.



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- The **Falls Desk** has secured funding for the current year and is demonstrating clear impact. However, there is no confirmed funding beyond this period, and further evaluation will be undertaken in year to support a case for continuation, with potential reliance on internal prioritisation if external funding is not secured.
- The **single clinical queue/Integrated Care Clinical Queue** has been implemented, with a stabilising position; however, further data reporting investigation is required for accurate callback times and consult and close rates.
- Improvements have been made in **workforce planning and training**, with a revised approach to MIST delivery reducing pressure on management and training teams. Our Trade Unions Partners were recognised for the partnership working to improve the experience for all involved.
- The next phase of **NEPTS roster changes** remains on track and is expected to deliver additional operational capacity through Q2.
- Delivery of £4.3m of **operational savings** was noted, with associated capacity impacts.

Governance Reports

14. The **audit tracker for Q4** was received with no escalations to the board.
15. In **private session** members received an update on the forward plan of contracts within board delegation over the next 18 months, the strategic commercial partnership and contractual arrangements paper, the cyber papers and audit tracker for Q4. There were no escalations to the board with respect to those items. The private session also considered and endorsed a contract replacement, call prioritisation streaming system and online symptom checkers paper and the 2026/27 capital plan for approval by the board. All items taken in private session were done based on commercial or security sensitivity and will be reported to the open session of the board in due course.

RISKS

The committee received the **Risk and Board Assurance Framework report** noting all risks have undergone their quarterly review, with no changes in scores. The activity undertaken during this period is due to be considered by the Executive Leadership Team on 27 May 2025.

Risk 139 Finance

The risk remains at a score of 8 (2x4) but it is expected to increase to reflect the emerging financial pressures, reliance on key assumptions that are still emerging and increased overall risk exposure.

Risk 641 Manchester Arena Inquiry

Members noted that the independent review commissioned by the JCC was largely supportive of the Trust's position. It was helpful to attend a facilitated meeting with the reviewer, hosted by the JCC, to discuss the small number of areas of divergence. Ongoing engagement with commissioners continues, although timelines on the formal outcome and funding remain uncertain. A further focused update will be provided as the position develops.



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Risk 542 Decarbonisation

Members noted that while the risk retains its high score, mitigation continues to be constrained by capacity limitations. Members acknowledged that this remains a stand-alone risk and not part of a wider regulatory /compliance risk. Committee noted the ongoing review of the score to ensure that it remains proportionate in the context of the wider risk landscape and reflective of what is within the Trust's control as we navigate a challenging financial position.

COMMITTEE AGENDA FOR MEETING

Operations Q4 2025/26 report	Internal audit – Capacity Management Plan (Ambulance Care)	Rurality, including overruns
Financial position M12 2025/26 Financial position M1 2026/27	Commercial plan	IMTP Year End 2025/26 assurance
MIQPR March/April 2026	Digital reporting May 2026	Information Governance Progress Report
Information Governance Toolkit	Risk management report	Audit tracker Q4 2025/26

COMMITTEE ATTENDANCE

Name	19 May 2026	21 Jul 2026	15 Sep 2026	17 Nov 2026	19 Jan 2027	16 Mar 2027
Jayne Beeslee (Chair)						
Bethan Evans						
Peter Curran						
Chris Turley						
Rachel Marsh						
Lee Brooks						
Liam Williams						
Carl Kneeshaw						
Jonny Sammut						
Trish Mills	Julie Boalch					
Hugh Parry	Until 12:40					
Damon Turner						
Matt Dugdale						

	Attended
	Deputy attended
	Apologies received
	No longer member



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

REAP 4, Critical Incident and Major Incident

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

National Operations & Support

Challenges

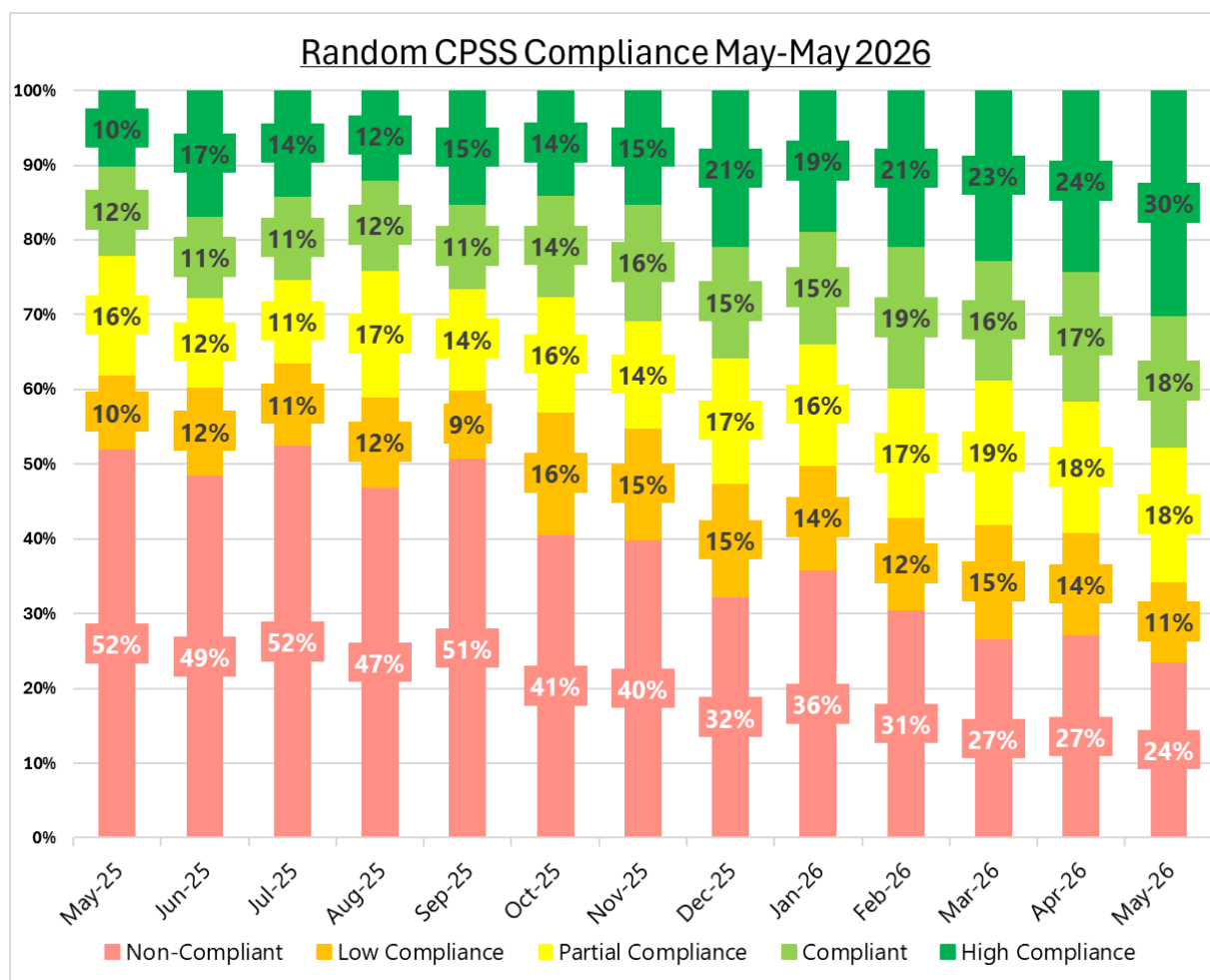
General Update

ECNS and CPSS Compliance

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

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

CPSS compliance (last 12 months):



ECNS for May 2026:

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

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

IMTP

Volunteers in Major Incidents

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

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

GRS Cloud

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

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

Volunteer Closure Report

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

National Operations Coordination Centre (NOCC)

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

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

Coordination & Integrated Care

Challenges

Integrated Care System Business Continuity Arrangements

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

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

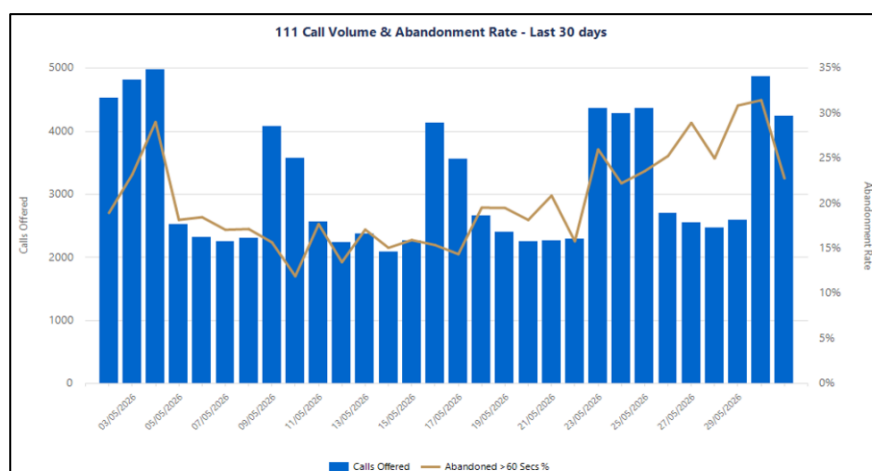
Operational Delays due to Clinical Information Visibility

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

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

Exceptional NHS 111 Wales May Demand

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



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

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

Integrated Care and EMS Coordination Abstractions

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

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

IMTP

Integrated Care Clinical Queue (ICQ)

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

111 Roster Review

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

Welsh Language Clinical Consultations Plan 2026–2031

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

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

General Update

Falls Desk

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

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

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

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

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

Introduction of the new 1st Line Management Structure:

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

EMSC Locality Manager Programme of Work

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

Health Care Professional Test of change HCP

The tests of change focused on alternative approaches to how community Healthcare Professional (HCP) calls are managed with the aim of improving clinical prioritisation, reducing unnecessary emergency dispatch, and increasing use of alternative care pathways.

Two tests of change have been undertaken throughout April to support early clinical involvement and robust information capture at the point of call through the use of the Medical Priority Dispatch System (MPDS) Medical Transfer Protocol Suite (MTPS) initial findings indicate clear opportunities to better align response levels with patient need, reduce avoidable ambulance dispatch, and strengthen use of alternative pathways, informing the development of a more efficient and clinically robust future model.

Improving Response Times for High-Risk Stroke Patients

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

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

Immediate Release and Rapid Handover at English Hospital

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

Multiagency Incident Transfer Update – Dyfed-Powys Police Go-Live

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

Emergency Operations

Challenges

Handover 45

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

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

IMTP

APP Roster Review

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

Fleet Review T&F Group

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

Multi Casualty Triage Bags (MCTB)

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

Business Continuity

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

HART Uplift Business Case

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

Wales Risk Register

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

Euros & Tour De France

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

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

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

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

General Update

TOIL Pilot

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

Ambulance Care

Challenges

Demand and CMP challenges

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

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

IMTP

NEPTS Improvement Programme

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

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

NEPTS Roster Review progress

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

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

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

General Update

NEPTS Annual Report

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

Patient Feedback

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

SMS - Digital Enhancements to Patient Communication

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

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

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

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

Pan Directorate Updates

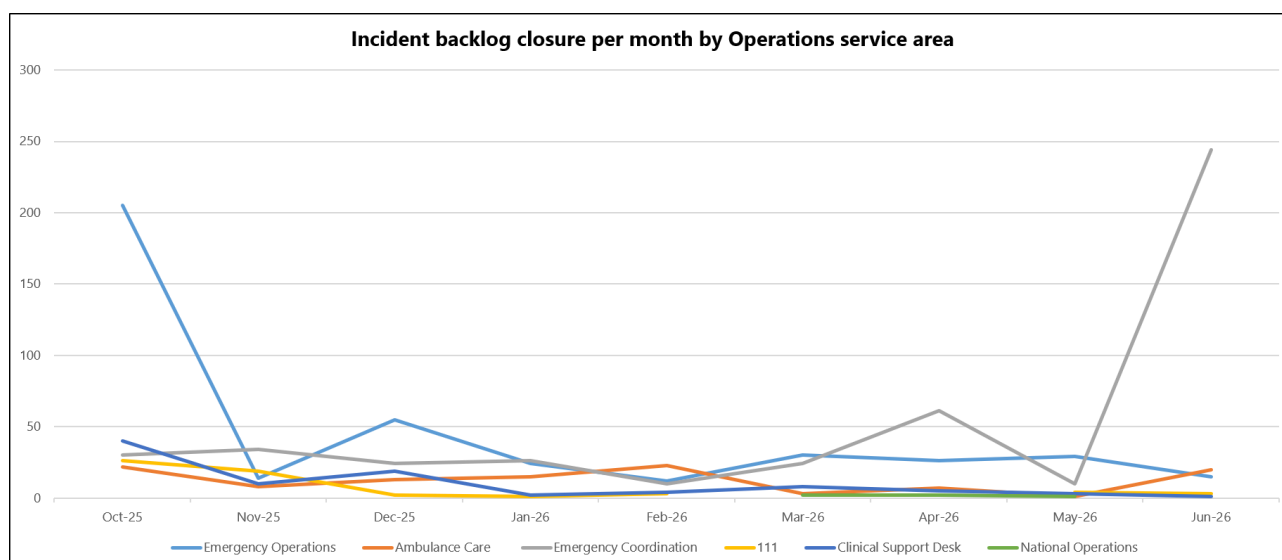
Financial Savings

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

CC Level 3	CC Level 4	Scheme	Annual Plan	CM Plan	CM Actual	CM Variance	YTD Plan	YTD Actual	YTD Variance	Forecast Plan	Forecast Actual	Forecast Variance
DX01-Operations Directorate	DX02-ADO-NOS	Non Pay MWF	215,000	18,000	18,000	0	35,000	35,000	0	215,000	215,000	0
DX01-Operations Directorate	DX02-ADO-NOS	Non Pay Travel & Subs, Conferences	14,000	0	0	0	0	0	0	14,000	14,000	0
DX01-Operations Directorate	DX02-ADO-NOS	Non Pay Volunteers	25,000	0	0	0	25,000	25,000	0	25,000	25,000	0
DX01-Operations Directorate	DX02-ADO-NOS	Pay Vacancy Operations - IRD	265,843	55,595	55,595	0	111,000	111,000	0	265,843	265,843	0
DX01-Operations Directorate	DX02-ADO-NOS	Pay Vacancy Operations - Non Frontline	61,000	12,000	12,000	0	49,000	49,000	0	61,000	61,000	0
DX01-Operations Directorate	DX02-ADO-NOS	Pay Vacancy Operations - ODU	18,157	6,052	6,052	0	12,104	12,104	0	18,157	18,157	0
DX01-Operations Directorate	DX02-ADO-NOS Total		600,000	91,557	91,557	0	232,114	232,114	0	600,000	600,000	0
DX01-Operations Directorate	DX03-ADO - Coordination & IC	Non Pay Tai	18,000	0	0	0	0	0	0	18,000	18,000	0
DX01-Operations Directorate	DX03-ADO - Coordination & IC	Non Pay Travel & Subs, Conferences	2,000	0	0	0	0	0	0	2,000	2,000	0
DX01-Operations Directorate	DX03-ADO - Coordination & IC	Pay Management Operations - IC Desk	289,000	35,000	35,000	0	70,000	70,000	0	289,000	289,000	0
DX01-Operations Directorate	DX03-ADO - Coordination & IC	Pay Management Operations - IC Manager	38,000	3,000	3,000	0	6,000	6,000	0	38,000	38,000	0
DX01-Operations Directorate	DX03-ADO - Coordination & IC	Pay Vacancy Operations - Non Frontline	64,000	6,000	6,000	0	6,000	6,000	0	64,000	64,000	0
DX01-Operations Directorate	DX03-ADO - Coordination & IC Total		591,000	44,000	44,000	0	82,000	82,000	0	591,000	591,000	0
DX01-Operations Directorate	DX04-ADO - Emergency Medical Services	Non Pay Fuel	100,000	9,000	0	-9,000	18,000	0	-18,000	100,000	48,000	-52,000
DX01-Operations Directorate	DX04-ADO - Emergency Medical Services	Non Pay Help Point	40,000	0	0	0	40,000	40,000	0	40,000	40,000	0
DX01-Operations Directorate	DX04-ADO - Emergency Medical Services	Non Pay Hospital Concessions	100,000	10,000	10,000	0	20,000	20,000	0	100,000	100,000	0
DX01-Operations Directorate	DX04-ADO - Emergency Medical Services	Non Pay M&SE Stock Control	100,000	9,000	20,000	11,000	18,000	41,000	23,000	100,000	123,000	23,000
DX01-Operations Directorate	DX04-ADO - Emergency Medical Services	Non Pay Travel & Subs, Conferences	40,000	0	0	0	0	0	0	40,000	40,000	0
DX01-Operations Directorate	DX04-ADO - Emergency Medical Services	Non Pay Uniforms	12,000	1,000	7,000	6,000	2,000	16,000	14,000	12,000	26,000	14,000
DX01-Operations Directorate	DX04-ADO - Emergency Medical Services	Non Pay Winter Vehicles	50,000	0	0	0	0	0	0	50,000	50,000	0
DX01-Operations Directorate	DX04-ADO - Emergency Medical Services	Non Pay Wreatham ATC	10,000	0	0	0	10,000	10,000	0	10,000	10,000	0
DX01-Operations Directorate	DX04-ADO - Emergency Medical Services	Pay Management Operations - Paramedics (APP)	145,000	12,000	12,000	0	24,000	24,000	0	145,000	145,000	0
DX01-Operations Directorate	DX04-ADO - Emergency Medical Services	Pay Management Operations - Skill Mix	500,000	42,000	42,000	0	84,000	84,000	0	500,000	500,000	0
DX01-Operations Directorate	DX04-ADO - Emergency Medical Services	Pay Variable Operations - End of Shift	96,000	8,000	13,000	5,000	16,000	25,000	9,000	96,000	105,000	9,000
DX01-Operations Directorate	DX04-ADO - Emergency Medical Services	Pay Variable Operations - Overtime	850,000	71,000	71,000	0	142,000	142,000	0	850,000	850,000	0
DX01-Operations Directorate	DX04-ADO - Emergency Medical Services Total		2,043,000	162,000	175,000	13,000	374,000	402,000	28,000	2,043,000	2,037,000	-6,000
DX01-Operations Directorate	DX05-ADO - Ambulance Care	Non Pay FALLS	150,000	12,000	0	-12,000	24,000	0	-24,000	150,000	150,000	0
DX01-Operations Directorate	DX05-ADO - Ambulance Care	Non Pay Fuel	40,000	3,000	0	-3,000	6,000	0	-6,000	40,000	20,000	-20,000
DX01-Operations Directorate	DX05-ADO - Ambulance Care	Non Pay Tai	208,000	14,000	14,000	0	26,000	26,000	0	208,000	208,000	0
DX01-Operations Directorate	DX05-ADO - Ambulance Care	Non Pay Travel & Subs, Conferences	26,000	0	0	0	0	0	0	26,000	26,000	0
DX01-Operations Directorate	DX05-ADO - Ambulance Care	Pay Management Operations - UCS	415,000	35,000	35,000	0	65,000	65,000	0	415,000	415,000	0
DX01-Operations Directorate	DX05-ADO - Ambulance Care	Pay Variable Operations - End of Shift	14,000	2,000	2,000	0	4,000	4,000	0	14,000	14,000	0
DX01-Operations Directorate	DX05-ADO - Ambulance Care	Pay Variable Operations - Overtime	250,000	0	0	0	0	0	0	250,000	250,000	0
DX01-Operations Directorate	DX05-ADO - Ambulance Care Total		1,103,000	66,000	51,000	-15,000	125,000	95,000	-30,000	1,103,000	1,083,000	-20,000
DX01-Operations Directorate Total			4,337,000	363,557	361,557	-2,000	813,114	811,114	-2,000	4,337,000	4,311,000	-26,000
Grand Total			4,337,000	363,557	361,557	-2,000	813,114	811,114	-2,000	4,337,000	4,311,000	-26,000

Datix Backlog

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



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

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

Listening to People (LTP)

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

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

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

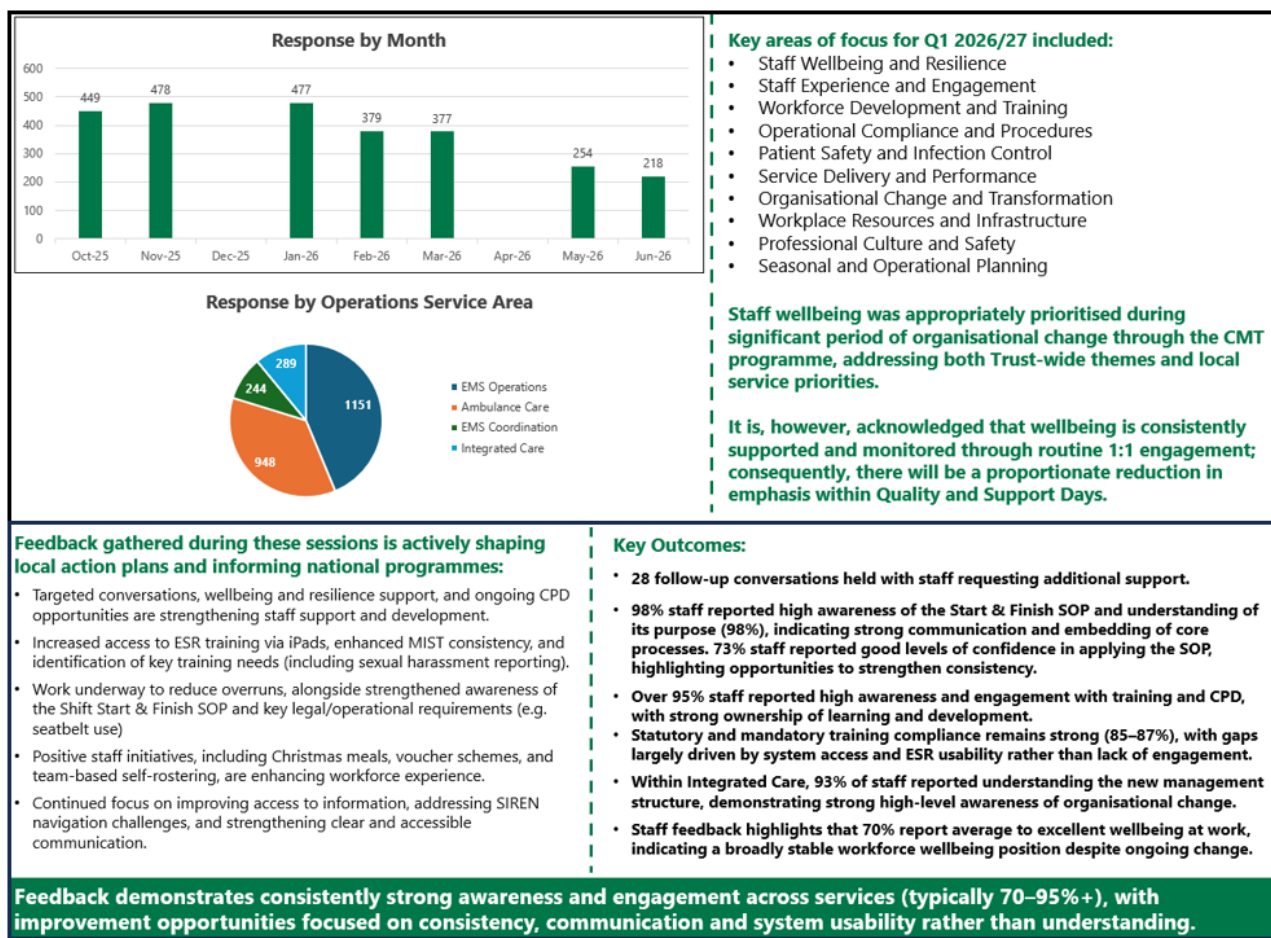
The Directorate continues to work towards embedding more sustainable processes and consistent management of concerns across service areas. A key focus remains improving both the timeliness and quality of responses while reducing the number of overdue cases. Further work is required before confidence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

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

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

Quality and Support Days

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



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

Essential Conversations

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



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Agenda Item No.

06

REPORT TITLE

Financial Performance as at Month 2 2026/27

MEETING

Name of meeting	Finance & Performance Committee
Date of meeting	21 July 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Chris Turley, Executive Director of Finance & Corporate Resources
Author(s) of report	Edward Roberts, Interim Assistant Director of Finance Steph Taylor, Deputy Head of Financial Business Intelligence & Capital Planning

PURPOSE OF REPORT

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



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REPORT SUMMARY

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

1. This paper presents to the committee the latest Financial Performance Report of the 2026/27 financial year, the reported position as at Month 2 (May 2026).
2. The committee is asked to review, comment, note and receive assurance on the financial position and 2026/27 outlook and forecast of the Trust, noting the risks to in year delivery in doing so.
3. Key highlights from the report for the committee to note are:
 - The Trust is reporting a breakeven position for month 2 2026/27, but the assumptions made in doing so need to be noted;
 - Capital expenditure plans are being finalised with plans to fully achieve in year;
 - In line with the balanced financial plan approved as part of the submitted 2025-28 IMTP, the Trust continues to forecast a breakeven position by the 2026/27 financial year end;
 - In line with the financial plans that support the IMTP, gross savings of £1.423m have been achieved in month 2 against a target of £1.342m; and
 - Public Sector Payment Policy is on track with performance, against a target of 95%, of 97.7% for the number, whilst slightly off track in terms of value at 87.5% of non-NHS invoices paid within 30 days.

RECOMMENDATION(S)

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

The committee is requested to:

1. **Note** and gain **assurance** in relation to the Month 2 revenue financial position and performance of the Trust as at 31 May 2026.
2. **Note** the delivery of the 2026/27 savings plan, and the context of this within the overall financial position of the Trust.
3. **Note** the initial capital programme for 2026/27.
4. **Note** the Month 2 Welsh Government monitoring return submission (as required by WG).

ADDITIONAL PAPER(S)

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

The committee is requested to receive the following:

Annex 1 Monitoring return submitted to Welsh Government for month 2, as required by WG

Annex 2 Monitoring return letter submitted to Welsh Government for month 2, as required by WG



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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

RISK(S) THIS REPORT MITIGATES

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

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

IMPACT ASSESSMENTS FOR CONSIDERATION

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

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
n/a	n/a



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SITUATION

1. This report provides the committee with a summary of the revenue financial performance of the Trust as at 31 May 2026 (Month 2 2026/27), along with a brief update on the initial 2026/27 capital programme.

BACKGROUND

2. The key points to note in relation to the **delivery of the Statutory Financial Targets for 2025/26** (1 April 2026 – 31 May 2026) are that:
 - The revenue financial position reported is **breakeven**, based on some key assumptions consistent with that within the IMTP financial plan and the Board approved budget for 2026/27. The underlying year-end forecast for 2026/27 is currently a balanced position;
 - In line with the financial plans that supported the submitted Annual Plan within the IMTP for this financial year, gross savings of **£1.423m** have been achieved against a target of **£1.342m**;
 - Public Sector Payment Policy is on track with performance, **against a target of 95%, of 97.7% for the number**, whilst slightly off track in terms of value at **87.5% of the value** of non-NHS invoices paid within 30 days.
3. At the planning stage of the 2026/27 financial year the Trust assumed it would need to cover in full the emerging cost pressure of the increase in the Welsh Risk Pool (WRP) costs, as such the Trust strove to identify savings to cover the whole £2.355m estimated cost increase, as part of the £9.000m total savings requirement. However, following the submission of the plan, Welsh Government (WG) confirmed that if organisations could deliver a balanced position other than for the WRP element then WG would fund this pressure. As such the Trust is now assuming cover for this. Whilst work continues to seek delivery of the full opening savings plan, including the residual shortfall (£1.200m) that existed at the time of the plan sign off, there may be some shortfall in the delivery of this, noting that this element of that required was solely driven by the estimated increase in WRP costs in the first place.
4. In terms of the current reported position, this is further compounded by the cost pressure that has materialised following the completion of the plan in relation to fuel price increases, due to the impact of the war in the Middle East. Should prices remain as they are throughout the financial year, this would translate into a



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c£1.500m additional cost pressure not able to be recognised as such in the financial plan.

5. Whilst reporting a balanced position therefore at the outset of the financial year, which is clearly encouraging, it is key to also note the following assumptions that have been made in reporting this current and forecast position:
 - The ability to deliver a minimum of at present £7.800m (£9.000m per the IMTP and initial budget setting) in savings and efficiencies in year. Work continues to progress the residual gap of £1.200m, in the context of other emerging issues, pressures and potential additional funding.
 - Assumed financial cover from WG for the increased WRP costs – at a value of £2.355m.
 - No other developments, enhancements or cost increases not currently funded within budgets will be able to be progressed until a confirmed funding source for them is found, or an agreed equivalent value of cost is stopped or reduced elsewhere.
 - The ability to manage any other in year cost pressures as they arrive, within the small contingency the Trust continues to hold, as per the IMTP / 2026/27 financial plan.
 - Income assumptions in opening financial plan are fully funded via commissioners and Welsh Government (i.e. pay awards / Employers National Insurance increases)
6. As we know, no plan, forecast or reported delivery at this stage of the financial year is risk free. The risks included in the Welsh Government Monitoring Return at Month 2 are set in line with the submitted IMTP and summarised later in this report. Accepting that it is early in the new financial year, as we go through the next few months these will continue to be scrutinised and amended accordingly, with mitigations and management plans in place.
7. However, the key updates from the Trust Board approved financial plan and budget set needs to be understood in reviewing the detail of this M02 position, and in particular the additional income now assumed and the emerging impact on the costs and forecast spend of current fuel pump prices. Without making some of these assumptions the Trust would have been in a deficit.



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ASSESSMENT

REVENUE FINANCIAL PERFORMANCE – MONTH 2 2026/27

8. The table below presents an overview of the financial position for the period 1 April 2026 to 31 May 2026.

Revenue Financial Position for the period 1st April - 31st May				
	Annual Budget	Year to date		
		Budget	Actual	Variance
	£000	£000	£000	£000
Income	-333,722	-54,241	-54,358	-118
Expenditure				
Pay	252,123	41,573	41,270	-303
Non-pay	64,714	9,935	10,374	440
Total pay & non-pay expenditure	316,837	51,508	51,644	137
Depreciation & Impairments / interest payable & receivable	16,885	2,733	2,714	-19
Total	0	0	0	0

Income

9. Reported Income against the initial budget set to Month 2 shows an overachievement of **£0.118m**.

Pay Costs

10. Overall, the total pay variance at Month 2 is an underspend of **£0.303m**.

Non-pay Costs

11. The non-pay position at Month 2 is an overspend of **£0.440m**. In addition, for reporting purposes Depreciation, Impairment and Interest is excluded from the above figure, which underspent by **£0.019m**, hence the total overspend to budget of **£0.421m**.

Savings

12. As above, the 2026/27 financial plan identifies that a minimum of **£9.000m** of planned savings (including income generation) are required to achieve financial balance in 2026/27, of which all is reported as recurrent.
13. Month 2 in month performance was, plan of £0.617m and £0.690m achieved, therefore an overachievement of £0.073m (as per the below table).



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	Annual Plan £000	In Month			Cumulative			Forecast		
		Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000
BX01-Chief Executive Directorate	107	5	5	-1	11	10	-1	107	107	0
BX02-Corporate Governance	39	1	1	0	2	2	0	39	39	0
CX01-Partnerships & Engagement Directorate	40	3	3	0	7	6	0	40	40	0
DX01-Operations Directorate	4,337	364	362	-2	813	811	-2	4,337	4,311	-26
FX01-Finance and Corporate Resources Directorate	1,064	64	76	12	151	128	-23	1,064	1,024	-40
HX01-Planning and Performance Directorate	267	10	41	31	19	75	55	267	356	89
JX01-Quality, Safety and Patient Experience Directorate	420	35	29	-6	70	57	-13	420	391	-29
KX01-Digital Directorate	720	60	90	30	120	175	55	720	707	-13
PX01-People and Culture Directorate	402	41	69	27	82	128	46	402	500	98
RR01-Trust Reserves	1,220	2	2	0	3	3	0	1,220	-16	-1,236
UX01-Medical & Clinical Services Directorate	384	32	14	-18	64	27	-37	384	341	-43
Totals	9,000	617	690	73	1,342	1,423	81	9,000	7,800	-1,200

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

14. **Annex 1** provides the overall detail for Month 2 by theme.

Financial Performance by Directorate

15. Whilst there is a breakeven position at Month 2, 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. These are fairly minor in nature, given we are so early in the financial year, but they will be continued to be closely monitored.

Financial position by Directorate @ 31st May	Annual Budget £000	Year to date			
		Budget	Actual	Variance	Tolerance 5%
		£000	£000	£000	%
Directorate					
Operations Directorate	226,856	37,478	37,473	-5	0.0%
Chief Executive Directorate	2,189	387	386	-1	-0.3%
Board Secretary	781	137	136	-1	-0.4%
Partnerships & Engagement Directorate	716	102	95	-8	-7.6%
Finance and Corporate Resources Directorate	38,444	6,295	6,433	138	2.2%
Planning and Performance Directorate	3,242	560	501	-59	-10.5%
Quality, Safety and Patient Experience Directorate	8,120	1,352	1,337	-15	-1.1%
Digital Directorate	17,304	2,454	2,378	-77	-3.1%
People and Culture	6,993	1,017	1,037	20	2.0%
Medical & Clinical Services Directorate	6,782	1,064	1,073	9	0.9%
Trust Reserves	4,283	78	76	-1	-1.8%
Trust Income (mainly JCC)	-315,710	-50,924	-50,924	-0	0.0%
Overall Trust Position	0	0	-0	-0	

PUBLIC SECTOR PAYMENT POLICY PERFORMANCE (PSPP)

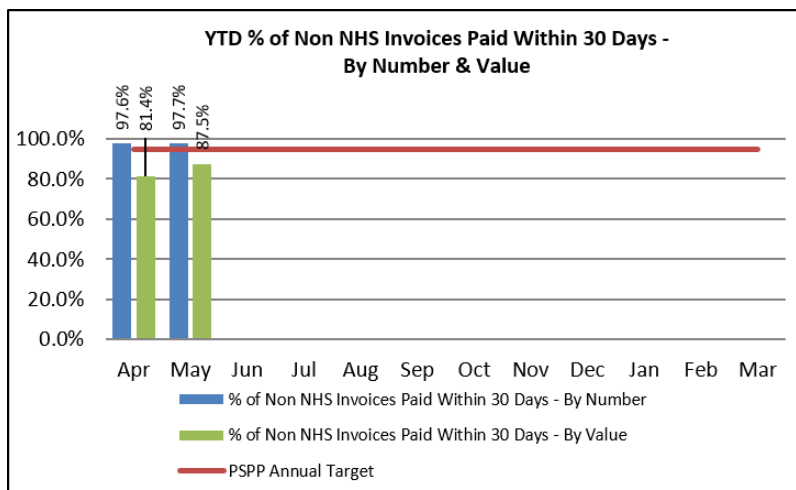
16. Public Sector Payment Policy (PSPP) compliance to Month 2 was **97.7%** against the **95%** WG target set for non-NHS invoices by number and **87.5%** by value.

17. Whilst the number is in line with the target, due to an AP issue with the system one large value invoice failed to process correctly in month 1, resulting in the 30 day target for value being missed.



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2026-27 INITIAL CAPITAL PROGRAMME

18. As we are in the early stages of the financial year the discretionary capital programme and resulting budgets are only now being finalised.
19. At Month 2, the Trust's approved Capital Expenditure Limit (CEL) set by and agreed with WG for 2026/27 is **£30.928m**. This includes **£24.133m** of All Wales Approved schemes and **£6.795m** for Discretionary schemes.

RISKS AND ASSUMPTIONS

20. Understandably this early in the financial year, the risks reported are still being fully assessed. However, at present, it is considered that there are no individual high likelihood risks as reported to WG, but as we move through the next few months we will continue to review the risks to ensure that the level of likelihood is assessed along with the financial value. Depending on the outcome of some of the issues highlighted, we may be moving towards higher risks having to be reported in due course. This will also inform a further review of risk 139 in the BAF.
21. However, at the outset of this financial year there are a number of risks that need to be documented within this initial reported financial position, which aligns to that fully described within the financial plan submitted as part of the IMTP.
22. A low risk has been included around any JCC additional saving request. Whilst nothing further has been formally raised in relation to this risk, and work is in development to quantify the performance improvements, the Trust has included an updated low risk of **£2.000m** based on the possibility that there may be a request we go further with our savings. However, the Trust does now have a signed agreement for the core monies from the JCC so this has been reduced from month 1 and is now reported as a low risk.



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23. Given the pressures the Trust is already seeing in relation to the war in the Middle East, the Trust has included a low risk of **£0.500m** around further increases in energy prices. Whilst the forecast for WAST via Shared Services was a reduction for WAST, this was based on the baskets of energy already secured. However, as we move through the year the amount secured for each month is reducing. In addition to this, the Trust have a number of sites which are outside of this supply, one with a high usage amount which is recharged via the landlord and is more heavily impacted by these rate increases.
24. At this stage it is prudent to include a risk of the WRP funding not being provided by Welsh Government, as such a risk has been included for the full amount of **£2.355m**. However, given the assurance from WG that if we achieve our forecast, it will be covered in full, it has been reduced to a low risk.
25. In addition to the current forecast around the Risk Pool, given the additional work being undertaken and the change in methodologies being applied by the courts, an unquantified low risk has been included.
26. As noted above, there are therefore no current individually assessed high financial risks as we enter the financial year, however when this is then considered alongside continuing significant service pressure and the likely balancing of this risk against patient safety, quality and experience, it is clear that, as expressed within the IMTP, this will likely be another challenging financial year, despite the initially reported financial performance in M02, based on the assumptions made in reporting this.
27. Full consideration and management of all these risks will clearly be high on the agenda for the Trust Board and its relevant Committees.

RECOMMENDATION(S)

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

NEXT STEPS

29. Monitor the ongoing revenue and capital position as we move through 2026/27, linking in with key stakeholders, to ensure delivery to plan.
30. Continue to closely monitor risks and ensure plans are developed to ensure the Trust can meet its statutory duties.



Annex 1

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

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Savings Performance by Theme 26-27

Reporting Month

2

	Annual Plan £000	In Month			Cumulative			Forecast		
		Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000
Income Commercialisation Opportunities	150	0	0	0	0	0	0	150	150	0
Non Pay Estates Efficiencies - Corporate	135	11	11	0	23	18	-5	135	135	0
Non Pay Fleet Efficiencies - Corporate	250	21	10	-11	42	10	-31	250	170	-80
Non Pay Local Schemes - Corporate	471	39	32	-8	79	54	-24	471	307	-164
Non Pay Local Schemes - Operations	915	46	51	5	115	128	13	915	880	-35
Non Pay Local Schemes - Operations Contract Reviews	415	30	18	-12	109	85	-24	415	415	0
Non Pay Unallocated Balance - to be further identified Qtr 1 26/27	600	0	0	0	0	0	0	600	0	-600
Pay Agency Reduction	89	7	7	0	15	15	0	89	89	0
Pay Cost Management (Variable Cost reductions) - Operations	1,100	71	71	0	142	142	0	1,100	1,100	0
Pay End of Shift Overrun - Operations	110	10	15	5	20	29	9	110	119	9
Pay Skill Mix Modernisation - Operations	500	42	42	0	84	84	0	500	500	0
Pay Unallocated Balance - to be further identified Qtr 1 26/27	600	0	0	0	0	0	0	600	0	-600
Pay Vacancy Management - Corporate	2,368	174	268	94	371	515	144	2,368	2,638	270
Pay Vacancy Management - Operations	1,297	165	165	0	343	343	0	1,297	1,297	0
Totals	9,000	617	690	73	1,342	1,423	81	9,000	7,800	-1,200

Savings Performance by Theme 26-27 - Recurrent

Reporting Month

2

	Annual Plan £000	In Month			Cumulative			Forecast		
		Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000
Income Commercialisation Opportunities	150	0	0	0	0	0	0	150	150	0
Non Pay Estates Efficiencies - Corporate	135	11	11	0	23	18	-5	135	135	0
Non Pay Fleet Efficiencies - Corporate	250	21	10	-11	42	10	-31	250	170	-80
Non Pay Local Schemes - Corporate	471	39	32	-8	79	54	-24	471	307	-164
Non Pay Local Schemes - Operations	915	46	51	5	115	128	13	915	880	-35
Non Pay Local Schemes - Operations Contract Reviews	415	30	18	-12	109	85	-24	415	415	0
Non Pay Unallocated Balance - to be further identified Qtr 1 26/27	600	0	0	0	0	0	0	600	0	-600
Pay Agency Reduction	89	7	7	0	15	15	0	89	89	0
Pay Cost Management (Variable Cost reductions) - Operations	1,100	71	71	0	142	142	0	1,100	1,100	0
Pay End of Shift Overrun - Operations	110	10	15	5	20	29	9	110	119	9
Pay Skill Mix Modernisation - Operations	500	42	42	0	84	84	0	500	500	0
Pay Unallocated Balance - to be further identified Qtr 1 26/27	600	0	0	0	0	0	0	600	0	-600
Pay Vacancy Management - Corporate	2,368	174	268	94	371	515	144	2,368	2,638	270
Pay Vacancy Management - Operations	1,297	165	165	0	343	343	0	1,297	1,297	0
Totals	9,000	617	690	73	1,342	1,423	81	9,000	7,800	-1,200

Savings Performance by Theme 26-27 - Non Recurrent

Reporting Month

2

	Annual Plan £000	In Month			Cumulative			Forecast		
		Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000
Income Commercialisation Opportunities	0	0	0	0	0	0	0	0	0	0
Non Pay Estates Efficiencies - Corporate	0	0	0	0	0	0	0	0	0	0
Non Pay Fleet Efficiencies - Corporate	0	0	0	0	0	0	0	0	0	0
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
Non Pay Local Schemes - Operations Contract Reviews	0	0	0	0	0	0	0	0	0	0
Non Pay Unallocated Balance - to be further identified Qtr 1 26/27	0	0	0	0	0	0	0	0	0	0
Pay Agency Reduction	0	0	0	0	0	0	0	0	0	0
Pay Cost Management (Variable Cost reductions) - Operations	0	0	0	0	0	0	0	0	0	0
Pay End of Shift Overrun - Operations	0	0	0	0	0	0	0	0	0	0
Pay Skill Mix Modernisation - Operations	0	0	0	0	0	0	0	0	0	0
Pay Unallocated Balance - to be further identified Qtr 1 26/27	0	0	0	0	0	0	0	0	0	0
Pay Vacancy Management - Corporate	0	0	0	0	0	0	0	0	0	0
Pay Vacancy Management - Operations	0	0	0	0	0	0	0	0	0	0
Totals	0	0	0	0	0	0	0	0	0	0

Please note figures are rounded to the nearest whole number

VALIDATION SUMMARY 2026-27

Your organisation is showing as :	WELSH AMBULANCE TRUST
Period is showing :	MAY 26
TABLE A : MOVEMENT	WELSH AMBULANCE TRUST IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE A2: RISKS	WELSH AMBULANCE TRUST IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE B : MONTHLY POSITIONS	WELSH AMBULANCE TRUST IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE B3 : PAY & AGENCY/LOCUM	WELSH AMBULANCE TRUST IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE C, C1 & C2 : SAVINGS SCHEMES	WELSH AMBULANCE TRUST IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE C3 : TRACKER	WELSH AMBULANCE TRUST IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE E : RESOURCE LIMITS	WELSH AMBULANCE TRUST IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE E1 : INVOICED INCOME	WELSH AMBULANCE TRUST IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE F : STATEMENT OF FINANCIAL POSITION	WELSH AMBULANCE TRUST IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE G : MONTHLY CASHFLOW	WELSH AMBULANCE TRUST IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE I : CAPITAL RESOURCE / EXPENDITURE LIMIT	WELSH AMBULANCE TRUST IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE J: CAPITAL IN YEAR SCHEMES	WELSH AMBULANCE TRUST IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE K : CAPITAL DISPOSALS	WELSH AMBULANCE TRUST IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE M : GENERAL MEDICAL SERVICES	WELSH AMBULANCE TRUST IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE N : GENERAL DENTAL SERVICES	WELSH AMBULANCE TRUST IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE P: IFRS 16	WELSH AMBULANCE TRUST IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TOTAL ERRORS FOR YOUR MAY 26 RETURN IS	YOUR RETURN HAS ZERO ERRORS

Welsh Ambulance Trust

Period : May 26

Summary Of Main Financial Performance

Revenue Performance

		Actual YTD £'000	Annual Forecast £'000
1	Under / (Over) Performance	0	0

Table A - Movement of Opening Financial Plan to Forecast Outturn

This Table is currently showing 0 errors

Line 12 should reflect the corresponding amounts included within the latest IMTP/AOP submission to WG
Lines 1 - 12 should not be adjusted after Month 1

	In Year Effect £'000	Non Recurring £'000	Recurring £'000	FYE of Recurring £'000
1 Underlying Position b/fwd from Previous Year - must agree to M12 MMR (Deficit - Negative Value)	-3,746	0	-3,746	-3,746
2 Cost Pressures (Negative Value)	-13,533	0	-13,533	-13,533
3 Allocation Letter Revenue Funding Uplift / WG RRL / WG Income Uplift	5,124	0	5,124	5,124
4 Other Income Uplift / (Reduction)	3,155	0	3,155	3,155
5 RRL Profile - phasing only (in-year effect should total nil /Column C)	0	0	0	0
6 Planned (Finalised) Green and Amber Savings Plan	7,650	0	7,650	7,650
7 Planned (Finalised) Net Income Generation	150	0	150	150
8 Planned Profit / (Loss) on Disposal of Assets	0	0	0	0
9 Planned Release of Uncommitted Contingencies & Reserves (Positive Value)	0	0		
10	0	0		
11 Red, Pipeline and Planning Assumption Savings still to be finalised at Month 1	1,200	1,200		
12 Opening IMTP / Annual Operating Plan	0	1,200	-1,200	-1,200
13 Reversal of Red, Pipeline and Planning Assumption Savings still to be finalised at Month 1	-1,200	-1,200	0	0
14 Additional In Year & Movement from Planned Profit / (Loss) on Disposal of Assets	0	0		
15 Other Movement in Month 1 Planned & In Year Net Income Generation	0	0	0	0
16 Other Movement in Month 1 Planned Savings - (Underachievement) / Overachievement	0	0	0	0
17 Additional In Year Identified Savings - Forecast	0	0	0	0
18 Variance to Planned RRL	0	0		
19 Additional In Year & Movement in Planned Welsh Government Funding & Other Income (Positive Value - additional)	0	0		
20 In Year Accountancy Gains	0	0	0	0
21 Unplanned Spend Reductions	2,358	0	2,358	2,358
22 Unplanned Cost Pressures	-1,158	0	-1,158	-1,158
23 Planned Mitigations Yet To Be Finalised	0	0	0	0
24 Unplanned Additional Required Mitigations Yet To Be Finalised	0	0	0	0
25 Other	0	0	0	0
26	0	0		
27	0	0		
28	0	0		
29	0	0		
30	0	0		
31	0	0		
32	0	0		
33	0	0		
34	0	0		
35 Forecast Outturn (- Deficit / + Surplus)	0	0	0	0

	Apr £'000	May £'000	Jun £'000	Jul £'000	Aug £'000	Sep £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £'000	YTD £'000
1	-312	-312	-312	-312	-312	-312	-312	-312	-312	-312	-312	-314	-624
2	-1,104	-995	-1,055	-1,191	-1,181	-1,142	-1,150	-1,151	-1,151	-1,149	-1,136	-1,129	-2,098
3	427	427	427	427	427	427	427	427	427	427	427	427	854
4	263	263	263	263	263	263	263	263	263	263	263	263	526
5												0	0
6	726	617	677	663	653	614	622	623	623	621	609	603	1,342
7	0	0	0	17	17	17	17	17	17	17	17	17	0
8													0
9													0
10													0
11				133	133	133	133	133	133	133	133	133	0
12	0	0	0	0	0	0	0	0	0	0	0	0	0
13	0	0	0	-133	-133	-133	-133	-133	-133	-133	-133	-133	0
14													0
15	0	0	0	0	0	0	0	0	0	0	0	0	0
16	8	73	6	-8	-3	-15	-9	-6	-15	-15	-2	-13	81
17	0	0	0	0	0	0	0	0	0	0	0	0	0
18													0
19	196	-196											0
20	0	0	0	0	0	0	0	0	0	0	0	0	0
21	0	368	200	200	200	200	199	199	198	198	198	198	368
22	-204	-245	-206	-58	-63	-51	-56	-59	-50	-50	-62	-52	-449
23	0	0	0	0	0	0	0	0	0	0	0	0	0
24	0	0	0	0	0	0	0	0	0	0	0	0	0
25	0	0	0	0	0	0	0	0	0	0	0	0	0
26													0
27													0
28													0
29													0
30													0
31													0
32													0
33													0
34													0
35	0	0	0	0	0	0	0	0	0	0	0	0	0

TABLE A : Movement of Opening Financial Plan to Forecast Outturn

Monthly Positions (- Deficit / + Surplus) reconciles to Table B Monthly Positions	Ok
Recurring & Non Recurring Analysis of In Year items is not greater than In Year items	Ok
FYE of Recurring items are greater than, or equal to, the In Year Recurring amount	Ok
FYE of Recurring items only reported against Recurring items	Ok
Has Organisation name being selected	Ok

Table A1 - In Year Material Recurrent Analysis Impacting on Underlying Position (>£200k for Trusts/SHA and >£500k for HBs)

A. In Year Recurrent Unplanned Cost Pressure Analysis (Re: Table A Line 22)

	Description	SoCNE/SoCNI Expenditure Category	Service Area	Theme	In Year Recurring Impact £000 (-value)	FYE Recurring Impact £000 (-value)
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						
26						
27						
28						
29						
30						
31						
32						
33						
34						
35						
36						
37						
38						
39						
40						
41						
42						
43						
44						
45						
46						
47						
48						
49						
50						
				Total	0	0

B. In Year Recurrent Unplanned Spend Reduction Analysis (Re: Table A Line 21)

	Description	SoCNE/SoCNI Expenditure Category	Service Area	Theme	In Year Recurring Impact £000 (+value)	FYE Recurring Impact £000 (+value)
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						
26						
27						
28						
29						
30						
31						
32						
33						
34						
35						
36						
37						
38						
39						
40						
41						
42						
43						
44						
45						
46						
47						
48						
49						
50						
				Total	0	0

C. In Year Recurrent Income benefit/ Reduction Analysis (Re: Table A Line 18 & 19)

	Description	Service Area	Theme	In Year Recurring Impact £000 (+Benefit/-Reduction)	FYE Recurring Impact £000 (+Benefit/-Reduction)
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					
25					
26					
27					
28					
29					
30					
31					
32					
33					
34					
35					
36					
37					
38					
39					
40					
41					
42					
43					
44					
45					
46					
47					
48					
49					
50					
			Total	0	0

Welsh Ambulance Trust

Period : May 26

This Table is currently showing 0 errors

Table A2 - Overview Of Key Risks & Opportunities		FORECAST YEAR END	
		£'000	Likelihood
Pressures Not Assumed in the Forecast Outturn (Negative Values):			
1	Continuing Healthcare		
2	Out of Area Mental Health Placements		
3	Primary Care Drugs		
4	Secondary Care Drugs including NICE		
5	Joint Commissioning Committee - Outturn Risk		
6	Joint Commissioning Committee - Contract Performance		
7	JCC request saving in excess of Trust's plan	(2,000)	Low
8	Energy prices	(500)	Low
9	Failure to break even resulting in the Trust not meeting the requirements to access the	(2,355)	Low
10	WRP contribution increases above current forecast, and this not being supportable by WG		Low
11			
12			
13			
14			
15			
16			
17			
Benefits Assumed in the Forecast Outturn at Risk (Negative Values):			
18	Under delivery of Amber Schemes included in Outturn via Tracker		
19	Non Delivery of Planned Mitigations Yet To Be Finalised		
20	Non Delivery of Unplanned Additional Required Mitigations Yet To Be Finalised		
21	GMS Ring Fenced Allocation Underspend Potential Claw back		
22	Dental Ring Fenced Allocation Underspend Potential Claw back		
23			
24			
25			
26			
27	Total Risks	(4,855)	
Opportunities Not Factored into the Forecast Outturn (Positive Values)			
28			
29			
30			
31			
32			
33			
34			
35	Total Further Opportunities	0	
36	Current Reported Forecast Outturn	0	
37	Worst Case Outturn Scenario	(4,855)	
38	Best Case Outturn Scenario (Opportunities Only)	0	

Table A2 - Risks

Risks reported negative	OK
Opportunities reported positive	OK
Description completed	OK
Likelihood completed	OK

Welsh Ambulance Trust

Table B - Monthly Positions

Period : May 20

This Table is currently showing 0 errors

[illegible]

B. Assessment of Financial Forecast Positions

Year-to-date (YTD)	£'000
28. Actual YTD surplus/(deficit)	0
29. Actual YTD surplus/(deficit) last n	0
30. Current month actual surplus/(deficit)	0
	Trend
31. Average monthly surplus/(deficit)	0 ▼
32. YTD /remaining months	0

C. Depreciation & Impairments

			1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Forecast year-end position
			Apr £'000	May £'000	Jun £'000	Jul £'000	Aug £'000	Sep £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £'000		
	Depreciation															
41	Owned Asset Baseline Provider Depreciation	Actual/F'cast	1,382	1,260	1,261	1,260	1,261	1,260	1,261	1,261	1,261	1,261	1,261	1,261	2,642	15,250
42	Owned Asset Strategic Depreciation	Actual/F'cast													0	0
43	Owned Asset Accelerated Depreciation	Actual/F'cast													0	0
44	Donated Asset Depreciation	Actual/F'cast													0	0
45	IFRS16 ROU Depreciation	Actual/F'cast		219	217	219	218	219	218	218	218	218	218	218	218	2,400
46	IFRS16 ROU Peppercorn Depreciation	Actual/F'cast													0	0
47	Total		1,382	1,479	1,478	1,479	1,479	1,479	1,479	1,479	1,479	1,479	1,479	1,479	2,861	17,650
	Impairments															
48	Owned Asset Impairments	Actual/F'cast													0	0
49	Owned Asset Impairments Reversals (negative values)	Actual/F'cast													0	0
50	IFRS16 ROU Impairments	Actual/F'cast													0	0
51	Total		0	0	0	0	0	0	0	0	0	0	0	0	0	0

D. Accountancy Gains

[illegible]

E. Committed Reserves & Contingencies

[illegible]

Welsh Ambulance Trust

Table B1 - SOCNE / SOCNI Movement

This table needs completing monthly from Month 1

[illegible][illegible]

The 'Current Month' figures would come from the from the existing Table

[illegible][illegible]

PMA = Prior Month Actuals

PMF = Prior Month Forecast

PMFYF = Prior Month Full Year Forecast

Welsh Ambulance Trust

[illegible][illegible][illegible][illegible][illegible][illegible]

		1	2	3	4	5	6	7	8	9	10	11	12			
Section D: Provider Services - Non Pay (excluding drugs & depreciation)		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	Forecast year-end position	
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	
46.	Annual Plan (plus finalised savings identified at month 1) - Fixed after month 1 (Positive Value)	4,100	4,108	4,109	4,087	4,087	4,087	4,087	4,066	4,066	4,066	4,046	4,047	4,048	8,216	48,825
47.	Remove Red. Pipeline and Planning Assumptions - Fixed after month 1 (Positive Value)					67	67	67	67	67	67	67	67	67		600
48.	Latest Month Annual / Forecast	Actual/Fcast	4,026	4,060	4,251	4,755	4,676	4,340	4,480	4,377	4,370	4,173	4,132	3,997	6,085	51,636
49.	Variation From Operating Annual Plan		(83)	(48)	143	691	822	186	347	244	237	68	18	(117)	(13)	2,112
Explanation of Variation:																
50.	Additional Spend Associated with In Year Funding / Income above plan (Positive Value)	Actual/Fcast				400	400	100	245	170						1,485
51.	Savings Delivery (i.e. M1 schemes movements to plan plus additional In Year schemes)	Actual/Fcast	46	25	62	50	27	26	12	9	9	9	(4)	7	72	279
52.	Accountancy Gains	Actual/Fcast	0	0	0	0	0	0	0	0	0	0	0	0	0	0
53.	Unplanned Spend Reductions (i.e. re-assessment of original planned spend assumption) (Negative Value)	Actual/Fcast														0
54.	Unplanned Cost Pressures (not required in narrative) (Positive Value)	Actual/Fcast														0
55.	Payments of Planned (included in annual plan above) / Above Plan (Positive Value)	Actual/Fcast	234	245	206		63	63	51	56	59	50	62	52	449	1,158
56.	Payments of Planned (included in annual plan above) / Below Plan (Negative Value)	Actual/Fcast	(333)	(216)	(129)	83	38	9	34	6	8	2	(60)	(176)	(6)	0
57.	Planned Mitigations - Yet To Be Finalised (assumed in future month spend) (Negative Value)	Fcast														0
58.	Unplanned additional required Mitigations Yet To Be Finalised (assumed in future month spend) (Negative Value)	Fcast														0
59.	Other (Positive or Negative Value) - (not required in narrative)	Actual/Fcast														0
59.	Total Variation Explanation	Actual/Fcast	(83)	(48)	143	691	822	186	347	244	237	68	18	(117)	(13)	2,112

[illegible]

60	Check Variation Fully Explained:	ok	ok	ok	ok	ok	ok	ok	ok	ok	ok	ok	ok	ok		
----	----------------------------------	----	----	----	----	----	----	----	----	----	----	----	----	----	--	--

Section I: Other Private & Voluntary Sector														1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Forecast year-end position		
														Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	£'000	£'000		
														£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000		
121 Annual Plan (plus finalised savings identified at month 1) - Fixed after month 1 (Positive Value)														958	958	958	958	958	958	958	958	958	958	958	958	1,917	11,200		
122 Remove Red. Pipeline and Planning Assumptions - Fixed after month 1 (Positive Value)																										0	0		
123 Latest Month Actual / Forecast														Actual/Pcast	1,016	1,015	1,007	1,007	1,007	1,007	1,008	1,008	1,008	1,008	1,008	2,031	12,106		
124 Variation From Opening Annual Plan															58	57	49	49	49	49	50	50	50	50	50	114	606		
Explanation of Variation:																													
126 Additional Spend Associated with In Year Funding / Income above plan (Positive Value)														Actual/Pcast		11	12	11	12	11	12	11	12	12	12	11	127		
127 Savings Delivery (i.e. M1 schemes movements to plan plus additional In Year schemes)														Actual/Pcast	0	0	0	0	0	0	0	0	0	0	0	0	0		
127 Accountancy Gains														Actual/Pcast	0	0	0	0	0	0	0	0	0	0	0	0	0		
128 Unplanned Spend Reductions (i.e. re-assessment of original planned spend assumption) (Negative Value)														Actual/Pcast												0	0		
129 Unplanned Cost Pressures (b/d required in narrative) (Positive Value)														Actual/Pcast													0	0	
130 Viewments of Planned (included in annual plan line above) Spend Between Categories or Periods (Positive or Negative values)														Actual/Pcast	58	46	37	38	37	38	37	39	38	39	38	38	103	479	
131 Planned Mitigations Yet To Be Finalised (assumed in future month spend) (Negative Value)														Pcast													0	0	
132 Unplanned additional required Mitigations Yet To Be Finalised (assumed in future month spend) (Negative Value)														Pcast													0	0	
133 Other (Positive or Negative Value) - (b/d required in narrative)														Actual/Pcast													0	0	
134 Total Variation Explanation														Actual/Pcast	58	57	49	49	49	49	49	50	50	50	50	50	114	606	
Check Variation Fully Explained:															ok	ok	ok	ok	ok	ok	ok	ok	ok	ok	ok				
135																													
Section J: Joint Financing and Other														1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Forecast year-end position		
														Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	£'000	£'000		
														£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000		
136 Annual Plan (plus finalised savings identified at month 1) - Fixed after month 1 (Positive Value)																										0	0		
137 Remove Red. Pipeline and Planning Assumptions - Fixed after month 1 (Positive Value)																										0	0		
138 Latest Month Actual / Forecast														Actual/Pcast	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
139 Variation From Opening Annual Plan															0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Explanation of Variation:																													
140 Additional Spend Associated with In Year Funding / Income above plan (Positive Value)														Actual/Pcast													0	0	
141 Savings Delivery (i.e. M1 schemes movements to plan plus additional In Year schemes)														Actual/Pcast	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
142 Accountancy Gains														Actual/Pcast	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
143 Unplanned Spend Reductions (i.e. re-assessment of original planned spend assumption) (Negative Value)														Actual/Pcast													0	0	
144 Unplanned Cost Pressures (b/d required in narrative) (Positive Value)														Actual/Pcast													0	0	
145 Viewments of Planned (included in annual plan line above) Spend Between Categories or Periods (Positive or Negative values)														Actual/Pcast													0	0	
146 Planned Mitigations Yet To Be Finalised (assumed in future month spend) (Negative Value)														Pcast													0	0	
147 Unplanned additional required Mitigations Yet To Be Finalised (assumed in future month spend) (Negative Value)														Pcast													0	0	
148 Other (Positive or Negative Value) - (b/d required in narrative)														Actual/Pcast													0	0	
149 Total Variation Explanation														Actual/Pcast	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Check Variation Fully Explained:															ok	ok	ok	ok	ok	ok	ok	ok	ok	ok	ok	ok			
150																													
Section K: Losses, Special Payments and Irrecoverable Debts														1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Forecast year-end position		
														Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	£'000	£'000		
														£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000		
151 Annual Plan (plus finalised savings identified at month 1) - Fixed after month 1 (Positive Value)														314	311	311	311	311	311	311	310	310	310	310	310	625	3,729		
152 Remove Red. Pipeline and Planning Assumptions - Fixed after month 1 (Positive Value) - Not Applicable																										0	0		
153 Latest Month Actual / Forecast														Actual/Pcast	314	(83)	85	85	85	85	85	85	86	86	86	86	231	1,865	
154 Variation From Opening Annual Plan															0	(394)	(224)	(226)	(226)	(226)	(225)	(225)	(224)	(224)	(224)	(224)	(394)	(2,644)	
Explanation of Variation:																													
155 Additional Spend Associated with In Year Funding / Income above plan (Positive Value)														Actual/Pcast													0	0	
156 Savings Delivery (i.e. M1 schemes movements to plan plus additional In Year schemes) - Not Applicable														Actual/Pcast													0	0	
157 Accountancy Gains - Not Applicable														Actual/Pcast													0	0	
158 Unplanned Spend Reductions (i.e. re-assessment of original planned spend assumption) (Negative Value)														Actual/Pcast		(368)	(200)	(200)	(200)	(200)	(199)	(199)	(198)	(198)	(198)	(198)	(368)	(2,358)	
159 Unplanned Cost Pressures (b/d required in narrative) (Positive Value)														Actual/Pcast													0	0	
160 Viewments of Planned (included in annual plan line above) Spend Between Categories or Periods (Positive or Negative values)														Actual/Pcast		(26)	(26)	(26)	(26)	(26)	(26)	(26)	(26)	(26)	(26)	(26)	(26)	(26)	
161 Planned Mitigations Yet To Be Finalised (assumed in future month spend) (Negative Value)														Pcast													0	0	
162 Unplanned additional required Mitigations Yet To Be Finalised (assumed in future month spend) (Negative Value)														Pcast													0	0	
163 Other (Positive or Negative Value) - (b/d required in narrative)														Actual/Pcast													0	0	
164 Total Variation Explanation														Actual/Pcast	0	(394)	(224)	(226)	(226)	(226)	(225)	(225)	(224)	(224)	(224)	(224)	(394)	(2,644)	
Check Variation Fully Explained:															ok	ok	ok	ok	ok	ok	ok	ok	ok	ok	ok	ok			
165																													
Section L: Total Analysis														1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Forecast year-end position		
														Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	£'000	£'000		
														£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000		
166 Annual Plan (plus finalised savings identified at month 1) - Fixed after month 1 (Positive Value)														26,330	26,327	26,327	26,326	26,326	26,326	26,326	26,325	26,325	26,326	26,326	26,327	52,658	315,920		
167 Remove Red. Pipeline and Planning Assumptions - Fixed after month 1 (Positive Value)																0	0	133	133	133	133	133	133	133	133	0	1,220		
168 Latest Month Actual / Forecast														Actual/Pcast	25,917	25,801	26,581	26,580	26,580	26,581	26,580	26,582	26,583	26,582	26,583	51,718	317,132		
169 Variation From Opening Annual Plan															(413)	(826)	254	128	128	121	123	123	124	123	122	122	(940)	412	
Explanation of Variation:																													
170 Additional Spend Associated with In Year Funding / Income above plan (Positive Value)														Actual/Pcast	0	11	12	411	412	11	257	181	182	11	12	12	11	1,612	
171 Savings Delivery (i.e. M1 schemes movements to plan plus additional In Year schemes)														Actual/Pcast	(6)	(73)	(6)	0	0	15	0	0	15	15	2	13	(81)	0	
172 Accountancy Gains														Actual/Pcast			0	0	0	0	0	0	0	0	0	0	0	0	0
173 Unplanned Spend Reductions (i.e. re-assessment of original planned spend assumption) (Negative Value)														Actual/Pcast		(368)	(200)	(200)	(200)	(200)	(199)	(199)	(198)	(198)	(198)	(198)	(368)	(2,358)	
174 Unplanned Cost Pressures (b/d required in narrative) (Positive Value)														Actual/Pcast	204	245	206	58	63	51	56	59	50	50	62	52	349	1,186	
175 Viewments of Planned (included in annual plan line above) Spend Between Categories or Periods (Positive or Negative values)														Actual/Pcast	(604)	(341)	242	(157)	(158)	144	(2)	75	244	244	243	0	(65)	0	
176 Planned Mitigations Yet To Be Finalised (assumed in future month spend) (Negative Value)														Pcast			0	0	0	0	0	0	0	0	0	0	0	0	0
177 Unplanned additional required Mitigations Yet To Be Finalised (assumed in future month spend) (Negative Value)														Pcast			0	0	0	0	0	0	0	0	0	0	0	0	0
178 Other (Positive or Negative Value) - (b/d required in narrative)														Actual/Pcast			0	0	0	0	0	0	0	0	0	0	0	0	0
179 Total Variation Explanation														Actual/Pcast	(413)	(826)	254	128	128	121	123	123	124	123	122	122	(940)	412	
Check Variation Fully Explained:															ok	ok	ok	ok	ok	ok	ok	ok	ok	ok	ok	ok			
180																													
Check: The planned assumed mitigations yet to be identified profiles agrees with Line 11 of Table A															ok	ok	ok	ok	ok	ok	ok	ok	ok	ok	ok	ok			
181																													

Period : May 26

Table B3 - Pay Expenditure Analysis

A - Pay Expenditure		1	2	3	4	5	6	7	8	9	10	11	12		
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	Forecast year-end position
REF	TYPE	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
1	Administrative, Clerical & Board Members	3,763	3,732	3,880	3,788	3,802	3,864	3,838	3,857	3,859	3,895	3,902	3,927	7,495	46,107
2	Medical & Dental	13	16	13	13	13	13	13	13	13	13	13	13	29	159
3	Nursing & Midwifery Registered	1,327	1,380	1,368	1,336	1,341	1,363	1,354	1,361	1,361	1,374	1,377	1,384	2,707	16,326
4	Prof Scientific & Technical	16	14	16	16	16	16	16	16	16	16	16	17	30	191
5	Additional Clinical Services	7,954	8,087	8,225	8,028	8,059	8,190	8,135	8,176	8,178	8,254	8,270	8,323	16,041	97,879
6	Allied Health Professionals	7,188	7,277	7,431	7,254	7,282	7,400	7,351	7,387	7,390	7,459	7,473	7,520	14,465	88,412
7	Healthcare Scientists	0	0	0	0	0	0	0	0	0	0	0	0	0	0
8	Estates & Ancillary	248	255	256	250	251	255	253	254	254	257	257	259	503	3,049
9	Students	0	0	0	0	0	0	0	0	0	0	0	0	0	0
10	TOTAL PAY EXPENDITURE	20,509	20,761	21,189	20,685	20,764	21,101	20,960	21,064	21,071	21,268	21,308	21,443	41,270	252,123

11	LHB Provided Services - Pay	20,509	20,761	21,189	20,685	20,764	21,101	20,960	21,064	21,071	21,268	21,308	21,443	41,270	252,123
12	Other Services (incl. Primary Care) - Pay													0	0
13	Total - Pay	20,509	20,761	21,189	20,685	20,764	21,101	20,960	21,064	21,071	21,268	21,308	21,443	41,270	252,123

[illegible][illegible]

Table C - Identified Expenditure Savings Schemes (Excludes Income Generation & Accountancy Gains)

This Table is currently showing 0 errors

			1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Full-year forecast	YTD as %age of FY	Assessment		Full In-Year forecast		Full-Year Effect of Recurring Savings
			Apr £'000	May £'000	Jun £'000	Jul £'000	Aug £'000	Sep £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £'000			YTD variance as %age of YTD	Green £'000	Amber £'000	non recurring £'000	recurring £'000	£'000
1	Pay	Budget/Plan	506	469	523	493	481	431	443	430	428	427	418	415	975	5,464		5,464	0			
2		Actual/F'cast	560	568	592	535	505	442	445	432	422	421	412	409	1,128	5,743	19.84%	5,743	0	0	5,743	5,743
3		Variance	54	99	69	42	24	11	3	3	(6)	(6)	(6)	(6)	153	279	15.66%	279	0			
4	Non-Pay	Budget/Plan	220	148	154	171	172	183	180	194	196	195	191	188	367	2,186		2,186	0			
5		Actual/F'cast	173	122	91	120	144	156	168	185	187	186	194	181	295	1,907	15.49%	1,907	0	0	1,907	1,907
6		Variance	(46)	(25)	(62)	(50)	(27)	(26)	(12)	(9)	(9)	(9)	4	(7)	(72)	(279)	(19.49%)	-279	0			
7	Primary Care - Drugs & Appliances	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
8		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
9		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
10	Secondary Care Drugs	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
11		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
12		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
13	CHC/FNC	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
14		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
15		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
16	Primary Care Contractor	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
17		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
18		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
19	Healthcare Services Provided by Other Healthboards	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
20		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
21		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
22	Non-healthcare Services Provided by Other Healthboards	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
23		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
24		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
25	Other Private & Voluntary Sector	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
26		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
27		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
28	Joint Financing & Other	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
29		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
30		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
34	Total	Budget/Plan	726	617	677	663	653	614	622	623	623	621	609	603	1,342	7,650		7,650	0			
35		Actual/F'cast	734	690	683	655	649	598	613	617	608	606	608	590	1,423	7,650		7,650	0	0	7,650	7,650
36		Variance	8	73	6	(8)	(3)	(15)	(9)	(6)	(15)	(15)	(2)	(13)	81	0		0	0			

37	Variance in month	1.10%	11.87%	0.96%	(1.27%)	(0.52%)	(2.50%)	(1.49%)	(1.01%)	(2.39%)	(2.40%)	(0.40%)	(2.10%)	6.05%
38	In month achievement against FY forecast	9.59%	9.02%	8.93%	8.56%	8.49%	7.82%	8.01%	8.06%	7.95%	7.93%	7.92%	7.72%	

Table C1- Savings Schemes Pay Analysis

		Month	1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Full-year forecast	Assessment		Full In-Year forecast		Full-Year Effect of Recurring Savings
			Apr £'000	May £'000	Jun £'000	Jul £'000	Aug £'000	Sep £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £'000			Green £'000	Amber £'000	non recurring £'000	recurring £'000	£'000
1	Pay - General & Substantive	Budget/Plan	418	381	411	380	369	319	330	317	316	315	306	303	798	4,165	4,165	0			
2		Actual/F'cast	468	474	479	422	393	330	333	320	310	309	300	297	942	4,435	4,435	0	0	4,435	4,435
3		Variance	50	94	69	42	24	11	3	3	(6)	(6)	(6)	(6)	144	270	270	0			
4	Pay - Variable	Budget/Plan	81	81	105	105	105	105	105	105	104	104	105	105	162	1,210	1,210	0			
5		Actual/F'cast	85	86	105	105	105	105	105	105	104	104	105	105	171	1,219	1,219	0	0	1,219	1,219
6		Variance	4	5	0	0	0	0	0	0	0	0	0	0	9	9	9	0			
7	Pay - Agency	Budget/Plan	7	7	7	7	7	7	7	7	7	7	7	7	15	89	89	0			
8		Actual/F'cast	7	7	7	7	7	7	7	7	7	7	7	7	15	89	89	0	0	89	89
9		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			
10	Total	Budget/Plan	506	469	523	493	481	431	443	430	428	427	418	415	975	5,464	5,464	0			
11		Actual/F'cast	560	568	592	535	505	442	445	432	422	421	412	409	1,128	5,743	5,743	0	0	5,743	5,743
12		Variance	54	99	69	42	24	11	3	3	(6)	(6)	(6)	(6)	153	279	279	0			

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Welsh Ambulance Trust

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Table D - Income/Expenditure Assumptions

Annual Forecast

	LHB/Trust	Contracted Income £'000	Non Contracted Income £'000	Total Income £'000	Contracted Expenditure £'000	Non Contracted Expenditure £'000	Total Expenditure £'000
1	Swansea Bay University	481	210	691	0	129	129
2	Aneurin Bevan University	684	202	886	0	182	182
3	Betsi Cadwaladr University	1,281	623	1,904	94	320	414
4	Cardiff & Vale University	0	290	290	0	85	85
5	Cwm Taf Morgannwg University	0	845	845	0	98	98
6	Hywel Dda University	1,422	88	1,510	0	90	90
7	Powys	0	100	100	0	84	84
8	Public Health Wales	0	84	84	2	0	2
9	Velindre	1,037	0	1,037	1,075	1,512	2,587
10	DHCW	236	0	236	1,889	0	1,889
11	Welsh Ambulance Services			0			0
12	JCC	307,761	0	307,761	0	0	0
13	HEIW	496	273	769	0	4	4
14	NHS Wales Performance and Improvement			0			0
15	Total	313,398	2,715	316,113	3,060	2,504	5,564

Welsh Ambulance Trust

This Table is currently showing 0 errors

Period : May 26

Table E - Resource Limits

1. BASE ALLOCATION	STATUS OF ISSUED RESOURCE LIMIT ITEMS				Total Revenue Resource Limit	Recurring (R) or Non Recurring (NR)	Total Revenue Drawing Limit	Total Capital Resource Limit	Total Capital Drawing Limit	WG Contact and Date Item First Entered into Table
	HCHS £'000	Pharmacy £'000	Dental £'000	GMS £'000	£'000		£'000	£'000	£'000	
1 LATEST ALLOCATION LETTER/SCHEDULE REF:										
2 Total Confirmed Funding					0					
2. ANTICIPATED ALLOCATIONS										
3 Owned Asset Baseline Provider Depreciation					0					
4 Owned Asset Strategic Depreciation					0					
5 Owned Asset Accelerated Depreciation					0					
6 Donated Asset Depreciation					0					
7 IFRS 16 ROU Depreciation					0					
8 IFRS 16 ROU Peppercorn Depreciation					0					
9 Owned Asset Impairments					0					
10 Owned Asset Impairments Reversals					0					
11 IFRS 16 Impairments					0					
12 Removal of Donated Assets / Government Grant Receipts					0					
13 Removal of IFRS-16 Leases (Revenue)					0					
14 Real Living Wage (Care Homes)					0					
15 WRP Forecast Contribution					0					
16					0					
17					0					
18					0					
19					0					
20					0					
21					0					
22					0					
23					0					
24					0					
25					0					
26					0					
27					0					
28					0					
29					0					
30					0					
31					0					
32					0					
33					0					
34					0					
35					0					
36					0					
37					0					
38					0					
39					0					
40					0					
41					0					
42					0					
43					0					
44					0					
45					0					
46					0					
47					0					
48					0					
49					0					
50					0					
51					0					
52					0					
53					0					
54					0					
55					0					
56					0					
57					0					
58					0					
59 Revenue Working Balances Request					0					
60 Capital Working Balances Request					0					
61 Capital IFRS 16 Leases Working Balances Request					0					
62 Total Anticipated Funding	0	0	0	0	0		0	0	0	
3. TOTAL RESOURCES & BUDGET RECONCILIATION										
63 Confirmed Resources Per 1. above	0	0	0	0	0		0	0	0	
64 Anticipated Resources Per 2. above	0	0	0	0	0		0	0	0	
65 Total Resources	0	0	0	0	0		0	0	0	

This Table is currently showing 0 errors

Table E1 - Invoiced Income Streams - TRUSTS ONLY

		Swansea Bay ULHB £'000	Aneurin Bevan ULHB £'000	Betsi Cadwaladr ULHB £'000	Cardiff & Vale ULHB £'000	Cwm Taf Morganwg ULHB £'000	Hywel Dda ULHB £'000	Powys LHB £'000	Public Health Wales NHS Trust £'000	Welsh Ambulance NHS Trust £'000	Velindre NHS Trust £'000	NWSSP £'000	DHCW £'000	HEIW £'000	WG £'000	JCC £'000	Other (please specify) £'000	Total £'000	WG Contact, date item first entered into table and whether any invoice has been raised.
1	Agreed full year income	691	886	1,904	290	845	1,510	100	84		1,037		236	769	17,129	307,761	1,487	334,729	
	Details of Anticipated Income																		
2	Owned Asset Baseline Provider Depreciation																	0	
3	Owned Asset Strategic Depreciation																	0	
4	Owned Asset Accelerated Depreciation																	0	
5	Donated Asset Depreciation																	0	
6	IFRS16 ROU Depreciation																	0	
7	IFRS16 ROU Peppercorn Depreciation																	0	
8	Owned Asset Impairments																	0	
9	Owned Asset Impairments Reversals																	0	
10	IFRS16 Impairments																	0	
11	Removal of IFRS-16 Leases (Revenue)														(1,333)			(1,333)	Repayment of IFRS monies based on latest estimates
12	Real Living Wage (Care Homes)																	0	
13	WRP Forecast Contribution														(674)			(674)	Negative income related to WRP repayment to WG
14	PIBS														1,000			1,000	mate of PIBS based on prior years - awaiting discount and life ta
15																		0	
16																		0	
17																		0	
18																		0	
19																		0	
20																		0	
21																		0	
22																		0	
23																		0	
24																		0	
25																		0	
26																		0	
27																		0	
28																		0	
29																		0	
30																		0	
31																		0	
32																		0	
33																		0	
34																		0	
35																		0	
36	Total income	691	886	1,904	290	845	1,510	100	84	0	1,037	0	236	769	16,122	307,761	1,487	333,722	

Welsh Ambulance Trust

Period : May 26

 This table needs completing monthly from Month: 3
 This Table is currently showing 0 errors

Table F - Statement of Financial Position For Monthly Period

	Opening Balance Beginning of Apr 26	Closing Balance End of May 26	Forecast Closing Balance End of Mar 27
Non-Current Assets	£'000	£'000	£'000
1 Property, plant and equipment			
2 Intangible assets			
3 Trade and other receivables			
4 Other financial assets			
5 Non-Current Assets sub total	0	0	0
Current Assets			
6 Inventories			
7 Trade and other receivables			
8 Other financial assets			
9 Cash and cash equivalents			
10 Non-current assets classified as held for sale			
11 Current Assets sub total	0	0	0
12 TOTAL ASSETS	0	0	0
Current Liabilities			
13 Trade and other payables			
14 Borrowings (Trust Only)			
15 Other financial liabilities			
16 Provisions			
17 Current Liabilities sub total	0	0	0
18 NET ASSETS LESS CURRENT LIABILITIES	0	0	0
Non-Current Liabilities			
19 Trade and other payables			
20 Borrowings (Trust Only)			
21 Other financial liabilities			
22 Provisions			
23 Non-Current Liabilities sub total	0	0	0
24 TOTAL ASSETS EMPLOYED	0	0	0
FINANCED BY: Taxpayers' Equity			
25 General Fund			
26 Revaluation Reserve			
27 PDC (Trust only)			
28 Retained earnings (Trust Only)			
29 Other reserve			
30 Total Taxpayers' Equity	0	0	0

	Opening Balance Beginning of Apr 26	Closing Balance End of May 26	Closing Balance End of Mar 27
EXPLANATION OF ALL PROVISIONS			
31			
32			
33			
34			
35			
36			
37			
38			
39			
40 Total Provisions	0	0	0

ANALYSIS OF WELSH NHS RECEIVABLES (current month)

41 Welsh NHS Receivables Aged 0 - 10 weeks	£'000
42 Welsh NHS Receivables Aged 11 - 16 weeks	0
43 Welsh NHS Receivables Aged 17 weeks and over	0

ANALYSIS OF TRADE & OTHER PAYABLES (opening, current & closing)

	£'000	£'000	£'000
44 Capital	0	0	0
45 Revenue	0	0	0

ANALYSIS OF CASH (opening, current & closing)

	£'000	£'000	£'000
46 Capital	0	0	0
47 Revenue	0	0	0

Welsh Ambulance Trust

Period : May 26

This Table is currently showing 0 errors

This table needs completing monthly from Month: 2

Table G - Monthly Cashflow Forecast

		April £'000	May £'000	June £'000	July £'000	Aug £'000	Sept £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £'000	Total £'000
	RECEIPTS													
1	WG Revenue Funding - Cash Limit (excluding NRL) - LHB & SHA only													0
2	WG Revenue Funding - Non Resource Limited Cash (NRL) - LHB & SHA only													0
3	WG Revenue Funding - Other (e.g. invoices)	1,701	3	3	11,540	3	3	1,190	3	3	1,191	3	2,177	17,820
4	WG Capital Funding - Cash Limit - LHB & SHA only													0
5	Income from other Welsh NHS Organisations	25,417	25,535	28,832	26,464	26,464	26,464	26,464	26,464	26,464	26,464	26,464	26,458	317,954
6	Short Term Loans - Trust only													0
7	PDC - Trust only	0	0		0	10,000	0	0	10,000	0	11,380	0	0	31,380
8	Interest Receivable - Trust only	91	96	80	81	81	81	81	81	82	82	82	82	1,000
9	Sale of Assets	35	40	62	62	62	62	62	62	62	62	62	62	695
10	Other - (Specify in narrative)	468	268	776	480	500	500	500	500	500	500	500	499	5,991
11	TOTAL RECEIPTS	27,712	25,942	29,753	38,627	37,110	27,110	28,297	37,110	27,111	39,679	27,111	29,278	374,840
	PAYMENTS													
12	Primary Care Services : General Medical Services													0
13	Primary Care Services : Pharmacy Services													0
14	Primary Care Services : Prescribed Drugs & Appliances													0
15	Primary Care Services : General Dental Services													0
16	Non Resource Limited Payments													0
17	Salaries and Wages	20,392	20,548	20,858	20,900	21,935	21,160	21,060	21,060	21,060	21,060	21,060	21,060	252,153
18	Non Pay Expenditure	9,570	8,219	8,119	8,119	8,119	8,119	8,119	8,119	8,119	8,119	8,119	8,123	98,983
19	Short Term Loan Repayment - Trust only													0
20	PDC Repayment - Trust only	0											0	0
21	Capital Payment	4,371	3,767	4,539	4,433	2,989	2,989	2,989	2,989	2,989	2,989	2,989	3,092	41,125
22	Other items (Specify in narrative)	130	0	0	0	0	0	0	0	0	0	0	0	130
23	TOTAL PAYMENTS	34,463	32,534	33,516	33,452	33,043	32,268	32,168	32,168	32,168	32,168	32,168	32,275	392,391
24	Net cash inflow/outflow	(6,751)	(6,592)	(3,763)	5,175	4,067	(5,158)	(3,871)	4,942	(5,057)	7,511	(5,057)	(2,997)	
25	Balance b/f	17,877	11,126	4,534	771	5,946	10,013	4,855	984	5,926	869	8,380	3,323	
26	Balance c/f	11,126	4,534	771	5,946	10,013	4,855	984	5,926	869	8,380	3,323	326	

Period : May 26

This table needs completing on a quarterly basis
NOTE: Data to 1 decimal place

30 DAY COMPLIANCE			ACTUAL Q1		ACTUAL Q2		ACTUAL Q3		ACTUAL Q4		YEAR TO DATE		FORECAST YEAR END	
		Target %	Actual %	Variance %	Actual %	Variance %	Actual %	Variance %	Actual %	Variance %	Actual %	Variance %	Forecast %	Variance %
	PROMPT PAYMENT OF INVOICE PERFORMANCE													
1	% of NHS Invoices Paid Within 30 Days - By Value	95.0%		-95.0%		-95.0%		-95.0%		-95.0%		-95.0%		-95.0%
2	% of NHS Invoices Paid Within 30 Days - By Number	95.0%		-95.0%		-95.0%		-95.0%		-95.0%		-95.0%		-95.0%
3	% of Non NHS Invoices Paid Within 30 Days - By Value	95.0%		-95.0%		-95.0%		-95.0%		-95.0%		-95.0%		-95.0%
4	% of Non NHS Invoices Paid Within 30 Days - By Number	95.0%		-95.0%		-95.0%		-95.0%		-95.0%		-95.0%		-95.0%

[illegible]

Welsh Ambulance Trust

Period : May 26

This Table is currently showing 0 errors

Table I - 2026-27 Capital Resource / Expenditure Limit Management

£'000 30,928
Approved CRL / CEL issued at : 31/3/26

Ref:	Performance against CRL / CEL	Year To Date			Forecast		
		Plan £'000	Actual £'000	Variance £'000	Plan £'000	F'cast £'000	Variance £'000
	Gross expenditure						
	All Wales Capital Programme:						
	Schemes:						
1	ESMCP - Control Room Solutions	0	0	0	181	181	0
2	MDVS	0	0	0	100	100	0
3	Welsh Ambulance Services NHS Trust – Vehicle Replacement Programme – 2026-27	583	583	0	23,110	23,110	0
4	TEF - Infrastructure	0	0	0	517	517	0
5	TEF - Decarbonisation	0	0	0	225	225	0
6				0			0
7				0			0
8				0			0
9				0			0
10				0			0
11				0			0
12				0			0
13				0			0
14				0			0
15				0			0
16				0			0
17				0			0
18				0			0
19				0			0
20				0			0
21				0			0
22				0			0
23				0			0
24				0			0
25				0			0
26				0			0
27				0			0
28				0			0
29				0			0
30				0			0
31				0			0
32				0			0
33				0			0
34				0			0
35				0			0
36				0			0
37				0			0
38				0			0
39				0			0
40				0			0
41				0			0
42	Sub Total	583	583	0	24,133	24,133	0
	Discretionary:						
43	I.T.	69	69	0	985	985	0
44	Equipment	138	138	0	1,160	1,160	0
45	Statutory Compliance	0	0	0	0	0	0
46	Estates	138	138	0	3,950	3,950	0
47	Mental Health	0	0	0	0	0	0
48	Other	7	7	0	700	700	0
49	Sub Total	352	352	0	6,795	6,795	0

	Other (Including IFRS 16 Leases) Schemes:							
50				0			0	
51				0			0	
52				0			0	
53				0			0	
54				0			0	
55				0			0	
56				0			0	
57				0			0	
58				0			0	
59				0			0	
60				0			0	
61				0			0	
62				0			0	
63				0			0	
64				0			0	
65				0			0	
66				0			0	
67				0			0	
68				0			0	
69				0			0	
70	Sub Total	0	0	0	0	0	0	0
71	Total Expenditure	935	935	0	30,928	30,928	0	
	Less:							
	Capital grants & Capital AME (e.g. dilapidations):							
72				0			0	
73				0			0	
74				0			0	
75				0			0	
76				0			0	
77	Sub Total	0	0	0	0	0	0	
	Donations:							
78				0			0	
79	Sub Total	0	0	0	0	0	0	
	Asset Disposals:							
80				0			0	
81				0			0	
82				0			0	
83				0			0	
84				0			0	
85				0			0	
86				0			0	
87				0			0	
88				0			0	
89				0			0	
90				0			0	
91	Sub Total	0	0	0	0	0	0	
92	Technical Adjustments			0			0	
93	CHARGE AGAINST CRL / CEL	935	935	0	30,928	30,928	0	
94	PERFORMANCE AGAINST CRL / CEL (Under)/Over		(29,993)			0		

Period : May 26

This Table is currently showing 0 errors

Table J - In Year Capital Scheme Profiles

[illegible]

Table K - Capital Disposals

This Table is currently showing 0 errors

A: In Year Disposal of Assets

	Description	Date of Ministerial Approval to Dispose (Land & Buildings only)	Date of Ministerial Approval to Retain Proceeds > £0.5m	Date of Disposal	NBV	Sales Receipts	Cost of Disposals	Gain/ (Loss)	Comments
		MM/YY (text format, e.g. Apr 26)	MM/YY (text format, e.g. Apr 26)	MM/YY (text format, e.g. Feb 27)	£'000	£'000	£'000	£'000	
1	Disposals	n/a	n/a	26-27	0	695	0	695	
2								0	
3								0	
4								0	
5								0	
6								0	
7								0	
8								0	
9								0	
10								0	
11								0	
12								0	
13								0	
14								0	
15								0	
16								0	
17								0	
18								0	
19								0	
	Total for in-year				0	695	0	695	

B: Future Years Disposal of Assets

	Description	Date of Ministerial Approval to Dispose (Land & Buildings only)	Date of Ministerial Approval to Retain Proceeds > £0.5m	Date of Disposal	NBV	Sales Receipts	Cost of Disposals	Gain/ (Loss)	Comments
		MM/YY (text format, e.g. April 27)	MM/YY (text format, e.g. April 27)	MM/YY (text format, e.g. Feb 28)	£'000	£'000	£'000	£'000	
20								0	
21								0	
22								0	
23								0	
24								0	
25								0	
26								0	
27								0	
28								0	
29								0	
30								0	
31								0	
32								0	
33								0	
34								0	
35								0	
36								0	
37								0	
38								0	
	Total for future years				0	0	0	0	

Welsh Ambulance Trust

Period : May 26

Table M - General Medical Services

Table to be completed from Q1 / Month:

3

This Table is currently showing 0 errors

Operating Expenditure - ring fenced GMS budget

SUMMARY OF GENERAL MEDICAL SERVICES FINANCIAL POSITION

	LINE NO.	WG Allocation £000's	Current Plan £000's	Forecast Outturn £000's	Variance £000's	Year to Date £000's
Global Sum	1					
Practice support payment	2					
Total Global Sum and MPIG	3				0	0
QIF Aspiration Payments	4					
QIF Achievement Payments	5					
QIF - Access Achievement Payments	6					
Total Quality	7				0	0
Direct Supplementary Services (To equal data in Section A (i) Line 31)	8				0	
National Supplementary Services (To equal data in Section A (ii) Line 41)	9				0	
Local Supplementary Services (To equal data in Section A (iii) Line 94)	10				0	
Total Supplementary Services (To equal data in section A Line 94)	11		0	0	0	0
LHB Administered (To equal data in Section B Line 109)	12				0	
Premises (To equal data in section C Line 138)	13				0	
IM & T	14				0	
Out of Hours (including OOHDF)	15				0	
Dispensing (To equal data in Line 154)	16				0	
Community by Design (To equal data in Line 157)	17				0	
Total	18	0	0	0	0	0

SUPPLEMENTARY INFORMATION

Directed Enhanced Services Section A (i)	LINE NO.	£000's	£000's	£000's	£000's	£000's
Childhood Immunisation Scheme	19				0	
Mental Health	20				0	
Influenza & Pneumococcal Immunisations Scheme	21				0	
Services for Violent Patients	22				0	
Minor Surgery Fees	23				0	
MENU of Agreed DSS						
Asylum Seekers & Refugees	24				0	
Care of Diabetes	25				0	
Care Homes	26				0	
Extended Surgery Opening	27				0	
Gender Identity	28				0	
Homeless	29				0	
Oral Anticoagulation with Warfarin	30				0	
TOTAL Supplementary Services (must equal line 8)	31		0	0	0	0

National Supplementary Services A (ii)	LINE NO.	£000's	£000's	£000's	£000's	£000's
INR Monitoring	32				0	
Shared care drug monitoring (Near Patient Testing)	33				0	
Drug Misuse	34				0	
IUCD	35				0	
Alcohol misuse	36				0	
Depression	37				0	
Minor injury services	38				0	
Diabetes	39				0	
Services to the homeless	40				0	
TOTAL National Supplementary Services (must equal line 9)	41		0	0	0	0

Local Supplementary Services	A (iii)	LINE NO.	£000's	£000's	£000's	£000's	£000's
ADHD		42				0	
Asylum Seekers & Refugees		43				0	
Cardiology		44				0	
Care Homes		45				0	
Care of Diabetes		46				0	
Chiropody		47				0	
Counselling		48				0	
Depo - Provera (including Implanon & Nexplanon)		49				0	
Dermatology		50				0	
Dietetics		51				0	
DOAC/NOAC		52				0	
Drugs Misuse		53				0	
Extended Minor Surgery		54				0	
Gonaderlins		55				0	
Homeless		56				0	
HPV Vaccinations		57				0	
Immunisations (inc Pertussis excluding DES - Childhood Imm & Influenza & Pneumococcal		58				0	
Learning Disabilities		59				0	
Lithium / INR Monitoring		60				0	
Local Development Schemes		61				0	
Mental Health		62				0	
Minor Injuries		63				0	
MMR		64				0	
Multiple Sclerosis		65				0	
Muscular Skeletal		66				0	
Nursing Homes		67				0	
Orthopaedic (Upper Limb GPwSi/Clinical Assessments)		68				0	
Osteopathy		69				0	
Phlebotomy		70				0	
Physiotherapy (inc MT3)		71				0	
Referral Management		72				0	
Respiratory (inc COPD)		73				0	
Ring Pessaries		74				0	
Sexual Health Services		75				0	
Shared Care		76				0	
Smoking Cessation		77				0	
Substance Misuse		78				0	
Suturing		79				0	
Swine Flu		80				0	
Transport/Ambulance costs		81				0	
Vasectomy		82				0	
Weight Loss Clinic (inc Exercise Referral)		83				0	
Wound Care		84				0	
Zoladex		85				0	
		86				0	
		87				0	
		88				0	
		89				0	
		90				0	
		91				0	
		92				0	
		93				0	
		94				0	
TOTAL Local Supplementary Services (must equal line 10)		34		0	0	0	0
TOTAL Supplementary Services (must equal line 11)		95		0	0	0	0
GENERAL MEDICAL SERVICES Operating Expenditure							
LHB Administered	Section B	LINE NO.	WG £000's	Current Plan £000's	Forecast £000's	Variance £000's	Year to Date £000's
Seniority		96					
Doctors Retention Scheme Payments		97					
Locum Allowances consists of adoptive, paternity & maternity		98					
Locum Allowances : Cover for Sick Leave		99					
Locum Allowances : Cover For Suspended Doctors		100					
Prolonged Study Leave		101					
Recruitment and Retention (including Golden Hello)		102					
Appraisal - Appraiser Costs		103					
Primary Care Development Scheme		104					
Partnership Premium - GP partners		105					
Partnership Premium - Non GP Partners		106					
Supply of syringes & needles		107					
Other (please provide detail below, this should reconcile to line 128)		108					
TOTAL LHB Administered (must equal line 12)		109				0	0

Analysis of Other Payments (line 108)	LINE NO.	£000's	£000's	£000's	£000's	£000's
Additional Managed Practice costs (costs in excess of Global Sum/MPiG)	110					
CRB checks	111					
GP Locum payments	112					
LHB Locality group costs	113					
Managing Practice costs (LHB employed staff working in GP practices to improve GP services)	114					
Primary Care Initiatives	115					
Salaried GP costs	116					
Stationery & Distribution	117					
Training	118					
Translation fees	119					
COVID vaccination payments to GP practices	120					
	121					
	122					
	123					
	124					
	125					
	126					
	127					
TOTAL of Other Payments (must equal line 108)	128					0

Premises	Section C	LINE NO.	£000's	£000's	£000's	£000's	£000's
Notional Rents		129					
Actual Rents: Health Centres		130					
Actual Rents: Others		131					
Cost Rent		132					
Clinical Waste/ Trade Refuse		133					
Rates, Water, sewerage etc		134					
Health Centre Charges		135					
Improvement Grants		136					
All other Premises (please detail below which should reconcile to line 146)		137					
TOTAL Premises (must equal line 13)		138				0	0

Analysis of Other Premises (Line 137)	LINE NO.	£000's	£000's	£000's	£000's	£000's
	139					
	140					
	141					
	142					
	143					
	144					
	145					
TOTAL of Other Premises (must equal line 137)	146					0

Memorandum item						
Supplementary Services included above but in dispute with LMC (TOTAL)	147					
Supplementary Services included above but not yet formally agreed LMC	148					

GENERAL MEDICAL SERVICES						
Dispensing						

Dispensing Data	LINE NO.	WG £000's	Current Plan £000's	Forecast £000's	Variance £000's	Year to Date £000's
Cost of Drugs and Appliances, after discounts and plus container allowance (and plus VAT where applicable)						
Dispensing Doctors	149					
Prescribing Medical Practitioners - Personal Administration	150					
Dispensing Service Quality Payment	151					
Professional Fees and on-cost						
Dispensing Doctors	152					
Prescribing Medical Practitioners - Personal Administration	153					
TOTAL DISPENSING DATA (must equal line 16)	154				0	0

GENERAL MEDICAL SERVICES						
Community by Design						

Directed Collaborative Services	LINE NO.	£000's	£000's	£000's	£000's	£000's
Workforce fund	155				0	
Change Fund	156				0	
TOTAL Directed Collaborative Services (must equal line 17)	157		0	0	0	0

Welsh Ambulance Trust

Period : May 26

Table N - General Dental Services

This Table is currently showing 0 errors

Table to be completed from Q1 / Month: 3

Operating Expenditure from the revenue allocation for the dental contract

SUMMARY OF DENTAL SERVICES FINANCIAL POSITION		WG Allocation	Current Plan	Forecast Outturn	Variance	Year to Date
Expenditure / activities included in a GDS contract and / or PDS agreement	LINE NO.	£000's	£000's	£000's	£000's	£000's
Gross Contract Value - Personal Dental Services	1				0	
Gross Contract Values - Personal Dental Services for Orthodontic Provision	2				0	
Gross Contract Value - General Dental Services	3				0	
Emergency Dental Services (inc Out of Hours)	4				0	
Additional Access	5				0	
Business Rates	6				0	
Domiciliary Services	7				0	
Maternity/Sickness etc.	8				0	
Sedation services including GA	9				0	
Seniority payments	10				0	
Employer's Superannuation	11				0	
Oral surgery	12				0	
OTHER (PLEASE DETAIL BELOW)	13				0	
TOTAL DENTAL SERVICES EXPENDITURE	14		0	0	0	0
OTHER (PLEASE DETAIL BELOW) - Activities / expenditure not included in a GDS contract and / or PDS agreement. This includes payments made under other arrangements e.g. GA under an SLA and D2S, plus other or one off payments such as dental nurse training	LINE NO.		£000's	£000's	£000's	£000's
Financial Recoveries/ clawbacks	15					
Emergency Dental Services (inc Out of Hours)	16					
Additional Access	17					
Sedation services including GA	18					
Continuing professional development	19					
Occupational Health / Hepatitis B	20					
Gwen Am Byth - Oral Health in care homes	21					
Refund of patient charges	22					
Design to Smile	23					
Other Community Dental Services	24					
Dental Foundation Training/Vocational Training	25					
DBS/CRB checks	26					
Health Board staff costs associated with the delivery / monitoring of the dental contract	27					
Oral Surgery	28					
Orthodontics	29					
Special care dentistry e.g. WHC/2015/002	30					
Oral Health Promotion/Education	31					
	32					
	33					
	34					
	35					
	36					
	37					
	38					
	39					
	40					
	41					
	42					
	43					
TOTAL OTHER (must equal line 13)	44			0		0
RECEIPTS						
TOTAL DENTAL SERVICES INCOME (Enter as a negative value)	45				0	

Table O - Ringfenced

Table C - Ringiered
This table needs to be completed from month 3

[illegible][illegible]

List below which allocations have been included in the In-Year Plan Sections (state if received or anticipated):

[illegible]

This Table is currently showing 0 errors

Table P - IFRS16 & CAME - Dilapidations
Table to be completed from Q1 / Month 3:

		Lease Payments Exc. Interest & VAT (Value to be repaid to WG) £000	Interest £000	IFRS16 ROU Depreciation £000	IFRS16 ROU Peppercorn Depreciation £000
1	Existing leases prior to 2026/27	1,333			
2	26/27 New/Renewal - Approved				
3	Total Approved	1,333	0	0	0
4	26/27 New/Renewal - Unapproved				
5	Total Approved/Unapproved	1,333	0	0	0
		£000			
6	CAME Dilapidations				



GIG
CYMRU
NHS
WALES

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

Cadeirydd

Chair: Colin Dennis

Prif Weithredwr

Chief Executive: Emma Wood

Swyddfa Cyllid ac Adnoddau Corfforaethol

Finance and Corporate Resource Office

Mrs A Hughes
Head of NHS Financial Management
Welsh Government
North Wales NHS Financial Management
Sarn Mynach
Llandudno Junction
LL31 9RZ

11th June 2026

Your ref:

Dear Andrea,

Re: MAY 2026 (MONTH 02 2026/27) MONITORING RETURN

Please find attached the Monitoring Returns for the Welsh Ambulance Services University NHS Trust for May 2026.

All automatic validation rules incorporated in the reporting template have been successfully passed.

In line with our submitted IMTP, our opening budgets and financial plan for the year reflected the level of assumed funding, expenditure plans and savings requirement included and submitted and supported by our Commissioners and approved by the Trust Board in March 2026.

The Trust's performance against financial targets for Month 02 2026/27 is as follows: -

1. Actual Year to Date 2026/27 (Tables A, B & B2)

Income assumptions reflect those agreed within the IMTP, and are used to support cost pressures identified in the Trust's detailed budget setting. The key funding assumptions at the outset of 2026/27 being that the 2025/26 funding is, where applicable, fully recurrent, and the 2026/27 funding will include: -

- The nationally made available 1.11% uplift for core cost growth, which excludes any funding to meet the 2026/27 pay award costs, which will be subject to a future additional funding allocation;
- Impact of previously agreed developments/other adjustments including income support, in line with support by Commissioners in previous and current IMTPs, along with funding for other nationally delivered projects.
- The Trust is assuming full financial support for the increase in the Welsh Risk Pool costs for 2026/27 in line with the guidance issued for those NHS bodies who are able to develop and deliver financial balance, excluding this Risk Pool increase.

Mae'r Ymddiriedolaeth yn croesawu gohebiaeth yn y Gymraeg neu'r Saesneg, ac na fydd gohebu yn Gymraeg yn arwain at oedi

The Trust welcomes correspondence in Welsh or English, and that corresponding in Welsh will not lead to a delay

www.ambulance.wales.nhs.uk

Pencadlys Rhanbarthol
Ambiwylans a Chanolfan
Cyfathrebu Clinigol

Regional Ambulance
Headquarters and
Clinical Contact Centre

Beacon House
William Brown Close
Llantarnam
Cwmbran NP44 3AB
Ffôn/Tel
01633 626262

Included within the income assumptions is the full pass through of both the 2025/26 and 2026/27 pay funding and recurrent NI ERS from 2025/26 funding, whilst the recurrent pay element has passed through for 2025/26 along with the NI element, the 2026/27 pay element is assumed to be recovered via WG and we await guidance for this. Resolution will be required soon, as this could have an impact on the Trusts cashflow as we move through the financial year

The reported performance at Month 2, as set out in Table B, is breakeven. However, at this early stage in the financial year, it is important to clearly articulate the key assumptions underpinning both the in-month position and the forecast year-end outturn.

Following the confirmation in the month 1 reply letter the Trust has now removed the impact of the uplift of the WRP forecast and as per the guidance assumed this will be covered in full based on the Trust continuing to forecast and achieving a breakeven position.

Whilst the Trust Board was able to approve a balanced financial plan for 2026/27 in March 2026, it was clear within this that there was further work required to get to balance in year, with a minimum of £1.2m of additional and pipeline savings required, wholly driven by the expected increase in WRP costs. Compounding this as we enter the financial year, significant cost pressures are emerging, even since the financial plan and budgets were set, arising from the ongoing conflict in the Middle East, particularly in relation to fuel prices. The forecast now incorporates an estimated pressure of approximately £1.15m, based on current pump price modelling and should prices remain at these levels throughout 2026/27. Given the timing of these impacts, they could not have reasonably been foreseen or included within the Trust approved financial plan and budget therefore, resulting in an immediate significant in year cost pressure, and one which will not be able to be managed through any contingency held.

Taking all these aspects into consideration and based on the confirmation around the additional WRP costs,, the forecast, as detailed above, remains a balanced one this financial year, however as will be documented later this clearly isn't risk free and the Trust has a very demanding savings target even before the residual £1.2m requirement.

The reported total pay variance against plan as at Month 2 is an underspend of **£0.303m**, set against the budgets set at the start of the financial year, this includes the impact of the NHS Wales pay award.

The non-pay position at Month 2 is a reported overspend of **£0.421m**.

Income at Month 2 shows an overachievement of **£0.118m**.

2. Movement (Table A)

The Movement table has been completed in accordance with the new guidance, incorporating the submitted Annual Plan (AOP) data.

Profiles are based on the budgets set at the outset of the year based on the local intelligence around spend profile, this is closely monitored with variance analysis being undertaken to ensure the budgets reflect plans. **(Action Point 1.1)**

Given the savings identified being recurrent and the ongoing work of directorates it was possible to reduce the underlying deficit to nil **(Action Point 1.2)**

Thank you for the confirmation within the reply letter that if the Trust continues to forecast and maintain its plan to break even that WG will support the forecasted WRP additional costs, as such the Trust has now removed the expenditure element and assumed income as was presented from all the relevant tables. **(Action Point 1.3)**

Included within both Table A and Table B2 are the impact of the Fuel forecourt price increases as stated this is going to be closely monitored and modelled based on latest intelligence of current prices. **(Action Point 1.5)**

3. Risk (Table A2)

Understandably this early in the financial year, the risks reported in Table A2 are still being fully assessed, however at present it is considered that there are no medium or high likelihood risks, but as we move through the next few months we will continue to review the risks to ensure that the level of likelihood is assessed along with the financial value. Depending on the outcome of some of the issues highlighted elsewhere in this return, we may be moving towards higher risks having to be reported in due course, alongside ensuring that the Trust Board and the Finance & Performance Committee remain fully apprised of such risks and any mitigating actions.

However, at the outset of this financial year there are a number of risks that need to be documented within this initial reported financial position, which aligns to that fully described within the financial plan submitted as part of the IMTP.

A low risk has been included around the JCC additional saving request, whilst nothing further has been formally raised in relation to this risk, and work is in development to quantify the performance improvements, the Trust has included an updated low risk of £2m based on the possibility that there may be a request we go further with our savings. However the Trust does now have a signed agreement for the core monies from the JCC so as stated above this has been reduced from month 1 and is now reported as a low risk. **(Action Point 1.7)**

Given the pressures the Trust is already seeing in relation to the war in the Middle East the Trust has included a risk around further increases in Energy prices, whilst the forecast for WAST via Share Services was a reduction for WAST this was based on the baskets of energy already secured, however as we move through the year the amount secured for each month is reducing, in addition to this the Trust have a number of sites which are outside of this supply, one with a high usage amount which is recharged via the landlord and is more heavily impacted by these rate increases. **(Action Point 1.6)**

Given the position now includes a forecasted impact on Fuel prices this element hasn't been included within the tables but may need to feature in future returns should the position further worsen or some of the income levels assumed within our current reporting not be forthcoming.

In relation to the WRP cost increase, thank you for the guidance within the reply letter, based on this the title of this risk has now been amended, given this is still a real risk to the Trust it has remained in the table however given the assurance that if we achieve our forecast it will be covered in full, it has been reduced to a low risk. **(Action Point 1.8)**

In addition to the current forecast around the Risk Pool given the additional work being undertaken and the change in methodologies being applied by the courts, given this is currently unquantified a line has been included on the table, but no value has been included against it.

As noted above, whilst there are now therefore no current individually assessed high financial risks, however when this is then considered alongside continuing significant service pressure and the likely balancing of this risk against patient safety, quality and experience, it is clear that, as expressed withing the IMTP, this will likely be another challenging financial year, despite the initially reported financial performance in month 2, based on the assumptions made in reporting this.

Full consideration and management of all these risks will clearly be high on the agenda for the Trust Board and its relevant Committees, including Finance and Quality Committees. Alongside this, the risk of non-delivery of statutory financial duties has also been increased, alongside a more detailed review of this risk on the Trust's Corporate Risk Register.

4. Monthly Profiles (Table B)

This table has now been completed in full, and in accordance with the guidance.

5. Expenditure Movement (Table B2)

Table B2 has been completed in accordance with the guidance, as requested the table has been restated to align with the MDS figures, thus showing the movements and amendments post the budgets being uploaded in the ledger, these adjustments are then being shown separately within the tables.

Due to the assumptions the Trust had made around the WRP at the MDS stage the Trust in order to show the true effect, has had to show an adjusted opening position, due to the way FP&D had requested the WRP impact to be shown in the MDS, i.e. the Trust didn't show the expenditure it showed a negative income adjustment, as it is not possible to reflect this in Table A, the Trust is assuming the cost pressure of £2.355m is shown in the opening position as stated at month 1, then this is removed as an in-year spend reduction, in line with the suggestion in the month 1 reply letter. **(Action Point 1.9)**

6. Pay and Agency/Locum (premium) Expenditure (Table B3)

Agency costs for Month 2 totalled £0.015m. The current percentage of agency costs against the total pay figure remains very small, at 0.1%. This is to cover a small number of vacancies, in areas across the Trust which the Trust is having difficulties recruiting into, however it is hoped that some of these agency staff will be replaced by permanent staff as we work through the financial year.

The negative £5k shown in month 1 related to the reversal of a year end accrual, this was due to the accrual being based on a set number of days however when the invoice hit the ledger it was for a lower number than assumed resulting in the accrual needing to be reversed. **(Action Point 1.10)**

7. Saving Plans (Table C, C1, C2 & C3)

For Month 2 the Trust is reporting planned savings (including Income generation) of £1.342m and actual savings of £1.423m.

As can be seen from Table C3, the Trust overachieved its savings target in month 2. These tables have now been adjusted to remove the pipeline schemes and per the guidance received in the month 1 reply letter these have now been correctly shown within Table A. **(Action Point 1.4)**

8. Income/Expenditure Assumptions (Tables D and E1)

These are set out in Tables D, E and E1. As requested the Trust has actively engaged with Health bodies to update these tables in accordance with the request at month 1. **(Action Point 1.12)**

Due to the nature of the way the Trust has been commissioned, we don't have a traditional SLA/LTA with the JCC per se - we did however confirm to the mailbox that the Trust had actively engaged with the JCC to finalise the main elements of the service they commission, and the initial 2026/27 agreed financial value within.. **(Action Point 1.11)** In addition, work has been ongoing for some time to align the more ad hoc work the Trust undertakes for Health Boards under the JCC agreement, and our ambition remains to do so although at present we haven't been able to progress this fully with JCC colleagues, given the resource and capacity to do so and set against a range of other priorities. These are not treated as standard SLA/LTAs and as you are hopefully aware have never given rise to any invoice / income dispute between us and the relevant HB.

The WRP recovery amount of £0.674m has included in line 13 of table E1 as requested **(Action Point 1.13)**

The IFRS16 income recovery has now been included in table E1 and also included in table P to remove the validation error, this is based on the latest forecast and will be updated as we move through the next few months. **(Action Point 1.14)**

9. Aged Welsh NHS Debtors (Table L)

At Month 2 there were 3 invoices over 11 weeks, one of which has been paid in full following the closing of the month 2 position the other two have been confirmed that payment is being made. **(Action Point 1.15)**

10. Cash flow (Table G)

The cash flow has been completed in accordance with the guidance, included below is the details of 'Other' receipts and 'Other' payments as shown within lines 10 and 22 of Table G.

	Apr £,000	May £,000	Jun £,000	Jul £,000	Aug £,000	Sep £,000	Oct £,000	Nov £,000	Dec £,000	Jan £,000	Feb £,000	Mar £,000	Total £,000
RECEIPTS													
other (specify in narrative)													
CRU Income	15	13	0	0	0	0	0	0	0	0	0	0	28
Other Non NHS Income	208	255	200	200	200	200	200	200	200	200	200	200	2,463
Pensions Agency	0	0	0	0	0	0	0	0	0	0	0	0	0
Vat Refund	245	0	576	280	300	300	300	300	300	300	300	299	3,500
Risk Pool Refund	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	468	268	776	480	500	500	500	500	500	500	500	499	5,991
PAYMENTS													
Other items (specify in narrative)													
VAT Payment	0	0	0	0	0	0	0	0	0	0	0	0	0
Pensions / Retirements	130	0	0	0	0	0	0	0	0	0	0	0	130
Total	0	0	0	0	0	0	0	0	0	0	0	0	130

11. Public Sector Payment Compliance (Table H)

As per the guidance this will be completed for quarter 1.

12. Capital (Tables I, J and K)

The capital tables have been completed for month 2 in accordance with the guidance. Indicative budgets have been allocated to schemes and work is currently ongoing to take these schemes through the tendering process to allow for detailed business cases to be constructed, for them to then be taken through the relevant governance channels for approval.

13. Committee to receive Financial Monitoring Return

The Trust confirms that financial information reported in the monitoring return is entirely consistent with financial details reported internally, including details within Trust Board papers and that of its committees.

The month 2 Financial Monitoring Return will be presented to Finance and Performance Committee on 21st July 2026.

Governance arrangements for formal sign off of the monitoring return narrative in the absence of the Director of Finance or Chief Executive will be delegated to their Deputies but in exceptional circumstances could be signed by a Senior Finance Manager and an Executive Director. Signatures on this return contain Chris Turley, Executive Director of Finance & Corporate Resources and Emma Wood, Chief Executive.

14. Other Issues

There are no other matters of major significance to draw to your attention at this stage.

As requested the email will include the Word version of this letter excluding the signatures

If you would like to discuss any matter included in this monitoring return letter or attached tables, please do not hesitate to contact me.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Chris Turley'.

Chris Turley
Executive Director of Finance & Corporate Resources

A handwritten signature in blue ink, appearing to read 'Emma Wood'.

Emma Wood
Chief Executive

Enc cc:
Mr C Dennis, Chairman
Non-Executive Directors Executive Directors



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Agenda Item No.

07

REPORT TITLE

Financial Sustainability Programme Governance Group Meeting Update

MEETING

Name of meeting	Finance and Performance Committee
Date of meeting	21 July 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsors	Chris Turley, Executive Director of Finance & Corporate Resources Rachel Marsh, Deputy Chief Executive
Author(s) of report	Richard Baxter, Senior Project Manager Matt Dugdale, Head of Commercial Development

PURPOSE OF REPORT

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

REPORT SUMMARY

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

1. This report provides the Finance and Performance Committee with an assurance update on the Financial Sustainability Programme and delivery of the Trust's 2026/27 recurrent savings requirement.
2. The programme has made positive early progress. At Month 2, savings delivery is ahead of plan, with £1.423m achieved against a planned £1.342m, resulting in a favourable variance of £81k. Programme governance has also been strengthened through the establishment of four workstreams covering targeted cost reduction, productivity, commercial development, and future financial planning, each with identified senior responsible officers.
3. There are also emerging opportunities to support delivery. The Travel and Subsistence review has identified potential annual savings of £50k–£100k through strengthened controls, improved compliance, exception reporting, and commercial engagement. In addition, five productivity themes have been identified and are moving into more detailed development, including contact centre attendance, use of remote clinical skills, rest break arrangements, dispatch optimisation, and on-scene times.
4. However, assurance on full-year recurrent delivery remains partial. The Trust has not yet identified schemes to deliver £1.2m of the £9.0m recurrent savings requirement. This gap is planned from Month 4, but the current year-end forecast assumes it will not be delivered, creating a material risk to achieving the recurrent savings target. This potential in-year savings shortfall then needs to be considered with WAST's continued reporting of a forecast balanced year-end overall financial position for 2026/27 due to the removal of cost pressures that were assumed in the opening financial plan for this year (i.e. Welsh Risk Pool contribution).
5. Further assurance work is also required in relation to NHS Wales Grip and Control requirements. Although several controls are reported as business as usual, evidence of compliance, gaps, and mitigating actions needs to be documented ahead of submission to Welsh Government and the Financial Delivery Unit.
6. Quality Impact Assessment and Equality Impact Assessment reviews have identified recurring themes relating to workforce capacity, organisational resilience, statutory functions, governance, assurance, and patient safety capacity. These themes require continued corporate oversight to ensure that the cumulative impact of savings delivery is understood and mitigated.
7. The committee is therefore asked to receive assurance on the strengthened governance arrangements and early delivery position, while recognising the material risks associated with the unidentified £1.2m recurrent savings gap, completion of Grip and Control evidence, and the cumulative quality, equality, and organisational resilience impacts.



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RECOMMENDATION(S)

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

The Finance and Performance Committee is requested to:

1. Receive assurance on the strengthened governance arrangements established for the Financial Sustainability Programme;
2. Note the Month 2 savings position, with £1.423m achieved against a planned £1.342m;
3. Recognise that assurance on full-year recurrent savings delivery remains partial because £1.2m of the recurrent savings requirement has not yet been identified and is currently assumed not to be delivered in the year-end forecast. Although this needs to be considered with WAST's continued reporting of a forecast balanced year-end overall financial position for 2026/27 due to the removal of cost pressures that were assumed in the opening financial plan for this year; and
4. Seek assurance that the remaining savings gap, NHS Wales Grip and Control requirements, productivity opportunities, travel and subsistence actions, and cumulative QIA/EQIA themes are being actively monitored, mitigated, and escalated through the programme governance arrangements.

ADDITIONAL PAPER(S)

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

n/a



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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

☐ SO1: Providing the right care or advice, in the right place, every time	☐ SO2: Enabling our people to be the best they can be
☒ SO3: Being at the forefront of innovation and technology	☒ SO4: Developing services in collaboration
☐ SO5: Being quality driven and clinically led	☒ SO6: Delivering exceptional value

RISK(S) THIS REPORT MITIGATES

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

This paper mitigates Risk 139 by providing Committee-level oversight of recurrent savings delivery, the residual £1.2m unidentified savings gap, Grip and Control compliance, and the quality, equality, and workforce resilience impacts arising from savings plans.

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

☐ Safe	☒ Timely	☒ Effective
☒ Efficient	☐ Equitable	☐ Person Centred

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

☒ Leadership	☐ Workforce	☐ Culture
☐ Information	☒ Learning Improvement & Research	☒ Whole Systems Approach

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

☐ A socially responsible and inclusive employer	☒ An innovative and sustainable organisation	☐ A pro-active, accessible and equitable care provider
☒ n/a	☐ n/a	☒ n/a

IMPACT ASSESSMENTS FOR CONSIDERATION

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

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

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
13 July 2026	Strategic Transformation Programme Board



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SITUATION

1. This paper provides the Finance and Performance Committee with an update on the current position of the Financial Sustainability Programme and delivery of the Trust's 2026/27 recurrent savings requirement.
2. The Trust is required to deliver £9.0m of recurrent savings in 2026/27. At Month 2, delivery is ahead of plan, with £1.423m achieved against a planned £1.342m. However, £1.2m of the recurrent savings requirement remains unidentified and is currently assumed not to be delivered in the year-end forecast.
3. The Committee is therefore asked to receive assurance on the strengthened programme governance arrangements and early savings delivery, while recognising that assurance on full-year recurrent delivery remains partial until the £1.2m gap is addressed (if required to ensure year-end financial balance) and supporting Grip and Control evidence is completed.

BACKGROUND

4. The Financial Sustainability Programme was established to provide a structured and coordinated approach to supporting the Trust in achieving its statutory financial duties, while maintaining the quality, safety, and effectiveness of services.
5. The programme provides oversight of savings delivery, productivity improvement, commercial opportunities, and longer-term financial planning. It also ensures that associated quality, equality, workforce, and operational impacts are identified, assessed, and managed through appropriate governance and assurance arrangements.
6. For 2026/27, the Trust is required to deliver £9.0m of recurrent savings to support financial balance and improve the sustainability of its financial position. This represents a continued shift towards recurrent savings delivery. In 2025/26, the Trust's savings target was £8.5m, of which 73% was recurrent, and 27% was non-recurrent. In 2024/25, the £6.421m savings target was split between 57% recurrent and 43% non-recurrent.
7. The Finance and Performance Committee received its previous update on the Financial Sustainability Programme in March 2026. This report provides an update on progress since that point, including the current savings position, programme governance arrangements, emerging opportunities, risks to delivery, and the next steps required to strengthen assurance.



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ASSESSMENT

8. Savings delivery position

- 8.1. The Trust's 2026/27 savings target is £9.0m, all of which is reported as recurrent. At Month 2, delivery is ahead of plan, with £1.423m achieved against a planned £1.342m. This represents a favourable variance of £0.081m.
- 8.2. This early position provides positive assurance that identified schemes are being delivered in line with, and slightly ahead of, the profiled plan. However, this assurance is limited to the current in-year position and does not yet provide full assurance on the achievement of the recurrent full-year savings requirement.
- 8.3. The most significant risk remains the £1.2m of recurrent savings that has not yet been identified through specific schemes. This element of the savings requirement is planned to be phased in from the start of July 2026, but the current year-end forecast assumes that it will not be delivered. This creates a risk to the achievement of the Trust's full-year recurrent savings target. But needs to be considered with WAST's continued reporting of a forecast balanced year-end overall financial position for 2026/27 due to the removal of cost pressures that were assumed in the opening financial plan for this year.

9. Programme governance

- 9.1. The Financial Sustainability Programme Governance Group has reviewed the proposed programme structure and control pack. The Group agreed the establishment of four workstreams to provide focused oversight of delivery, opportunities, and risks:
- Targeted Cost Reduction Workstream - Senior Responsible Officer: Chris Turley
 - Productivity Workstream - Senior Responsible Officer: Lee Brooks
 - Commercial Development Workstream - Senior Responsible Officer: Rachel Marsh
 - Future Financial Planning Workstream - Senior Responsible Officer: Programme Director for Financial Sustainability
- 9.2. These arrangements provide a strengthened governance framework for the delivery of the programme. They are intended to improve accountability, ensure clearer ownership of opportunities and risks, and support more consistent reporting of financial and non-financial benefits.



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- 9.3. The committee can take assurance that a more structured governance approach is now in place. However, continued focus will be required to ensure that each workstream has clear objectives, measurable benefits, delivery milestones, and escalation routes.

10. **NHS Wales Grip and Control requirements**

- 10.1 The Governance Group received an update on the NHS Wales Grip and Control checklist. While the Trust is forecasting a break-even position, NHS Wales overall is forecasting a significant deficit, and the Grip and Control requirements are therefore an important part of the wider national financial assurance framework.
- 10.2 Many of the required controls are reported to be operating as business as usual within the Trust. However, further work is required to document evidence of compliance, identify any gaps, and set out mitigating actions ahead of submission to the Welsh Government and the Financial Delivery Unit.
- 10.3 Assurance in this area is therefore partial at this stage. The key next step is to complete the self-assessment and supporting evidence base, so that the Trust can demonstrate compliance with the relevant Grip and Control requirements and identify any areas requiring further action.

11. **Targeted cost reduction: travel and subsistence**

- 11.1 A detailed review of travel and accommodation expenditure has been undertaken, with the review identifying potential savings of £50k–£100k annually through improved threshold compliance, stronger controls, exception reporting, and commercial engagement with providers.
- 11.2 A Task and Finish Group will be established and aligned to the Targeted Cost Reduction Workstream to progress this opportunity. This will support the development of specific actions, delivery timescales, ownership arrangements, and benefits monitoring.
- 11.3 This provides early assurance that targeted opportunities are being identified and progressed. However, the financial benefit will need to be baselined, tracked, and reported before full assurance can be taken on delivery.



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12. **Productivity opportunities**

12.1 The Operations Directorate presented outputs from the productivity workshop. Five priority themes have been identified:

- contact centre attendance
- maximising remote clinical skills
- rest break arrangements
- dispatch optimisation
- on-scene times

12.2 These opportunities will now move into a more structured development phase, supported by Planning and Performance. This will ensure that each opportunity has a clear baseline, defined actions, measurable benefits, and appropriate monitoring arrangements.

12.3 These areas have the potential to support both financial and non-cash-releasing productivity benefits. However, further work is required to quantify the expected impact and ensure that any operational changes are assessed for quality, safety, workforce, and service implications.

13. **Quality and Equality Impact Assessment themes**

13.1 Following the development of savings plans across all directorates, each directorate was asked to complete a Quality Impact Assessment and, where required, an Equality Impact Assessment.

13.2 The Governance Group reviewed the completed assessments. While most proposals were assessed as manageable, several common themes were identified. These included workforce capacity, organisational resilience, patient safety functions, governance, and assurance arrangements.

13.3 These themes indicate that, while individual schemes may be manageable in isolation, the cumulative impact of savings delivery needs continued corporate oversight. This is particularly important where risks relate to statutory functions, organisational resilience, patient safety capacity, and the Trust's ability to maintain effective governance and assurance arrangements.

13.4 Specific concerns also remain within Digital, including contractual inflationary pressures and uncertainty relating to assumed income streams. These risks will need to be kept under review as part of the wider programme governance arrangements.



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14. Overall assurance assessment

- 14.1. The Committee can take reasonable assurance that the Financial Sustainability Programme has strengthened its governance arrangements, and that identified savings are currently ahead of plan at Month 2.
- 14.2. However, assurance on full-year recurrent delivery remains partial. This is because £1.2m of the recurrent savings requirement remains unidentified and is currently assumed not to be delivered in the year-end forecast. Although this needs to be considered with WAST's continued reporting of a forecast balanced year-end overall financial position for 2026/27 due to the removal of cost pressures that were assumed in the opening financial plan for this year.
- 14.3. Further assurance is also required in relation to completion of the NHS Wales Grip and Control evidence submission, delivery of identified travel and subsistence savings, development of productivity benefits, and management of cumulative quality, equality, workforce, and organisational resilience impacts.
- 14.4. The programme's immediate priority is therefore to close the unidentified recurrent savings gap, strengthen benefits tracking, and ensure that risks and mitigating actions are clearly escalated through the agreed governance structure.

RECOMMENDATION(s)

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

NEXT STEPS

16. The programme will continue to identify, develop, and implement additional recurrent savings schemes to address the remaining £1.2m savings gap (if required in the context of WAST's year-end break-even position) and improve confidence in delivery of the full-year recurrent savings target.
17. The revised Financial Sustainability Programme structure will be embedded, with each workstream expected to report against agreed objectives, milestones, risks, and measurable benefits.



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18. The Travel and Subsistence Task and Finish Group will be established and aligned to the Targeted Cost Reduction Workstream. The Group will develop and implement actions to strengthen controls, improve compliance, introduce exception reporting, and realise identified savings opportunities.
19. The Productivity Workstream will further develop the five priority opportunities identified through the productivity workshop. This will include establishing baselines, benefits profiles, and monitoring arrangements to demonstrate operational and financial impact.
20. The Trust will complete the NHS Wales Grip and Control self-assessment and supporting evidence in preparation for submission to the Welsh Government and the Financial Recovery Unit.
21. A corporate approach will be established to monitor themes, risks, and mitigations arising from Quality Impact Assessments and Equality Impact Assessments. This will help ensure that savings delivery does not result in unintended consequences for service quality, workforce wellbeing, organisational resilience, or equality outcomes.
22. A further update will be provided to the Finance and Performance Committee on programme progress, savings delivery, realised benefits, and emerging risks through the Trust's established governance arrangements.



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Agenda Item No.

8

REPORT TITLE

Integrated Medium-Term Plan (IMTP) 2026/27 Update & Q1 Progress Report

MEETING

Name of meeting	Finance & Performance Committee
Date of meeting	21 July 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Rachel Marsh, Deputy Chief Executive Officer
Author(s) of report	James Houston, Assistant Director of Planning & Transformation

PURPOSE OF REPORT

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



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REPORT SUMMARY

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

1. The purpose of this paper is to provide Finance and Performance Committee (FPC) with an update on Integrated Medium-Term Plan (IMTP) development and delivery. This report includes an assessment of progress reported during the first quarterly reporting cycle (Q1), overview of the proposed changes to committee level reporting arrangements and update against the Clinical Model Transformation (CMT) Programme.

RECOMMENDATION(S)

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

The committee is asked to:

NOTE progress outlined in the Q1 IMTP delivery & assurance report

ADDITIONAL PAPER(S)

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

Annex 1 IMTP 2026-29 Delivery & Assurance Report (Q1)



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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

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

RISK(S) THIS REPORT MITIGATES

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

n/a

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

☒ Safe	☒ Timely	☒ Effective
☒ Efficient	☒ Equitable	☒ Person Centred

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

☒ Leadership	☒ Workforce	☒ Culture
☒ Information	☒ Learning Improvement and Research	☒ Whole Systems Approach

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

☒ A socially responsible and inclusive employer	☒ An innovative and sustainable organisation	☒ A pro-active, accessible and equitable care provider
☐ n/a	☐ n/a	☐ n/a

IMPACT ASSESSMENTS FOR CONSIDERATION

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

Does this paper require an impact assessment ☒ No ☐ Yes

If yes, what impact assessment is attached

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
13 July 2026	Strategic Transformation Board (STB)



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SITUATION

1. The purpose of this paper is to provide Finance and Performance Committee (FPC) with an update on Integrated Medium-Term Plan (IMTP) development and delivery. This report includes an assessment of progress reported during the first quarterly reporting cycle (Q1), overview of the proposed changes to committee level reporting arrangements and update against the Clinical Model Transformation Programme (CMT).

BACKGROUND

2. Following Trust Board approval, the organisation submitted its 2026-29 IMTP to Welsh Government on the 31 March 2026. The IMTP sets out the key organisational priorities and IMTP Deliverables to be achieved over the next three-year planning cycle, mapped to the Trust's six strategic objectives as set out in the Long-Term Strategy 'Delivering Excellence'. The Q1 IMTP progress report attached was reviewed and considered at the Strategic Transformation Board (STB) on the 13 July.

ASSESSMENT

Welsh Government Submission & Feedback

3. Welsh Government has completed its initial IMTP rapid review and assessment process and it is understood that some NHS organisations have received initial feedback outlining requirements for further revision and development of their plans. To date the Trust has not received any formal request for any material / substantial changes to the submitted IMTP or 2026/27 Financial Plan.
4. Formal feedback was expected to be received in late June; however Welsh Government have indicated that feedback is expected mid to late July including a formal feedback letter and the Trust's Accountability Conditions.

IMTP Quarterly Reporting Approach for 2026/27

5. Work has commenced at pace to transition the internal planning processes to embed the refreshed 2026-29 IMTP Deliverables in readiness for delivery and



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monitoring. A total of 37 IMTP deliverables have been embedded into the refreshed directorate level plans; the remaining 10 deliverables have been embedded across the CMT programme.

6. The IMTP delivery and reporting approach has been strengthened for 2026/27, underpinned by a consistent organisation wide directorate planning approach. This approach includes an interim planning solution and PowerBI dashboard whilst work continues to develop and embed a long-term digitised solution.
7. The IMTP quarterly report is organised by strategic objectives as a key enabler to support a broader approach to committee level reporting and assurance. The report seeks to provide a greater degree of analysis and intelligence to strengthen assurance processes and strengthen the alignment between IMTP activities and performance metrics. This is a first step, and further work will be undertaken to strengthen this approach alongside the integration of strategic risks which is included in the next phase of development and refinement.
8. For Q1, FPC will receive the full IMTP progress report (as per last year's reporting process). From Q2 onwards the IMTP assurance process will evolve, and committees will receive assurance reports for specific strategic objectives aligned to the committees' portfolio (outlined in table below). FPC will receive a tailored quarterly IMTP progress and assurance pack covering Strategic Objectives 1, 3 & 6.

Table 1: IMTP Committee Reporting Approach

Committee	Reported Strategic Objectives
STB	Full IMTP Progress Report - All Strategic Objectives
FPC	SO1: Providing the right care or advice in the right place, every time SO3: Being at the forefront of Innovation and Technology SO6: Value and Sustainability
P&C	SO2: Enabling our people to be the best they can be
Quest	SO1: <i>(Clinical outcomes-based focus – approach to be agreed with Quest)</i> SO5: Quality driven and clinically led
Trust Board	SO4: <i>Developing services in collaboration</i> Composite Overview

IMTP Q1 Progress Report

9. The graphic overleaf provides a breakdown of the distribution of the 47 IMTP deliverables by directorate / CMT Programme.



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47
deliverables

10
CMT

9
Digital

8
P&C

7
Ops

5
QSPE

4
Clinical

2
SP&P

1
P&E

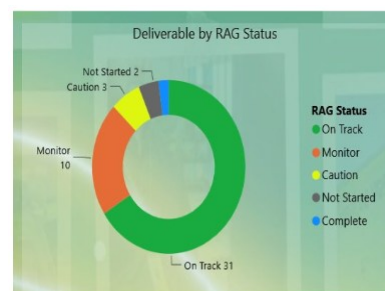
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10. The Trust has made a strong start to delivery in Q1 and the table below provides a summary of progress by strategic objective and associated RAG status across the 47 IMTP deliverables.

SO	On Track	Action Required/Caution	Monitor	Paused	Not Started	Complete	Total
SO1			2	3	10		17
SO2			2		6		8
SO3			2		6	1	9
SO4					2		2
SO5			3		6		9
SO6			1		1		2
Total			10	3	31	2	47

Key:

- On Track
- Action Required/Caution
- Monitor
- Paused
- Not Started
- Complete



11. Overall progress and delivery confidence remains high with 1 completed deliverable reported in Q1 following the implementation and launch of the single RICS clinical queue. Good progress has been made across a range of work streams and a total of 31 deliverables (66%) are reported as Green and on track.

Table 2: Summary of progress by Strategic Objective

SO1	- Improvement activities outlined in the Out of Hospital Cardiac Arrest Plan - Receipt of £400k funding to support the Falls Desk continuation - Approval of the Capital Business Case for the Incident Response Desk.
SO2	- Progress to develop the anti-sexual harassment implementation plan - Launch and promotion of the People Development Plan - Organisational readiness and preparation for ESR replacement
SO3	- Preparation to launch the Digital, Data and Technology governance framework - Renewal of the EPCR contract - Exploration of options to co-term 999 CAD and 111 CAD contract end
SO4	- Strategic intelligence gathering work commenced to support strategy refresh - Broader stakeholder engagement options being explored
SO5	- Options explored to strengthen and broaden Patient Voice Network - Mental Health Delivery Plan being reviewed and wider engagement being undertaken - Flu vaccination preparations underway and end of season flu report developed
SO6	Commercial plan developed and approved by Trust Board



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12. There were no deliverables reported Red and off track requiring urgent action / mitigation.

13. A total of 10 deliverables were assigned as Amber (monitor) status in which potential issues / delays have been flagged for early sighting and consideration. STB undertook a more detailed assessment of the 4 deliverables assigned an Orange Monitor status with a 'low' delivery confidence. These are further stepped out in the table overleaf detailing the mitigating actions agreed in STB.

Table 3: IMTP Deliverables Amber (Monitor) and Low Delivery Confidence

SO1 - Providing the right care or advice in the right place, every time						
Ref	Deliverable	RAG	Priority	Confidence	Issue	Mitigations
7	Operationalise the key recommendations of the Emergency Ambulance (EA) skill mix review	Monitor	Must Do	Low	Further work required to explore the broader impacts of EMT transitioning from Band 4 to EAP and Band 5 and ongoing work regarding the retire and return policy.	Work to continue to finalise the retire and return policy and wider work by the project team to be undertaken regarding the transition and broader skills mix impacts linked to the new integrated clinical services model.
9	Work with supplier to pilot and evaluate the alignment of MPDS and CPSS	Monitor	Could Do	Low	Implementation plan being finalised, however capacity constraints to support key elements including education and digital support may cause some delay into Q3 (Oct onwards).	Further exploration of capacity constraints with directorate leads to support this work.

SO5 – Being quality driven and clinically led						
Ref	Deliverable	RAG	Priority	Confidence	Issue	Mitigation
41	Implement and embed a person-centred, compassionate and learning-focused concerns management system .	Monitor	Must Do	Low	Concerns programme has been impacted by leadership changes and capacity challenges and postponement of concerns workshop due to REAP 4.	Agreement to re-set the improvement programme arrangements with a focus on streamlining and simplifying governance arrangements. Further work required to re-prioritise critical improvement activities to focus on key areas to drive continuous improvement.
44	Implementation of the Medicines Management Hub systems and processes, subject to funding.	Monitor	Should Do	Low	Omnicell business case in development – however changes in Health Board medicines management approaches need to be factored into WAST approach.	Engagement with Health Boards to help refine Medicine's Management Hub business case.



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14. One key risk that was surfaced in both CMT and STB was linked to organisational capacity and pressure which could impact delivery during the year, noting the volume of work scheduled through Q1-Q3. To help mitigate this risk, it was agreed that further prioritisation of work contained within directorate level plans would be undertaken to identify opportunities to re-profile delivery dates and to consider opportunities to pause / defer work to later in the year or into 2027/28. This prioritisation work will be co-ordinated by Planning Business Partners in collaboration with directorate leads.

Clinical Model Transformation Programme (Q1 Update)

15. The CMT Programme remains in a positive delivery position, with focus increasingly shifting towards benefits realisation, programme closure and transition planning.
16. Governance arrangements for benefits realisation are now established, lessons learnt from Phase Three workshops are being translated into an improvement plan, and workstream transition arrangements are being developed for CMT Board endorsement. This will include consolidation of existing groups in order to streamline leadership and delivery capacity.
17. While overall progress against audit actions and IMTP deliverables remains strong, some areas require further development around benefits measurement, including scorecard integration into regular Board reporting, and confirmation of delivery and implementation timelines for emerging phases.

Table 4: Overview of the CMT Q1 2026/27 Highlight report

Workstream		RAG	Notes
Digital Front-End		Green	On Track: Upward trend following Apr-26 Board, remaining Symptom Checker deliverable rolled over into 2026/27 (Q2).
Remote Integrated Care		Yellow	On Track (cautionary status): Yellow RICS status reflects continued dependency on operational capacity, data availability, and alignment across workstreams to fully embed delivery & demonstrate measurable impact.
Urgent Community Response		Yellow	On Track (cautionary status): No change. Status due to requirement of APP Scheduling mitigations (completion of Roster Review and software functionality). No major disruption anticipated at this point, but cautionary status remains.
Emergency Response	Call Flow and Prioritisation	Green	On Track: No change. Closure Report for Call Flow Phase One and RCS approved, and Call Flow Phase Two is due for approval. Health Care Professional (HCP) flows Tests of Change underway, and Communications and Messaging (SMS Functionality) Project on Track
	Out of Hospital Cardiac Arrest	Green	On Track: No change.



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Workstream	RAG	Notes
Health Transport	Closed	Workstream closed resource reallocated to Non-Emergency Patient Transport (NEPTS) Improvement Programme
CMT Metrics	Closed	Closed: Outstanding items transferred to Benefits Realisation Steering Group.
Change Management	Yellow	On Track (cautionary status): Work ongoing on action plan development following feedback received from the Staff Survey. Series of recommendations proposed with minor alterations required following review at July CMT Board.
Partnerships & Engagement	Green	On Track: No change
CMT Benefits Realisation Steering Group	Yellow	On Track (cautionary status): Dedicated sub-groups established and work progressing. Yellow status reflects interim use of reporting data graphs over digitised scorecards as well as analytical capacity, competing operational priorities, and dependencies on wider transformation activity, particularly around flow optimisation and system-wide data integration

18. Accessing Online Digital Advice: Delivery of the Digital Front End programme remains broadly on track, with symptom checker implementation progressing well through testing and clinical assurance activities. A short-term delay to WhatsApp integration caused by cyber security assurance requirements has now been resolved and delivery has resumed. Virtual Assistant capabilities are also continuing to develop through planned integration with symptom checker journeys. Planning for a new phase of delivery is underway, following receipt of funding.

19. Emergency Response: The workstream has continued to evolve encompassing several core areas of focus. Rapid Clinical Screening and Call Categorisation Phases One and Two have closed, with closure reports approved or due to be approved imminently. Call Flow Optimisation (Phase Three) has initiated and is focussing on flow optimisation across six key areas of the patient pathway (including Breathing Difficulties, Dispatch, Call-to-Door, On Scene Times, Orange Now Call Distribution, and Clinical Navigation/Screening). The HCP Call Flow Group has continued work on identifying solutions for Healthcare Professionals to access our services and has undertaken Tests of Change on the use of Protocol 45, with limited success. Ongoing engagement with fellow Ambulance Trusts on shared solutions is ongoing. The OHCA improvement programme remains on track, with strong progress across guidance, training, community response, defibrillator access, and clinical assurance. Data and analytics remain a key risk, with delays to national registry development impacting the ability to fully measure outcomes. The SMS and Communications Group are currently process mapping and developing SMS scripting with a hybrid model emerging that



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combines automated triggers and operational input to support patient interactions. Further development (e.g. two-way SMS) is underway but constrained by technical dependencies, with key decisions and documentation aligned for CMT Board review in July. Project documentation is in draft, including Terms of Reference and a supporting project plan. Interim Ambulance Performance Framework evaluations will take place throughout the year, and regular monthly reporting will look to demonstrate improved patient safety, improved patient outcomes, and a better understanding developing demand.

20. **Remote Integrated Care:** Delivery across workforce development, digital enablement and service optimisation continues to progress, with CPD, clinical supervision and career framework initiatives advancing despite capacity and evaluation challenges. Key digital workstreams including ICCQ transition, CPSS implementation planning and system integration developments remain on track for Q3, subject to technical dependencies. Operational reporting and evaluation arrangements are now established for the specialist desks.
21. **Urgent Community Response (UCR):** Delivery of the UCR workstream continues to progress, with procurement of the scheduling solution underway in Q1/Q2. APP workforce model changes are moving towards implementation as the roster review draws to a close and strengthened governance arrangements are being developed to enable transition of UCR deliverables BAU structures. Local service optimisation initiatives, including falls and palliative care pathways, are advancing with recent deep dives on referral issues in the BCUHB Health Board area identifying limited clinical risk, although progress on mitigations remains dependent on further engagement with Health Boards.

RECOMMENDATION

22. The recommendation(s) are as set out on the front cover above.

NEXT STEPS

23. The next steps are as follows:
 - Transition revised committee level reporting from Q2 onwards
 - Continue to refine and mature the IMTP quarterly reporting and assurance process
 - Undertake a further review and prioritisation exercise against directorate plans and continue development of digitised reporting solution.

Welsh Ambulance Services University NHS Trust

IMTP 2026-29

Quarterly Reporting Progress Update

Quarter 1: April – June 2026



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IMTP Deliverables Q1 Updates
Version 1.0
Released: July 2026

Planning & Performance
AMB_Planning_&Performance@wales.nhs.uk

Introduction

New Quarterly Reporting Approach

- The IMTP quarterly report has been refreshed to provide a more detailed and intelligence led update to enable effective review and assurance
- Report to be read in conjunction with the IMTP Plan on a Page Milestone document

Phase 1

- 47 IMTP 26-29 deliverables reported by Strategic Objectives & Productivity Gains
- Linkage to MIQPR Performance Measures

Phase 2 (future enhancements)

- Inclusion of Improvement Expectations, as set out in the IMTP
- Alignment with strategic risks
- Change control process to be fully embedded

New Quarterly Reporting Model

- Dashboard-led reporting (PowerBi) a single, consistent Trust-wide view of delivery
- Balanced intelligence – combining narrative and performance to inform decision-making
- Iterative development – **feedback welcome** as we continue to refine the model
- Scheduled cycles of business - fully embedded into routine organisational oversight



Proposed Oversight Route

Proposed oversight route for IMTP 26-29 quarterly progress reports

Committee coverage

Principle

Route the right level of detail to each committee, while keeping STB and Trust Board sighted on the full delivery position.

Decision to confirm

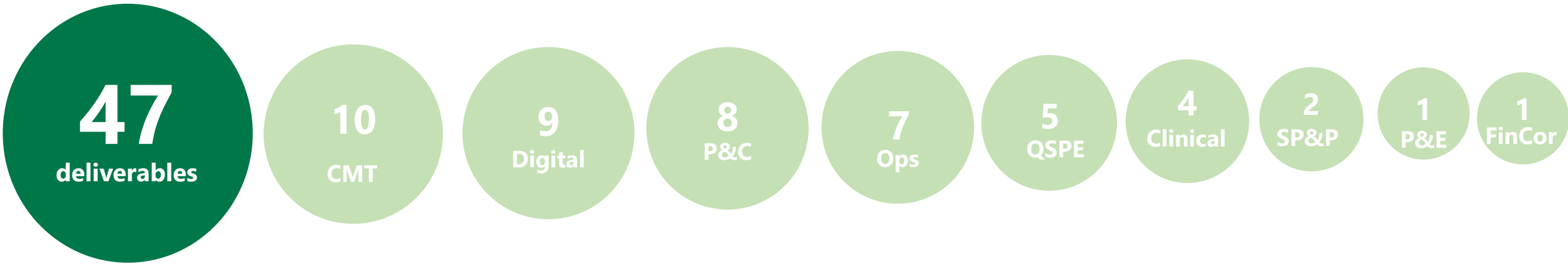
Agree pack routes and whether a one-page Trust Board version is required.

Committee	Receives
STB	All Strategic Objectives
P&C	SO2
FP&C	SO3, SO4, SO6
Quest	SO1, SO5
Trust Board	Summary Overview

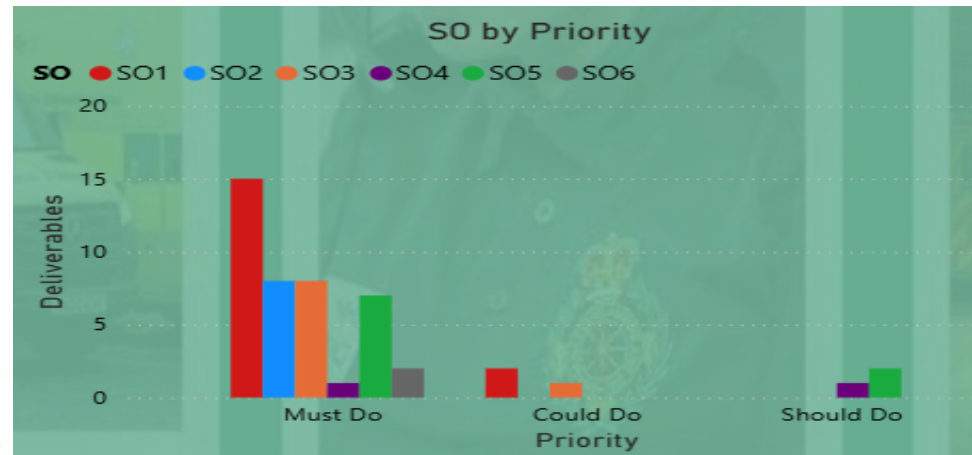
Strategic Objectives Key	
S01	Providing the right care or advice in the right place, every time
S02	Enabling our people to be the best they can be
S03	Being at the forefront of Innovation and Technology
S04	Developing services in collaboration
S05	Quality driven and clinically led
S06	Value and Sustainability

Total number of deliverables by Directorate

Distribution of the 2026–29 IMTP deliverables



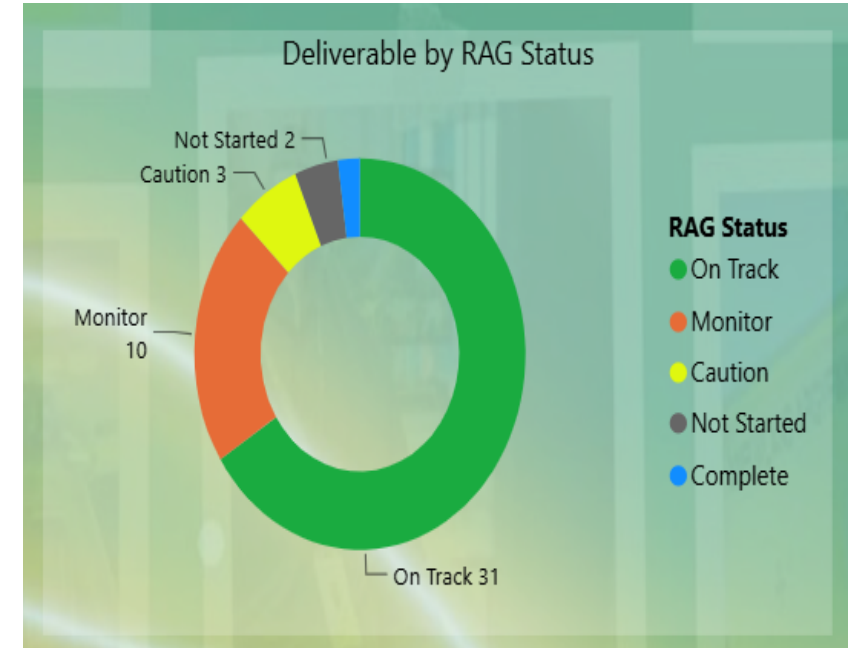
Largest portfolios: CMT, Digital and P&C account for more than half of tracked deliverables.



Overall Summary By Strategic Objective RAG

47 IMTP 26-29 deliverables

SO								Total
SO1		2	3	10		1	1	17
SO2		2		6				8
SO3		2		6		1		9
SO4				2				2
SO5		3		6				9
SO6		1		1				2
Total		10	3	31		2	1	47



Key:

 Action Required/Caution
  Monitor
  Caution
  On Track
  Paused
  Not Started
  Complete

S01	Providing the right care or advice in the right place, every time
S02	Enabling our people to be the best they can be
S03	Being at the forefront of Innovation and Technology
S04	Developing services in collaboration
S05	Quality driven and clinically led
S06	Value and Sustainability

Overall Summary Position

MOSCOW: 87% MUST, 7% SHOULD, 6% COULD

47 IMTP 26-29 deliverables

RAG

0%
Action
Required

66%
On Track

22%
Monitor

4%
Not started/
Paused

6%
Caution

2%
Complete

Confidence

9%
Low

17%
Moderate

66%
High

8%
Not
Applicable

Summary overview

- Q1 shows a **strong** and **confident** start to delivery **across all 6 strategic objectives**, with clear evidence of organisational momentum, strengthened governance, and early impact across clinical, operational, digital, workforce and financial programmes.
- Across SO1–SO6, delivery confidence is **generally high**, with 66% of deliverables **On Track** and showing tangible progress against milestones. Where 'monitor' and 'caution' exists (22% / 6%), it is explainable and manageable, typically linked to external dependencies (e.g., funding approvals, DPIA requirements), capacity constraints, or the need for further validation of emerging schemes.
- Several cross-cutting themes define the Q1 position:
 - Clinical and operational transformation is progressing at pace with major programmes (CMT Evaluation, HCP call flows, OHCA improvement, APP optimisation moving from design into delivery and early evaluation)
 - Workforce wellbeing and culture programmes are gaining traction, particularly sexual safety and work-related stress, supported by national leadership and strong organisational engagement
 - Digital enablement is accelerating, with multiple new dashboards, technical integrations, and patient facing digital products advancing through testing and implementation
 - Strategic collaboration and long-term strategy planning are maturing, focus on strengthening Health Board engagement and early work underway to refresh the Trust's Long-Term Strategy.
 - Quality governance is strengthening, with improved assurance processes, patient voice expansion and mental health transformation progressing well
 - Financial sustainability foundations are in place, with mobilisation of Trust-wide FSP Board approval of the commercial plan

Changes requested for STB approval / direction

In development – to be supported by a revised change control process guidance document

STB decision log

Items needing approval, direction or escalation.

Decision options

Approve
Defer
Request more info
Escalate

RAG slides retain rationale; this slide records the ask.

Requests for approval / direction

Ref	Change type	Requested change	Rationale / impact	Decision required	Owner / date
1	<i>e.g. Directorate move</i>	<i>Describe change requested</i>	<i>Why change is needed; risk / dependency</i>	<i>Approve / direction</i>	<i>Owner / date</i>
2	<i>e.g. Stop / pause</i>	<i>Describe change requested</i>	<i>Why change is needed; risk / dependency</i>	<i>Approve / direction</i>	<i>Owner / date</i>
3	<i>e.g. Scope / timing</i>	<i>Describe change requested</i>	<i>Why change is needed; risk / dependency</i>	<i>Approve / direction</i>	<i>Owner / date</i>
4	<i>e.g. Escalation</i>	<i>Describe change requested</i>	<i>Why change is needed; risk / dependency</i>	<i>Approve / direction</i>	<i>Owner / date</i>

Suggested completion: populate only where a decision is required; otherwise, mark “No STB approval / direction requested this quarter”.

Welsh Ambulance Services University NHS Trust

IMTP 2026-29 Strategic Objective 1

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



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

17 IMTP 26-29 deliverables

High Level Achievements

- Clinical Model and APF evaluation formally mobilised
- Major digital and clinical transformation programmes progressing strongly
- System-wide OHCA improvement actions delivering early impact

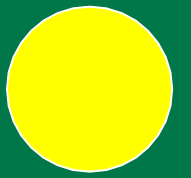


Assurance Narrative

- Delivery against **SO1** is progressing well, with most deliverables **on track** and demonstrating clear movement against milestones.
- Several workstreams are entering **implementation, optimisation and evaluation phases**, reflecting maturity of the CMT programme
- Where 'caution' exists, it is explainable, manageable and already mitigated through governance, interim solutions or planned Q2 actions.
- A small number of deliverables are paused or pending external decisions limiting progress.
- Themes emerging across SO1 :
 - Strong and sustained clinical transformation delivery
 - Digital enablement accelerating
 - Operational readiness strengthening
 - Dependencies and capacity constraints
- Overall, SO1 demonstrates a **strong Quarter 1 position**, with significant operational, clinical and digital complexity.

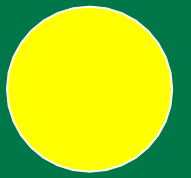
SO								Total
SO1		2	3	10		1	1	17

SO1 Deliverables by RAG - Caution



Ref	Deliverable	RAG	Priority	Confidence	Update	Rationale
2	Undertake a detailed assessment of clinical flows, processes and functions to optimise productivity, efficiency and outcomes across the model, with a specific focus on improving care for high-risk patient groups (Stroke, STEMI, NOF). This will be enabled through targeted improvement and a consistent approach to benefits realisation, using clear metrics, measures and baselines to improve clinical outcomes, care and experience.	Caution	Must Do	Moderate	Benefits Framework reviewed and updated in line with progress. Scorecards remain in development, and yet to be communicated, however interim solution in place using key measures and indicators approved by Trust Board in March 2026. Unlikely to be completed in Q1.	Remains Yellow following initiation of Steering Group and all underlying Task & Finish Groups. All sub-groups have developed targeted problem statements, and work is underway to scope the issue, identify opportunities, recommend optimisation approach.
3	Develop a business case to secure external or internal funding for a modern digital front end for NHS 111 Wales including simultaneous replacement of the current Content Management System and establishment of a substantive NHS 111 Wales Online multi-disciplinary team	Caution	Must Do	Moderate	Due to recurrent BAU funding received from Welsh Government the previous requirement for a business case is no longer required.	A decision on the future of the Digital Front End workstream is now under consideration, accounting for potential transition to new structures.

SO1 Deliverables by RAG - Caution



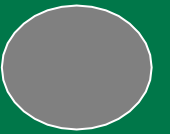
Ref	Deliverable	RAG	Priority	Confidence	Update	Rationale
10	Optimise and evaluate current provision of the falls desk to inform delivery of the function post current funding arrangements	Caution	Must Do	Moderate	Funding of circa. £400k received for the falls desk. A monthly operational performance report has been established and submitted to Welsh Government and dashboard capability has improved reporting efficiency vs. previous manual processes. Refinements to the falls desk operating model to be reviewed in conjunction with the implementation of the Single RICS CAD.	Full evaluation to be conducted following a year of operationalisation.

SO 1 Deliverables by RAG – Amber



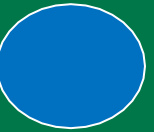
Ref	Deliverable	RAG	Priority	Confidence	Update	Rationale
7	Operationalise the key recommendations of the Emergency Ambulance (EA) skill mix review	Monitor	Must Do	Low	Activity this quarter has focused on rebasing vacancies to Band 4 posts, with the associated narrative reflected within the savings plan	STB Mitigation: Work to continue to finalise the retire and return policy and wider work by the project team to be undertaken regarding the transition and broader skills mix impacts linked to the new integrated clinical services model.
9	Work with supplier to pilot and evaluate the alignment of MPDS and CPSS	Monitor	Could Do	Low	Finalising implementation plan for the trial encompassing the elements associated: education, technical (systems and hardware), reporting, operations.	A lack of defined implementation date however trajectory is looking for implementation Q3 (October) due to capacity to deliver from areas such as digital and education in line with conflicting priorities. STB Mitigation: Further exploration of capacity constraints with directorate leads to support this work.

SO 1 Deliverables by RAG - Not started



Ref	Deliverable	RAG	Priority	Confidence	Update	Rationale
13	Undertake a strategic service review of NEPTS	Not Started	Could Do	N/A	Funding will come from next years IMTP process	In Q2 we will establish the Board which will provide sufficient time to complete ready for the IMTP planning cycle to secure the funding.

SO 1 Deliverables by RAG – Complete



Ref	Deliverable	RAG	Priority	Confidence	Update
8	Implement a Single RICS clinical queue to streamline Remote Clinical Consultation and standardise clinical queue management across 999 and 111 services	Complete	Must Do	N/A	Closure report and transition will occur after the Issue Management Response is complete in line with the reporting / data element. Ongoing stabilisation of the system in play with reporting, cultural, and process elements being refined and the project undergoing transition into business-as-usual.

SO 1 Deliverables by RAG - Green



Ref	Deliverable	RAG	Priority	Confidence	Update
1	Complete a formal academic evaluation of the Clinical Model and Ambulance Performance Framework changes to understand the benefits, impact and opportunities for improvement	On Track	Must Do	High	Methodology and approach approved by CMT Board, and initial documentary analysis well underway. Data plan with measures provided to Edge Hill, along with completed process map of end-to-end patient flow.
4	Replace the outdated Online Symptom Checker (OSC) tool to align with the 111 Call Prioritisation and Streaming System (CPSS).	On Track	Must Do	High	Beta testing complete, with UAT scripts in development and preparation of the live environment progressing. The test system is nearing readiness to support stakeholder demonstrations, while ITK is being tested internally ahead of planned external testing with health boards.



SO 1 Deliverables by RAG - Green



Ref	Deliverable	RAG	Priority	Confidence	Update
5	Deliver a system-wide action plan to accelerate improvements in out-of-hospital cardiac arrest (OHCA) outcomes in Wales by implementing targeted interventions in public awareness, CPR training, defibrillator access, advanced life support, and data analytics	On Track	Must Do	High	Bespoke CPR resources have been developed and are now being embedded across key touchpoints, including schools, community settings and public engagement activity to improve confidence and willingness to perform bystander CPR. Work with Cardiff Metropolitan University continues to progress CPR curriculum development within Wales, supported by bilingual resources and wider stakeholder engagement to strengthen CPR awareness and capability.
6	Redesign and implement revised Health Care Professional (HCP) call flows aligned to our integrated Clinical Services Model, and evaluate and optimise them post implementation	On Track	Must Do	High	The project has completed two Tests of Change. Engagement with the Scottish Ambulance Service (SAS) highlighted that Protocol 45 is not working as intended. Collaborative work with SAS and Northern Ireland Ambulance Service (NIAS) is underway to shape a shared solution and take an agreed proposal to the Academy. Looking at stakeholder engagement to collaborate forward thinking with the interim solution for a long-term solution

SO 1 Deliverables by RAG - Green



Ref	Deliverable	RAG	Priority	Confidence	Update
11	Increase the number of patients treated at home or in the community by optimising and more effectively utilising our advanced practice resources across Wales (including APP roster review, scheduling advanced practice clinicians and increasing utilisation) aligned to the 'preferred response' outlined in the Ambulance Performance Framework	On Track	Must Do	High	Funding of circa. £400k received for the falls desk. A monthly operational performance report has been established and submitted to Welsh Government and dashboard capability has improved reporting efficiency vs. previous manual processes. Refinements to the falls desk operating model to be reviewed in conjunction with the implementation of the Single RICS CAD. Full evaluation to be conducted following a year of operationalisation.
12	Establish a NEPTS improvement programme and detailed plan to increase the productivity and efficiency of the NEPTS service to address current performance challenges and risks. Improvement actions will include (1) NEPTS roster review	On Track	Must Do	High	Workstreams 3 and 4 now have data to support SMS notifications and responses, which will be able to support trends. Awaiting final approval for DPIA. There is an option to move forward without, as vehicle tracking can be disabled as an interim solution.
14	Implement two key recommendations from the Manchester Arena Inquiry (Incident response desk and additional duty operations manager capacity) to enhance organisational readiness for major incidents and events	On Track	Must Do	High	IRD (Incident Response Desk) Capital Business Case approved in May, room designs finalised and procurement progressing as planned HART Uplift - Awaiting approval of funding from Welsh Government.

SO 1 Deliverables by RAG - Green



Ref	Deliverable	RAG	Priority	Confidence	Update
15	Develop and implement operational plans for upcoming major national events , working with Welsh Government and partner organisations as a Category 1 Responder (including the Tour de France and the UEFA European Football Championship).	On Track	Must Do	High	Outline delivery plan being created and due to be submitted to SLT by end of July.
16	Deliver the Covid Inquiry recommendations to enhance organisational readiness for major incidents	On Track	Must Do	High	Module 3 report received, however, yet to meet to go through this in detail. Pandemic Governance Group established
17	Undertake a review of preparedness against the Wales resilience framework to improve compliance with national resilience standards and ensure that arrangements under the Civil Contingencies Act remain robust and up to date	On Track	Must Do	High	WAST specific risk scoring has been agreed and being applied to all risks with gap analysis being submitted by August to SLT.

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



MIPQR Metrics: Accessing our Services

Theme	Metric	Ambition / threshold	RAG April	RAG May	RAG June
Accessing our services	Number of patients using the NHS 111 Virtual Assistant 'Albot' option	Increasing trajectory			
Accessing our services	NHS 111 webchat as a % of website hits	Ambition of 1.35%			
Accessing our services	999 calls answered within 6 seconds, Median	Maintain current target			
Accessing our services	999 calls answered within 6 seconds, 95th percentile	Maintain current target			
Accessing our services	NHS 111 call handling abandonment rate	Maintain within 10–15% rate			

RAG Indicators =

TBD: Status cannot be calculated (To Be Determined)

MOA – Measure of Activity

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

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

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

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



MIPQR Metrics: Our Emergency Response

Theme	Metric	Ambition / threshold	RAG April	RAG May	RAG June
Primary Clinical Outcome Measures	ROSC at hospital	Improve to 25–30%			
	Stroke call-to-door median	1.5 hours			
	STEMI call-to-door median	1.5 hours			
	NOF call-to-door median	Develop measure			
	Chain of survival metrics	Improve trajectory			
Secondary Response Measures	Arrest / Purple response	6–8 min median; 20 min P90			
	Emergency / Red response	6–8 min median; 20 min P90			
	Now / Orange response	60-minute median			

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

MIPQR Metrics: Our Emergency Response



Theme	Metric	Ambition / threshold	RAG April	RAG May	RAG June
Other Measures	% (to plan) of EMS Hours produced	Maintain 95%			
	Average jobs per shift (Emergency Ambulance)	Improve to 2.3 jobs per shift			
	Hospital Handover Wait 15/Wait 45 and Total lost hours	0 waits >45m; <6,000 hrs p.a.			
	'Cant send' and cancelled by patients (volume)	Reduction > 5,770 per month			

MIPQR Metrics: Remoted Integrated Care

Theme	Metric	Ambition / threshold	RAG April	RAG May	RAG June
Remote integrated care	Time to integrated care consultation (RICS 1), 90th percentile and associated median	Improvement trajectory			
Remote integrated care	% and activity Consult and Close (999)	Improvement trajectory to 22%			
Remote integrated care	111 outcomes (in particular to 999 and ED)	Maintain current levels			

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



MIPQR Metrics: Urgent Community Response

Theme	Metric	Ambition / threshold	RAG April	RAG May	RAG June
UCR	APP jobs per shift	Improve trajectory to 4.75 patients per shift			
UCR	% and activity of see and treat/pathway (non-convey to ED from on scene)	Improvement trajectory >20%			
UCR	Reduction in the number of conveyances into ED as a % of verified incidents	Decreasing trajectory			

MIPQR Metrics: Non-Emergency Patient Transport

Theme	Metric	Ambition / threshold	RAG April	RAG May	RAG June
NEPTS	% of NEPTS activity cancelled (by capacity management plan, by patients and by Health Boards)	Improvement trajectory < 10%			
NEPTS	Renal repeat cancellation rates	Reduction – 0 cancellations			
NEPTS	Oncology journeys arriving within 45 minutes in advance of, and 15 minutes after appointment (NEPTS)	Maintain achievement against 70% target			
NEPTS	Advanced discharge and transfer journeys collected less than 60 minutes after booked time (NEPTS)	Improvement trajectory to <60 minutes			

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IMTP 2026-29 Strategic Objective 2

**Enabling our people to be the
best they can be**



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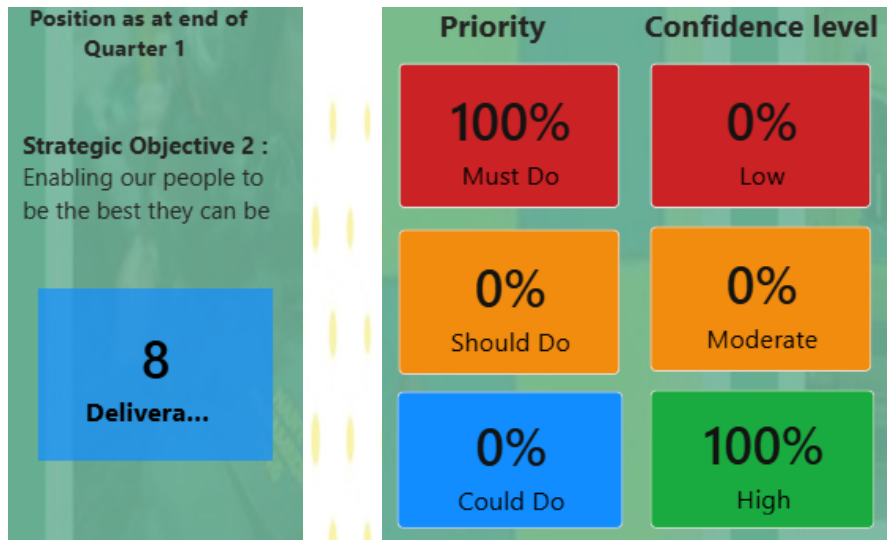


SO2 – Enabling Our People To Be The Best They Can Be

8 IMTP 26-29 deliverables

High Level Achievement

- Sexual safety programme delivering strong national leadership
- Digital stress risk assessment tool completed
- Strengthened organisational insight into sickness absence



SO								Total
SO2		2		6				8

Assurance narrative

- Progress against **SO2 deliverables** shows strong early movement, particular across sexual safety and work-related stress. Most activity is on track, with clear evidence of structured implementation, national collaboration and targeted training
- Where delays exist, they relate primarily to policy governance timelines, capacity constraints and the need for wider consultation
- Themes emerging across SO2:
 - Strong national collaboration
 - Growing digital enablement
 - Clear organisational engagement
 - Governance dependencies
- Overall, SO2 demonstrates **clear progress, strong organisational engagement, and credible delivery foundations** for Quarter 2

SO 2 Deliverables by RAG - Amber



Ref	Deliverable	RAG	Priority	Confidence	Update	Rationale
19	Absence Management: Achieve a sustained reduction in sickness absence through targeted action on work-related stress, supporting colleagues and managers to take timely action and promote long-term wellbeing.	Monitor	Must Do	High	Sickness Absence Data: Work is currently in progress to establish a multi-disciplinary working group. Digital Risk Assessment Tool finalised, with next steps for testing which will be done in line with the Stress Management Policy throughout Q2. Stress Management Policy: Further consultation is required with stakeholders outside of the core stakeholder group, and an Equality Impact Assessment (EQIA) must be completed before the proposal can be presented to the People and Culture Business Meeting and Policy Group	To align with the policy governance process, the completion date will be revised from Q2 to Q3.
24	Recruitment Strategy: Design and implement an inclusive Recruitment Strategy that attracts, engages, and retains diverse top talent aligned with our organisational values and workforce needs.	Monitor	Must Do	High	Stakeholder engagement due to be complete by end of Q1 however this is continuing until July 2026 as first draft document is in development and additional engagement is planned on the first draft. Inclusive Recruitment Initiative workshops complete. Progress has been made in strengthening support for new employees through the development of Digital WAST Onboarding and the Warm WAST Welcome initiative.	Whilst the original objective focused on providing work experience placements, further consideration has identified a number of alternative engagement opportunities that may be more achievable and Impactful in the short term.

SO 2 Deliverables by RAG - Green



Ref	Deliverable	RAG	Priority	Confidence	Update
18	Sexual Safety: Embed the Anti Sexual-Harassment Policy and deliver the supporting implementation plan to create a culture of sexual safety across the Trust	On Track	Must Do	High	Work continues through national working groups to develop an implementation plan, including standardised resources and training materials, with WAST sharing its general awareness training as the only programme currently developed and delivered. The policy has been approved and published on SIREN, alongside ongoing work to strengthen communications and alignment with safeguarding and disciplinary policies. Feedback from the Sexual Safety General Awareness sessions has been reviewed and is being developed into a visual summary, highlighting strong engagement and positive responses to the training materials Training delivery continues to progress, with 209 staff (including 78 volunteers) completing general awareness sessions

SO 2 Deliverables by RAG - Green



Ref	Deliverable	RAG	Priority	Confidence	Update
20	Staff Survey & Pulse Survey: Increase engagement and participation through targeted interventions, ensuring all colleague voices are heard, and effectively use data to drive informed decisions and actionable insights.	On Track	Must Do	High	Questions will be aligned to the 3 priorities identified at the WASPT workshop; first pulse survey will commence upon completion of procurement exercise. Slight delay in progressing with first round of Pulse Surveys due to the Procurement Exercise requiring additional sign off by ELT. First Pulse Survey is now scheduled for July 26. Pulse Survey Digital Platform: Paper approved by ELT and procurement exercise complete to replace Hive with Engage 365, this will be available from July onwards. Staff Survey : Completed Q1 milestone data shared at PCC meeting and directorate packs shared across the organisation and meetings with Directorate Leads underway. Refresh of communication plan for 2026 has commenced.
21	Our WAST Way: Embed Our WAST Way Leadership Behaviours and Development Framework (inc. Managers Essentials) and progress the next phase to strengthen leadership and effective management.	On Track	Must Do	High	Phase 2 scope has been refined in line with financial constraints and agreed with ELT, with delivery now set out in the 2026/27 plan. External partners are confirmed

SO 2 Deliverables by RAG - Green



Ref	Deliverable	RAG	Priority	Confidence	Update
22	Change Management: Enhance managers' ability to lead and navigate change confidently, reinforcing cultural transformation and organisational resilience	On Track	Must Do	High	Toolkit : A suite of practical tools has been designed and developed to support managers and change leads to better understand and apply different approaches to involvement, engagement and participation. Change Heat Map developed and plan in place on how this will be implemented and delivered. Change Community Initial work has now commenced, with a focus on the development of the approach.
23	Development for All: Ensure development for all by delivering a comprehensive approach to career pathways, succession planning, and professional development across the Trust. This includes establishing talent pipelines for Executive and Senior Leadership roles, launching the People Development Plan, and expanding Apprenticeship and Essential Skills provision to support career progression. In addition, strengthen Trust-wide Education Quality Assurance by implementing consistent, accredited, high-quality curriculum and professional practice standards	On Track	Must Do	High	PDP launched end of March. Session at CEO Roadshow. Further work around promotion required, going to meet with the OD team to link to PADR. Education Quality Assurance: External quality assurance exercise for TEMT programme in June 2026. Met with EMSC colleagues to initiate development and support for the introduction of call handler apprenticeships. Continued support to ambulance care for their induction programmes. Professional Practice Training (RAG: Green): Progressing well, full cohort on the programme. Enough interest for another cohort.

SO 2 Deliverables by RAG - Green



Ref	Deliverable	RA G	Priority	Confidence	Update
25	Future Workforce Solution: Undertake preparatory work to support the implementation of the Future Workforce Solution (ESR replacement)	On Track	Must Do	High	Design: Workshop held on "End User Payroll". Involved in a national CRP1 Domain Sessions which provided WAST with an opportunity to provide feedback on the first run throughs of the system. Organisational readiness and engagement: Attended FWS Foundational Readiness Delivery Group, informing that the "Organisational Readiness" Documents will now be ready in September, instead of June, this does not impact on our delivery.



SO2 – Enabling Our People To Be The Best They Can Be



MIPQR Metrics

Metric	Ambition / threshold	RAG April	RAG May	RAG June
% of successful applicants (recruited) from under-represented groups	Improvement trajectory to 7%			
% of 111 calls presented in Welsh and answered in Welsh	Improvement trajectory to 70%			
Staff sickness	Improvement trajectory to <6%			
Staff turnover	Maintain <10%			
PADR completion rate	Improvement trajectory to >85%			
Statutory and mandatory training completion	Maintain >85%			

RAG Indicators =

TBD: Status cannot be calculated (To Be Determined)

MOA – Measure of Activity

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

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

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IMTP 2026-29 Strategic Objective 3

**Being at the forefront of
innovation and technology**



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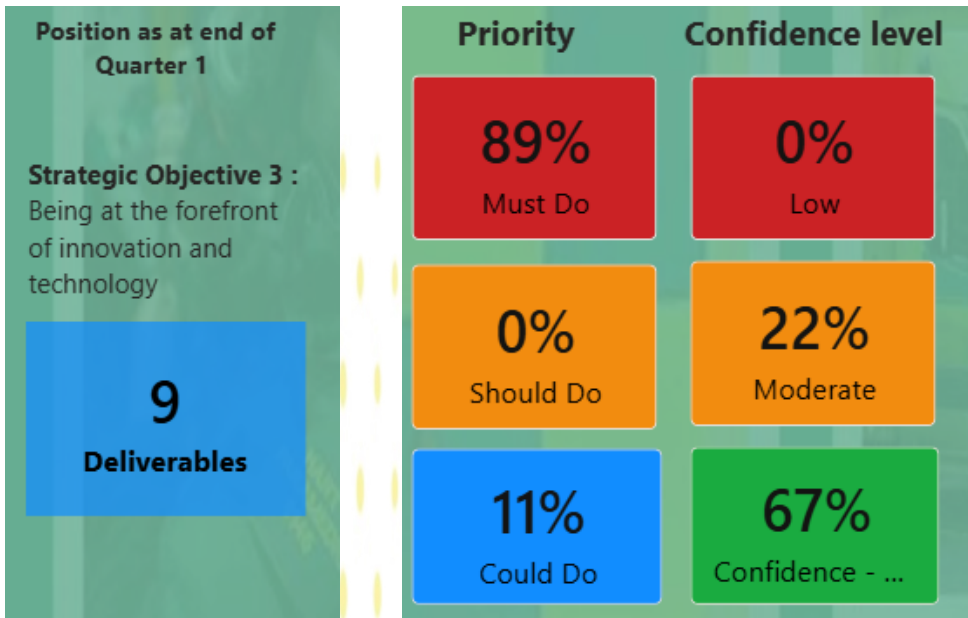
SO3 – Being At The Forefront Of Innovation And Technology

9

IMTP 26-29 deliverables

High Level Achievements

- Live operational dashboards deployed and expanding
- Digital solutions improving productivity and patient experience
- App optimisation and clinical pilots showing early benefits



SO								Total
SO3		2		6		1		9

Assurance narrative

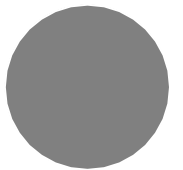
- SO3 shows **steady early-stage progress**, with most deliverables moving through foundational work such as scoping, data development, early testing, and initial implementation.
- Where delays exist, they are largely due to capacity constraints, external dependencies, or policy/technical approvals. Some concerns have been raised regarding IDS capacity aligned to CMT and wider digital priorities.
- Positive progress across eight/nine **Must Do** digital and technology commitments.
- Overall delivery confidence is **moderate-to-high**, with clear momentum across most commitments.
- Themes emerging across SO3:
 - Digital transformation accelerating
 - Operational optimisation strengthening
 - Governance and assurance maturing
 - Dependencies slowing progress
- Overall, **SO3** demonstrate solid quarter 1 progress, strong digital momentum, and credible foundations for continued delivery into quarter 2.

SO 3 Deliverables by RAG - Amber



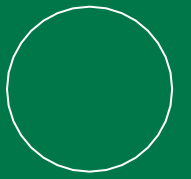
Ref	Deliverable	RAG	Priority	Confidence	Update	Rationale
30	Develop key requirements and appraisal of options for EMS, 111 and NEPTS CAD Replacements, including strategic direction	Monitor	Must Do	High	Investigating option to co-term 999 CAD contract with 111 CAD contract end	Seeking project support from Planning team
34	Strengthen information governance arrangements and technical development to enable WAST to continue to support the all-Wales data sharing ambitions via the National Data Resource.	Monitor	Must Do	Moderate	National data sharing into the NDR remains dependent on resolution of national legislative issues and clarity on DHCW roles and responsibilities.	Being led by DHCW, WAST continues to support but no further clarity on IG arrangements yet.

SO3 Deliverables by RAG - Grey



Ref	Deliverable	RAG	Priority	Confidence	Update
28	Expand SMS functionality across services to improve access for patients and their engagement with key frontline services e.g. clinical navigator function (FY27/28)	Not Started	Could Do	N/A	Deliverable due to start 27/28

SO 3 Deliverables by RAG – Green



Ref	Deliverable	RAG	Priority	Confidence	Update
26	Deliver a cloud-based Global Rostering System (GRS) solution, enabling an organisational decision on implementing the e-timesheet solution	On Track	Must Do	High	Completed Live system migration into Cloud. Training and UAT pending, along with Android mobile application.
27	Launch and embed updated Digital, Data and Technology (DDAT) Governance Framework	On Track	Must Do	High	Digital Oversight group ToR completed and SOP for process. Digital request form completed. Go Live date for DOG set as 29th July 2026
29	Establish safe, ethical and effective use of AI across WAST through a Responsible AI Framework and targeted staff capability-building	On Track	Must Do	High	AISG developed a governance mechanism to support Responsible AI judgement, decisions and advice.
31	Develop the full Business Case for Emergency Services Network (ESN) Phase 2, covering handheld radios, fixed vehicle devices, field services, and resource funding through 2031/32 (as part of the UK national programme)	On Track	Must Do	Moderate	The ESN Phase 2 Full Business Case (FBC) has been completed and has been shared internally for review.

SO 3 Deliverables by RAG – Green



Ref	Deliverable	RAG	Priority	Confidence	Update
32	Implementation of ePCR application refresh and renewal of contract	On Track	Must Do	High	epcr contract renewed for 6 years,
33	Combine internal WAST datasets and link with external datasets (e.g. ED data) to provide richer intelligence and to evidence impact of the CMT and other improvements	On Track	Must Do	High	Data Linkage group established under CMT Benefits workstream. This will support linkage for patient outcomes, population health, and clinician level insights. Project Initiation Doc in development.

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IMTP 2026-29 Strategic Objective 4

Developing our services in collaboration



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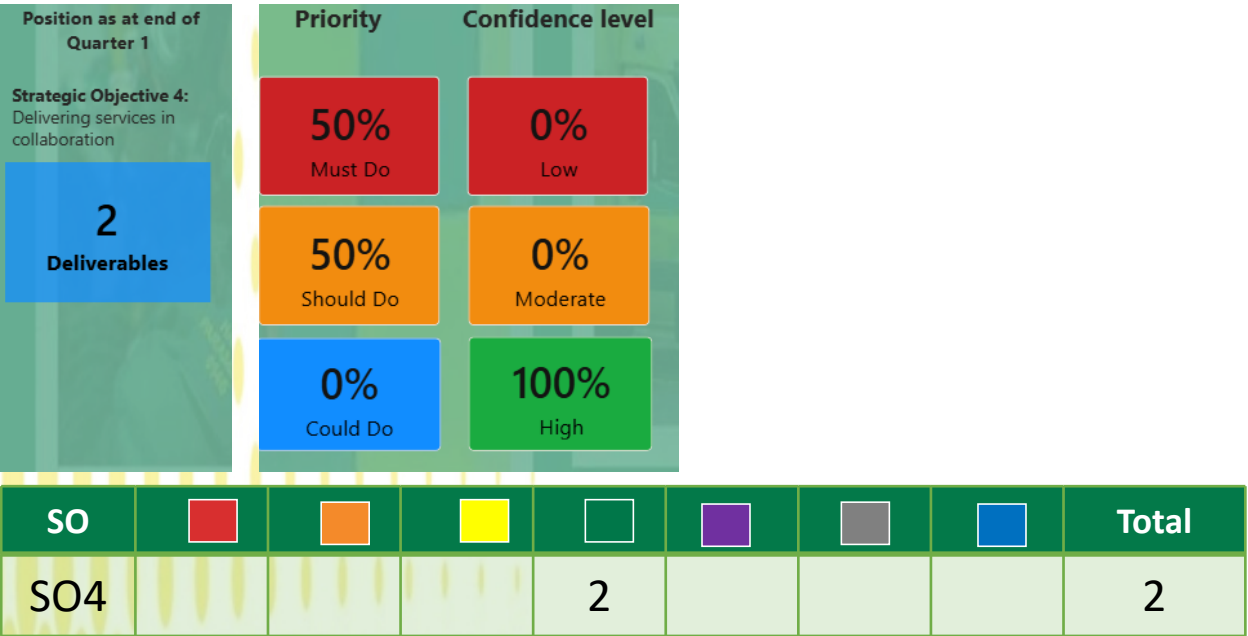


SO4 – Developing Our Services In Collaboration

2 IMTP 26-29 deliverables

High Level Achievements

- Strengthened strategic engagement with Health Boards
- Long-term strategy refresh foundations established
- Cross system collaboration delivering tangible progress (joint work with SAS and NIAS on HCP call flows, OHCA curriculum development with Cardiff Met, multi-agency engagement on major events planning)



Assurance narrative

- SO4 is **On Track**, with strong early progress across both Health Board collaboration and the long-term strategy refresh.
- Quarter 1 has focused on building the foundations: strengthening strategic engagement routes, maturing the stakeholder mapping, and establishing the core framework and intelligence base required for the strategy refresh. There is clear traction at ELT and STB, supported by increasing organisational involvement.
- Next focus areas:
 - Collaboration: Embed a structured account management approach to Health Board engagement to ensure consistent, strategic and insight-drive relationships across Wales.
 - LTS: Produce a consolidated report to outline findings from intelligence gathering and data analysis to inform the refreshed strategic direction.

SO 4 Deliverables by RAG – Green



Ref	Deliverable	RAG	Priority	Confidence	Update
35	Create strategic opportunities for increased Health Board engagement and collaborative working	On Track	Must Do	High	Paper going to ELT on July 22 having been rescheduled from end May Updated stakeholder engagement mapping in progress Options appraisal for Exec-level stakeholder engagement approach drafted P&E workstream transition from CMT to wider organisational engagement in progress AB Operational/Planning Meeting attendance mapping complete
36	Develop and deliver a robust approach to refresh the organisation's Long -Term Strategy, using an internally produced strategic development and engagement framework	On Track	Should Do	High	Strategic gathering intelligence approach presented to STB on 28th April and support received. Scoping now underway for specific elements with key leads and analysis work has commenced on elements owned by SDM e.g. ambulance sector strategy reviews, mid-strategy assessment etc. Strategy Team Focus Day planned on 28th May for dedicated time on developing draft refresh framework. Initial research and collation of ideas has been completed.

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IMTP 2026-29 Strategic Objective 5

**Quality Driven and Clinically
Led**



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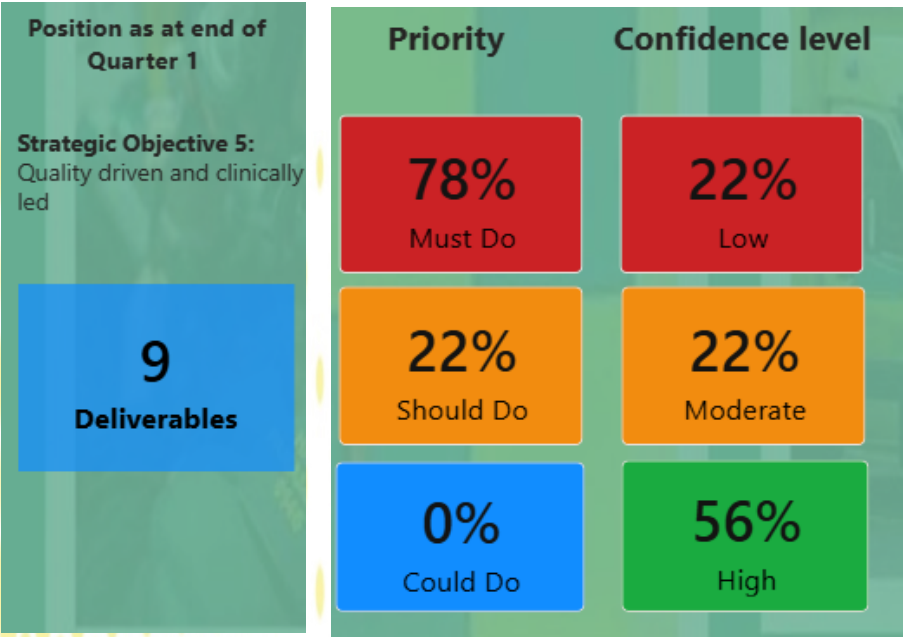


SO5 – Quality Driven And Clinically Led

9 IMTP 26-29 deliverables

High Level Achievements

- Quality assurance forward improvement plan gaining traction
- Mental health transformation accelerating
- Patient voice network strengthened



SO								Total
SO5		3		6				9

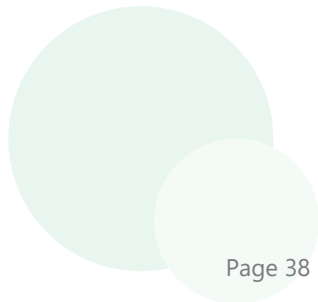
Assurance narrative

- SO5 shows **steady and credible early-stage progress** across all deliverables, with most workstreams focused on **framework development, self-assessment, governance alignment, and early implementation**.
- Delivery confidence is **mixed but broadly positive**, over half are rated high, while two areas show low confidence, one due to funding constraints.
- 3 areas requiring continued 'monitoring', 2 of which have low confidence levels due to scale and complexity.
- Themes emerging across SO5:
 - Quality governance maturing
 - Patient voice and lived experience strengthening
 - Mental health transformation accelerating
 - Operational readiness improving
 - Dependencies slowing progress
- **SO5** is broadly **On Track**, with strong progress across quality assurance, mental health transformation, patient voice and flu programme planning.

SO 5 Deliverables by RAG - Amber



Ref	Deliverable	RAG	Priority	Confidence	Update	Rationale
37	Develop a consistent organisational framework that brings together Quality Improvement, change management and project management methodologies	Monitor	Should Do	Moderate	Engagement undertaken with LAS to understand their approach to Planning & Quality Improvement. Opportunity to attend future Rapid Improvement Event (end of July). Greater collaboration between Planning & QI teams to support key organisational priorities (including TSO Process Mapping event and planned Concerns QI workshop - postponed due to business continuity arrangements). Meeting with Planning & QI lead arranged for July to discuss approach and framework development	Recommend revision of milestone dates. Timeline associated with Publication of approved Integrated Medium Term Plan and Directorate level Plans has impacted on the ability to appropriately cascade deliverables to teams. Slippage will be absorbed through the Quarter 3 and 4 period.



SO 5 Deliverables by RAG - Amber



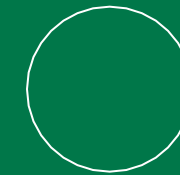
Ref	Deliverable	RAG	Priority	Confidence	Update	Rationale
41	Implement and embed a person-centred, compassionate and learning-focused concerns management system	Monitor	Must Do	Low	Work has commenced to deliver the Quarter 1 milestone at an organisational level. Listening Discussions are being embedded, triage is now undertaken by more senior and experienced staff and proportionate investigation pathways are being developed and scaled across the organisation. These developments provide the foundation for development of a new concerns management model, with detailed progress, risks and dependencies reported through the Concerns Management Improvement Programme (CMIP) governance arrangements.	Leadership changes and capacity challenges – organisational adjustments have been required to respond to changes across senior leadership positions and portfolios. Concerns workshop was postponed due to REAP 4 and Business Continuity Incident response. Compliance against key concerns metrics remain challenging. STB Mitigation: Agreement to re-set the improvement programme arrangements with a focus on streamlining and simplifying governance arrangements. Further work required to re-prioritise critical improvement activities to focus on key areas to drive continuous improvement.
44	Implementation of the Medicines Management Hub systems and processes, subject to funding.	Monitor	Should Do	Low	The Omnicell business case is still being pursued and without this, this cannot be progressed.	Business case still in progress. STB Mitigation: Engagement with Health Boards to help refine Medicine's Management Hub business case

SO 5 Deliverables by RAG – Green



Ref	Deliverable	RAG	Priority	Confidence	Update
38	Develop and implement a Trust-wide Quality Assurance Forward Improvement Plan, informed by self-assessment, aligned to strategic objectives and supported by clear ownership and monitoring arrangements	On Track	Must Do	Moderate	Operations 6/8 Self Assessments complete with Emergency Medical Services (EMS) now revisiting previous assessment in new format. EPRR Assessment complete with review at Quality Management Group (QMG) scheduled. Integrated Care and Volunteer teams engaged in process but have not completed Self Assessment yet. Corporate 13/26 Self Assessments complete. One additional due reivew at QMG, 3 further completed by service and feedback provided by Quality Assurance Lead. Nine service areas are engaged with process but have not produced a Self Assessment yet.

SO 5 Deliverables by RAG – Green

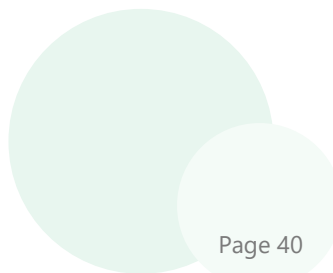


Ref	Deliverable	RAG	Priority	Confidence	Update
39	Review and refresh the Strategic Quality Plan to ensure it remains current, aligned to organisational strategic objectives, national policy requirements and emerging quality priorities, and deliver the updated plan through a phased implementation	On Track	Must Do	High	Meeting held with Strategic Leads to agree approach to review and refresh of Plan. Engagement with Planning Team regarding alignment with Integrated Medium Term Plan completed. Revised Plan now being drafted for review and approval.
40	Strengthen the Patient Voice Network to support meaningful and effective community involvement in the development of planned service changes.	On Track	Must Do	High	Network membership reviewed, including the regional distribution, age demographics and ethnicity profile of membership. Analysis report completed with the aim to progress a targeted recruitment specifically for young people (16-30 year olds), minority ethnic communities and under represented regions across North & Mid Wales

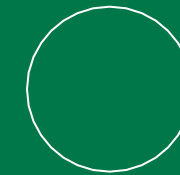
SO 5 Deliverables by RAG – Green



Ref	Deliverable	RAG	Priority	Confidence	Update
42	Deliver clinically led, evidence based mental health care that provides the right care, in the right place at the right time	On Track	Must Do	High	The Trust's Mental Health Delivery Plan went through CQGG in June ensuring alignment with the Welsh Government Mental Health and Wellbeing Strategy, the Trust Clinical Strategy and emerging Remote Care transformation programmes. Engagement has continued with Health Boards, Police Services, Local Authorities, Third Sector Organisations and Welsh Government to strengthen mental health crisis pathways, support implementation of Right Care Right Person (RCRP) principles and improve access to appropriate alternatives to Emergency Department attendance. Work has progressed through established partnership forums to improve access to community mental health services, crisis resolution teams, places of safety and third sector support, enabling more person centred and appropriate responses to mental health presentations. Initial work has also commenced to develop mental health specific outcome measures, including clinical outcomes, patient experience, non-conveyance assurance and pathway utilisation data to support service evaluation and continuous improvement via a mental health end to end review



SO 5 Deliverables by RAG – Green



Ref	Deliverable	RAG	Priority	Confidence	Update
43	Establish a skilled, empowered mental health workforce through CPD, innovation, partnership working and lived experience	On Track	Must Do	High	Work has commenced to develop a structured mental health education and workforce development programme to support operational, remote care and specialist clinicians in delivering evidence based, trauma - informed mental health care. We have successfully managed to get free train the trainer trauma informed training and have a plan to deliver this alongside well being on 20th July. Discussions have progressed regarding strengthening the involvement of people with lived experience in service design, quality improvement, education and policy development to ensure services remain person centred and co-produced. Planning has also commenced for enhanced training resources and clinical supervision approaches focused on mental health crisis assessment, suicide prevention, trauma-informed practice, safeguarding, reasonable adjustments and signposting to appropriate care pathways for people accessing WAST services.
45	Restructure and deliver the Flu Vaccination Programme for 2026/27 aligning with 2025/26 report recommendations	On Track	Must Do	High	Planning has commenced with flu meetings scheduled, vaccinations have been ordered in preparation for the programme. The end of season flu report is due to be presented to SOT 30/6 with recommendations for future delivery and improvement.

SO5 – Quality Driven And Clinically Led



MIPQR Metrics

Metric	Ambition / threshold	RAG April	RAG May	RAG June
National Patient Reported Experience Measure	Average overall score of 85%	●	●	●
Concerns (Stage 1) early resolution	Improvement trajectory to 40%	●	●	●
Enactment of the Duty of Candour within five days of receipt of request	Improvement trajectory to 100%	●	●	●
National reportable incidents, including. never events	Reduction	●	●	●
Joint Investigation Framework (referrals to health boards)	Reduction to 7	●	●	●

RAG Indicators =

TBD: Status cannot be calculated (To Be Determined)

MOA – Measure of Activity

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

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

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

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IMTP 2026-29 Strategic Objective 6

Value and Sustainability



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SO6 – Value And Sustainability

2 IMTP 26-29 deliverables

High Level Achievements

- FSP Programme mobilised at pace
- Commercial plan approved at Committee and Trust Board
- Early development of recurrent efficiency schemes



SO								Total
SO6		1		1				2

Assurance narrative

- SO6 shows **clear early-stage progress** across both deliverables, with governance established, key workstreams mobilised, and senior-level approvals secured.
- Delivery confidence is **Moderate to High**, reflecting strong mobilisation but recognising that several savings schemes and commercial opportunities still require further validation and development before they can be fully quantified and delivered.
- Themes emerging across SO6:
 - Strong mobilisation and governance
 - Increasing organisational engagement with financial sustainability
 - Early shift towards recurrent efficiencies
 - Commercial maturity developing
 - Dependencies on validation and quantification
- Overall, SO6 is **progressing well**, with solid foundations in place for accelerated delivery in Quarter 2. Continued focus on validating savings schemes and maturing commercial opportunities will be critical to improving delivery confidence and securing sustainable financial impact.

SO 6 Deliverables by RAG - Amber



Ref	Deliverable	RAG	Priority	Confidence	Update	Rationale
46	Embed a Trust-wide Financial Sustainability Programme (FSP) to improve financial decision-making, organisational capability, and delivery of recurrent cost efficiencies aligned to the Trust's financial plan.	Monitor	Must Do	Moderate	Priority workstreams have been mobilised, governance established and visibility of directorate savings plans improved. Work has progressed to finalise 2026/27 savings targets and develop recurrent efficiency schemes.	Some savings targets and identified opportunities require further validation and development into fully quantified, deliverable schemes, resulting in an Amber delivery confidence.

SO 6 Deliverables by RAG - Green



Ref	Deliverable	RAG	Priority	Confidence	Update
47	Establish a fully functioning Commercial Function, underpinned by an approved Trust-wide Commercial Plan and delivering at least two sustainable income-generation streams.	On Track	Must Do	High	Commercial Plan approved by Finance and Performance Committee on 19 May 2026. It was approved at Trust Board on 28th May 2026. Business Development Manager recruited

SO6 – Value and Sustainability

MIPQR Metrics



Metric	Ambition / threshold	RAG April	RAG May	RAG June
Financial balance – annual expenditure YTD as % of budget expenditure YTD	Maintain 100% balance			

RAG Indicates =

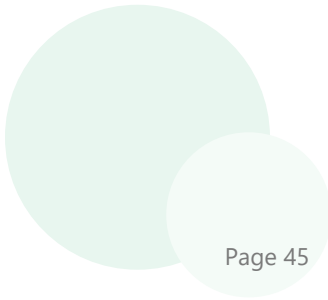
TBD: Status cannot be calculated (To Be Determined)

MOA – Measure of Activity

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

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

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



Productivity Gains

What this slide shows

Estimated annual productivity gains from five areas. Figures are related to additional journeys/patients reached, not cash savings.

NEPTS Re-roster (additional journeys undertaken)

16,424

Efficiency Gain

Extra journeys as a result of the re-roster. Based on ORH modelled gain of 315 journeys per week,

Progress

On track - ACA1 voting complete in July. Implementation expected through Q2. ACA2 roster commenced in Q1.

Aligned to IMTP deliverable 12

APP Utilisation (additional patients reached)*

15,859

Efficiency Gain

APP utilisation average ytd 46.8%, with modelled position of 70%. Current jobs per shift is 2.78. 80%, would give 4.75 jobs per shift ($2.78 / 46.8 \times 80$), therefore efficiency again of 1.97 jobs per shift.

Progress

On Track - Work continuing via the UCR work stream to develop and embed scheduling technical solution to enable improved tasking and co-ordination of APP appointments.

Aligned to IMTP deliverable 11

* note: all things APPs need to be treated with a degree of caution due to data accuracy.

Handover W15 & W45 (additional patients reached)

194,074

Efficiency Gain

Average conveyance per month is $14,856 \times 0$ minutes = 0. Lost hours for last 12 months = 194,074 the gain would be $194,074 / 11.5 \times 3$ (EA jobs per shift = 50,62

Progress

Work continuing via Health Boards led W45 improvement groups to improve patient flow and hospital processes to reduce handover delays, coupled with the work WAST is leading to reduce hospital conveyance.

Abstractions (additional patients reached)

4,589

Efficiency Gain

Benchmark 29.91%; 12-month average 31.64%. A 1.73% reduction releases 17,552 hours / 11.5×3 jobs per shift = 4,589

Progress

Work continuing to reduce abstraction levels.

Aligned to IMTP Deliverable 19 and local work undertaken operationally.



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Agenda Item No.

09

REPORT TITLE

Monthly Integrated Quality Performance Report – May/June 2026

MEETING

Name of meeting	Financial and Performance Committee (FPC)
Date of meeting	21 July 2026
Public or Private	Public
If private - rationale	Choose item from below

REPORT SPONSOR

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

PURPOSE OF REPORT

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

REPORT SUMMARY

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

1. The purpose of this report is to provide the committee with the Monthly Integrated Quality and Performance Report for **May and June 2026**, bringing together the Trust's key indicators across Our Patients, Our People, Finance and Value, and Partnerships and System Contribution, in the top scorecard that goes to every committee and Trust Board, and then more committee specific indicators.
2. The report has been further refined this month to strengthen specific committee oversight, including a clearer focus on specific measures, greater use of trajectories, and more explicit interpretation of SPC charts. This remains an evolving product and further refinement will continue as the new format beds in.
3. For ambulance response, the new Purple (Arrest), Red (Emergency), Orange (Now), Yellow (Soon) and Green (Planned) categories are now established. Arrest performance remains within the expected target range, while Emergency and Orange (Now) performance continue to indicate that the current system is not yet capable of consistently achieving the required standards. Stroke and STEMI call-to-door times also remain significantly above the required standard, reflecting the wider pressures across ambulance response and hospital handover.
4. Hospital handover performance has improved materially compared with the same period last year, with 13,813 hours lost in June 2026 compared with 15,278 in June 2025. This is welcome progress, but performance remains significantly above the level the Trust's operating model is designed to cope with i.e. half this number of lost hours.
5. 111 call handling performance has deteriorated in recent months. June 2026 abandonment rate was 16.1%, and SPC indicates the service is not currently capable of reliably achieving the 10–15% ambition within the existing resource envelope.
6. Ambulance Care performance remains mixed. While cancellation performance overall remains a concern and is now a key area of focus within the wider NEPTS Improvement Programme.
7. Finance and Value indicators show a mixed position: the Trust remains on plan financially, EA productivity remains above the modelled ambition, but APP productivity and NEPTS cancellations continue to indicate areas where the current system is not yet delivering the required level of value and efficiency consistently.
8. Partnerships and System Contribution indicators show encouraging progress in some areas, particularly the consult and close rate (although this has dipped in recent months), reduced patient cancellations and 111 outcomes, but system indicators such as conveyance to ED and hospital handover require further transformation.



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RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The FPC is requested to:

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

ADDITIONAL PAPER(S)

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

Annex 1 Monthly Integrated Quality and Performance Dashboard

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

RISK(S) THIS REPORT MITIGATES

Where relevant note the local, directorate, corporate or BAF risk number
223 - The Trust's inability to reach patients in the community causing patient harm and death
224 - Significant Handover of Care Delays Outside Accident and Emergency Departments Impacts on Access to Definitive Care Being Delayed and Affects the Trust's Ability to Provide a Safe & Effective Service for Patients
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
139 - Failure to deliver our Statutory Financial Duties in accordance with Legislation

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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



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IMPACT ASSESSMENTS FOR CONSIDERATION

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

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

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
14 July 2026	Hugh Bennett – Assistant Director, Commissioning & Performance
15 July 2026	Rachel Marsh, Deputy Chief Executive Officer



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SITUATION

1. The purpose of this report is to provide the F&P Committee with the Trust's performance scorecard (Our Patients, Our People, Value and Partnerships/System Contribution) to give an overall view on the Trust's performance, and then committee specific metrics. This report is for **May/June 2026**.

BACKGROUND

2. The F&P Committee specific MIQPR continues to evolve. This is the first committee specific iteration of the F&P MIQPR. The scorecard is the Trust Board approved one, but the graph pack includes some proposed additional F&P metrics, based on discussions with the lead executives for this committee and the Director of Corporate Governance/Board Secretary. The proposed metrics focus on time, capacity, resource and value. This iteration also includes trajectories for two measures for the first time. Further discussions will continue with Directors to finalise this set of metrics and Committee will be asked to confirm and approve at its next meeting.
3. Trajectories are not yet included for the operational time-based response metrics. These measures are more complex to model and require a longer period of stable data from the new clinical model before reliable modelling can be presented to the committees and Trust Board. The Trust is taking active steps to update its simulation models and is aiming to model the planned changes it is making to patient flow optimisation through the new model, in time for winter and the associated winter plan.
4. Previous iterations of the MIQPR have included Statistical Process Control (SPC) charts.

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

Patterns within the limits indicate common cause variation. Patterns such as a sustained shift above or below the average, a trend, or a single point outside the limits indicate special cause variation and should prompt further consideration.



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SPC helps decision makers assess not only whether performance is above or below target, but whether the current system is capable of achieving that target consistently.

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

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

ASSESSMENT

Our Patients

6. **Ambulance Response** (safety / patient experience): on 1 July 2025, the Trust's New Ambulance Performance Framework was implemented, and two new response categories replaced the previous (old) Red category. The new categories are Arrest (Purple), for cardiac and respiratory arrests, and Emergency (Red), for major trauma and other incidents where patients are at significant risk of cardiac or respiratory arrest if they do not receive a rapid response. In June 2026, there were 1,008 purple calls to the ambulance service, around 2.75% of all calls, and 5,054 (Emerg) red calls, around 13.81% of all calls. The main measure for Purple Arrest calls is the Return to Spontaneous Circulation (ROSC) rate which was 20.3% in June 2026 compared to 22.1% in May 2026, with an underlying upward trend.
7. The June 2026 median response times for Purple and Red calls were 7 minutes 42 seconds and 9 minutes 32 seconds respectively, against the required range of 6–8 minutes. Purple performance remains within range; however, Red performance remains above the required standard and continues to reflect the impact of wider system pressures, including handover delays and available capacity. Improvement work is being progressed through the Clinical Model Transformation Programme, with a specific Task and Finish Group focused on call categorisation and flow optimisation. This includes work on breathing difficulties and RCS/Clinical Navigator capacity, with the aim of increasing the proportion of RCS0 incidents clinically screened and appropriately directed into RICS before timing out into the Emergency dispatch queue.



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8. This work is being supported by continued operational grip through the weekly Operations Performance Meeting, winter planning, the Productivity Improvements Tracker, and ongoing focus on workforce planning, recruitment and unit-hours production. Delivery of the W45 ambition remains a key dependency for sustained improvement in response performance.
9. On 2 December, the second phase of the New Ambulance Performance Framework went live. Amber and Green categories were removed, and new Orange (Now), Yellow (Soon) and Green (Planned) categories were introduced for those patients needing a face-to-face response. The changes are designed to improve patient safety and patient outcomes by better stratifying patient demand. The June 2026 median response times for Now (Orange) was 1 hour 29 minutes, higher than the ambition of one hour.
10. **RICS 90th Percentile** reporting metric under development and should be available for formal reporting within the next two to four weeks. Internally, operational managers do have access to RICS metrics, but further work is required to assure the changes and data definitions before public reporting can commence.
11. **Can't Send and Cancelled by Patient Volume** In June 2026,). 5,882 ambulances were cancelled by patients, a slight increase from the 5,693 cancelled in May 2026.
12. **111 call answering** performance has minimally improved over recent weeks, with the call abandonment rate for June 2026 being 16.1%, and therefore not achieving the 10% to 15% ambition. The SPC chart in the slide deck would suggest that the current system, capacity and processes will not deliver the required level of performance. 111 demand in June 2026 did see an 15% increase compared to June 2025. The ELT have recently received a detailed paper setting out a performance improvement plan focusing on areas of efficiency.
13. **111 Welsh Call Answering**, in June 50% of Welsh calls offered were answered. This remains below the 70% ambition and has remained below target since November 2024. The improvements set out in paragraph 12 above apply here also.
14. **999 call answering** times during June 2026 saw the 95th percentile increasing to 37 seconds. However, the 65th percentile and median performance times remained consistently good. Work has been undertaken on demand and capacity analysis of 999 call demand, but further work is required, due to a disparity between internal modelling and external modelling.



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15. **Advanced discharge and transfer journey** performance decreased to 67.6% (95% target), with this primarily being an issue with capacity. Same day discharge and transfer journey performance achieved 95%, hitting the 95% target. The same day discharge and transfer performance is a positive metric, but discussions through the IMTP development process have identified that cancellations (whether by the Trust, by patients or by health boards) are too high, accounting for 18% of demand (serviced demand + cancellations). The Trust is already undertaking a complex and difficult re-roster of NEPTS transport and has a range of improvement actions underway, with a particular focus around digital solutions e.g. two way texting, apps for patients and apps for

Finance & Value

16. **NEPTS Activity Total cancellations** reached 19.3% in June 2026. Ambulance Care cancellations, although above target, have been within normal process limits over the past 12 months. The NEPTS Improvement Programme is the main transformational response to this metric.
17. **Financial Balance:** At Month 3 the Trust achieved both its External Financing Limit and its Capital Resource Limit.
18. **Average Jobs per Shift** Overall, EAs averaged 3.02 jobs per shift during June 2026. The ambition for this metric has been set at 2.3 and above. APPs attended an average of 2.57 jobs per shift during June 2026, with planned improvements to achieve the ambition of 4.75 jobs per shift.
19. **Fleet** reporting metric under development.

Our People

20. **Produced:** The Trust produced 115,208 Ambulance Response unit hours during June 2026 and delivered an emergency ambulance unit hours production (UHP) of 90%, not achieving the 95% target. Reduced overtime (linked to the financial plan), abstractions (IMTP productivity measure) and UCS recruitment (under review) are the underlying causes.

Partnerships & System Contribution

21. **Albot and Webchats.** In June 2026, the website had 349,123 visits and Albot hosted 5,286 conversations, reaching 1.51% achieving the 1.35% ambition, this has been consistent for the past two months. The Trust is anticipating further investment from commissioners into the 111 digital front end.



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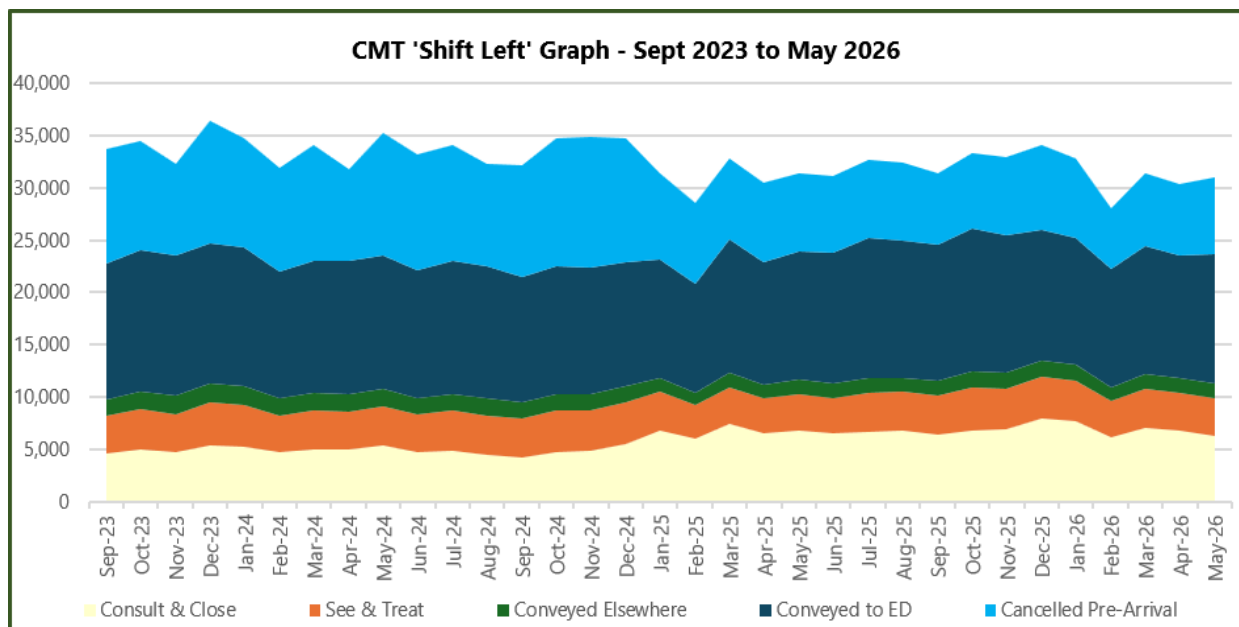
22. **111 Outcomes** from February 2025 to June 2025, a concern was noted as outcomes were increasing; however, recently there has been an improvement (reduction) in 111, 999 & ED outcomes over the past three months. In June 2026 outcomes to 999 and EDs reached 17%.
23. The **consult & close** rate was 17.1% in June 2026, a minimal decrease from the previous month (17.2%) and not achieving the IMTP ambition of 22%; however, there has been a material uplift in the consult & close rate as a result of the CMT Programme.
24. **See and Treat** the number of incidents treated at scene and referred to alternative pathways have both remained relatively stable over the past year. There are different definitions available for see & treat in different parts of the UK and this needs to be reviewed further for the next iteration of this report.
25. Traditionally, the main factors which affect response times are demand and capacity (recruitment and lost hours). EMS demand has increased over the past two months within past seasonal trends but also due to the heatwave currently being experienced. EMS production has increased to 90% in June 2026. Whilst there has been a reduction in handover lost hours, the Trust **lost 13,874 hours in June 2026**, with W45 equating to less than 7,000 hours per month, so the lost hours remain a significant drain on the Trust's ability to respond in a timely manner. The Trust's main focus is to continue to implement a material change in how it responds to patient demand by evolving its clinical model through the Clinical Model Transformation (CMT) programme. Areas of focus for 2025/26 include:
- Further investment and improvement into remote clinical capacity and process;
 - Further improvement to APPs, in particular, scheduling and re-rostering;
 - Further development of the remote integrated care service (111 clinicians and CSD clinicians);
 - Continued focus on a range of responses that support non-conveyance, where it is clinically safe and appropriate to do so: use of volunteers, Falls Desk, Falls response etc.; and
 - The transformation of the various clinical model categories as per the previous paragraph.



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26. For the **W45 target**, the chart shows there was a sustained improvement in performance between April 2025 and December 2025, with variation remaining below the mean for seven consecutive months. Recently, the Trust has supported three workshops with ABUHB, BCUHB and SBUHB, as requested by NHS Wales Performance & Improvement. The main outputs from these meetings are performance plans with performance trajectories to achieve the W45 target. The Trust will start monitoring these internally.
27. **Number of Conveyances to ED** these conveyance rates remain above the 30% target, meaning the system is not currently capable of delivering the target. It is likely that the deteriorating conveyance rates were due to a reduction in the number of lost hours to handover.
28. Finally, the following graph aims to provide a composite picture of the impact of the Trust's CMT Programme through a longer period of time. The time series analysis clearly shows the uplift in the consult & close rate, a reduction in patient cancellations, with conveyance to ED remaining stable (the Trust has actually seen increased conveyance of high acuity patients resulting from reduced cancellations and increased ambulance availability), but with see & treat not really demonstrating any movement. This is an area of focus into 2026/27.



RECOMMENDATION

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

Welsh Ambulance Services University NHS Trust

Monthly Integrated Quality & Performance Report

May/June 2026

Annex 1 – Top Indicator Dashboard



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

by Commissioning & Performance Team



Section 1: Monthly Indicators / Top Indicator Dashboard



Top Monthly Indicators	Target 2026/27	Apr-26	May-26	Jun-26	2 Year Average	RAG	Top Monthly Indicators	Target 2026/27	Apr-26	May-26	Jun-26	2 Year Average	RAG
Our Patients (SO1&5)							Our People (SO2)						
Return of Spontaneous Circulation (ROSC)	25-30%	23.9%	22.1%	20.3%	21.6%	R	% of Under-represented Groups Offered	>7%	N/A	34.4%	26.70%	N/A	G
Stroke Call to Hospital Door Times	01:30	02:35	02:32	02:43	02:28	R	EMS Hours Produced	95%	89%	88%	90%	88.36%	A
STEMI Call to Hospital Door Times	01:30	02:25	02:46	02:35	02:33	R	Sickness Absence (<i>all staff</i>)	<6%	7.67%	7.57%	N/A	7.88%	R
NOF Call to Hospital Door Times							Staff Turnover Rate	<10%	7.87%	8.36%	8.32%	8.10%	G
Arrest (Purple) Median	6-8 Minutes	07:39	07:45	07:42	N/A	G	PADR/Medical Appraisal	>85%	76.52%	74.63%	73.67%	73.96%	R
Arrest (Purple) 90th	<20 Minutes	18:23	18:00	18:20	N/A	G	Statutory & Mandatory Training	>85%	89.40%	89.52%	89.31%	86.78%	G
Emerg. (Red) Median	6-8 Minutes	09:24	09:12	09:32	N/A	R	Finance & Value (SO6)						
Emerg. (Red) 90th	<20 Minutes	22:37	22:39	23:14	N/A	R	Average Jobs per Shift (EA)	>2.3	2.96	3.06	3.02	2.77	G
Now (Orange) Median	<60 Minutes	01:26	01:22	01:29	N/A	R	Average Jobs per Shift (APP)	4.75	2.57	2.59	2.59	2.98	R
Time to Integrated Care RICS 1 90th Percentile	<60 Minutes						NEPTS Activity Cancelled (by CMP, Patients & HBs)	<10%	19.1%	18.3%	19.3%	17.7%	R
Can't Send & Cancelled by Patient Volumes	<5,770	5,712	6,109	6,288	7,003	A	Financial balance - annual expenditure YTD as % of budget expenditure YTD	100%	100%	100%	N/A	100%	G
NHS111 Call Handling Abandonment Rates	<10-15%	18.8%	19.7%	16.1%	12.2%	A	Partnerships / System Contribution (SO3&4)						
Renal Repeat Cancellation	Zero						Number of Patients using Albot	MOA	5,374	5,263	5,286	N/A	MOA
Oncology Journeys arriving within 45 mins and up to 15 minutes after appointment time	>70%	73.9%	72.8%	74.5%	76.7%	G	Webchats as a % of Web Site Hits	>1.35%	1.43%	1.51%	1.51%	N/A	G
Advanced Discharge & Transfer journeys collected less than 60 minutes after booked time (NEPTS)	>95%	71.6%	72.7%	67.6%	77.8%	R	111 Outcomes (999 & ED)	MOA	16.1%	15.4%	17.0%	19.0%	MOA
% of 111 call presented in Welsh, Answered in Welsh	>70%	60.0%	51.3%	58.0%	58.4%	R	Successful Consult & Close Outcome	>22%	19.7%	17.2%	17.1%	17.9%	R
National Patient Reported Experience Measure (average overall experience score)	85%						% See & Treat & Alternative pathways (of verified activity)	>20%	10.36%	9.59%	10.03%	10.58%	R
Concerns Response within 30 Days	>40%						Number of Handover Lost Hours	<6000	13,748	14,057	13,874	17,512	R
Enactment of the Duty of Candour Total	100%	67%	100%	100%	N/A		Number of Handovers over 45 mins	Zero	4,534	4,597	4,612	5,562	R
National Reportable Incidents reports (NRI)	MOA	2	12	2	5	MOA	Reduction in Number of Conveyances to ED as % of Verified	30%	33.84%	37.92%	36.90%	35.44%	R
Joint Investigation Framework Referrals to HBs	<7	12	10	15	13	R							

RAG Indicates =
TBD: Status cannot be calculated (To Be Determined)
MOA – Measure of Activity
Green: Performance is at or has exceeded the target (*Indicates no action is required*)
Amber: Performance is at or within 10% of target (*Indicates some issues/risks to performance (monitoring is required)*)
Red: Performance is less than 10% of target (*Indicates close monitoring or significant action is required*)

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Delivering on our Strategic objectives



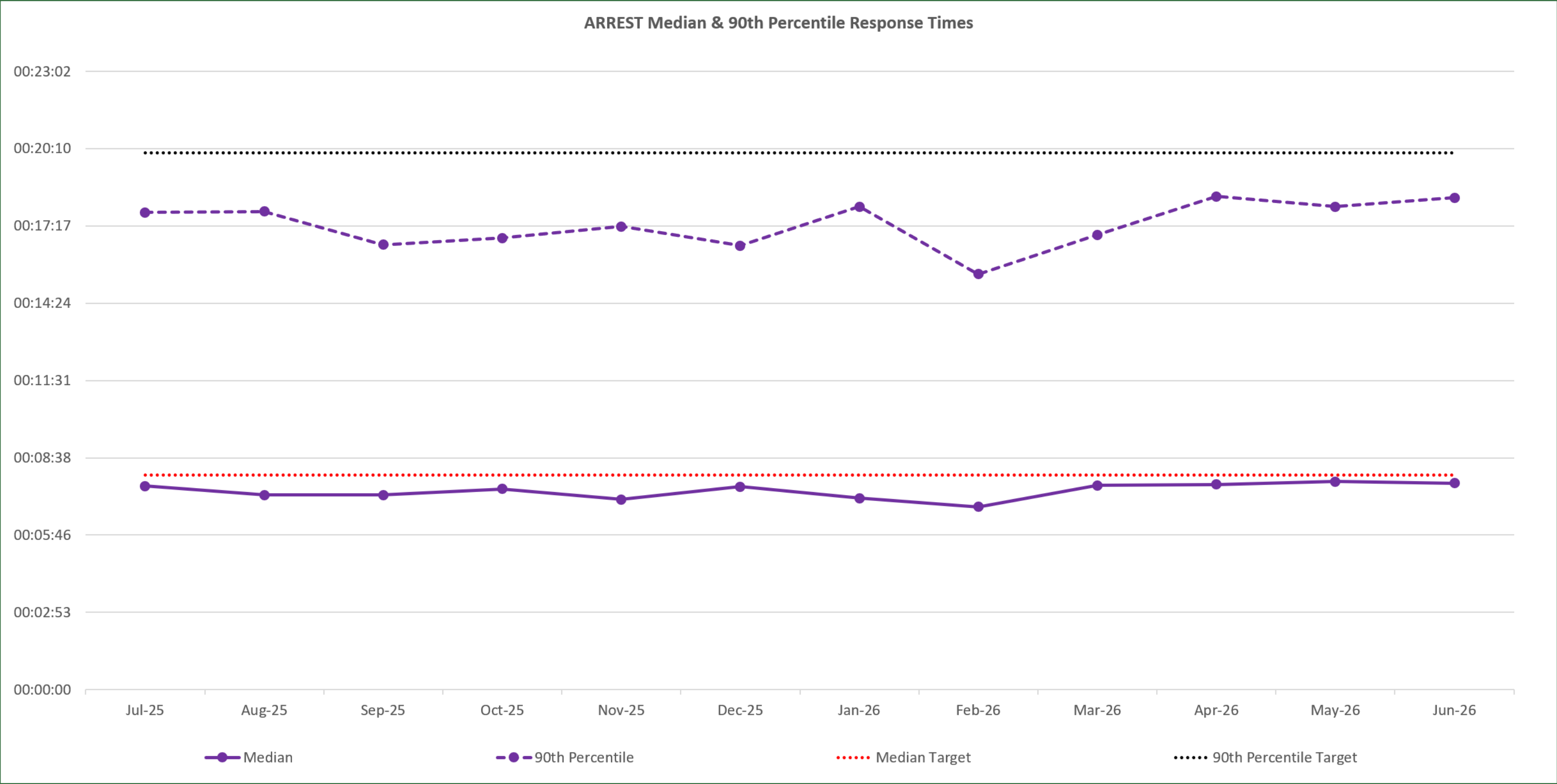
Strategic Objective 1	Are Patients getting the right care, in the right place, every time?													
Strategic Objective 2	Are our people enabled to be the best they can be?													
Strategic Objective 3	Are we at the forefront of innovation and technology?													
Strategic Objective 4	Do we develop services in collaboration?													
Strategic Objective 5	Are we clinically led and quality driven?													
Strategic Objective 6	Do we deliver exceptional value?													

Our Patients

Arrest (Purple) Indicators

Strategic Objective 1

Arrest Median	Arrest 90th
G	G

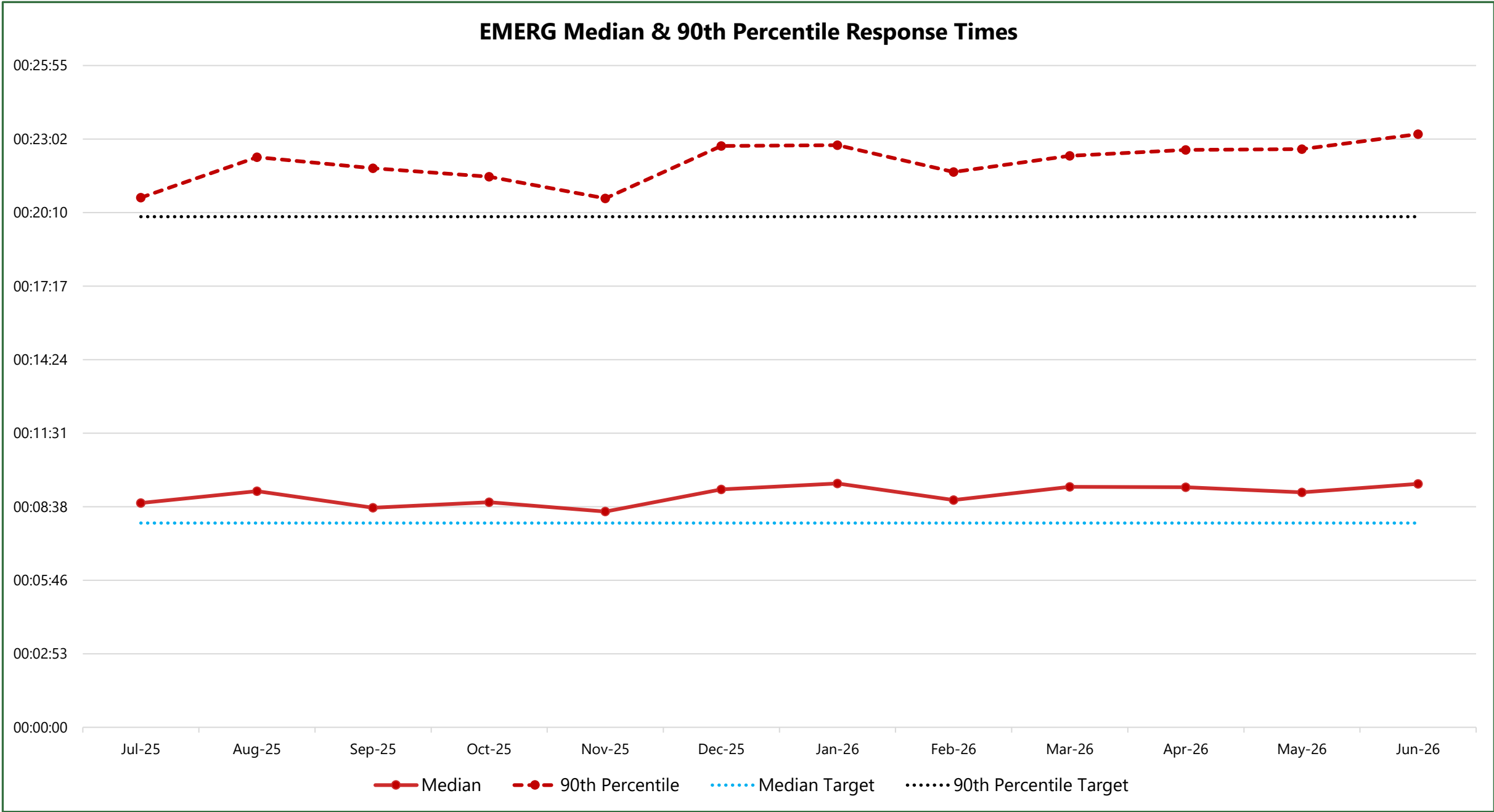


Our Patients

Emerg (Red) Performance Indicators

Strategic Objective 1

Emerg Median	Emerg 90th
R	R



Analysis

In June 2026 there were 5,054 Emerg (Red) incidents, around 13.81% of all verified incidents.

For Emerg calls the median and 90th percentile response time targets are 6-8 minutes and 20 minutes, respectively. Response times are not achieving performance targets.

The median response time in June 2026 for Emerg incidents was 9 minutes 32 seconds. Aneurin Bevan health board had the lowest median time of 8 minutes and 38 seconds, and Powys had the highest at 11 minutes and 24 seconds.

For Emerg calls, the 90th percentile response time was 23 minutes 14 seconds. Aneurin Bevan had the lowest time of 18 minutes and 46 seconds, and Powys had the highest at 34 minutes and 8 seconds.

Remedial Plans & Actions

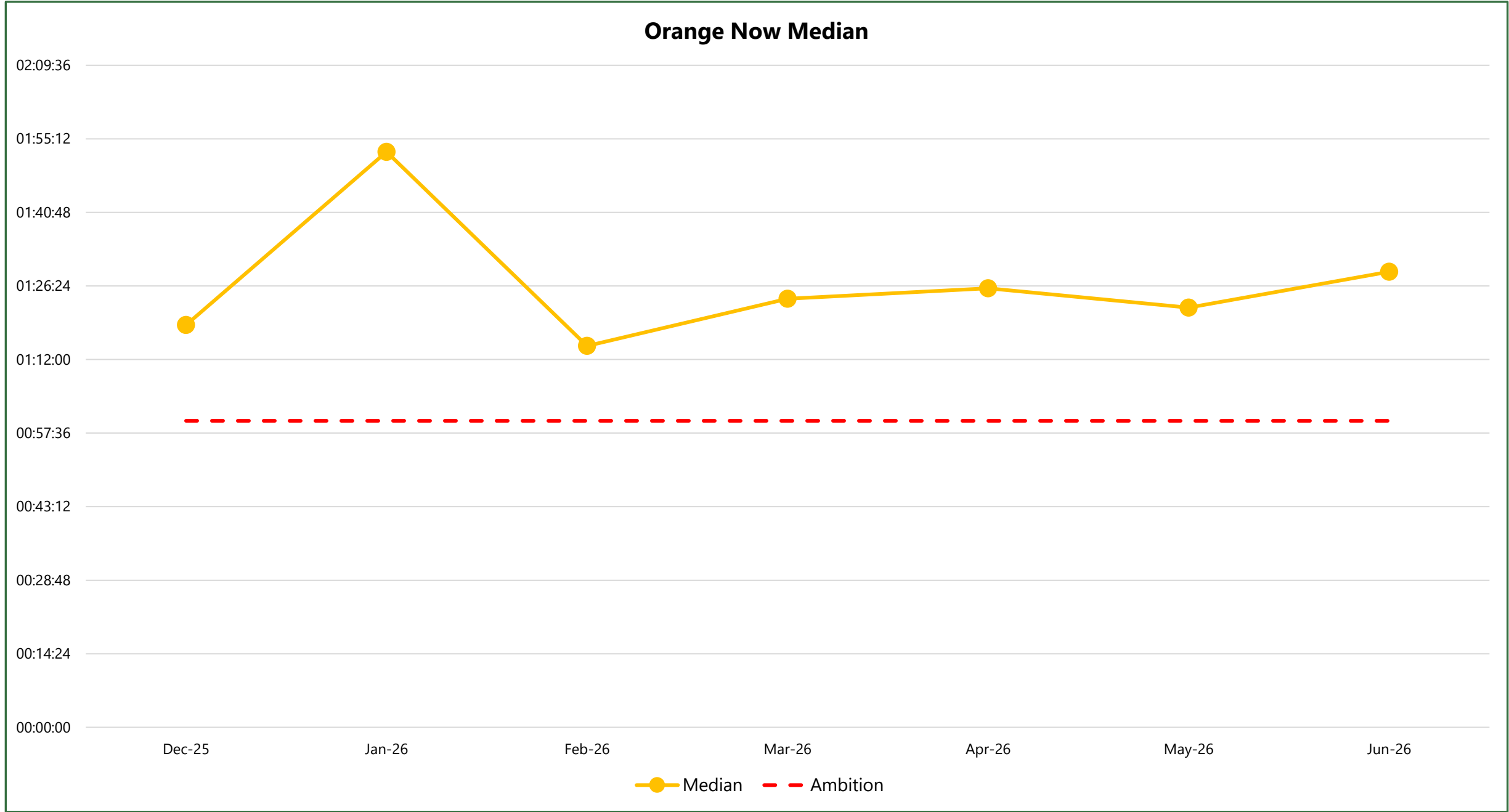
As part of the Clinical Model Transformation Programme, a Call Categorisation (3) Flow Optimisation Task & Finish Group has been set up to work on improving the patient flows through the new model, in advance of winter. Two of the six workstreams in this task & finish group are relevant to this indicator 1) breathing difficulties and 6) RCS/Clinical Navigators. The aim is to improve the deflection rate from RCS0 to RICS, thereby reducing the Emerg demand. This is about clinical process and clinical navigator capacity. W45 is also key.

Our Patients

Orange (Now) Performance Indicator

Strategic Objective 1

Now Median
R



Analysis

In December 2025 the existing Amber category, was replaced by Orange (now) and Yellow (soon). However, some calls were recorded as the old Amber category.

The median response time in June 2026 for Orange (Now) incidents was 1 hour 29 minutes 10 seconds. Powys health board had the lowest median time of 1 hour 1 minute and 38 seconds, and Swansea Bay had the highest at 1 hours 43 minutes and 49 seconds.

Remedial Plans and Actions

There are three key main ways of improving Orange Now performance: demand reduction, improved UHP and reduced handover delays. The Trust thinks there is over-triaging of patient demand into the Orange category and is working to reduce this, the Trust is focused on abstractions management and the recruitment trajectory for EMS and is engaged with NHS P&I health board required workshops on W45.

Expected Performance Trajectory

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

Our Patients

Time to Integrated Care – RICS1

Strategic Objective 1

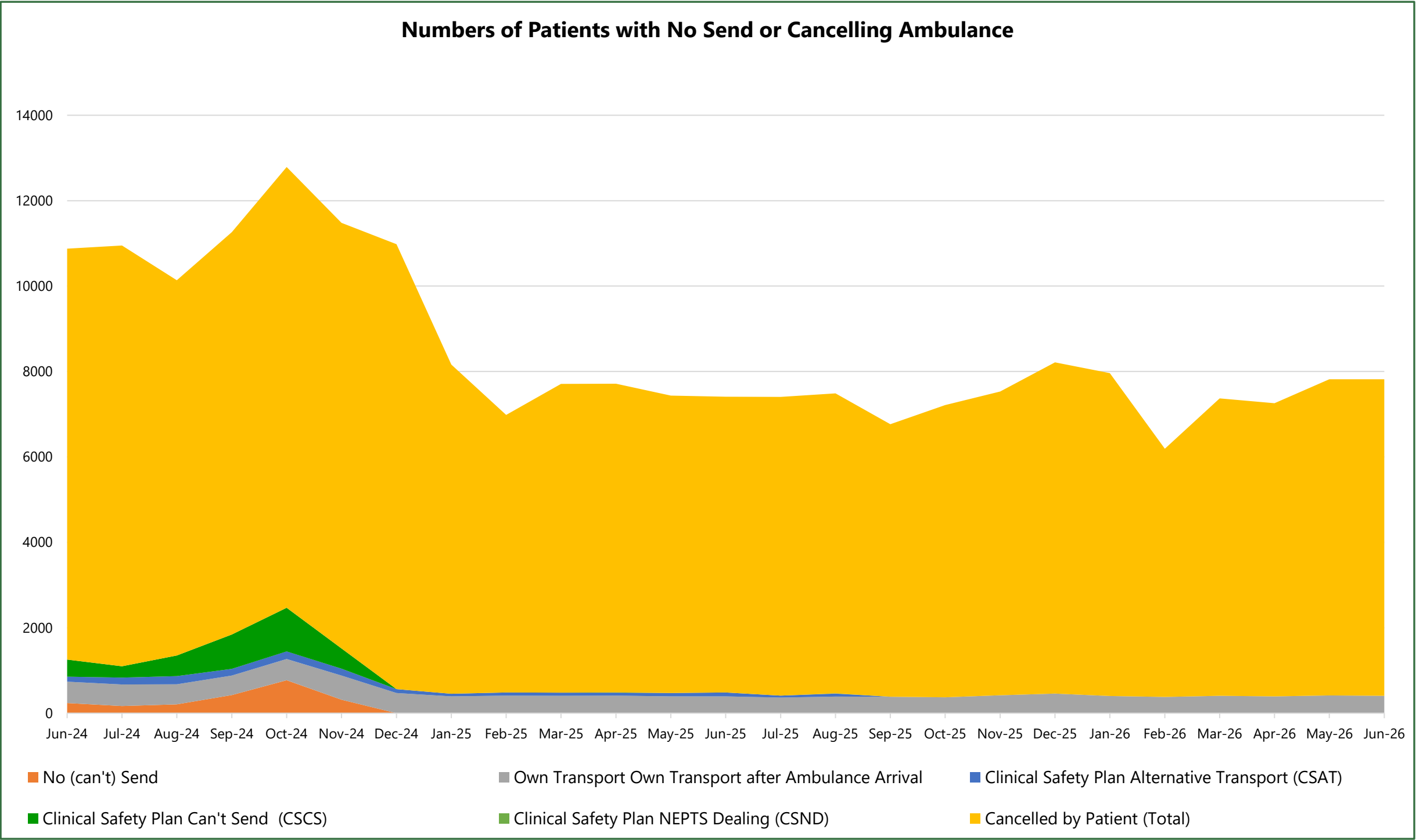
Under Development

Our Patients

No Send or Patient Cancellations

Strategic Objective 1

Can't Send
A



Analysis

5,882 ambulances were cancelled by patients, a slight increase from the 5,693 cancelled in May 2026. Patient cancellations has remained relatively static since early 2025, following a significant reduction from figures seen during 2024. The Trust believes this was connected to the implementation of Rapid Clinical Screening during the winter of 24/25.

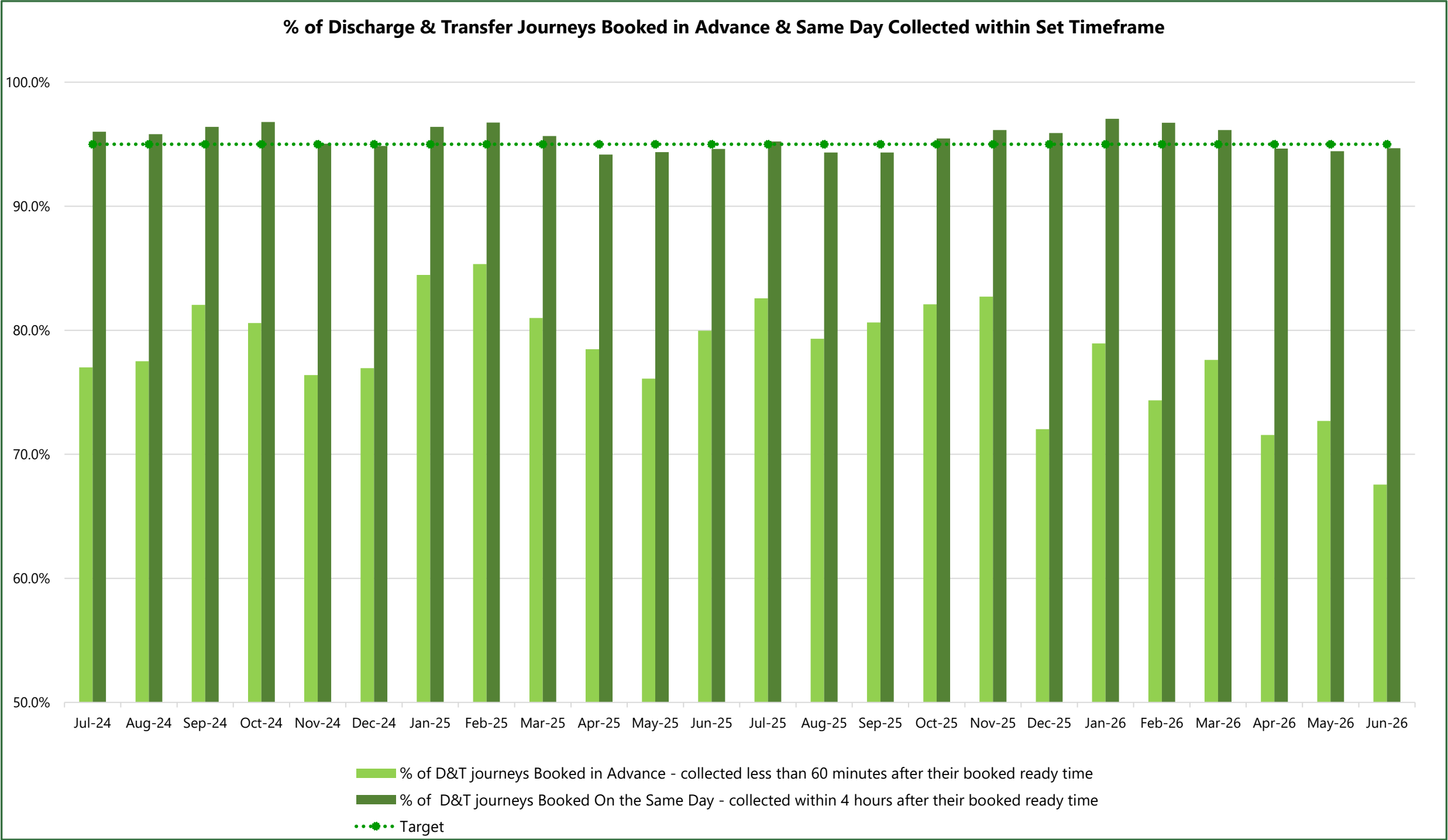
Expected Performance Trajectory

The Trust Board ambition is to reduce cancellations to <5,770, linked to the further transformation work on-going through the CMT Programme and the delivery of W45 by all health boards. It is difficult to put a trajectory on this, but the winter plan is predicated on delivery of both of these, so by December 2026.

Our Patients

Ambulance Care Indicators – Discharge & Transfers

Strategic Objective 1



Analysis

Discharge and Transfer journeys booked in advance and collected less than 60 minutes after their appointment decreased in June 2026 to 67.6% and remains below the 95% target. Discharge and Transfer journeys booked on the same day achieved 95% in June 2026, achieving the target (95%).

Remedial Plans and Actions

Performance on advanced discharges and transfers has been challenging throughout the last quarter. This position is driven pretty much solely by BCU where 30% of journeys are hitting target. Local work to identify why and options paper for improvement in development.

Expected Performance Trajectory

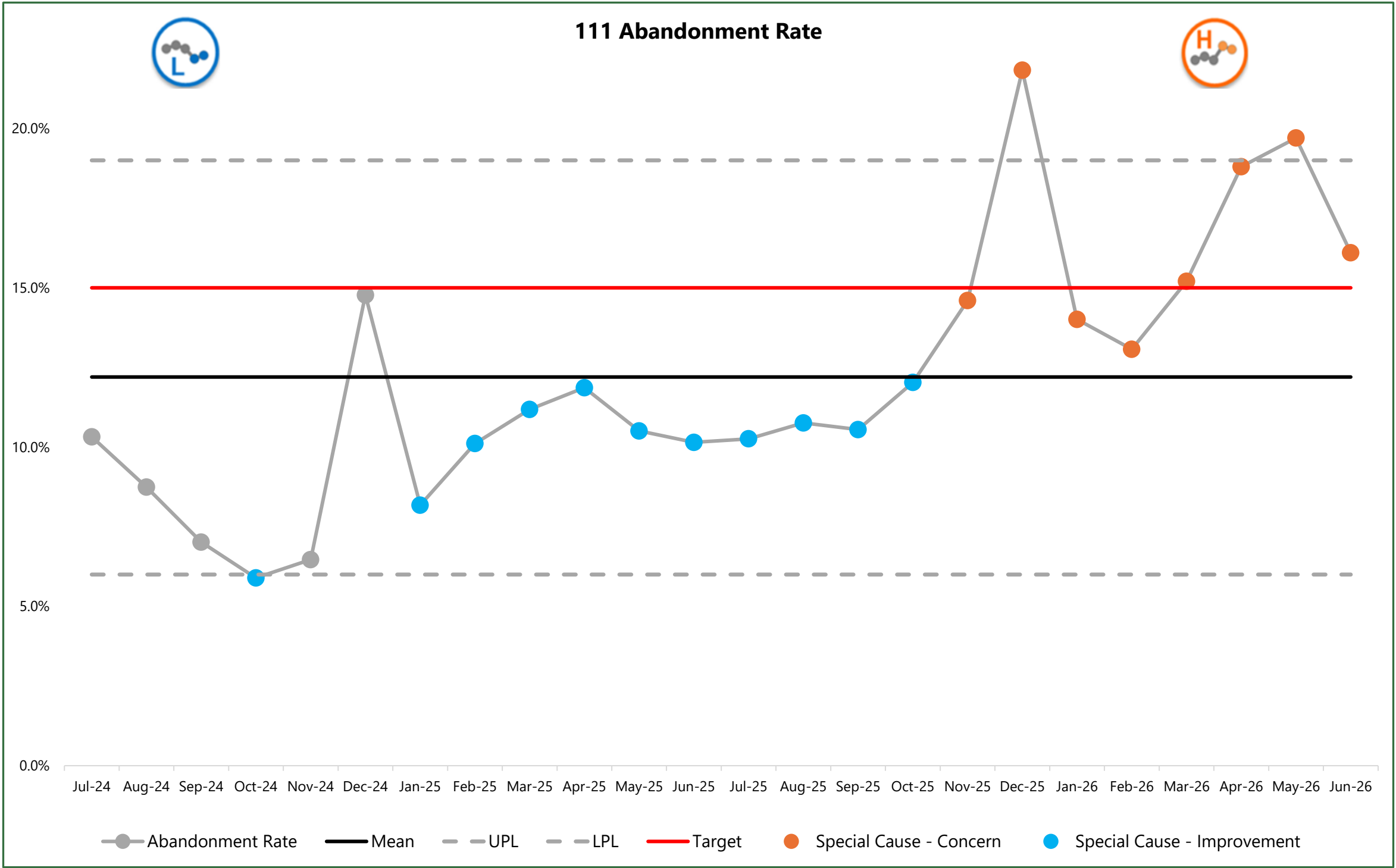
Dependent on options paper.

Our Patients

111 Call Abandonment Performance Indicators

Strategic Objective 1

Abandonment Rate
A



Analysis

The 111-call abandonment rate decreased to 16.1% in June 2026. Based on the SPC chart, the service is not currently able to meet the target consistently. The most recent months are predominantly above the target and include a special-cause signal (two points above the upper control limit), indicating the system has shifted in an unfavourable direction.

111 call demand decreased to 88,109. This follows historical patterns whereby high levels of demand negatively impact performance.

Remedial Plans and Actions

Key actions were taken to improve the call handling resourcing position through the summer; this included an active recruitment plan. A 111-re-roster review is underway, with new rosters expected to be in place by the Autumn, which should help reduce sickness and turnover. Actions are also underway to increase the utilisation of virtual queuing and review the way patients who are re-accessing for the same care episode could be managed differently. The Trust is also working on new processes around the use of the Clinical Advice Line (CAL) by call handlers, linked to clinician performance, but also aimed at improving call handler productivity by reducing CAL wait times. Transformation of the 111 digital front end is also key. Shift fill is in the high eighties and low nineties and remains an area of focus. Finally, ELT recently received a paper on 111 performance, covering the above.

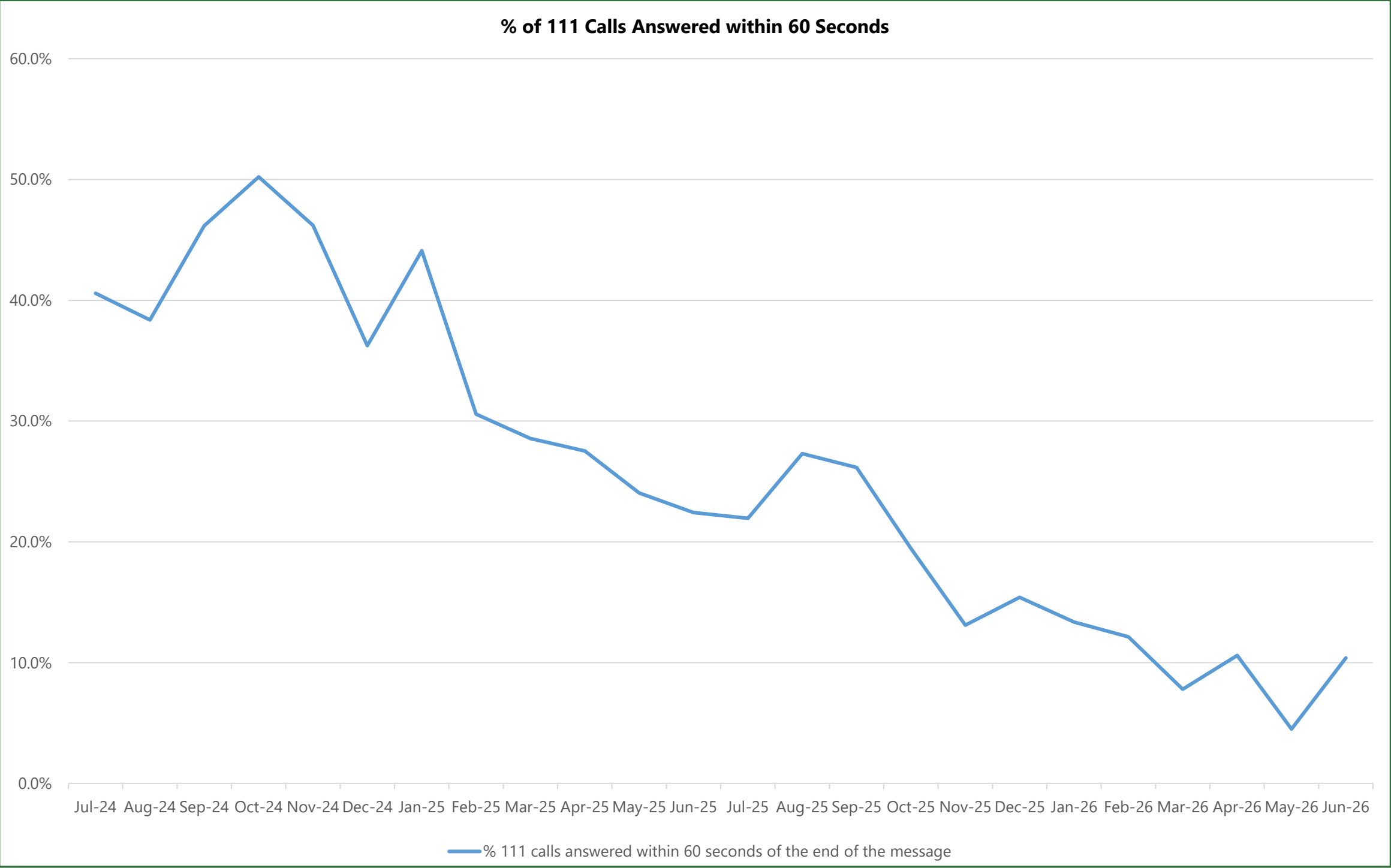
Expected Performance Trajectory

The independent modelling indicates that the Trust should expect to see a performance range of 10%-15% based on the current commissioned establishment. To further expand on this, the Trust can achieve a range of 10%-15% on normal days, but for days with high demand e.g. bank holidays, winter etc. the Trust cannot. The roster keys are designed to cope with c2,500 calls, for period of high demand, this can double or even triple.

Our Patients

111 Call Answering

Strategic Objective 1



Analysis

The call answer rate within 60 seconds in June 2026 was 10.4%, which, although an improvement on the 4.5% in May 2026, is significantly below performance levels seen during 2024. This is at a time when UHP capacity for call handlers has increased slightly.

The external rostering review suggests there is a demand and capacity gap within the current funded establishment, and the Trust is therefore unlikely to achieve the performance targets without an increased workforce.

Remedial Plans and Actions

Key actions include:

Actions have been undertaken to try and improve the call handling resourcing position throughout the summer; this includes an active recruitment plan.

A 111-re-roster review, is currently being implemented, which 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.

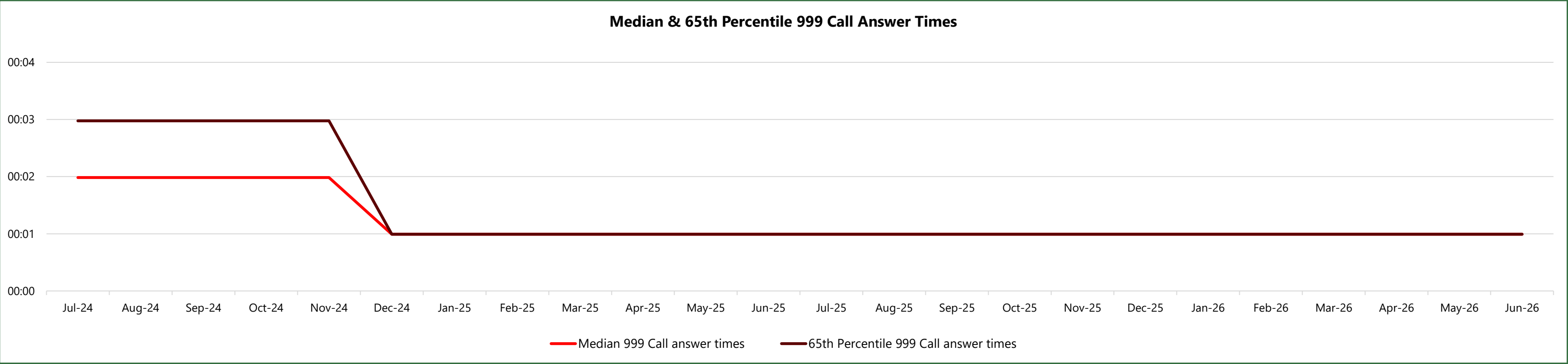
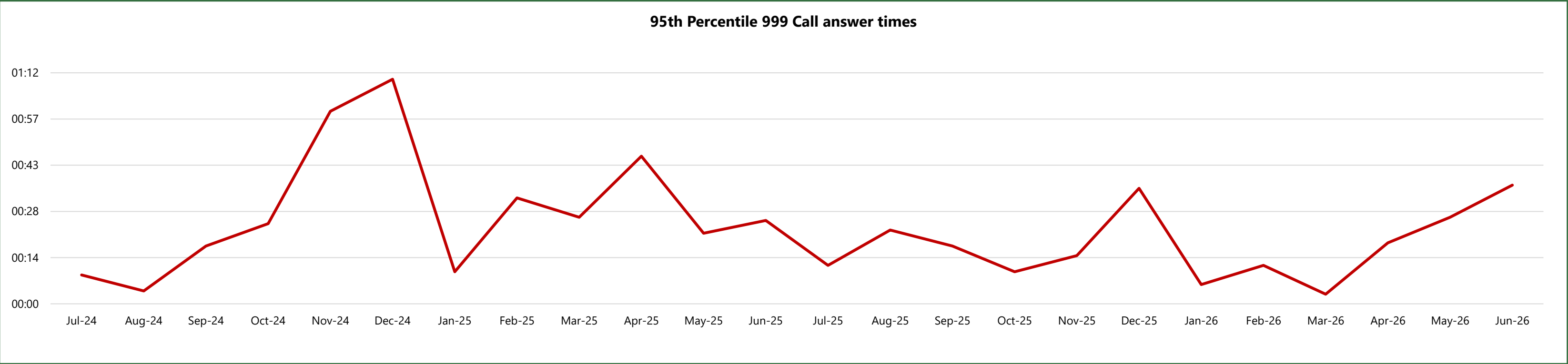
Expected Performance Trajectory

We would expect to see performance levels remain low during the summer as abstraction levels historically rise slightly.

Our Patients

999 Call Answering

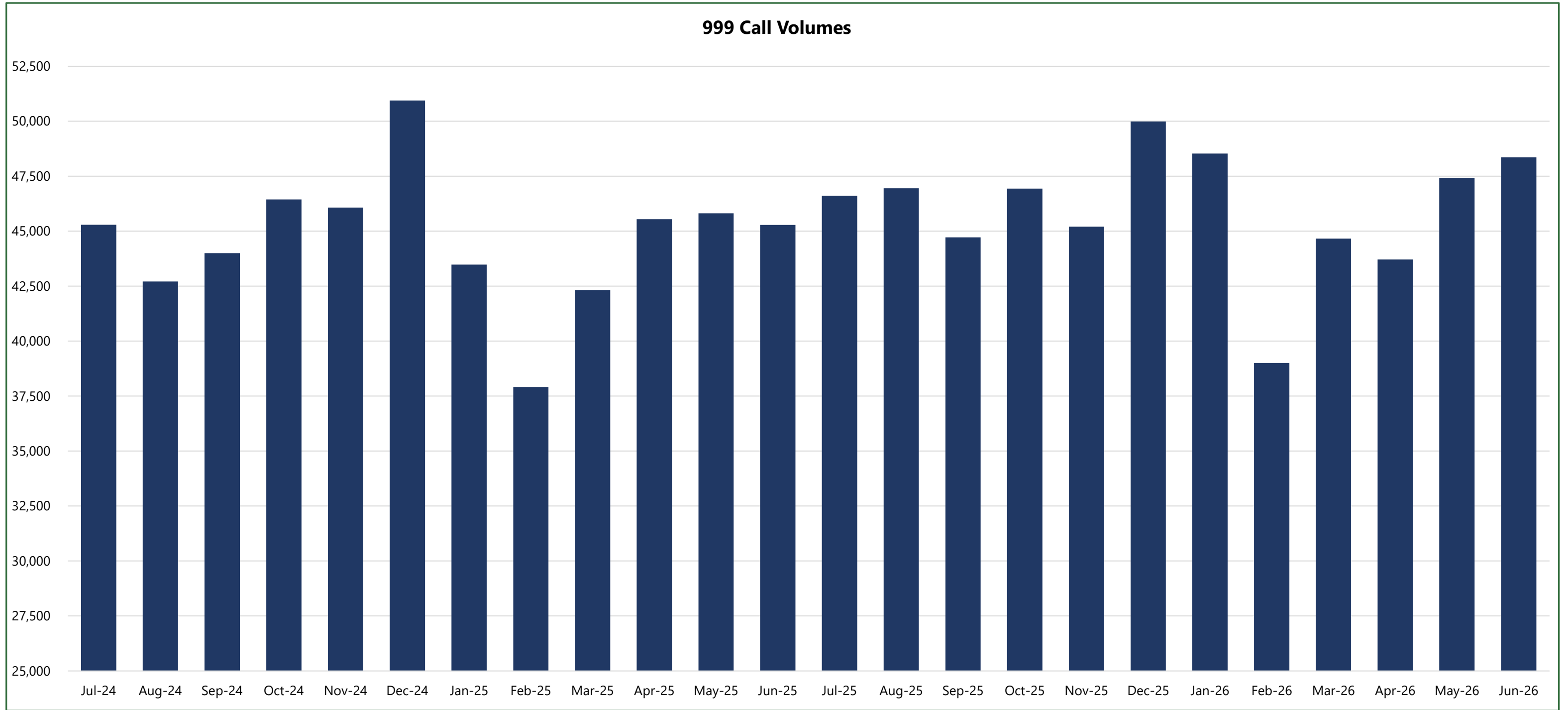
Strategic Objective 1



Our Patients

999 Call Demand

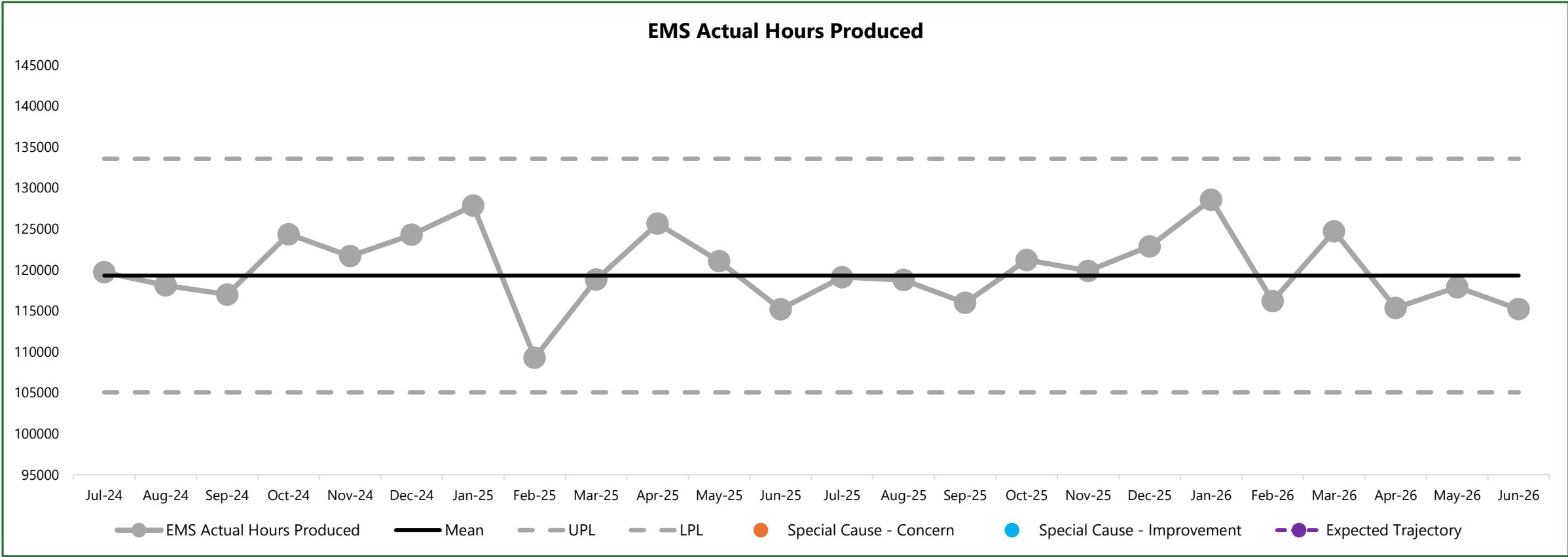
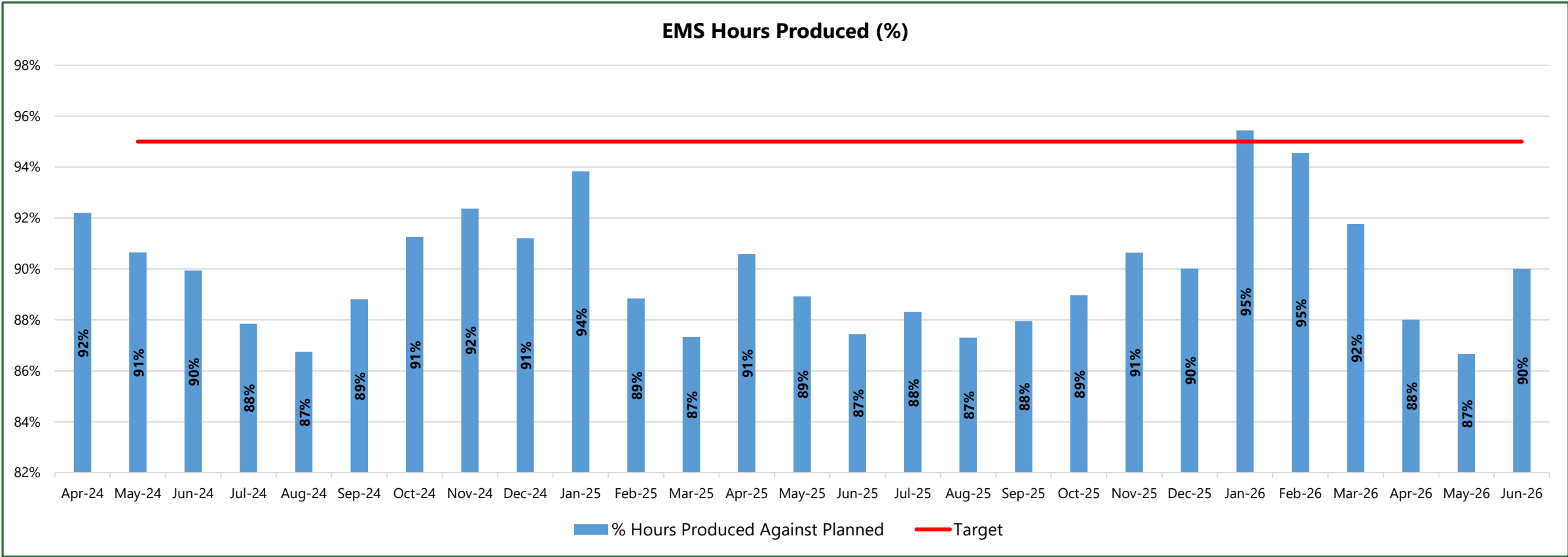
Strategic Objective 1



Our People

EMS Hours Production Indicators

Strategic Objective 2



Analysis

The total EMS hours produced is a key metric for patient safety. The SPC chart highlights that over the past two years this metric has stayed within normal process limits.

EMS Hours Produced achieved 90% in June 2026 which equated to 115,208 Actual Hours, against a planned total of 131,855, and remained below the 95% target, with reduced overtime availability linked to financial constraints a factor.

Remedial Plans and Actions

There are three issues affecting EMS UHP: abstractions (maternity, other, sickness) are higher than benchmark; overtime is closely managed to produce a balanced financial plan and vacancies in UCS, which are picked up in EMS in this case.

Expected Performance Trajectory

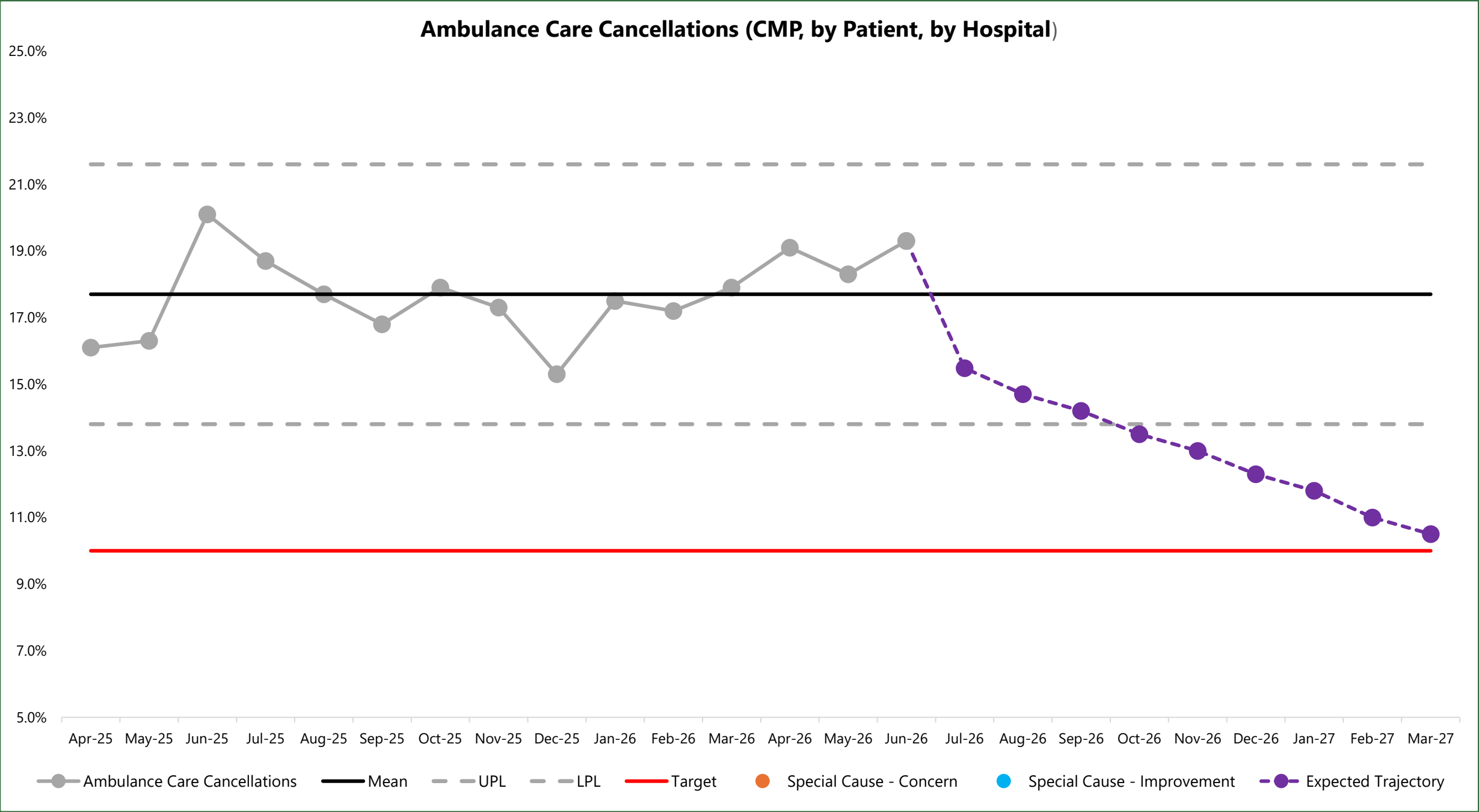
A UHP trajectory is being developed. The UCS recruitment gap is projected to close over this financial year, with a meeting arranged to consider how this can be sped up. The Trust maintains an ambition to reduce sickness to 6% and maintain abstractions to 30%. Reduced overtime availability will reduce future levels of production.

Finance, Resources and Value

Ambulance Care Indicators

Strategic Objective 6

NEPTS Activity
Cancelled
R



Analysis

The chart shows that Ambulance Care cancellations, although above target, have been within normal process limits over the past 12 months.

The expected trajectory (purple line) indicates a predicted sustained improvement in cancellation performance over the next 12 months.

Remedial Plans and Actions

As the Ambulance Care service works to fully define the benefits of the actions set out in the NEPTS Improvement Programme, the trajectory provided should be considered a developing ambition for now.

Capacity Management Plan improvements will be driven by increased available capacity due to re-rostering and improvements in efficiency and reductions in demand through adjustments to journey booking and planning processes.

Booking cancelled by others (patients and hospitals) are not fully in the direct control of WAST and will require a change in patient behaviour and Health Board process. Digital improvements such as system integration and additional messaging will also be key.

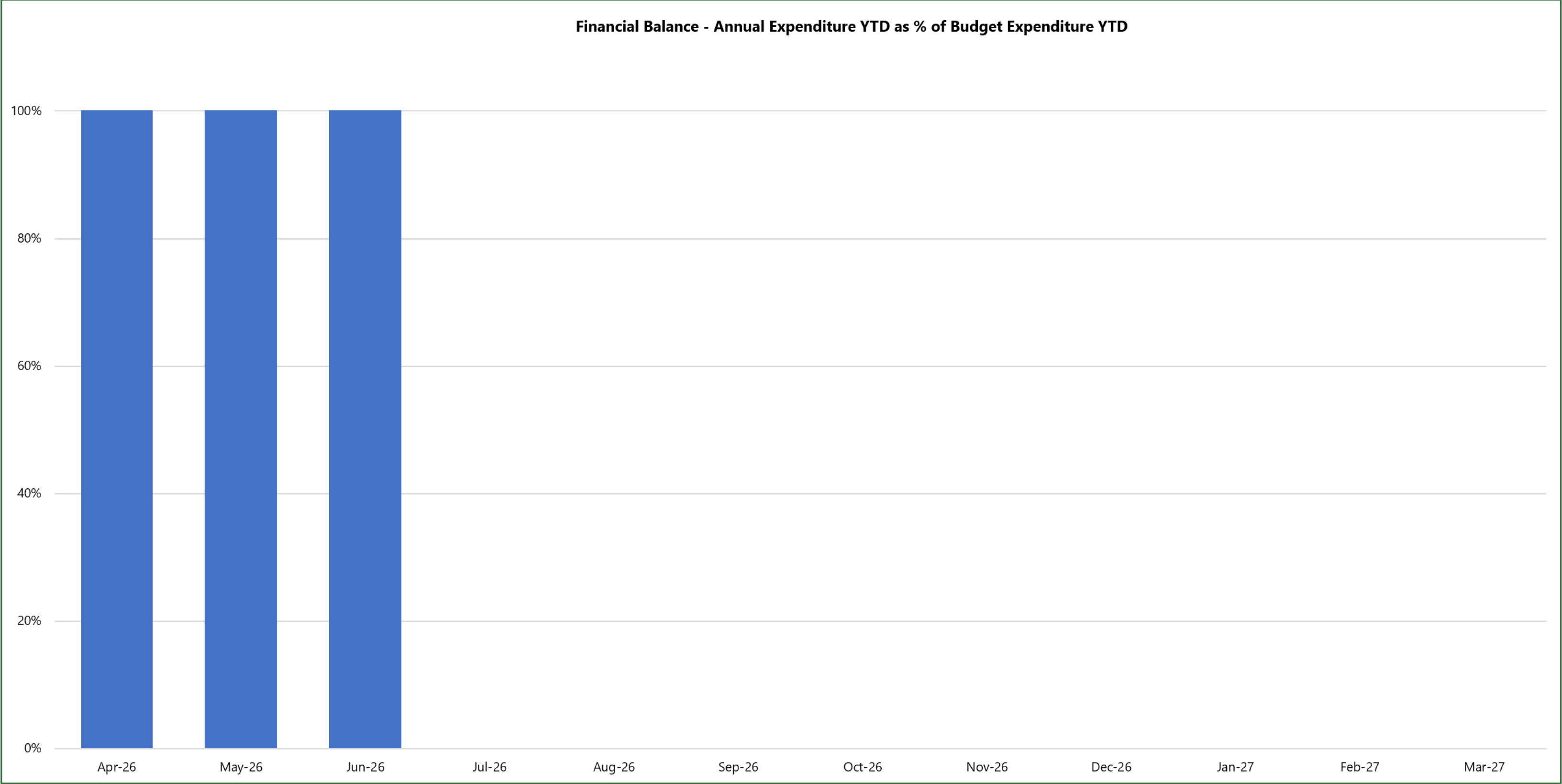
Expected Performance Improvement

The chart illustrates the expected performance improvement, but the ambition of moving from 19% to less than 10%, needs to be reconsidered, in the light of a revised metric for this indicator.

Finance, Resources and Value

Financial Balance

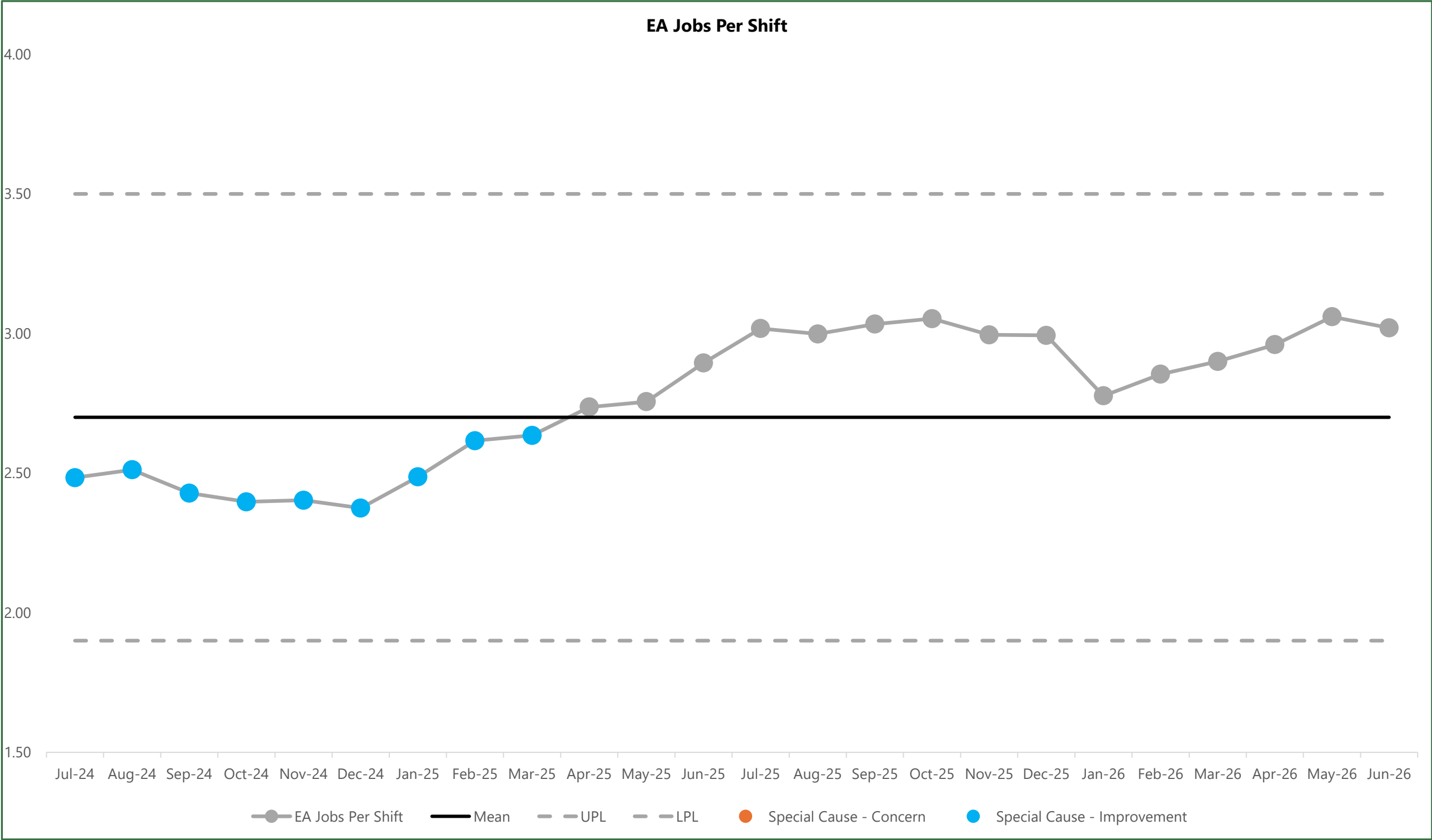
Strategic Objective 6



Finance, Resources and Value

EA Average Jobs Per Shift

Strategic Objective 6



Analysis
Overall, EAs averaged 3.02 jobs per shift during June 2026. The modelled ambition for this metric has been set at 2.3 jobs per shift or above.

The SPC chart shows that there has been a sustained increase in the number of jobs per shift being carried out by EAs, as a result of improved handover.

Remedial Plans and Actions
This metric is red as it is above the “optimal” modelled jobs per shift of 2.3. Further consideration needs to be given to this metric as performance is actually better than target here. See below.

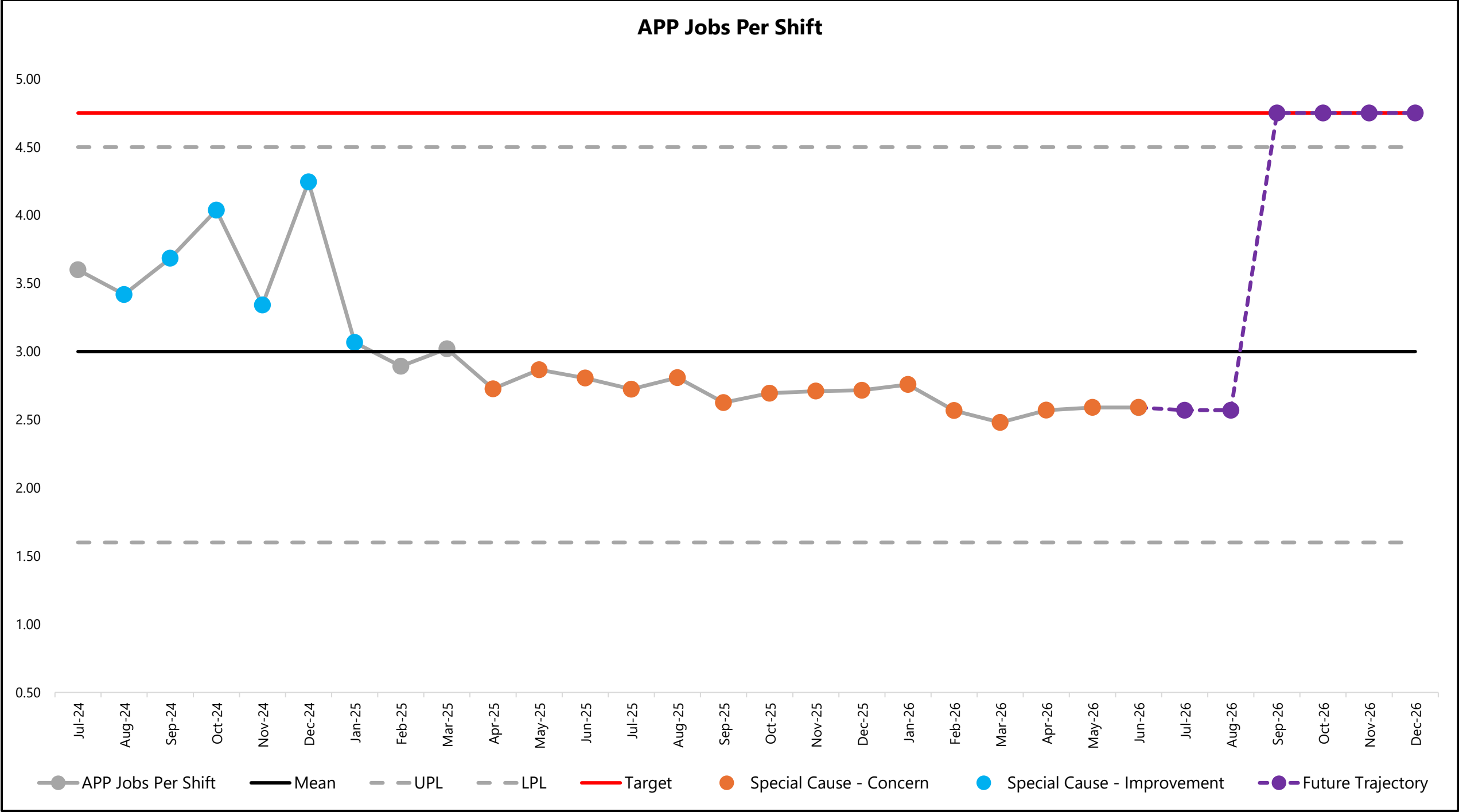
Expected Performance
The ambition for this metric is based on the 2023 Demand & Capacity Review modelling, which produced a rate of 2.3 jobs per shift or above, based on reduced handover lost hours of 7,000.

The Trust has already exceeded this ambition and if health boards can deliver further reductions on handover lost hours and the Trust works on improved job cycle productivity on the aspects it controls, further improvement should be possible. For this metric, further consideration needs to be given to the ambition, potentially linked to modelling.

Finance, Resources and Value

APP Average Jobs Per Shift

Strategic Objective 6



Analysis
APPs attended an average of 2.57 jobs per shift during June 2026. The SPC chart shows a special-cause deterioration from early 2025, with a sustained run of points below the historical mean (~3.0) and a new, lower level of performance which is well below the target (4.75) — indicating the current system is not capable of meeting the target consistently..

Remedial Plans and Actions
There are two key actions underway for APPs
a) scheduling (that is responding to the code set they are designed to focus on), and
b) the APP re-roster, which is due to take place in in Q1 + Q2 this year.

Expected Performance Improvement
As the purple future trajectory line indicates, due to the use of advanced simulation software to develop recommended roster keys for APP response resources, taking place over the first 6-months of the year, the Trust is expecting to see an improved step change in both the utilisation of APPs and the number of jobs per shift they attend after August 2026.

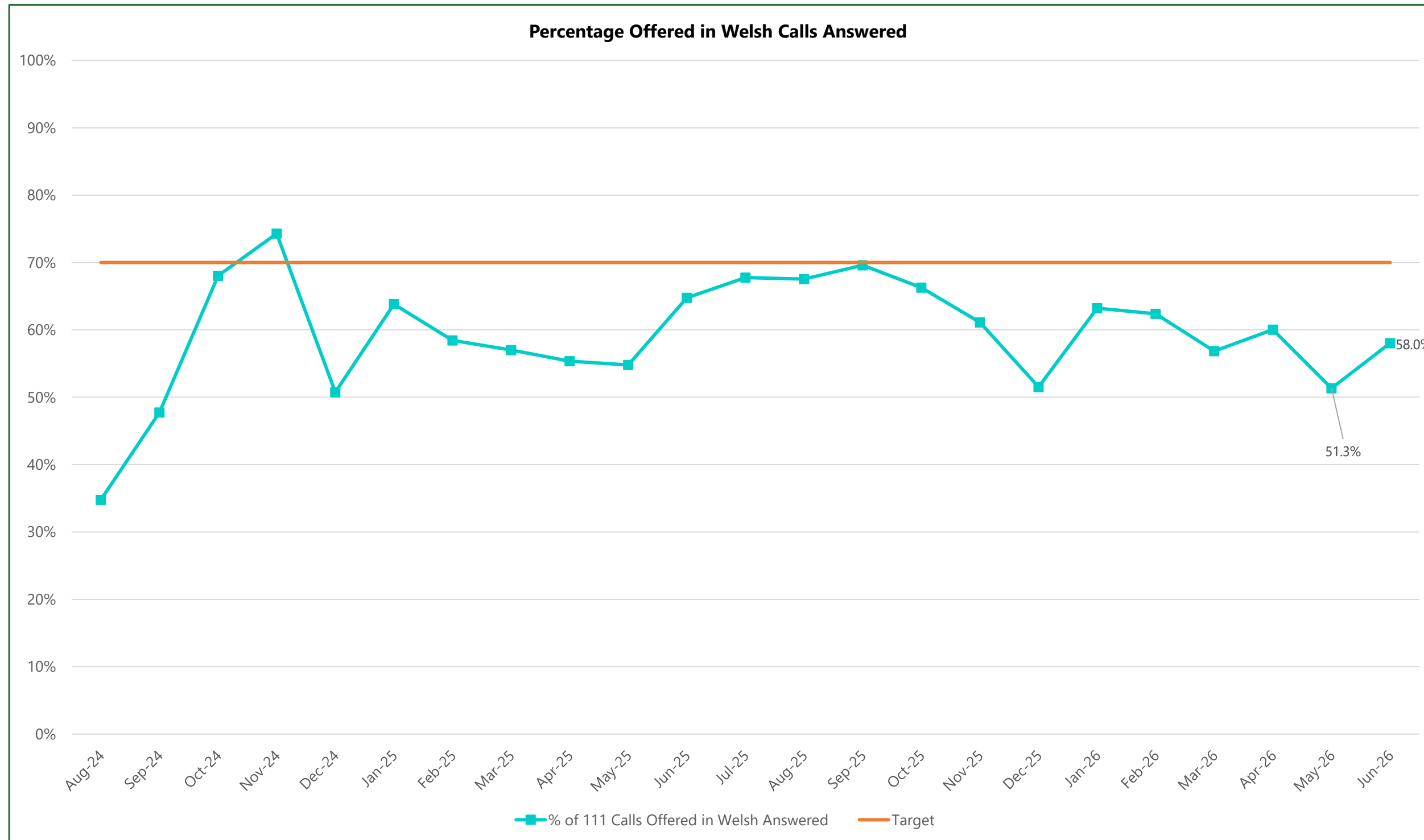
Under Development

Partnerships / System Contribution

NHS111 Outcomes and Welsh Calls

Strategic Objective 1

R



Analysis

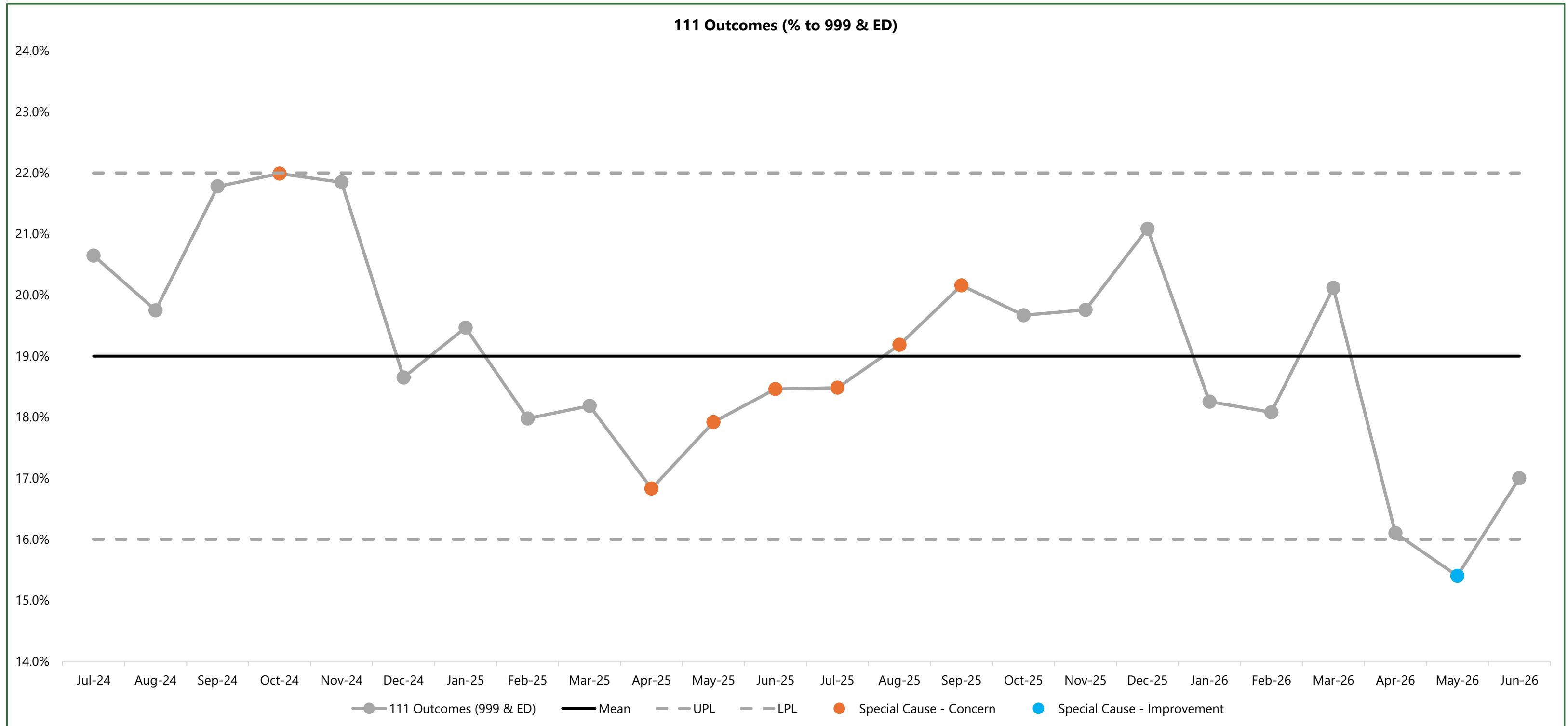
In June 2026, the total number of Welsh calls offered was 1,470 calls, 853 of these were answered, equating to 58%. This remains below the 70% ambition and has remained below target since November 2024.

Remedial Plans and Actions

See the plans and actions for calls abandoned and 60 seconds in previous slides.

Expected Performance Trajectory

The independent modelling indicates that the Trust should expect to see a performance range of 10%-15% based on the current commissioned establishment. To further expand on this, the Trust can achieve a range of 10%-15% on normal days, but for days with high demand e.g. bank holidays, winter etc. the Trust cannot. The roster keys are designed to cope with c2,500 calls, for period of high demand, this can double or even triple.



Partnerships / System Contribution

Albot and Web Chats

Strategic Objective 3

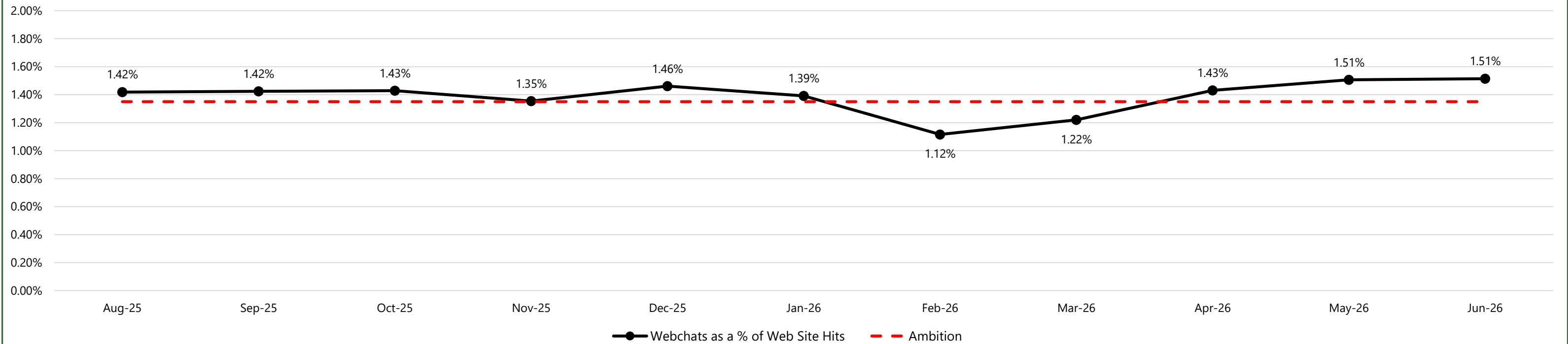
Web Chats

G

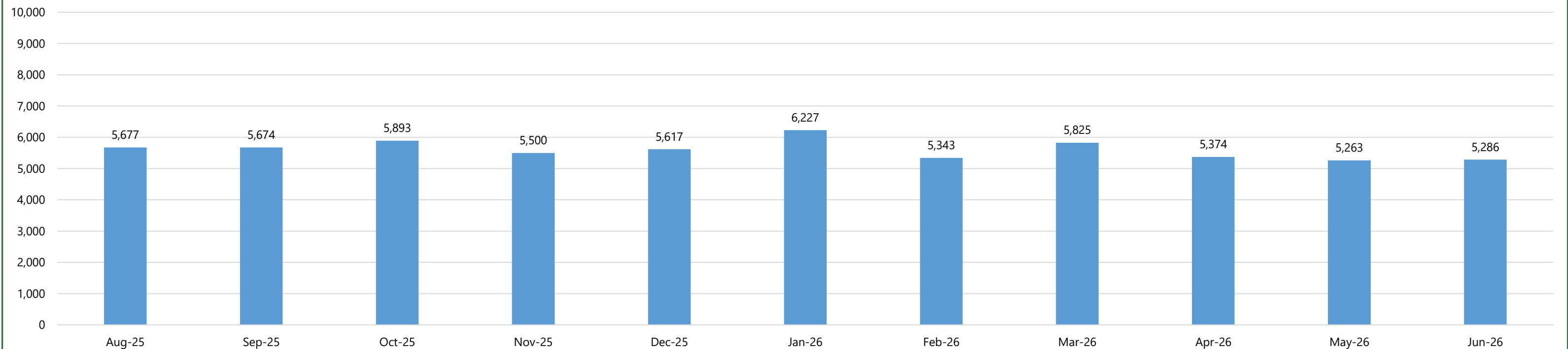
Albot

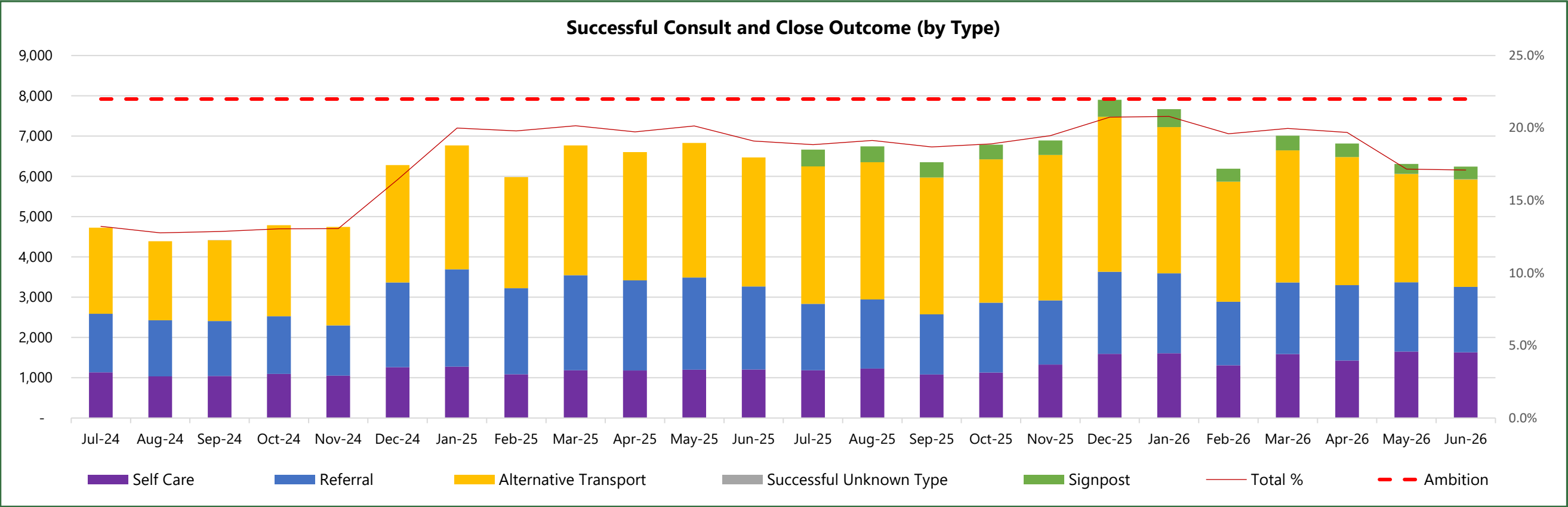
MOA

Webchats as a % of Web Site Hits



111 Wales Online - Virtual Agent (Albot) Interactions





Analysis

The new **Consult and Close** definition was agreed by Commissioners in May 2025 with reporting recommencing in June 2025 after backdating data collation to May 2024.

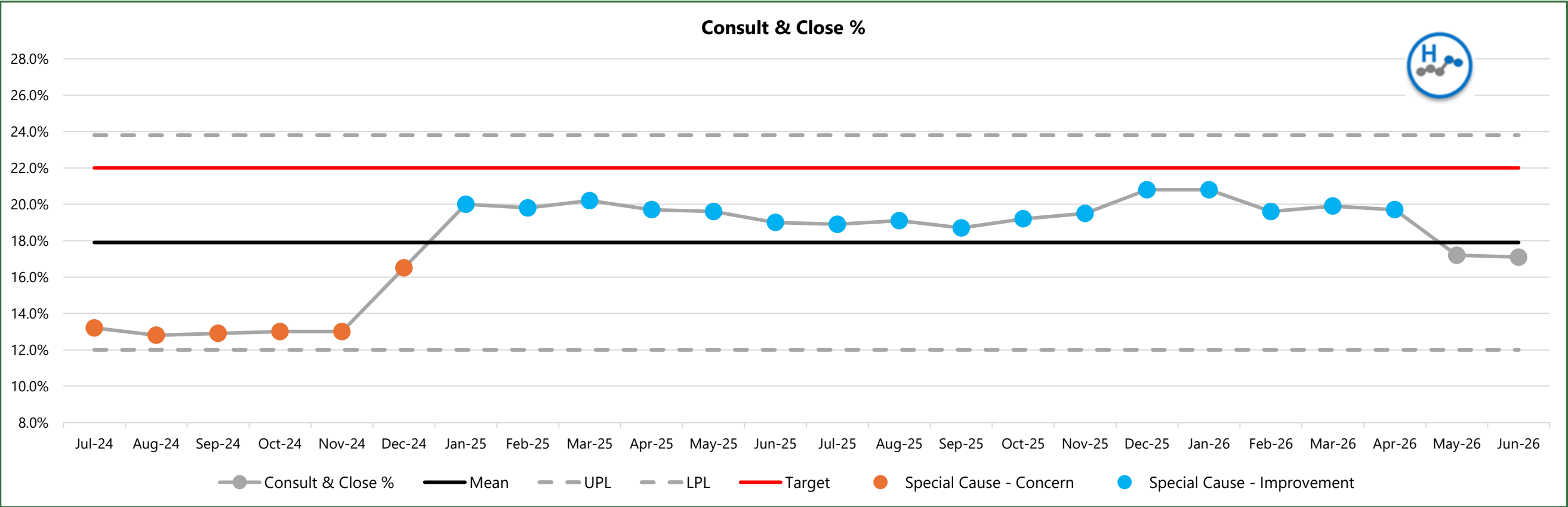
The SPC chart highlights a system improvement over the last year, with 16 consecutive data points exceeding the mean, indicating a sustained pattern of improvement in this metric, although performance has dropped below the mean the past two months, falling to 17.1% in June 2026.

Remedial Plans and Actions

Work that is underway reviewing processes, has yielded efficiencies in remote clinical support, in particular, digital transformation and increased staffing, linked to IMTP reinvestment decisions on the CMT Programme.

Expected Performance Trajectory

Further improvement is expected linked to CSD staff attendance (reduced abstractions and less vacancies) and the CMT model. The ambition remains at 22%.



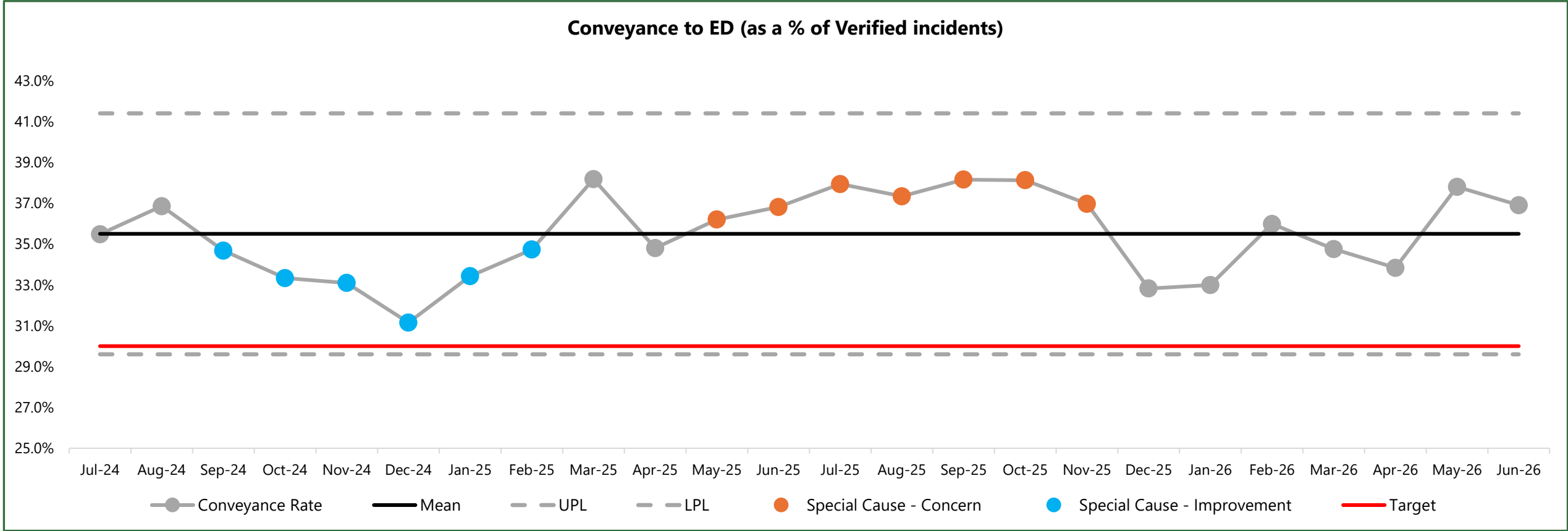
Partnerships / System Contribution

Conveyance to ED/See & Treat Indicators

Strategic Objective 4

Conveyed to ED
R

% See & Treat
R



Analysis

The SPC shows a period of special-cause deterioration in mid-2025, with a sustained run of points above the mean indicating higher conveyance rates. However, this was not sustained, and performance returned to its historical average, although the last two months has seen a return to monthly figures above the 2-year mean.

These conveyance rates remain above the 30% target, meaning the system is not currently capable of delivering the target. It is likely that the deteriorating conveyance rates were due to a reduction in the number of lost hours to handover, thereby freeing up more resources to respond to Amber 1 incidents.

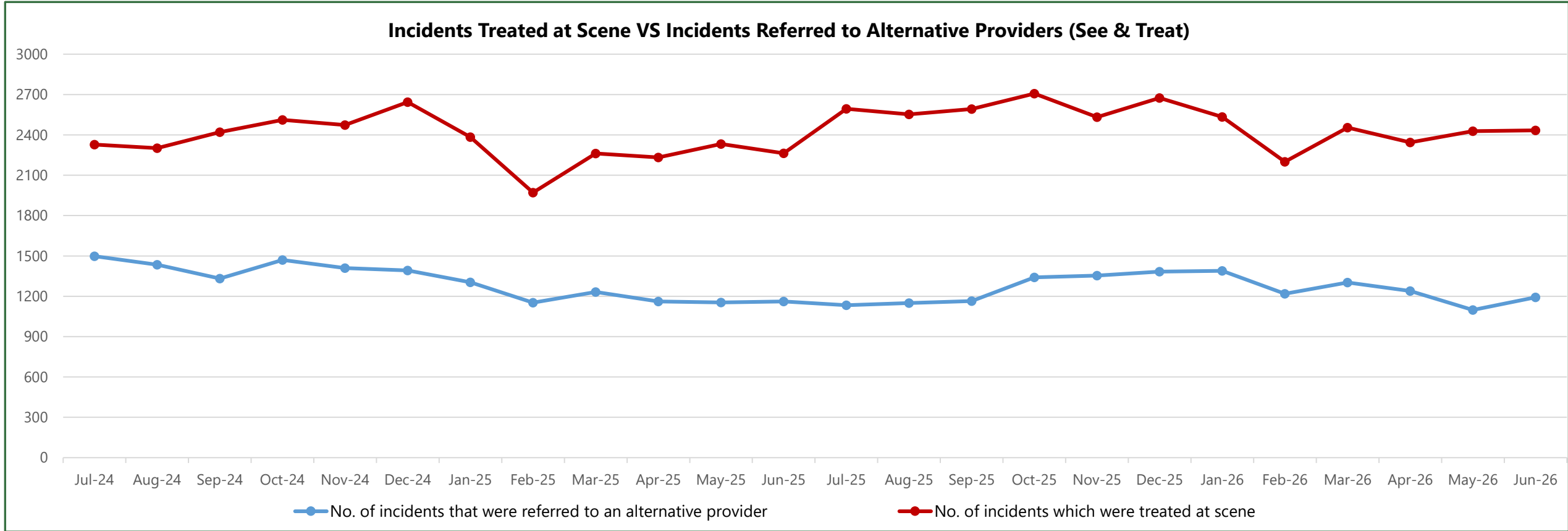
The number of incidents treated at scene and referred to alternative pathways have both remained relatively stable over the past year.

Remedial Plans and Actions

Transformation actions include continuing to work towards the 22% consult & close benchmark, improving see & treat rates through APP re-rostering & scheduling and health board support through SPOAs and alternative pathways.

Expected Performance Improvement

The 2023 Demand & Capacity Review, modelled a position of 30%, if all transformation changes are successfully implemented and W45 delivered.



Partnerships / System Contribution

Handover Indicators

Strategic Objective 4

W45
R

Lost Hours
R

Analysis

170,375 hours were lost to Notification to Handover, i.e. hospital handover delays, over the last 12 months (Jul-25 to Jun-26), compared to 249,721 hours over the same timeframe the previous year. There were 13,874 hours lost in June 2026.

In relation to the W45 target, the chart shows there was a sustained improvement in performance between April 2025 and December 2025, with variation remaining below the mean for seven consecutive months. However, although the number of handovers over 45 minutes has seen a slight increase over the past few months it remains significantly lower than numbers seen during the past few years.

The lower SPC chart shows there has also been a sustained improvement in handover since May 2025, with all bar one data point below the mean since this time. However, as the chart indicates, this is a metric that has still failed to achieve its target over the past two years.

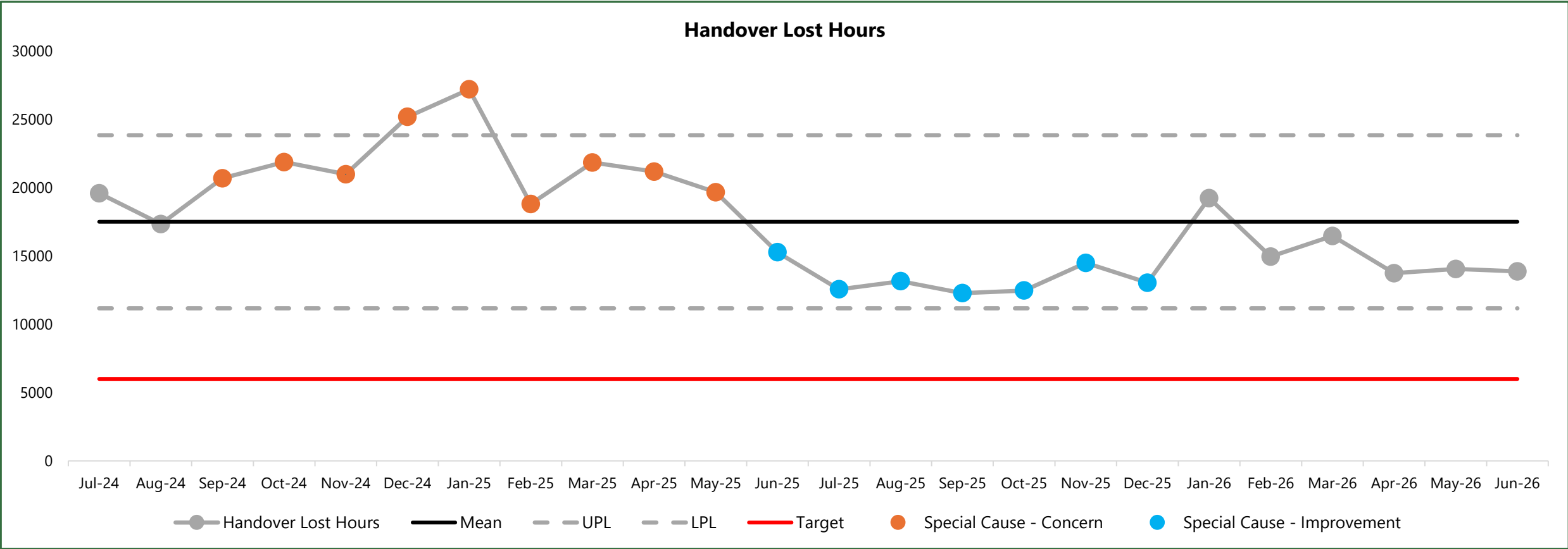
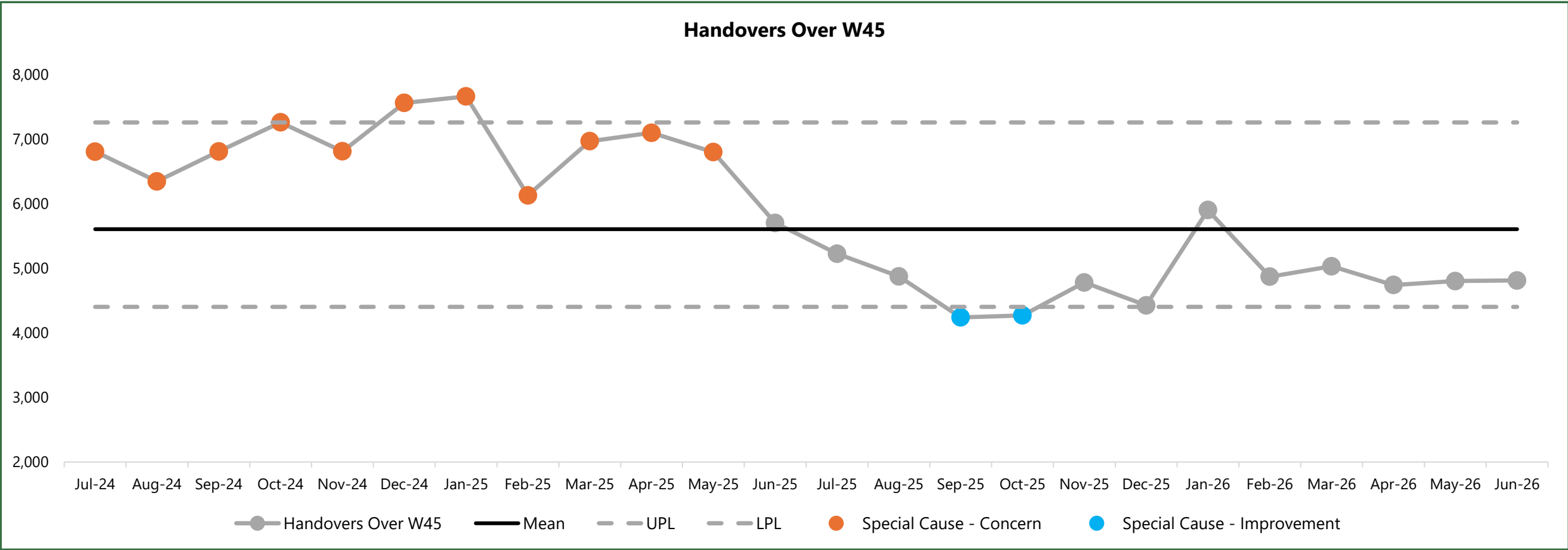
In June 2026, the Trust could have responded to approximately 4,357 more patients if handovers were reduced to the target level, which highlights the impact these numbers are still having on the service.

Remedial Plans and Actions

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

Expected Performance Trajectory

The expected ambition from Welsh Government is no waits over 45 minutes. W45 workshops have been facilitated with each health board by NHS Wales Performance & Improvement (previously the NHS Executive). Improvement plans have been developed for AB, BCU and SB, along with trajectories. The Trust has been supplied with these and these will now be monitored going forward.



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 / PCR's	Patient Care Record(s)	UHP	Unit Hours Production
CI	Clinical Indicator	ePCR	Electronic Patient Care Record	LTS	Long Term Strategy	JRCALC	Joint Royal Colleges Ambulances Liaison Committee	U/A RTB	Unavailable – return to Base
CHARU	Cymru High Acuity Response Unit	FTE	Full Time Equivalent	MACA	Military Aid to the Civil Authority	PECI	Patient Engagement & community Involvement	VPH	Vantage Point House (Cwmbran)
COOs	Chief Operating Officers	GDPR	General Data Protection Regulations	MIU	Minor Injury Unit	POD	Patient Offload department	WAST	Welsh Ambulance Services University NHS Trust
COPD	Chronic Obstructive Pulmonary Disease	GPOOH	General Practitioner Out of Hours	MPDS	Medical Priority Dispatch System	PPLH	Post Production Lost Hours	WG	Welsh Government
COVID-19	Corona Virus Disease (2019)	GTN	Glyceryl Trinitrate	NCCU	National Collaborative Commissioning Unit	PSPP	Public Sector Purchase Programme	WIIN	WAST Improvement & Innovation Network
CMT	Clinical Model Transformation	HB	Health Board	NEPTS	Non-Emergency Patient Transport Services	QPSE	Quality, Patient Safety & Experience		
CSD	Clinical Service Desk	HCP	Health Care Professional	NEWS	National Early Warning Score	RCS	Rapid Clinical Screening		
CSP	Clinical Safety Plan	HD / HDHB	Hywel Dda / Hywel Dda Health Board	NHS	National Health Service	RICS	Remote Integrated Care Service		

Definition of Indicators

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



GIG
CYMRU
NHS
WALES

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

Agenda Item No. 10

REPORT TITLE

Internal Audit Report – Fire Safety – ARAC Feedback

MEETING

Name of meeting	Finance and Performance Committee
Date of meeting	21 July 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Chris Turley, Executive Director of Finance and Resources
Author(s) of report	AnnaMaria Williams, Corporate Governance Officer

PURPOSE OF REPORT

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

REPORT SUMMARY

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

1. The Audit Risk and Assurance Committee (ARAC) received and discussed the **Fire Safety** Internal Audit Report at its meeting on 23 June 2026. This report summaries the discussion from that meeting in reference to this report and is included in the AAA report from ARAC to the board.
2. David Butler, NWSSP Internal Audit, presented the Fire Safety Internal Audit Report, which received an overall rating of **reasonable assurance**. Members noted the significant improvements made since the previous audit in 2021, including an increase in trained fire



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wardens, improved fire drill compliance and strengthened monitoring and reporting arrangements. Whilst recognising the challenges associated with managing fire safety across the Trust's extensive estate, the audit identified opportunities to further strengthen local controls, training, communication, risk assessment processes and reporting arrangements. No high-priority findings were identified, and Members noted that many of the issues raised were already being addressed by management.

3. Chris Turley welcomed the reasonable assurance rating, noting the significant improvements made since the previous audit and emphasising the importance of maintaining ongoing focus on fire safety given the Trust's extensive estate and inherent risks. Chris highlighted that further work was required to strengthen local operational compliance and reinforce that fire safety remained the responsibility of all staff.
4. The Chair welcomed the improved position since the previous audit and sought clarification on whether estate age influenced fire safety risks. David Butler advised that no direct correlation had been identified. Members queried the frequency of fire incidents and were advised that numbers remained very low. Members also sought assurance regarding fire warden coverage across sites, noting the arrangements in place to provide local leadership and oversight during emergency situations.

RECOMMENDATION(S)

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

The committee is asked to:

- (a) note the discussion and feedback from ARAC
- (b) review the report, noting the agreed management actions and mitigations of risk in the area of the report

The committee will have an opportunity to monitor the closure of these actions and scrutinise impact of those actions in response to audit recommendations via tracker reports and future assurance reporting on this issue.

ADDITIONAL PAPER(S)

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

The committee is requested to receive the following:

- **Annex 1** Fire Safety Internal Audit Report



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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

RISK(S) THIS REPORT MITIGATES

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

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

IMPACT ASSESSMENTS FOR CONSIDERATION

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

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
23 June 2026	Audit, Risk and Assurance Committee

Fire Safety [Subject]

Final Internal Audit Report 2025/26

Welsh Ambulance Services University NHS Trust



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Review Reference

WAS-SSU-2526-20

Fieldwork

July 2024 – December 2025

Executive Sign Off

June 2026

Audit Committee

June 2026

Executive Lead

Chris Turley, Director of Finance

Audit Team

Huw Richards, Head of Internal Audit

David Butler, Audit Manager

Executive Summary

Purpose

The Regulatory Reform [Fire Safety] Order 2005 (the Fire Safety Order) requires key safety compliances such as risk assessments. It also requires that procedures are operated to support compliance.

This audit undertook an assessment of the controls and practices in place within the Welsh Ambulance Services University NHS Trust (The Trust) to ensure that the key fire safety regulatory requirements were adequately addressed, controls were embedded within the organisation, and appropriate operational application of the defined controls was evidenced. It also sought to assess whether the key issues identified at the prior report had been addressed.

Overview

The previous audit undertaken in 2021 provided “**limited**” assurance. The key issues impacting the opinion at that time included the effective reporting to the Board, effective monitoring of risks, and the need for effective management of dangerous substances. Positive action has been demonstrated in addressing the issues previously raised, together with further implementation of appropriate fire safety governance arrangements within the Trust.

Significant improvements were evidenced since the prior audit, notably the comprehensive coverage of Fire Risk Assessments and substantial action in relation to the same e.g. trained Fire Wardens had increased from 158 to 347 in the preceding 18 months, and annual fire drill compliance had increased from less than 50% of premises to circa 80%. Fire maintenance systems were also subject to detailed and enhanced monitoring. Such improvements have been driven and enacted by the central Estates staff (Fire Safety Officer etc). A partial follow up of the recommendations raised at the 2021 audit (of the two high priority and a sample of medium priority items) determined substantial assurance. The current audit sought to fully review the 2021 agreed recommendations and has determined “reasonable” assurance of current implementation (see full details at **Objective 1** below).

The audit has determined “**reasonable**” overall assurance, with positive assessments determined in relation to four of the five areas considered as a part of the current review. Whilst noting the positive actions taken by management to improve the fire safety governance, procedural, monitoring and reporting arrangements operating within the Trust, weaknesses were identified in the local application of defined requirements at the five premises visited across Wales (Vantage House, Matrix One, Beacon House, Merthyr ambulance station, and Merthyr workshops). These provided a mix of landlord owned premises, ambulance stations, and key support premises (noting the potential for impact to ambulance services from fire at key support buildings).

Key matters raised for management attention included the need to ensure:

- drawings to include all in-situ fire safety controls (to appropriately inform risk assessments);
- additional monitoring (to include Fire Warden coverage and logbooks);
- site specific Fire Warden training
- approval of an in-date Fire Safety Policy (with enhanced procedural and governance content);
- enhanced reporting (to include the status of key actions for higher risk premises and fire drill monitoring updates); and
- compliance with display of evacuation instructions at exits at all sites;

Recognising the need for improved training of local leads, the above may also indicate a wider requirement for improved communication to raise the profile of fire safety issues for all staff.

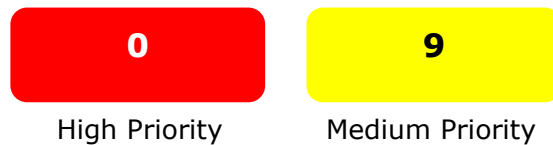
Positive action has been demonstrated by Trust officers in progressing a number of the above issues subsequent to the completion of the audit fieldwork i.e.

- work has commenced to update fire safety controls at drawings and incorporation into associated evacuation plans;
- a refresh of training needs assessments was underway (as advised by the Fire Safety advisers);
- a draft update of the Fire Safety Policy was being compiled to include controls in respect of audit findings; and
- fire evacuation notices had been revised to ensure compliance.

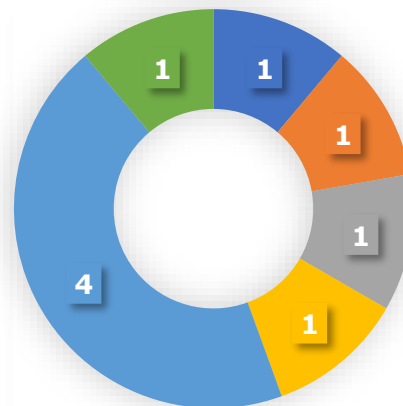
Scope & Assurance Summary

Objectives	<i>The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.</i>		Related Findings	Assurance
1	Validation of Management Action - That previously agreed actions had been appropriately actioned by management.			Reasonable
2	Governance arrangements - including effective structures, terms of reference, roles and responsibilities, collaboration, resource and expertise.			Reasonable
3	Appropriateness of procedures - including effective controls.		1, 2	Reasonable
4	Central monitoring & reporting – including drawings and risk assessments, training, incidents, inspections, investment, actions, and assurance provided to relevant forums and the Board (or delegated sub-committee).		3, 4, 5	Reasonable
5	Local/Operational arrangements - including: • local management and training; and • implementation of controls including signage, equipment, and guidance; and • records management		6, 7, 8, 9	Limited

Management Actions



Themes



- Contractual
- Governance
- Policies & Procedures
- Reporting
- Risk Management
- Training & Development

Risk Types

- Quality or Safety Issues
- Legal & Regulatory Non-Compliance

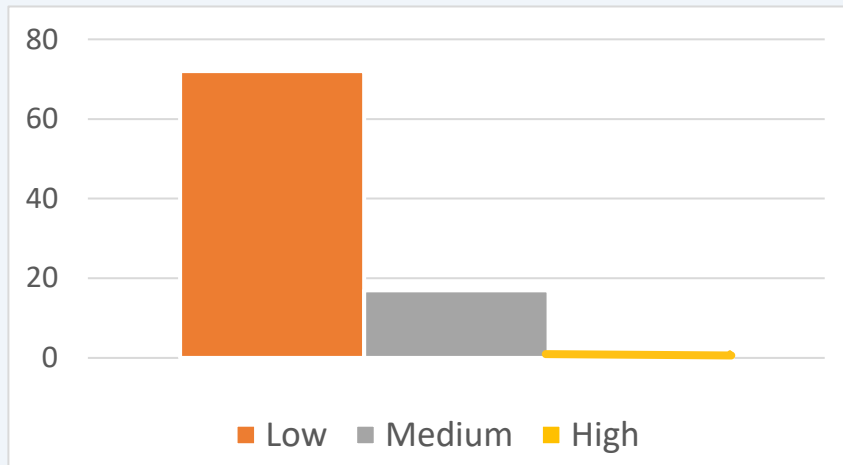
At a Glance

Performance

As reported at the annual Fire Safety Compliance Report (January 2025) all Trust **occupied** buildings (**117 in total**) had a current Fire Risk Assessment).

Fire Risk Assessments were categorised risk as follows:

Property Fire Risk Assessment Categorisation



Only one High risk. Circa 80% of Premises assessed as Low Risk

Issues identified at each Risk Assessment were categorised as:

Red (urgent), Amber (medium priority), and Green (lower priority)

All of the High Risk and Medium Actions had been addressed at the sole High-Risk property (Aberystwyth).

Management confirmed that in total:

- Red Risk - 192 Actions and 191 addressed (99.5%)
- Amber Risk - 616 Actions and 486 addressed (79%)

i.e. 84% of High & Amber risks have been addressed

Extract from the January 2026 Fire Safety Report



*19 sites had not completed a fire drill plus a further 6 landlord led sites (circa 40% of Trust owned sites - see **finding 9**)*

Findings & Agreed Action Plan

Objective 1: Validation of management action

Reasonable

Overview / Summary of Observations

The prior audit was published in August 2021 providing “**limited**” assurance. The follow-up position may be summarised as:

Recommendations	Priority Level	Implemented	Outstanding	Comments
The Trust should ensure that the reporting of Fire Safety issues is communicated through a formal assurance reporting framework to Board level.	High	1	-	Actioned, as narrated at the Governance section.
A DSEAR (Dangerous Substances and Explosive Atmospheres Regulations 2002) report should be commissioned to review the appropriateness of the dangerous substances management arrangements at the Lampeter Ambulance Station (and any other similar premises) and action taken to address any issues highlighted.	High	1	-	A DSEAR report was provided for the Lampeter station. Issues have been raised within this audit regarding DSEAR assessments (as arising from risk assessments). For context, it was noted many medical gas storage units were external to ambulance stations and within secure cupboards. These risks have been assessed within Risk Assessments, and none rated high at the present time.
The Fire Safety Policy will be reviewed (and updated as necessary) in line with the Trust's own requirements on updating Policies – for approval by an appropriate forum.	Medium	-	1	Following the prior audit the Fire Safety Policy was revised and approved on 17 th March 2022 in accordance with the recommendation. However, at the time of audit, its renewal was again overdue. Management stated that this was due to the need for a more fundamental review ahead of renewal (the prior author having retired in this interim period impacting this timing). See Policies and Procedures At the time of concluding the audit, management advised that procedures have now been re-drafted but await the publication of this audit to finalise. However, a quantum of matters have been identified at this audit requiring further management attention.

The Trust should ensure that the Fire Safety Group Meetings continue to be held on a quarterly basis.	Medium	1	-	Actioned - a Fire Safety Group now meets quarterly.
The Fire Safety Group should receive standardised and consistent reporting on fire.	Medium	1	-	Standardised and consistent reporting was found to be provided to the Fire Safety Group.
The Trust should produce an annual fire safety report in keeping with the requirements of the Trust's Fire Safety Policy.	Medium	1	-	Actioned, as narrated at the Central Monitoring and Reporting section.
Risk assessments should be updated within stipulated review periods.	Medium	1	-	Actioned, as per the At a Glance section
The Fire Safety Group should have its own fire risk register to ensure that all fire risks are captured.	Medium	1	-	Risk rated recommendations are monitored via a tracker with key thematic risks reported via presentation to the Fire Safety Group. Site specific risks are also fed back via each sites risk assessment.
In keeping with the requirements of the Fire Safety Policy, false alarms will be reported immediately using the Trust incident reporting procedure.	Medium	1	-	Fire safety incidents were recorded at Datix and regularly extracted and reported to the Fire Safety Group.
Fire Wardens will be identified and trained for the 13 Trust premises identified.	Medium	-	1	The Trust confirmed that Fire Wardens remained to be trained at 6 (of 117) premises (48 Trust owned). The current audit also found: <i>Local Fire Incident Co-ordinators (LFIC) training</i> LFICs were stated at the Fire Safety Policy as being staff who will have the necessary training to manage incidents. However, this training was not further specified or monitored. <i>Fire Warden training</i> Fire Warden training was generic rather than site specific. While training had been provided to operate Fire Safety Panels at some sites, the generic training did not include site related instruction e.g. for emergency light flick tests, rotational alarm testing, completion of the Fire Logbook, ensuring warden cover, or responsibilities as a Fire lead to raise and resolve issues, etc. Similarly, while Fire Warden training was monitored, there was no confirmed acceptance of duties and confirmation of

				familiarity / training with local controls for the Local Fire Incident Co-ordinators. Additionally noting operational issues raised at site observations, site specific duties and familiarisation should therefore be included within training. Specialist Fire Warden training was also available at the Shared Services Partnership Specialist Estates Services (NWSSP:SES) web site, which should also be reviewed for applicability. For context, it is noted that the requirement for Fire Safety Wardens and LFICs is as stipulated within the Fire Safety Policy and commissioned Risk Assessments and does not arise directly from the Regulatory Reform [Fire Safety] Order 2005.
Fire safety training in the Trust should be prioritised for all staff.	Medium	1	-	Trained Fire Wardens have increased from 158 to 347 from March 2024 to December 2025, with 82% ESR compliance for general staff fire safety training (noted at the annual report as a significant improvement on prior years). Monitoring and reporting of training was a focus of both the Fire Safety Group and Annual Compliance Report. While the current audit has identified additional issues relating to training of Local Fire Incident Co-ordinators, and the content of training (as assessed above), it also confirmed that Fire Wardens had been trained for all but 6 premises. Coupled with reporting and monitoring evidenced, notwithstanding new issues raised, it was concluded that there had been a prioritisation of fire safety training.
Fire Alarm Tests Either: - an appropriate forum should approve the reduced level of testing on a monthly basis; or - the weekly tests should be reinstated.	Medium	-	1	See findings 4 & 14 weekly alarm tests from rotated call points remains an issue, as highlighted at <i>some</i> Risk Assessments. As noted at the At a Glance section – management are prioritising and addressing all recommendations raised at Risk Assessments in a timely manner.
Total		9	3	

Both the High Priority items had been addressed, and there was partial / on-going actions in relation to the three outstanding. Accordingly, **reasonable** assurance has been determined in relation to delivery of previously agreed actions. However, some 5 years after the prior report full implementation remained to be achieved.

Overview / Summary of Observations

The Regulatory Reform [Fire Safety] Order 2005 imposes a duty to manage on the Responsible Person, being the person(s) having control over premises.

The Fire Safety Policy assigns Board level leadership to the Director of Finance. The Fire Safety Manager was designated as the Assistant Director Capital & Estates, with both the Head of Capital & Estates and the Estates Manager acting as Deputy Fire Safety Managers (for the operational application of the Policy). These roles were actively supported by the provision of relevant training.

A Fire Safety Group met quarterly led by the Fire Safety Manager with a wide range of attendees including the Deputy Fire Safety Managers, Estates staff, locality, and service leads. This group was informed by reporting of fire safety issues and additionally summarised within an annual report. However, monitoring systems were manually maintained requiring considerable vigilance and input. Accordingly, there may be an opportunity for improving the effectiveness of the use of existing resources in the operation of the existing monitoring systems, and facilitation of more dynamic reporting (see **Overview**).

The Terms of Reference (ToR) for the Fire Safety Group specified the formal assurance reporting line via the Quality, Patient Experience and Safety Committee through to the Board. The audit evidenced reporting and approvals to both the National Health & Safety Committee, and Finance and Performance Committee. However, both scrutiny and approval responsibilities and oversight and escalation arrangements were not appropriately defined within the procedures (see **Procedures** section finding 2).

While recognising the above matters, noting active monitoring and oversight by qualified officers via a regularly convened Fire Safety Group, **reasonable** assurance has been determined in relation to the existing governance arrangements.

Overview / Summary of Observations

The Regulatory Reform (Fire Safety) Order 2005 imposes a general duty on the employer to take such fire precautions as may be reasonably required to ensure that premises are safe for the occupants and those in the immediate vicinity via the application of fire safety procedures.

A Fire Safety Policy was in place containing a wide range of fire safety controls and was available at the Trust's Intranet site, however this had expired some months prior to the audit (see also **Objective 1**). While the reporting arrangements of the Fire Safety Group were detailed at its Terms of Reference, the Policy could also detail the scrutiny and approval roles of overseeing committees.

Management have advised that recognising a quantum of matters requiring amendment, it was deemed beneficial for a more fundamental review of the Policy ahead of re-publication

At the time of concluding the audit fieldwork, management advised that the Policy document had been re-drafted but were awaiting the publication of this audit report to also consider any additional points raised. Noting the same and conditional on the early application of the updated Policy, **reasonable** assurance has been determined.

Key Findings		Risk & Impact	Agreed Management Action
1	Fire Safety Policy a) Currency The Fire Safety Policy containing fire safety procedures was last approved on 17th March 2022 by the Fire Safety Group, Health & Safety Committee, and Finance and Performance Committee. Renewal was due within three years, and therefore the current policy had expired at the time of audit. b) Content It was evident that there were a range of matters identified within Risk Assessments not included within the Policy e.g. ○ weekly alarm tests from rotated call points; ○ monthly flick tests of emergency lighting; ○ electrical system inspection requirements & frequency. The annual Fire Safety Compliance Report also reported several key matters not contained within the Policy e.g.	Policy deficiencies impact operational controls.	The review and revision of the fire policy is currently underway and will incorporate the feedback and recommendations identified during the fire audit, prior to submission to the Policy Group for formal review.

- o 6 monthly maintenance checks for detection and alarm systems (as per BS 5839-1:2025); and - o EICR (Electrical Installation Condition Report) compliance including monthly flick tests. While planned maintenance frequencies were monitored, neither the Policy nor Compliance Report detailed the required frequency of fire drills and associated performance (which awaited risk assessment by the fire consultant), including associated requirements for lower risk premises. Similarly, the directions for DSEAR risk assessments were not specified (with assessments and follow-up actions not available for two of the three owned premises inspected). While recognising that DSEAR issues would be raised by Risk Assessments, specification of minimum requirements for the Annual Compliance Report could also usefully form part of the Fire Safety Procedures. c) Content - IT System Safeguards As of 2022 the Fire Safety Policy stated that: <i>"CT equipment rooms are considered critical in supporting Trust operations. ICT equipment in server rooms together with UPS's and battery storage rooms will be provided with Fire Alarm, Automatic Fire Detection and where appropriate to the risk, Fire Suppression systems. Consideration will be given to linking outputs to a building management system".</i> Noting the elapsed time since this observation, this matter should therefore now be implemented or rejected via a formally approved proposal as part of renewal of the Fire Safety Policy. There was therefore a need to review the Fire Safety Policy against required criteria both at Fire Risk Assessments, and matters raised within this audit (e.g. soft furniture fire safety labels).		Expected Evidence of Implementation: Approval and issue of the revised Fire Safety Policy following review by the Policy Group.
Theme: Policies & Procedures	Medium Priority Control Design	Officer: Assistant Director of Capital & Estates Date: November 2026

2	Committee reporting and oversight While the Fire Safety Policy identified the general responsibilities of the Trust Board, it did not specify delegated committee oversight e.g. scrutiny and approval responsibilities of the Health & Safety Committee, or the Finance and Performance Committee both of whom approved the current Fire Safety Policies. Management have commented that: • A member of the Senior Estates Team attends monthly/quarterly operational team meetings (e.g. South East Formal Business Meetings, Local Integrated Partnership Forum - all regions, Quarterly Fire Safety Group providing fire safety updates, and advice and discussion e.g. of any incidents). • Fire compliance information is now monitored and updated monthly and captured in an estate's presentation for cascading to the operational team meetings. This will allow enhanced reporting of high risks taken directly from the Fire Risk Assessments to be shared with senior management, the fire safety group and at numerous operational briefings.	Responsibilities may be unclear impacting effective scrutiny and oversight. Medium Priority Control Design	Agreed Management Action: Monitoring by relevant committees and associated reporting and including approval of the Fire Safety Policy will be clarified at the Fire Safety Group (e.g. to monthly estates meetings, local integrated partnership forums or operational management meetings). Expected Evidence of Implementation: We will reflect intended fire safety governance arrangements including monitoring to relevant committees within the Fire Safety Policy. Officer: Assistant Director of Capital & Estates Date: August 2026
	Theme: Governance		

Overview / Summary of Observations

The Fire Safety Policy states that the Trust Board expects those tasked with managing fire safety to develop and implement monitoring and reporting mechanisms appropriate to the management of fire safety. It specifically requires the production of an annual fire safety report and submission to the Trust Board. Associated reporting, notably via the Fire Safety Group is also required to support operational monitoring. Such reporting was in place.

An annual Fire Safety Compliance Report was provided to the Finance & Performance Committee in January 2025. This included commentary on technical compliance, risk assessments completed and associated actions. This was supplemented by reporting on operational matters to the quarterly Fire Safety Group (such as incidents, and completion of risk assessments, fire drills, and training). The Annual Report detailed the proportions of high / medium risk premises, together with top risks remaining (see **At a Glance** section), however, it did not report whether actions had addressed key issues at the highest risk premises.

Monitoring systems also included a Planned Preventative Maintenance system with a fire specific spreadsheet, and a Risk Action Tracker, all with alert provisions for any overdue actions. The audit determined that monitoring systems could usefully be supplemented by checklists of landlord and tenant responsibilities together with systems to ensure full coverage by Local Incident Co-ordinators (see **local/Operational arrangements**).

Risk Assessments were in place for all premises (refreshed cyclically on a 5 yearly basis, or upon significant change) as required by the Fire Safety Policy. However, there was a need for drawings to include all fire safety controls to inform these assessments. There was also a need for a system to trigger fresh reviews following building alterations. Management advised that new site drawings were in preparation and recognised the need for a system to trigger updates.

While recognising the above issues, noting a range of monitoring including reporting at both committee and operational levels, **reasonable** assurance has been determined in relation to central monitoring and reporting.

Key Findings		Risk & Impact	Agreed Management Action
3	Drawings Drawing information informs both risk assessment and Fire Service response. Indeed, the Risk Assessments test for both zone diagrams, and drawings highlighting fire safety and risk related items. Accordingly, while not mandatory, best practice and compliance with (the mandated) Risk Assessments would be for drawings to include such items as: ○ <i>fire detection systems;</i> ○ <i>emergency lighting;</i> ○ <i>hydrants and dry or wet risers;</i>	Fire safety risks are missed due to insufficient drawings. Fire service response is impacted by insufficient drawing information.	(a) Site drawings will include fire safety measures (b) The updated drawings will be displayed adjacent to the fire panel within premises. (c) The updated drawings will be displayed in the entrance to each premises.

	- o <i>suppression systems including sprinklers and dampers; and</i> - o <i>any high-risk areas / hazards.</i> Drawings included compartmentation, fire doors and escape routes, but not the above items. The drawings were also limited to the building interiors. At the time of the audit, site plans were not available detailing external hydrants or hazards within the site perimeter e.g. a hydrant at Merthyr workshops, and gas cylinder storage adjacent to ambulance parking at Beacon House. Risk Assessments were stated at the Fire Safety Policy to be refreshed five yearly "<i>in the absence of significant change</i>". There was therefore a need to trigger drawing and risk reviews following building alterations and / or review the frequency of renewal. Management advised that new site drawings were in preparation to address these matters. Coupled with this need, there was also scope for review of the Policy (noting its pending renewal), in liaison with consultants to ensure appropriate inclusions at drawings. At the time of publication of this report, management had provided evidence that drawings had been updated at 26 premises. These had been prioritised to ensure all larger premises, and those core to operations had been updated. These will displayed adjacent to the fire panel and may also be displayed in the entrance to each premises as per the Fire Risk Assessment guidance. The remainder of Trust premises were in process of being addressed.		Expected Evidence of Implementation: (a) Updated site drawings including fire safety measures (b) The updated drawings (including fire safety measures) will be displayed adjacent to the fire panel within premises. (c) The updated drawings (including fire safety measures) will be displayed in the entrance to each premises.
	Theme: Risk Management	Medium Priority	Officer: Assistant Director of Capital & Estates Date: November 2026
4	Monitoring landlord and tenant responsibilities For leased premises, any deficiencies in performance of landlord responsibilities were identified within Fire Risk Assessments. However, these were generally only refreshed every five years. It was not stated within the Risk Assessments as to whether they were based on typical responsibilities or assessment of the specific lease agreements. Operational monitoring arrangements do not currently detail landlord and tenant responsibilities (in accordance with the leases).	Control Operation	Agreed Management Action: Our appointed Fire Consultants are advising on this issue and will assist us in ensuring that landlord and tenant responsibilities are clearly delineated for properties not owned by the Trust. Expected Evidence of Implementation: Delineation of landlord and tenant responsibilities for properties not owned by the Trust at Fire Safety Group and Annual Fire Safety Report.

	Management advised that this matter was in process of being addressed.	Medium Priority	Officer: Assistant Director of Capital & Estates Date: November 2026
	Theme: Contractual	Control Operation	
5	Annual reporting <i>Priority ratings</i> Reporting showed proportions of high, medium and low risk premises. It also reported that 2/3rds of recommendations at the Risk Assessments were denoted as actioned. However, it was not possible to determine whether the urgent (red) issues relating to high or medium risk premises had been actioned. <i>Maintenance</i> The Policy requires appropriate maintenance of fire safety systems to be evidenced. However, associated performance was not summarised at the annual Fire Safety Compliance Report.	Reporting does not sufficiently inform management of risks to optimise mitigating actions.	Agreed Management Action: We will ensure that the Fire Safety Compliance Report includes both maintenance and a grid of prioritised actions at High, Medium and Low risk premises.
			Expected Evidence of Implementation: Publication of the Fire Safety Compliance Report including both maintenance and a grid of prioritised actions at High, Medium and Low risk premises.
		Medium Priority	Officer: Assistant Director of Capital & Estates Date: February 2027
	Theme: Reporting	Control Operation	

Overview / Summary of Observations

The Fire Safety Policy requires Local Fire Incident Co-ordinators (LFICs) to initiate the local fire emergency action plan. Similarly, a requirement is placed on Fire Safety Wardens for local application of the Fire Safety Policy.

Local systems were tested at walk arounds undertaken at five (of 117) sample premises. These were selected to include a mix of office premises with landlords (Vantage House and Matrix One), and ambulance stations with both external and integral ambulance parking (Beacon House – Cwmbran, and Merthyr respectively). The Merthyr fleet workshop was also sampled, being a single point of failure for the Trust ambulance support (as noted at the Fire Safety Policy).

Fire Wardens were in place at each of the five sampled premises. An appropriate range of in-date (tested) extinguishers were in place at these premises with appropriate exit and emergency door signage. With a single exception, all equipment was PAT tested, and fire exits were clear of obstruction. There were also contracts in place assuring maintenance of alarm and suppression systems and associated records. Local issues were found to be appropriately logged and escalated via an on-line reporting system via the Fire Wardens.

Fire drills are not required by the Fire Safety Order. However (externally commissioned) Fire Risk Assessments have stipulated the need for annual drills. The Fire Safety Policy recognises the need for regular drills and also notes the need for these to cover all shifts. Monitoring reports did not include reference to shifts and showed that annual fire drills remained to be undertaken at some premises.

A range of issues were found at audit walk around including several key matters at the 999 call centre, and issues of accessing a fire hydrant at the fleet workshop (both key facilities to Ambulance operations). Prior audits had highlighted matters such as the need to complete logbooks (recording fire drills, and equipment inspections etc). The current audit found recurrence of these issues and also noted the need for Fire Warden training to include building specific tasks such as log-book completion. The issues found at premises visited had not been raised by fire wardens (see **site observations**). There was also a need to specify / better specify evacuation procedures at the entrance to premises (continuing failure to comply with the requirements of the Fire Safety Policy at 40% of premises visited). As noted previously, there was additionally a need to ensure that sufficient and trained Fire Wardens and Local Incident Co-ordinators were in situ at all premises. Noting the number of sites and control issues, it was evident that communication and devolved control were key issues.

While recognising controls in place, noting the range and quantum of issues identified in a limited sample, **limited** assurance has been determined in relation to the application of procedural/policy requirements at Trust premises.

Key Findings	Risk & Impact	Agreed Management Action
Site observations At fleet workshops in Merthyr, prior to the audit the location of the fire hydrant was not immediately apparent, being both obscured and obstructed by parking (though a required plaque was in place at the main premises indicating its location). It was also absent from site drawings and therefore not shared with the Fire Services.	As assessed below	N/A - see sections below

At Vantage House, fire safety issues were apparent during the audit walk around e.g. non fire rated doors to two electrical cupboards labelled as fire doors (on the main corridor), gaps around cabling and cardboard storage in the cupboards. While maintenance of these doors and cupboards was a landlord responsibility, the deficient fire doors were an apparent risk for staff at the premises. A third electrical cupboard (Trust responsibility) had exposed wiring from a connector (lacking a cover). While the more general responsibility to identify risks rests with the expert Risk Assessments, it is noted that these are only renewed every five years. The observed matters are also relevant to obtaining appropriate landlord assurances (also see Finding 4 - Monitoring of landlord and tenant responsibilities). The above issues had not been raised by fire wardens (also see Finding 6 - Fire Warden / Local Incident co-ordinators).		
6 Fire Warden / Local Incident co-ordinators Coverage <i>Local Fire Incident Co-ordinators (LFIC)</i> LFICs were defined at the Fire Safety Policy as being responsible for overseeing all on-site emergency responses. The LFIC were typically the most senior manager for an area <i>"who have the necessary operational training to manage incidents"</i>, as listed by the Estates and Operations Departments. However, a system / list of Local Incident Co-ordinators assuring shift cover was not in place to provide clarity as to such expectations. <i>Fire Wardens</i> As previously noted, the annual Fire Safety Report noted the need to appropriately train Fire Wardens. Good practice was noted in the increase in Fire Warden training in recent years (from 158 officers in March 2024 to 276 by September 2025). The Fire Safety Policy assigns, Fire Wardens the key operational role for local fire controls. The annual report further states that: <i>"a suitable number of persons should be trained to ensure that adequate cover is provided in the event of an</i>	Fire Wardens are not appropriately trained impacting operational fire safety controls.	Agreed Management Action: We will therefore look to confirm full shift coverage of trained Fire Wardens for all premises, and Local Incident Co-ordinators at clinical contact centres and larger ambulance stations in accordance with the revised Fire Safety Policy with reporting via the Fire Safety Group. Expected Evidence of Implementation: Confirmation of full shift coverage of trained Fire Wardens at all sites and Local Incident Co-ordinators in accordance with the revised Fire Safety Policy via reporting to the Fire Safety Group.

	<i>evacuation for "every operational hour" and available 24 hours a day. A full list of trained site-specific Fire Warden's should be prominently displayed on site".</i> Fire Warden coverage remained to be put in place for 6 (of 48 Trust owned) premises (117 premises in total). Similarly, a theme at the commissioned Risk Assessments was the absence of Fire Warden lists at the entry to premises (though this was in place at three of the five tested premises). (see also Validation of Management Actions – Outstanding Action - Training – at Objective 1). Management have commented that: • A member of the Senior Estates Team attends monthly/quarterly operational team meetings (e.g. South East Formal Business Meetings, Local Integrated Partnership Forum - all regions), Quarterly Fire Safety Group) which allows us to provide updates in relation to Fire Warden training, advise of sites where more Fire Wardens are required and provide an update on annual fire drills completed/outstanding. It's also an opportunity to discuss any fire incidents that have taken place and any notable actions brought to the team once site-specific fire risk assessments have been completed. • Fire compliance information is now monitored and updated monthly and captured in an estate's presentation for cascading to the operational team meetings. This will allow enhanced reporting of high risks taken directly from the Fire Risk Assessments to be shared with senior management, the fire safety group and at numerous operational briefings.		
	Theme: Training & Development	Medium Priority Control Operation	Officer: Assistant Director of Capital & Estates Date: February 2027
7	Fire Logbook The Fire Safety Policy states that records of fire tests, drill and false alarms etc. will be held in the Fire Logbook located at all Trust premises and be reported to the Estates Helpdesk Fire Logbooks were not comprehensive across tested sites, though were supplemented by Estates records. In the case of Matrix One, records of fire exits, and maintenance were sought by the Facilities Manager (Deputy Fire Safety Manager) from the landlord to inform the audit.	Incomplete records and monitoring permit incomplete controls	Agreed Management Action: (a) Required inclusions within local logbooks, and local records to be provided held centrally will be clarified within the Fire Safety Policy including those to be held / provided by landlords. (b) Fire Warden and Local Incident Co-ordinator training will include reference to the Fire Safety Policy and the need to implement associated local procedures and local actions arising from Fire Risk Assessments and audit.

	Similarly, rotational testing of alarms was not evidenced in three of the five premises visited and flick testing was not recorded. Other local matters included the need for fire safety labels on soft furnishings (not provided at three of the four tested premises with such furniture) <i>(in accordance with Furniture and Furnishings [Fire Safety] Regulations 1988/1989, 1993 and 2010)</i>. There was therefore a need to review instructions and training in relation to completion of Fire Logbooks together with central monitoring of the same. As noted, in context, many of the records were variously available e.g. from electronic records or landlords but not facilitated by fully documented local logs. Noting the potential for duplication and omission, management could review the core content required locally and defined accordingly within the Fire Safety Policy.		Expected Evidence of Implementation: (a) Required inclusions within local logbooks and local records to be provided held centrally will be clarified within the revised Fire Safety Policy. (b) Inclusion within Fire Warden and Local Incident Co-ordinator training of reference to the Fire Safety Policy and the need to implement associated local procedures and local actions arising from Fire Risk Assessments and audit.
	Theme: Risk Management	Medium Priority Control Operation	Officer: Assistant Director of Capital & Estates Date: August 2026
8	Evacuation procedures The Fire Safety Policy states that <i>"each building is legally required to have a written evacuation procedure on display in the front entrance of the building near to the entrance or reception"</i>. Risk Assessments had documented that sufficient notices were not in place for two of the five tested premises (Beacon House, and Merthyr Workshops). The Facilities Manager described the evacuation procedures as being universal across the Trust - to simply exit the premises, with the Local Fire Incident Co-ordinator / lead Fire Warden conducting a sweep of the premises to confirm full exit. Accordingly, the need for instruction at entry to premises would be minimal but should include specific reference to assembly points. However, the approach was not defined within the central procedures, and it was unclear as to whether issues raised at the risk assessments had been satisfactorily resolved. There was also some disparity between this approach and certain local implementations where signing-in logs had also been reviewed in test exits.	Unclear evacuation procedures result in sub-optimal exit.	Agreed Management Action: (a) Evacuation procedures will be clarified within the Fire Safety Policy including requirements for exit signage e.g. as in accordance with British Standards and detailing local assembly points. (b) We will ensure the placement of appropriate evacuation procedures within buildings. Expected Evidence of Implementation: (a) Updated evacuation procedures within the Fire Safety Policy. (b) Placement of appropriate evacuation procedures within all buildings.

	At the time of publication of this report, management had provided evidence that a first tranche of 26 prioritised sites (including those with the largest floor areas) had been surveyed, with plans drawn up for means of escape, fire-fighting equipment and assembly points determined. These will be posted within each building by the end of May 2026. The remaining sites have been commissioned and the surveying process commenced (see also Finding 3 above).		
	Theme: Risk Management	Medium Priority	Officer: Assistant Director of Capital & Estates Date: (a) August 2026 - see finding 1 (b) June 2026
9	Fire Drills The Regulatory Reform [Fire Safety] Order 2005, requires that: <i>"The responsible person must establish and where necessary, give effect to appropriate procedures, including safety drills."</i> To accord with this, the Fire Safety Assessments (external assessor) recommended that fire drills should be undertaken as a minimum, annually. The Fire Safety Policy also noted the need for multiple drills at each premise for shift coverage. Good practice was evidenced at all five premises tested at this audit with in-date fire drills and monitoring reported at the Fire Safety Group. However, it was reported to the January 2026 Fire Safety Compliance Group that 19 sites (of the 48 Trust owned sites) remained to complete an annual fire drill, with a further 6 to be scheduled at landlord owned sites – circa 40%). Such monitoring related only to one annual drill per premise (not additionally for each shift). It also excluded small / rented office type premises with limited / occasional staffing. Management advised that this was to be reflected in the updated Fire Safety Policy. The 2025 Fire Safety Compliance Report stated that <i>"annual fire drills have now been added to the 3i Studio CAFM system and an annual planned preventative maintenance (PPM) task will be raised to prompt all site responsible persons that they</i>	Procedures are not appropriately tested risking safety errors in live evacuation.	Agreed Management Action: We will ensure annual Fire Drills for each shift within clinical contact centres and annually at all premises. Expected Evidence of Implementation: Reporting of full annual fire drill compliance for each shift within clinical contact centres and annually at all premises.

<i>need to complete their annual drill". It stated that drills were "being completed at larger sites but not historically at smaller Ambulance Stations" e.g. including road site facilities and small office rentals. Management further advised that the audit that the issue largely related a need to recognise a multi-tier requirement (based on risk) within revised procedures.</i>		
	Medium Priority	Officer: Assistant Director of Capital & Estates Date: August 2026
Theme: Risk Management	Control Operation	

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.

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



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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 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 Welsh Ambulance Service Trust. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.





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Agenda Item No. 11

REPORT TITLE

Internal Audit Report – Vehicle (Ambulance) Replacement Programme – ARAC Feedback

MEETING

Name of meeting	Finance and Performance Committee
Date of meeting	21 July 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Lee Brooks, Executive Director of Operations
Author(s) of report	AnnaMaria Williams, Corporate Governance Officer

PURPOSE OF REPORT

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

REPORT SUMMARY

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

1. The Audit Risk and Assurance Committee (ARAC) received and discussed the **Vehicle (Ambulance) Replacement Programme** Internal Audit Report at its meeting on 23 June 2026. This report summaries the discussion from that meeting in reference to this report.
2. Felicity Quance, NWSSP Internal Audit, presented the Vehicle (Ambulance) Replacement Programme Internal Audit Report, which received an overall rating of **reasonable assurance**. Members noted that the programme was supported by a Board-approved five-year procurement strategy, with strong governance, financial oversight and well-established funding



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arrangements in place. Of the 142 vehicles planned for procurement during 2025/26, 141 had been procured, with the remaining vehicle formally removed from the programme. The audit identified two medium-priority findings relating to project documentation and strategic performance reporting, whilst also highlighting the need to ensure risks associated with electric vehicle infrastructure capacity were appropriately reflected within programme risk registers. Management had accepted all recommendations and agreed implementation timescales.

3. Chris Turley welcomed the reasonable assurance rating and noted that the findings reflected a well-established and mature programme supported by strong governance arrangements. Chris advised that the scale of vehicle procurement activity had increased significantly in recent years as a result of additional Welsh Government investment and confirmed that management accepted the recommendations. Chris stated that the actions identified were relatively minor, building on previous work already underway, and was confident that they would be implemented and closed promptly. Chris also welcomed the assurance provided across all areas of the audit review.
4. The Chair welcomed the positive audit outcome and noted that, in his view, the report reflected a high level of assurance. The Chair acknowledged the significant increase in vehicle procurement activity during the year, recognising the additional complexity and workload associated with the expanded programme, and thanked Chris Turley and the wider team for their continued delivery and reporting to the committee.

RECOMMENDATION(S)

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

The committee is asked to:

- (a) note the discussion and feedback from ARAC
- (b) review the report, noting the agreed management actions and mitigations of risk in the area of the report

The committee will have an opportunity to monitor the closure of these actions and scrutinise impact of those actions in response to audit recommendations via tracker reports and future assurance reporting on this issue.

ADDITIONAL PAPER(S)

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

The committee is requested to receive the following:

- **Annex 1** Vehicle (Ambulance) Replacement Programme Internal Audit Report



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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

☒ SO1: Providing the right care or advice, in the right place, every time	☒ SO2: Enabling our people to be the best they can be
☐ SO3: Being at the forefront of innovation and technology	☒ SO4: Developing services in collaboration
☒ SO5: Being quality driven and clinically led	☒ SO6: Delivering exceptional value

RISK(S) THIS REPORT MITIGATES

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

n/a

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

☒ Safe	☒ Timely	☒ Effective
☐ Efficient	☒ Equitable	☒ Person Centred

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

☒ Leadership	☒ Workforce	☐ Culture
☒ Information	☐ Learning Improvement & Research	☒ Whole Systems Approach

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

☒ A socially responsible and inclusive employer	☒ An innovative and sustainable organisation	☒ A pro-active, accessible and equitable care provider
☐ n/a	☐ n/a	☐ n/a

IMPACT ASSESSMENTS FOR CONSIDERATION

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

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

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
23 June 2026	Audit, Risk and Assurance Committee

Vehicle Replacement Programme

Final Internal Audit Report

2025/26

Welsh Ambulance Services University NHS Trust



Reasonable Assurance

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Review Reference

Fieldwork

Executive Sign Off

Audit Committee

Executive Lead

Audit Team

WAS-SSU-2526-19

March - April 2026

26 May 2026

23 June 2026

Chris Turley, Executive Director of Finance and Corporate Services

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



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Audit and Assurance Services



Executive Summary

Purpose

Recognising the Welsh Government's prioritised capital funding provision allocated to the Ambulance Replacement Programme (£20m for 2025/26), this audit evaluated the processes and procedures established by the Trust to support effective management and control of its fleet replacement arrangements. This includes emergency and non-emergency ambulances, as well as specialist support vehicles.

The audit also incorporated follow-up work on previously agreed actions arising from the Vehicle Replacement Programme review undertaken in 2023.

Overview

The Trust is operating under an approved five-year Vehicle Procurement Strategy (VPS), developed through structured engagement with operational staff. Feedback from this engagement has informed vehicle design, procurement decisions, and strategic priorities, with the VPS approved by the Trust Board.

The VPS forms part of a wider fleet modernisation programme running to 2030 and is designed to modernise the fleet, improve vehicle reliability, support clinical transformation, and progress the Trust's decarbonisation objectives. The document sets out a structured, evidence-based investment plan supported by defined governance and financial arrangements, intended to deliver the vision set out in the Trust's Strategic Outline Programme.

The Vehicle Replacement Programme is currently in Year 1 (2025/26) of the five-year VPS and covers Emergency Ambulances (EAs), Solo Responder Vehicles (SRVs), Non-Emergency Patient Transport Service (NEPTS) vehicles and specialist operational vehicles. Alignment with evolving clinical models, including Cymru High Acuity Response Unit (CHARU), Advanced Paramedic Practitioner (APP) roles and growing community-based care pathways, remain key drivers for both the VPS and Vehicle Replacement Programme.

During 2025/26, the Trust planned to procure 142 new vehicles to strengthen frontline operational resilience; with 141 having been procured by the end of the financial year (noting one vehicle was formally withdrawn from the programme). Procurements were delivered through a combination of Crown Commercial Service (CCS) frameworks and competitive tendering routes, with support from NWSSP Procurement Services. The Programme is undertaken in two key stages: (1) acquisition of vehicle chassis from selected manufacturers; and (2) conversion required to meet the Trust's operational specifications. Of the vehicles procured, 56 are operational with the remainder at different stages of build and conversion. Deliveries have intentionally been staggered to reflect capacity limitations at the vehicle workshop, with appropriate contractual arrangements in place for those awaiting delivery and acceptance by the Trust.

Overall **reasonable** assurance has been determined. The processes for managing and requesting funding for vehicle replacement are mature and well understood by programme staff. Governance, financial monitoring and procurement controls are operating effectively, with the Programme currently delivering within budget and agreed timescales. While improvements are required in relation to documentation clarity, strategic reporting and risk completeness, these issues are not considered to undermine the overall effectiveness of programme management arrangements. The matters raised for management attention include:

- A review of the Project Initiation Document (PID) is required to ensure full compliance with PRINCE2 principles, as previously raised and accepted by management in the 2023/24 Vehicle Replacement Programme audit (issued February 2024: reasonable assurance). In particular, the PID does not clearly outline end-stage reporting requirements, nor does it explain how specifications are approved from start to finish, or who is responsible for talking to suppliers, negotiating costs, or agreeing prices; and
- Inclusion within the Business Justification Case of a comparison between investment to date and the Strategic Outline Programme, alongside variance analysis and commentary on vehicle numbers – an area previously raised and accepted by management in the 2023/24 audit report.

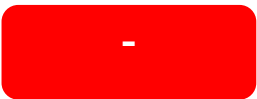
Full details of matters arising are detailed within the Findings & Agreed Action Plan. During the course of the audit fieldwork, we also noted that whilst a risk relating to electrical vehicle infrastructure capacity was recorded on the Decarbonisation risk register and the Transport Project Board risk register,

given its alignment with the programme, we would expect it to be captured on the project risk register too. We have highlighted this for management information, and it does not impact the overall opinion.

Scope & Assurance Summary

Objectives	The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.	Related Findings	Assurance
1	There is an established and approved strategy to the overall replacement programme, integrated with the approved Integrated Medium-Term Plans and annual plans. Assurance that decarbonisation and other emerging priorities have been adequately assessed within the strategies.	-	Substantial
2	To confirm appropriate programme management arrangements including client defined client requirements, adoption of project management tools, and commissioning arrangements.	1	Reasonable
3	The procurement of vehicles (and adaptation) complies with established local and national procurement requirements.	-	Reasonable
4	Appropriate financial monitoring and reporting arrangements are in place, including monitoring of in-year expenditure and overall budget.	2	Reasonable
5	The previously agreed recommendations (SSU-WAST-2324-01, issued February 2024, reasonable assurance) have been appropriately actioned by management.	1, 2	Reasonable

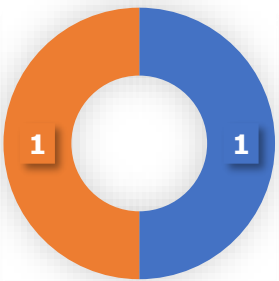
Management Actions



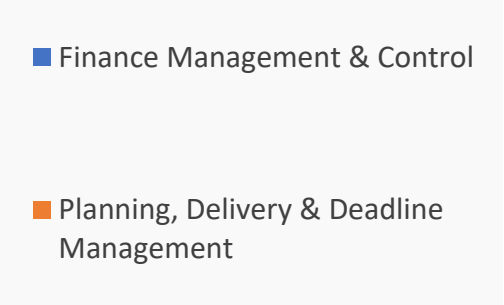
High Priority



Medium Priority



Themes



Risk Types

Quality or Safety Issues
Financial Loss

At A Glance: Vehicle Procurement 2025/26

Status of the approved vehicle procurement requirement, as at the date of reporting, is set out in the following table:

Categorisation of vehicle	Required	Procured	Operational	Status of remaining vehicles
Emergency Medical Services (EMS)	44	44	42	2: delivery imminent.
Fleet	3	3	2	1: conversion progressing with delivery imminent.
Occupational Health	2	2	-	2: vehicles have been converted; user training to be progressed before going into service.
Hazardous Area Response Team (HART)	1 ¹	-	-	-
Ambulance Care (large)	65	65	-	4: communications installed but some functionality issues with battery management side of the vehicles noted so reconfiguring the parameters and processes to ensure they perform in service. 28: at dealership for pre-delivery inspection and registration. 33: at various stages of build.
Ambulance Care (small)	13	13	-	13: at dealership for pre-delivery inspection and registration and waiting delivery logistics to the commissioning centre.
Rapid Response Vehicle (RRV)	12	12	12	-
Training	2	2	-	2: at dealership for pre-delivery inspection and registration; and dealership fitments.
	142	141 ¹	56	

¹ The HART command and control vehicle was formally withdrawn from the 2025/26 programme, following approval by the Fleet and Strategic Development Groups (FSDG) – see objective 3.

Findings & Agreed Action Plan

Objective 1: There is an established and approved strategy to the overall replacement programme, integrated with the approved Integrated Medium-Term Plans (IMTP) and annual plans. Assurance that decarbonisation and other emerging priorities have been adequately assessed within the strategies.	Substantial
--	--------------------

Strategic Planning and Approvals

The Trust’s five-year Vehicle Procurement Strategy (VPS) for 2025-30 was approved by Welsh Government on 31 January 2025. It sets out a needs-led and prioritised programme for vehicle replacement, supporting both fleet sustainability and wider clinical transformation objectives. The Strategy was developed through appropriate engagement with operational stakeholders and aligns with the Trust’s Delivery Excellence framework and the IMTP. The VPS responds to evolving Emergency Medical Services (EMS), Non-Emergency Patient Transport Service (NEPTS) and specialist services, including consideration of rural service delivery requirements and evidence-based assessment of fleet reliability risks.

The Year 1 (2025/26) capital requirements were incorporated directly within the VPS, mitigating the need for a separate Business Justification Case (BJC) for that year. Welsh Government approved capital funding of £22.542m on 12 March 2025, to support the replacement of 142 vehicles, with the approval letter stating that the funding is available for drawdown over the period 1 April 2025 to 31 March 2027.

The VPS recognises the need to support ongoing clinical and operational transformation, including expansion of rapid response and Specialist Response Vehicle (SRV) models, enhanced in-vehicle clinical environments, and the development of new and evolving care pathways supporting mental health, falls and frailty, palliative care and rural-based service delivery. It also reflects evolving operational requirements across NEPTS, transfer and discharge services, and specialist operational functions.

An IMTP-led Fleet Review, completed in February 2026, informed vehicle optimisation requirements and design enhancements, including improvements to ergonomics, storage capacity and dementia-friendly features within emergency ambulances. Such are intended to be incorporated into future BJCs submitted to Welsh Government, in line with principles and directions set out within the VPS.

Decarbonisation and Emerging Priorities

Being cognisant that fleet activity accounts for approximately 80% of the Trust’s total carbon emissions, the VPS is aligned with the NHS Wales Decarbonisation Delivery Plan 2021–2030 and the Trust’s Decarbonisation Action Plan (DAP). The Strategy supports projected emissions reductions of 16% by 2025 and 34% by 2030. Planned investment includes increased deployment of hybrid and electric vehicles, including trials of fully Electric Vehicle (EV) SRVs, expansion of site-based charging infrastructure, and operational practices designed to support Trust-wide carbon reduction targets.

We recognise that significant challenges remain in relation to charging infrastructure capacity across Trust sites. As a result, vehicle relocation is sometimes required to ensure EVs can be accommodated within available charging capacity. This issue is recognised by management as an organisational risk and is intended to be escalated to the corporate risk register following completion and review of EV trial reports. At the time of the audit, this risk was not recorded within the project risk register (see *Objective 2*).

Objective 2: To confirm appropriate programme management arrangements including client defined requirements, adoption of project management tools, and commissioning arrangements.

Reasonable

Client Requirements

The process for managing and requesting funding for vehicle refresh is mature and well understood by those involved in the Programme. This includes a clear understanding of whole-life vehicle costs and recognition that maintenance and retention costs increase significantly once manufacturer warranties expire, reinforcing the need for timely replacement decisions.

The Programme is overseen by an experienced National Fleet Manager, with day-to-day operational management of the procurement activity undertaken by a dedicated Project Manager. This is supported by specialist procurement officers and appropriate administrative support, providing a sound governance and delivery structure.

Project Management

Section 4.1 of the Project Initiation Document (PID) for Year 1 (2025/26) of the Vehicle Replacement Programme states that '*WAST will use a tailored project management methodology based on Projects in Controlled Environments (PRINCE2)*', with elements applied as deemed appropriate to the Programme.

A range of core project management controls are in place and operating effectively, providing an appropriate level of oversight. These include an approved project plan, maintained risk, issues and decisions registers, and established reporting and governance arrangements. The programme remains on track, with limited and managed slippage relating to NEPTS Large vehicles and one specialist workshop van conversion.

However, our review of the PID identified that gaps remain in demonstrating full compliance with PRINCE2 principles, consistent with findings raised in the previous audit (see *objective 5 – refs 1.1, 3.1 and 4.2*). Specifically, weaknesses remain in relation to end-stage reporting arrangements, clarity over specification approval processes, and the explicit delineation of roles and responsibilities for commercial and procurement-related decision-making (see **Key Finding 1**).

Risk Management

Review of the project risk register confirmed that, for risks currently captured (predominantly rated as low), appropriate mitigating actions are in place. Ongoing monitoring and oversight are evident, including continued management attention on: (1) ICT capacity and service continuity risks; and (2) residual delivery risks associated with slippage in NEPTS Large vehicles and the specialist workshop van. A risk relating to EV charging infrastructure capacity across Trust sites is not currently captured within the project risk register, representing a gap in formal project-level risk management. However, management has advised that the risk is being managed through the Decarbonisation Programme Board and is expected to be escalated following review of the EV trial outcomes. At present, the risk is recorded on the Decarbonisation risk register, the Transport Project Board risk register and the EV Infrastructure Project RAID (Risks, Assumptions, Issues and Dependencies) log but there is an expectation that the project risk register should reflect the same.

Commissioning

Robust commissioning arrangements are in place. Detailed inspections are undertaken by the Trust's fleet vehicle commissioning officers at the Merthyr Workshop, with engagement from clinical and operational representatives where appropriate, prior to vehicles being formally accepted into service. This ensures required fittings and equipment (for example, straps and fixtures) are consistently installed, minimising the need for remedial work post-delivery. Management advised that serious defects in Emergency Ambulances (EAs) are rare. At the date of reporting, 32 of the expected 44 EAs for 2025/26 had been successfully commissioned and were operational; with the remaining 12 going through the commissioning process.

Key Findings		Risk & Impact	Agreed Management Action
1	Project Initiation Document (PID) – PRINCE2 Compliance Review of the PID identified that gaps remain in demonstrating full compliance with PRINCE2 principles, consistent with findings reported in the previous audit. While key parties are identified, the PID does not include a clear, end-to-end specification approval workflow. Management previously agreed to enhance the specification agreement through the development of a visual process map; however, evidence of this has not been provided. In addition, although the PID identifies procurement and project roles and recognises NWSSP Procurement Services as the procurement lead, it does not explicitly define responsibility for commercial dialogue, cost negotiation or supplier pricing discussions. The separation of roles between procurement (commercial responsibility) and project officers (technical responsibility) is implied but not formally documented.	Failure to clearly document approval workflows and delineation of commercial responsibilities weakens project governance and may expose the Trust to avoidable commercial, financial, and assurance risks.	Update the PID to fully align with PRINCE2 principles by: - Documenting a clear, end to end specification approval workflow supported by a visual process map, which defines key stages, roles, approval points, and escalation routes. - Formally defining and documenting roles and responsibilities for procurement and project staff, explicitly distinguishing between commercial responsibilities and technical responsibilities.
		Medium Priority	Expected Evidence of Implementation: Updated version of the PID (2027/28 programme onwards) with explicit inclusion of an end-to-end specification approval workflow; and clearly defined roles and responsibilities for procurement and project staff.
	Theme: Planning, Delivery & Deadline Management	Control Operation	Officer: Andrea Davies, Project Manager / David Holmes, National Fleet Manager Date: May 2027 (subject to funding approval and associated timescales)

Objective 3: The procurement of vehicles (and adaptation) complies with established local and national procurement requirements.

Reasonable

Procurement Approach

Procurement activities for the Vehicle Replacement Programme comprise the sourcing of vehicle chassis and the procurement of fit-out and conversion services across a range of vehicle types. The largest element relates to emergency ambulances, with total conversion and equipment costs of approximately £10.49m, for which the Trust has historically utilised a preferred supplier.

During 2025/26, the Trust planned to procure 142 vehicle chassis through the Crown Commercial Services (CCS) Framework. Of these, 44 chassis were for EMS vehicles. The planned procurement of a Hazardous Area Response Team (HART) command and control vehicle was formally withdrawn from the 2025/26 programme, following approval by the Fleet and Strategic Development Group (FSDG) reducing the number of vehicles to 141. The associated funding was returned to contingency and along with project underspends, enabled the advance purchase of 22 vehicle chassis originally planned for the 2026/27 Vehicle Replacement Programme, secured at 2025/26 prices. This approach mitigated the impact of anticipated inflationary pressures and was approved by both the FSDG in October 2025 and Welsh Government in November 2025.

The Procurement Strategy is based on a purchase-only model. Competitive tendering was pursued for conversion and equipment supply, with appropriate approvals from both the Trust Board and Programme Board in line with delegated financial limits (see objective 5 – ref 5.1). NWSSP Procurement Services led commercial oversight and “All-Wales” procurement elements, providing assurance of compliance with national procurement requirement.

Technical evaluation of bids was undertaken by the Vehicle Working Group, with parallel scoring conducted by NWSSP Procurement Services (see **Key Finding 1**). A combined evaluation outcome was then agreed. Evaluation criteria were applied consistently and transparently in accordance with framework, pre-tender estimates and tender documentation.

For 2025/26, the Trust was already in-contract for EA and SRV conversions. New contracts were competitively tendered and awarded for the conversion of the Ambulance Care / Large NEPTS vehicles. Specialist occupational health vehicles, fleet workshop vehicles, and small NEPTS vehicles were awarded via the national ambulance vehicle conversion framework hosted by Southeast Coast Ambulance Service NHS Foundation Trust (SECAMB). Pre-build meetings were held with successful suppliers to confirm and validate that agreed specifications would be fully met prior to manufacture.

Contracts and Warranties

In light of the high-rated finding raised in the 2023/24 audit regarding contract approval and compliance with Standing Financial Instructions (SFIs) (see *Objective 5 – ref 5.1*), we reviewed the operation of the revised approval arrangements. Purchase Orders relating to all sampled chassis and conversions purchases were evidenced as being approved by Trust Board and Programme Board in line with delegated limits and procurement requirements.

We note that contractors are responsible for the safe storage and insurance cover for the period of time vehicles are at their assigned location until such time that the vehicles are completed, delivered to, inspected and accepted by the Trust.

Chassis warranties are provided through standard manufacturer warranties included under CCS framework agreements, with extended warranties specified within supplier quotations where applicable. Conversion warranties are set out within tender specifications and contract award documentation rather than on individual purchase orders. No significant warranty disputes have been identified in recent periods.

The long-term and annual budgets for the Vehicle Replacement Programme were formally approved through business case processes. For 2025/26, Welsh Government agreed an alternative approval approach whereby a separate BJC was not required (see *Objective 1*). This reflected the maturity of the programme and the prior approval of the overall funding envelope through the VPS.

As reported in our previous audit (refer to *Objective 5 – ref 6.1*), there is an expectation that progress against the Strategic Outline Programme (SOP) is demonstrable, including comparative analysis of planned versus actual vehicle numbers and associated financial values. Review of the 2026/27 BJC confirmed that while it aligns to the VPS and clearly articulates the strategic and operational justification for planned investment, it does not include a stage evaluation of investment to date against the SOP. This limits visibility of cumulative progress and variance analysis (see **Key Finding 2**).

Internal Governance and Financial Monitoring

The Vehicle Procurement Project Team meets on a monthly basis and reviews budget utilisation, forecast spend, supplier quotation, Purchase Order progression, vehicle delivery, commissioning and receipting. This provides operational-level oversight and supports early identification of financial and delivery risks.

A structured contingency is retained within the programme to mitigate identified risks, such as inflationary pressures and specification change. The withdrawal of the (HART) vehicle requirement released funding back into contingency. In addition, WG supported advance purchasing of chassis enabling the Trust to mitigate inflationary risk by securing vehicles at 2025/26 prices.

Monthly reporting to the FSDG provides Programme Board-level oversight and enables ongoing monitoring of expenditure against approved budgets. Delivery of vehicles planned for 2025/26 remain on track, including SRVs, EMS ambulances, NEPTS small vehicles, driver training vehicles, workshop vehicles and Occupational Health vehicles, with increased commissioning activity from February 2026.

As the time of audit fieldwork, FSDG reporting identified two amber-rated areas due to potential delivery slippage: (1) HART responder vehicle (awaiting chassis), subsequently withdrawn from the programme as noted above; and (2) NEPTS Large vehicle conversions, which may extend into the 2026/27 financial year.

Programme financial performance is also reported to the Capital Management Board (CMB) on a bi-monthly basis and to the Capital Management Group on a monthly basis, providing wider corporate oversight of capital expenditure and financial control.

External Oversight

Bi-monthly status reports are submitted to WG and considered through the All Wales Capital Programme meetings, supporting external assurance over in-year monitoring against the approved cost envelope. Cumulative expenditure of £6.757m to January 2026 reconciles to the Capital Resource Limit (CRL), demonstrating that, at the time of review, the Programme remained within approved budget and agreed timescales.

Key Findings		Risk & Impact	Agreed Management Action
2	Incomplete Strategic Outline Programme (SOP) Variance Analysis The 2026/27 BJC demonstrates strong alignment with the VPS and clearly articulates the strategic and operational justification for the planned investment. It does not include the expected comparison of cumulative investment to date against the SOP, nor does it provide variance analysis or commentary for planned versus actual vehicle numbers or associated financial values. We recognise, however, that the BJC was approved in November 2025, part way through the 25/26 programme delivery, therefore the full delivery provision was not yet known at that stage. Variance analysis should be appropriately reflected in a programme closure report, alongside an overall assessment of delivery. For transparency, a summary of progress and key variances should then be incorporated into the 2027/28 BJC.	The absence of SOP-level variance reporting reduces transparency over cumulative programme performance and may limit the timely identification and escalation of overspend, underspend, or delivery slippage.	The Trust will continue to ensure that future Project Closure Reports include a clear comparison of cumulative investment to date against the SOP. These will also be considered as part of future BJCs, as appropriate, highlighting where there are any material variances when compared to the VP Strategy (noting that timescales for BJC development and formal Project Closure are not always aligned).
		Medium Priority	Expected Evidence of Implementation: 2025/26 Programme closure report (at which point this action will be closed off the audit tracker). - Revised BJC template / written guidance explicitly including the cumulative investment to date; vehicle numbers (planned vs actual); and financial variance analysis if material and applicable to do so.
	Theme: Finance Management & Control	Control Design	Officer: Andrea Daves, Project Manager / Ed Roberts, Project Accountant Date: December 2026

Objective 5: The previously agreed recommendations (SSU-WAST-2324-01, issued February 2024, reasonable assurance) have been appropriately actioned by management.

Reasonable

The table below summarises the recommendations included in the 2023/24 audit report and the status of each at the date of audit fieldwork. While management has made progress in addressing the majority of recommendations, particularly in relation to procurement strategy, contract approval processes, commissioning arrangements, and articulation of whole-life cost considerations within Business Justification Cases (BJCs). However, evidence provided did not fully support closure for four recommendations that were recorded as closed on the Trust's tracker, relating to project governance, documentation clarity, and strategic performance monitoring.

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Update and Audit Assessment
Project Management (Design)				
1.1	Project controls should be reviewed for appropriate compliance with Prince2 principles, including: - Effective representation of Supplier, Customer, and Executive roles within the project management structure. - Clear delegation of financial tolerances for stage and annual delivery. - Formal end-stage reporting to assess project controls, benefits realised and lessons learned.	Fleet SOP Delivery Group (FSDG) Chair and Project Manager 30 June 2024	Medium	Partially Implemented: Superseded - Management has confirmed that a robust governance structure is now in place, with clear representation across business, user and supplier roles. - The Trust has taken a deliberate decision, which is explicitly documented within the PID, not to delegate financial tolerances to the Project Manager. Any deviation from approved stage or annual delivery is therefore subject to formal escalation through established governance arrangements. - However, while the PID outlines end-of project reporting arrangements, it does not define the requirements for formal <i>end-stage</i> reports in line with the recommendation. In addition, no end-stage reports for 2024/25 were provided as evidence. Management advise that project slippage was experienced and the programme has yet to be formally closed. As a result, we are unable to support the closure of this element of the recommendation at this time (see Key Finding 1).
Optimal Procurement Quantity (Design)				
2.1	The benefit of additional vehicle purchases should be contrasted with the associated costs of retaining older vehicles within business justification cases.	Head of Financial Business Intelligence & Capital Planning	Low	Closed Annual BJCs are now the formal mechanism through which fleet numbers and vehicle types are validated. Review of the approved 2026/27 BJC demonstrates an improved narrative outlining the operational and financial consequences of

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Update and Audit Assessment
		and Project Manager 30 June 2024		retaining older vehicles. This includes high-level modelling of additional revenue costs associated with non-replacement. The BJC also presents and contrasts strategic options which inherently reflect the trade-off between additional vehicle purchases and continued retention. Additionally, the supporting Benefits Realisation documentation provides an economic and operational rationale for replacing over-age vehicles. Consequently, the audit is able to support closure of this recommendation.
User Sign Off (Operation)				
3.1	The process of agreeing vehicle specification should be clearly defined within the Project Initiation Document. This should include involvement of relevant parties such as the Vehicle Working Group and the Project Board, and explicit user sign-off of requirements and minimum performance specifications.	Project Manager 30 June 2024	Low	Superseded Relevant parties are identified within the PID; however, it does not include a clear, explicit, end-to-end specification approval workflow. Management previously indicated that agreement would be enhanced through the development of a visual process map, however, no evidence of this has been provided. As a result, the audit is unable to confirm that specification approval and user sign-off arrangements are sufficiently defined or consistently applied. Consequently, this element of the recommendation cannot be considered closed and is reported as superseded , with the underlying control intent remaining outstanding (see Key Finding 1).
3.2	Inspections undertaken by technical staff should be formally documented and communicated to the Senior Supplier, User, and commissioning leads as part of the quality acceptance process.	Project Manager 30 June 2024	Low	Closed Vehicle inspections are undertaken and formally documented by the Vehicle Working Group. Inspection outcomes are reported to the Senior Supplier, User, and commissioning leads as part of the quality acceptance process. Sufficient evidence was provided to demonstrate that this recommendation has been implemented as intended and can therefore be considered closed.

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Update and Audit Assessment
Procurement Strategy (Operation)				
4.1	The various aspects of the procurement strategy should include: (a) Enhanced narrative within the business justification case; and (b) Evaluation and approval by appropriate parties to confirm that it remains optimal (as detailed within the business case for approval) ensuring procurement and contractual arrangements deliver best value and align with strategic partnering objectives.	National Fleet Manager and Project Manager At future business case compilation (by December 2024)	Medium	Closed (a) Review of the approved 2026/27 BJC confirms a substantially improved narrative, clearly setting out the procurement rationale, strategic alignment, constraints, and delivery mechanisms. (b) Governance approvals and oversight arrangements are clearly evidenced. The Procurement Strategy adopts a purchase only model, with leasing explicitly ruled out due to bespoke nature of ambulance builds. The rationale for this approach is clearly articulated within both the PID and BJC. On this basis, the audit is able to support closure of this recommendation.
4.2	Duties for dialogue and negotiation relating to specification costs and pricing should be clearly delineated between procurement and project officers within the Project Initiation Document.	Project Manager At future PID development as part of project delivery (anticipated June 2024)	Medium	Superseded While the PID identifies procurement and project roles and recognises NWSSP Procurement Services as the procurement lead, it does not explicitly define responsibilities for commercial dialogue, cost negotiation, or supplier pricing discussions. The separation of roles between procurement officers (commercial responsibility) and project officers (technical responsibility) is implied but not formally documented. Therefore, we are unable to support the closure of this element of the recommendation. The control intent remains relevant and has been re-reported through Key Finding 1.
Contracts (Operation)				
5.1	Contracts should be discretely authorised in accordance with Standing Orders and Standing Financial Instructions.	Executive Director of Finance & Corporate Services and Trust Board Secretary	High	Closed At the 2024/25 follow up, management confirmed that 'The Trust's Standing Orders and Standing Financial Instructions have been reviewed with regards to contract award approvals and delegated authority. As a result, a proposal to add an

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Update and Audit Assessment
		31 March 2024		<i>additional mechanism to ensure discrete Trust Board contract approval together with an amendment to the narrative relating to delegated authority for purchase order approvals was taken to and approved by the Trust Board in July 2024.'</i> As part of this review, Purchase Orders (POs) relating to vehicle conversions and chassis purchases awarded via the CCS framework were examined. For all samples reviewed, approval by the Trust Board and Programme Board was appropriately evidenced and confirmed to be in line with delegated limits. On this basis, audit is able to support closure of this recommendation.
5.2	Pre-tender estimates and variance analysis should be utilised to inform tender evaluations.	Head of Financial Business Intelligence & Capital Planning and National Fleet Manager At future business case compilation	Medium	Closed For the procurement exercises undertaken during 2025/26, review of the procurement outcome reports confirmed the inclusion of pre-tender estimates at the evaluation stage, noting any resulting cost pressures associated with the tender presented for approval.
Monitoring (Operation)				
6.1	Business Justification Cases should present cumulative investment to date (planned and approved) against plans of the Strategic Outline Programme, including variance analysis and commentary (for both vehicle numbers and financial values).	National Fleet Manager At future business case compilation	Medium	Superseded The 2026/27 BJC demonstrates strong alignment with the VPS and clearly articulates the strategic and operational justification for the planned investment. However, it does not include the expected comparison of investment to date against the SOP, nor does it provide variance analysis or commentary for vehicle numbers or financial values. Therefore, we are unable to support the closure of this recommendation at this time. The underlying control requirement remains outstanding and is reported through Key Finding 2.

Appendix A: Assurance Opinion & Prioritisation of Findings

Assurance Opinion

	Substantial	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	Unsatisfactory	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Advisory	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Disclaimer

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Welsh Ambulance Service 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 Welsh Ambulance Service 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.



Digital Business Continuity Management

Final Internal Audit Report 2025/26



Reasonable Assurance

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Review Reference	WAS_2526_15
Fieldwork	November / December 2025
Executive Sign Off	18 June 2026
Audit Committee	September 2026
Executive Lead	Jonny Sammut, Director of Digital
Head of Internal Audit	Osian Lloyd

Executive Summary

Purpose

To review the arrangements in place to enable the continued provision of services in the event of disruption to the digital environment, and to assess the effectiveness of response and recovery processes.

Overview

We have concluded Reasonable assurance for this area.

The Trust has an overarching Business Continuity Policy in place, with continuity plans established for Information and Communication Technology (ICT) and operational departments which outline roles, responsibilities, escalation routes, and actions to be taken in the event of digital disruption. These arrangements are underpinned by Business Impact Assessments to prioritise critical systems. Digital continuity and incident response arrangements have been tested to ensure they are operational, and an appropriate command and communication framework is in place to support effective incident response.

However, the following matters require management attention to strengthen overall resilience and assurance:

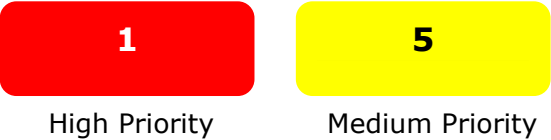
- ICT continuity arrangements are maintained across a suite of interrelated documents, but do not currently provide a clear overarching view of how all BIA-identified impacts — particularly non-technical scenarios such as loss of staff and premises — are translated into defined response actions.
- Disaster recovery arrangements are currently dispersed across multiple documents and do not provide a consolidated view of recovery priorities, Recovery Time Objectives (RTOs), Recovery Point Objectives (RPOs), or detailed system restoration procedures, which may reduce clarity during a major incident.
- There is limited evidence of consistent Trust-wide oversight confirming that all departmental business continuity plans are regularly reviewed, remain complementary, are kept up to date, and are exercised in accordance with policy requirements.
- Organisational learning from exercises was not consistently captured and tracked through a central mechanism, limiting assurance that identified actions were systematically progressed and embedded within updated plans.
- While critical systems are identified, the ICT Disruption Plan does not consistently demonstrate a clearly prioritised recovery approach aligned to BIA outputs, or how resources would be dynamically deployed during complex incidents.
- Although dependencies on Digital Health and Care Wales and national systems are documented, there is limited evidence of structured, end-to-end testing, including joint exercises with external partners, to validate these arrangements.

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

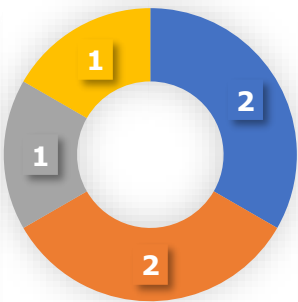
Scope & Assurance Summary

Objectives The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion		Related Findings	Assurance
1	Appropriate business continuity plans are in place for Digital Services, along with appropriate backup and disaster recovery arrangements.	1, 2	Reasonable
2	Departments understand their responsibilities and have appropriate business continuity plans and supporting processes in place. These enable the Trust’s critical operations to cope with the loss of IT functions, consider the potential time lag for restoration of services and include retrospective data capture.	3	Reasonable
3	The Trust has processes in place for testing continuity plans and incorporating lessons learned from recent events.	3, 4	Limited
4	Plans ensure that resources are available to manage a continuity incident, including out of hours, and are targeted to the most critical systems.	5	Reasonable
5	Plans ensure an appropriate command structure and communication mechanism are in place in the event of a continuity event occurring, with dependencies on DHCW and national systems clearly identified.	6	Reasonable

Management Actions



Themes



- Information, Data Quality & Data Accuracy
- Planning, Delivery & Deadline Management
- Governance
- Lessons Learnt

Themes

Information, Data Quality & Data Accuracy

Findings & Agreed Action Plan

Objective 1: Appropriate business continuity plans are in place for Digital Services, along with appropriate backup and disaster recovery arrangements.	Reasonable
There is a framework in place for enabling Digital Services business continuity, underpinned by a Trust-wide ICT Disruption Plan together with an ICT Disaster Response Plan. The content of these documents aligns with the Trust’s overarching Business Continuity Policy, clearly defining escalation procedures, command and control arrangements, and priority actions in response to ICT outages, cyber incidents, and major system failures. These arrangements are further supported by departmental Business Continuity Plans (BCPs). Business Impact Analyses (BIAs) undertaken across the Trust enable ICT to identify and prioritise critical digital systems, associated dependencies, and Recovery Time Objectives (RTOs). This supports a risk-based approach to digital continuity planning, ensuring focus is placed on systems that are operationally and clinically critical. The ICT Disruption Plan reflects this prioritisation and includes digital-specific considerations, such as fallback arrangements and remote access, to maintain essential services during periods of disruption. The ICT department has also undertaken a BIA identifying its own critical activities and the impacts associated with the loss of key resources, such as premises, staff, communications and vehicles. While this information is partially incorporated within the ICT Disaster Response Plan, not all identified impacts, such as loss of staff, are fully addressed. The BIA is clear that it should inform the basis of a BCP; however, although elements are covered within the Disaster Response Plan, it does not fully meet this requirement (See Key Finding 1). Backup arrangements are well established and robust, and are clearly defined within a formal procedure. These arrangements ensure systems are protected through automated backup schedules, strong encryption, and continuous monitoring of backup success and failure. The procedure also includes clear processes for onboarding new systems into the backup routine, providing confidence that data is consistently safeguarded. Furthermore, our testing confirmed that the backup and restore functions are appropriate and operating effectively. The WAST ICT Disaster Response Plan serves as the formal disaster recovery framework for ICT, detailing failover expectations, use of disaster recovery sites, and the roles of structured recovery teams. Detailed technical restoration instructions are in place for individual services. Management has confirmed that these arrangements are intentionally maintained across a suite of documents to reflect the complexity and interdependency of ICT services and to enable flexibility during incident response. However, while the plan provides high-level guidance and defines key response actions, key information derived from the BIAs, such as the expected RTOs, Recovery Point Objectives (RPOs), and detailed restoration sequences is not consistently presented in a consolidated format. This may reduce clarity during a major incident, particularly where competing service priorities arise or where rapid decision-making is required (See Key Finding 2).	

Key Findings		Risk & Impact	Agreed Management Action
1	Absence of a Complete ICT Business Continuity Plan While a range of ICT continuity documentation is in place, there is no overarching document or framework that brings together these elements and clearly demonstrates how all BIA-identified impacts — particularly non-technical scenarios such as loss of staff, premises and key resources — are translated into actionable continuity arrangements. Management has confirmed that a deliberate decision has been taken to operate a federated documentation approach, whereby continuity arrangements are managed through a suite of documents, including the ICT Disaster Response Plan, ICT Disruption Plan, BIAs and the wider Trust Business Continuity framework. This approach reflects the integrated nature of ICT services and their reliance on wider organisational infrastructure and incident response arrangements. Internal Audit acknowledges that many elements of continuity planning are in place. However, the absence of a clear overarching structure creates a risk that key impacts identified within BIAs are not consistently or clearly linked to defined response actions, which may reduce usability and clarity during a live incident.	The lack of a complete ICT Business Continuity Plan aligned to the BIA risks inconsistent disruption management and delayed system recovery, impacting critical services.	Agreed Action Formalise the federated ICT continuity approach by developing an overarching ICT Continuity Framework that consolidates and references all relevant documentation (e.g. DR Plan, ICT Disruption Plan, BIAs and Trust BC framework). The framework should map key BIA impacts (including staff, premises and resources) to defined response actions, cover both technical and non-technical scenarios, and provide a clear structure for use during incidents.
			Expected Evidence of Implementation: • Approved ICT Continuity Framework (version controlled) • Documented mapping of BIA impacts to response actions • Cross-referenced supporting plans and procedures • Evidence of governance approval • Evidence of communication to relevant staff
		Medium Priority	Officer: Assistant Director of Digital - ICT Target Implementation Date: December 2026
	Theme: Information, Data Quality & Data Accuracy	Control Operation	

2	Lack of a Consolidated and Approved Disaster Recovery Plan Disaster recovery arrangements are currently maintained across multiple documents, including the ICT Disaster Response Plan and detailed technical procedures. While this approach reflects the complexity of ICT systems and supports flexibility in managing incidents, it does not provide a single, consolidated view of recovery priorities, RTOs, RPOs or restoration sequencing. Management has advised that predefined recovery priorities may not always be appropriate given the dynamic nature of incidents and the need to respond in line with operational requirements at the time. Internal Audit recognises the need for flexibility; however, without clearly defined baseline priorities and recovery expectations, there is a risk of inconsistency or competing demands during a major incident, particularly where key decision-makers are unavailable or where multiple critical services are impacted simultaneously.	The absence of a consolidated and approved Disaster Recovery Plan increases the risk of inconsistent and delayed system recovery, leading to prolonged disruption of critical services.	Agreed Action Strengthen existing disaster recovery arrangements by introducing a consolidated DR Summary (playbook) to sit above existing technical documentation, defining system priority tiers, baseline RTOs/RPOs aligned to BIAs, and high-level restoration sequencing agreed with key services. Expected Evidence of Implementation: • Approved DR Summary / Playbook document • Documented priority tiers for systems/services • Evidence of RTO/RPO alignment with BIA outputs • Records demonstrating engagement and agreement with service areas • Cross-referencing to detailed technical recovery procedures/runbooks • Evidence of governance approval
	Theme: Planning, Delivery & Deadline Management	Medium Priority	Officer: Assistant Director of Digital - ICT Target Implementation Date: December 2026
		Control Operation	

Objective 2: Departments understand their responsibilities and have appropriate business continuity plans and supporting processes in place. These enable the Trust's critical operations to cope with the loss of IT functions, consider the potential time lag for restoration of services and include retrospective data capture.

Reasonable

Our review of a sample of departmental BCPs, including ICT, Computer Aided Dispatch (CAD) system for managing emergency 999 calls, NHS 111 Wales, the Clinical Service Desk, and Emergency Medical Services (EMS) Coordination, confirmed that departments understand their business continuity responsibilities and have documented processes in place to maintain critical operations during the loss of IT systems. Departments have developed practical and workable fallback arrangements, such as manual processes, paper-based forms, and the use of supporting resources including the NHS 111 Fallback Guardian. These arrangements explicitly consider the potential time lag associated with system restoration and are aligned to agreed RTOs and Maximum Tolerable Periods of Disruption (MTPDs), demonstrating that essential Trust activities can continue while digital services are unavailable.

Arrangements for capturing, managing, and restoring information and data generated during system outages are evident across departments. These include the use of manual call logs, paper-based Medical Case Disposition forms, and printed call summaries to ensure operational continuity. Several departments, particularly the Clinical Service Desk, have documented procedures for retrospective data entry and reconciliation once systems are restored, supporting the integrity and completeness of clinical and operational records and ensuring that incidents are appropriately resolved following disruption.

The Trust has a formal Business Continuity Policy which sets expectations that continuity plans remain current, operational, and routinely tested. Departments are required to complete and maintain up-to-date BIAs and BCPs that identify critical activities, dependencies, and risks, and to regularly test these arrangements through scheduled exercises or structured post-incident reviews, with lessons learned documented and applied. Governance mechanisms exist to support this, including version control, annual plan reviews, and a programme of exercising coordinated through the Emergency Preparedness, Resilience and Response (EPRR) team.

However, application of these governance arrangements is not consistent across all departments. There is no evidence of Trust-wide oversight mechanism providing assurance that all departmental BCPs are routinely reviewed, remain complementary and interoperable, are kept up to date, and are tested in line with policy requirements. As a result, some departmental plans have not been reviewed for several years, reducing assurance over their ongoing effectiveness (See **Key Finding 3**).

Key Findings		Risk & Impact	Agreed Management Action
3	Lack of Trust-Wide Oversight of Departmental Business Continuity Plans While some departments undertake annual reviews and regular testing of their business continuity plans, there is no Trust-wide oversight mechanism confirming that all departmental plans are routinely reviewed, remain complementary, are kept up to date, and are exercised in accordance with policy requirements.	The absence of Trust-wide oversight creates a risk that continuity plans are not consistently effective, reducing assurance over the Trust's resilience during disruption.	Agreed Action Embed and evidence the Trust-wide oversight framework for Business Continuity Plans through Continuity2 and governance arrangements, ensuring consistent application across all departments.
			Expected Evidence of Implementation: - Continuity2 central dashboard/register of departmental BCPs - Evidence of review cycles, version control and testing status - Regular assurance reports to governance forums (e.g. EPRR) - Evidence of follow-up actions where plans are overdue or incomplete - Periodic summary reporting demonstrating overall compliance levels
		Medium Priority	
Theme: Governance		Control Operation	Officer: Assistant Director of Digital - ICT Target Implementation Date: December 2026

Objective 3: The Trust has processes in place for testing continuity plans and incorporating lessons learned from recent events.

Limited

The Trust's Business Continuity Policy requires regular testing and review of continuity plans to ensure arrangements remain effective and current. In line with this requirement, a Business Continuity workshop was conducted, which involved structured testing and review activities and bringing together relevant stakeholders to assess preparedness and identify opportunities for improvement.

While the policy requires annual testing of all continuity plans, there is no established mechanism to ensure this occurs across the organisation. We note that some testing has taken place, including a Trust-wide business continuity exercise in November 2024 and participation in the NHS Wales Cyber exercise in September 2025, which enabled ICT to test its arrangements. However, there is no Trust process to ensure and confirm all departments routinely test their plans, and not all the departments whose plans we reviewed took part in the exercises undertaken above (See **Key Finding 3**).

Our review of departmental documentation confirmed continuity plans state that they should be reviewed at least annually, or sooner following an incident or significant change. However, version histories indicate that this has not been applied consistently in practice. Some plans show gaps of multiple years between major revisions, despite the policy requirement for annual review, reducing assurance that plans remain current and effective.

Business continuity and resilience exercises are generally well designed, with scenarios based on credible disruption events and involving a broad range of operational and digital teams. Exercises are planned, delivered, and evaluated against defined objectives, with outputs reported to the Business Continuity Steering Group and Strategic Group. Post-exercise reviews capture facilitator observations, participant feedback, and overall outcomes, demonstrating effective engagement and the ability of exercises to identify both strengths and weaknesses in current arrangements.

However, our review identified weaknesses in the consistent capture and tracking of organisational learning from exercises and incidents. While learning was identified through exercises and documented within exercise reports, this was not consistently recorded within the Trust's designated central tracking mechanism, the Organisational Learning Spreadsheet (OLSS). For example, the OLSS has not been updated to include lessons from the November 2024 business continuity exercise. As a result, there was limited visibility of how actions were monitored through to completion or embedded within updated plans. Until it is consistently and accurately maintained, the OLSS cannot be relied upon to support effective organisational learning, provide assurance, or enable continuous improvement of continuity arrangements.

The exercises reviewed identified a number of weaknesses, including departmental BCPs that were overly generic or lacked detailed recovery procedures, outdated BIAs, inconsistent availability of hard-copy resources for ICT outages, and vulnerabilities in communication resilience. As these issues were not formally recorded within the OLSS, there has been limited evidence of remedial action being taken, undermining the effectiveness of the exercising process and the Trust's ability to strengthen resilience over time (See **Key Finding 4**).

Key Findings		Risk & Impact	Agreed Management Action
4	Failure to Capture and Act on Organisational Learning from Business Continuity Exercises At the time of audit, organisational learning from business continuity exercises was not consistently captured and tracked through a single, central mechanism. While exercises identified a range of issues and actions, these were not fully reflected within the Organisational Learning Spreadsheet (OLSS), which is intended to act as the Trust's central record. As a result, there was limited assurance that identified actions were consistently recorded, monitored and progressed to completion, or that improvements were systematically embedded within departmental plans. Consequently, weaknesses identified within departmental BCPs have not been formally tracked or addressed, with some plans remaining overly generic, lacking sufficient detail on recovery procedures, or not identifying essential offline resources required during ICT outages.	The failure to capture and track lessons learned risks recurring weaknesses in continuity arrangements, undermining the Trust's resilience during disruption.	Agreed Action Implement a single, consistent mechanism for capturing, tracking and reporting organisational learning from exercises and incidents, ensuring all learning is centrally recorded, assigned ownership and timescales, and embedded within governance reporting.
	Theme: Lessons Learnt	High Priority Control Operation	Expected Evidence of Implementation: • Updated central learning tracker (e.g. OLSS or equivalent system) containing all relevant exercises • Clearly defined actions, owners and timescales • Evidence of regular progress monitoring and reporting • Demonstration that completed actions have been reflected in updated BCPs and documentation • Governance minutes evidencing oversight and challenge Officer: Patrick Rees, Locality Manager EPRR (Emergency Preparedness, Resilience and Response) Central Target Implementation Date: October 2026

Objective 4: Plans ensure that resources are available to manage a continuity incident, including out of hours, and are targeted to the most critical systems.

Reasonable

Our review confirmed that the Trust's continuity documentation, including the Business Continuity Plan 2025, EMS Coordination BCP, ICT Disruption Plan, and National 999 Call Handling BCP, outlines the roles, staffing, and technical resources required to respond to continuity incidents. Plans describe Strategic, Tactical, and Operational command arrangements; minimum staffing levels for Clinical Contact Centres; fallback arrangements for CAD and telephony; and supporting roles such as Duty National Inter-Agency Liaison Officer, (NILO), Tactical Advisors, ICT specialists, and mutual aid arrangements.

Out-of-hours capability is addressed through established 24/7 rotas for Strategic Command, on-call ICT support, and documented escalation processes that enable the timely activation of Business Continuity Cells when required. National 999 call-handling protocols also provide timely escalation pathways during periods of system disruption.

For ICT, resource requirements to enact the continuity arrangements are informed by the BIA, which identifies critical functions and supporting needs. Out of hours ICT support is provided through three on-call rotas covering critical incidents occurring outside normal office hours, with these staff acting as the first point of contact for reporting and managing ICT incidents. In addition, a senior ICT management rota is in place, enabling escalation of significant issues and providing a point of contact for national incidents affecting NHS Wales or UK ambulance services.

ICT resource prioritisation during continuity incidents is guided by BIAs, which identify critical functions and recovery time expectations. Continuity arrangements prioritise maintaining the Trust's most critical services, including 999 and 111 call handling, Computer-Aided Dispatch (CAD) and Mobile Data Terminal, (MDT) availability, core telephony infrastructure, and digital systems essential to patient safety.

However, while critical systems and resource requirements are identified, the ICT Disruption Plan does not consistently demonstrate how recovery activities would be prioritised and coordinated in practice during complex or prolonged incidents. In particular, there is limited clarity on how system recovery sequencing aligns to BIA-defined priorities, and how resources would be dynamically redeployed during prolonged or complex multi-system failures, limiting operational clarity in high impact scenarios (See **Key Finding 5**).

Key Findings		Risk & Impact	Agreed Management Action
5	Incomplete Prioritisation of ICT System Recovery The ICT Disruption Plan identifies the Trust's critical systems and supporting resources, but it does not consistently provide a fully prioritised recovery approach aligned with BIA outputs. While recovery expectations are outlined at a high level, there is limited visibility of how system recovery sequencing would be determined in practice, particularly where multiple critical systems are impacted. In addition, while resource requirements are defined, there is limited clarity on how these resources would be dynamically redeployed during prolonged or complex multi-system failures, limiting operational clarity in high impact scenarios.	The lack of a clearly prioritised, BIA-aligned recovery sequence increases the risk of mis-prioritised system recovery, leading to prolonged disruption of critical services during ICT incidents.	Agreed Action Enhance the ICT Disruption Plan by introducing a tiered system prioritisation model aligned to BIA outputs, defining system criticality, associated recovery expectations (RTO/RPO), and principles for dynamic reprioritisation during incidents.
			Expected Evidence of Implementation: • Updated and approved ICT Disruption Plan • Documented system categorisation model and definitions • Evidence of alignment with BIA priorities and recovery expectations • Defined prioritisation principles for incident response • Communication of updated prioritisation approach to ICT teams and relevant stakeholders
		Medium Priority	
Theme: Information, Data Quality & Data Accuracy		Control Operation	Officer: Assistant Director of Digital - ICT Target Implementation Date: December 2026

Objective 5: Plans ensure an appropriate command structure and communication mechanism are in place in the event of a continuity event occurring, with dependencies on DHCW and national systems clearly identified.

Reasonable

The Trust has a defined Strategic, Tactical, and Operational command framework, which is applied across core continuity and incident response documentation. This includes the Business Continuity Plan 2025, ICT Disruption Plan, EMS Coordination Plan, Cyber Incident Response SOP, and National Business Continuity Plan. Roles, responsibilities and escalation routes are clearly articulated, and additional command capacity can be established through Business Continuity Cells and Incident Coordination Centres during significant or prolonged incidents.

A range of communication mechanisms are in place to support continuity incidents, these include Everbridge for mass notification, Microsoft Teams for virtual coordination, Airwave talk groups for secure operational communications, and fallback telephony arrangements for ICT outages. Corporate Communications processes are in place to manage internal and external messaging, including stakeholder engagement and media management. These arrangements have been partially validated through business continuity and cyber incident exercises.

Key dependencies on Digital Health and Care Wales (DHCW) and national systems are documented. Identified dependencies include CAD, NHS 111 systems, Welsh Demographic Service (WDS), the Welsh Clinical Portal, interoperability services, and national telephony capabilities provided by NHS England and BT. Escalation routes to national bodies in the event of cyber or ICT incidents are also defined.

However, although dependencies are well documented, there is limited evidence that these arrangements have been jointly tested with external partners, such as DHCS or national system providers, to confirm the robustness of arrangements or to validate recovery time assumptions. Additionally, while alternative communication tools are in place, there is no recent evidence of an end-to-end test conducted under full ICT outage conditions to confirm the effectiveness of command, coordination and communication arrangements during a major system failure (see **Key Finding 6**).

Key Findings		Risk & Impact	Agreed Management Action
6	Limited Testing of External Dependencies and ICT Outage Arrangements Although dependencies on DHCW and national systems are documented, there is limited evidence of joint resilience testing with external partners or through end-to-end ICT outage scenarios. While some exercises and real-world activations have taken place, there is limited evidence of a structured and consistently evidenced approach to testing command, coordination and communication arrangements under full outage conditions. This reduces assurance that these arrangements would operate effectively during a major incident.	Limited resilience testing reduces assurance that command and communication arrangements would function effectively during a major system failure, increasing the risk of service disruption and patient safety impact.	Agreed Action Develop and implement a structured resilience testing programme covering ICT continuity, including external dependencies and full outage scenarios , ensuring lessons learned are captured and used to update plans.
			Expected Evidence of Implementation: • Documented annual testing schedule and programme • Records of completed exercises (plans, scenarios, attendance, outputs) • Evidence of external partner involvement where appropriate • Documentation confirming testing of communication and coordination arrangements • Action logs showing learning captured, owned and progressed • Updated BC/ICT plans reflecting tested and validated improvements • Reporting of outcomes to relevant governance forums
		Medium Priority	Officer: Assistant Director of Digital - ICT Target Implementation Date: December 2026
Theme: Planning, Delivery & Deadline Management		Control Operation	

Appendix A: Assurance Opinion & Prioritisation of Findings

Assurance Opinion

	Substantial	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	Unsatisfactory	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Advisory	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

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The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained. Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of the Welsh Ambulance Services University NHS Trust.

Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

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.

Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.





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University NHS Trust

Agenda Item No. 12.2

REPORT TITLE

Internal Audit Report – Data Management Practices / Devolved Data – ARAC Feedback

MEETING

Name of meeting	Finance and Performance Committee
Date of meeting	21 July 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Jonny Sammut, Director of Digital
Author(s) of report	AnnaMaria Williams, Corporate Governance Officer

PURPOSE OF REPORT

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

REPORT SUMMARY

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

1. The Audit Risk and Assurance Committee (ARAC) received and discussed the **Data Management Practices / Devolved Data** Internal Audit Report at its meeting on 23 June 2026. This report summaries the discussion from that meeting in reference to this report.
2. Felicity Quance, NWSSP Internal Audit, presented the Data Management Practices / Devolved Data Internal Audit Report, which received an overall rating of **reasonable assurance**. Members noted strong local analytical capability, a positive data-aware culture and well-established digital infrastructure across the Trust. However, the audit identified that data management practices were highly decentralised, resulting in inconsistent reporting and



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limited assurance regarding data quality and accuracy. Examples were noted where differing reports contained conflicting information and externally shared data did not always meet established standards. Three recommendations were agreed with management, comprising one high-priority and two medium-priority findings, aimed at strengthening governance, consistency and oversight of data management arrangements across the organisation.

3. Jonny Sammut welcomed the reasonable assurance rating and advised that the report highlighted the need for a more consistent organisational approach to data management. Jonny emphasised the importance of establishing a single source of truth for data across the Trust and confirmed that all recommendations had been accepted. Members noted that work was already underway to strengthen data governance, standards, training and reporting arrangements, with plans to develop a more integrated enterprise data model and establish a data community of practice.
4. The Chair sought assurance that the use of decentralised data reporting tools and practices did not introduce additional cyber security or data governance risks to the Trust. Jonny advised that all data products remained within the Trust's Microsoft 365 environment, enabling appropriate organisational control and oversight. Jonny confirmed that there were no unauthorised routes for data extraction or external access and that existing controls provided assurance over the security and management of Trust data.

RECOMMENDATION(S)

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

The committee is asked to:

- (a) note the discussion and feedback from ARAC
- (b) review the report, noting the agreed management actions and mitigations of risk in the area of the report

The committee will have an opportunity to monitor the closure of these actions and scrutinise impact of those actions in response to audit recommendations via tracker reports and future assurance reporting on this issue.

ADDITIONAL PAPER(S)

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

The committee is requested to receive the following:

- **Annex 1** Data Management Practices / Devolved Internal Audit Report



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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

RISK(S) THIS REPORT MITIGATES

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

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

IMPACT ASSESSMENTS FOR CONSIDERATION

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

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
23 June 2026	Audit, Risk and Assurance Committee

Data Management Practices/Devolved Data

Final Internal Audit Report

2025/26



Reasonable Assurance

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Review Reference	WAST-25265-13
Fieldwork	September-October 2025
Executive Sign Off	May 2026
Audit Committee	June 2026
Executive Lead	Jonny Sammut, Director of Digital
Head of Internal Audit	Osian Lloyd

Executive Summary

Purpose

To review the use of data and provision of information in areas outside the Digital function, and to assess the processes in place to ensure compliance with relevant standards and best practice.

Overview

We have concluded reasonable assurance in this area. There are a number of departments which provide information products to stakeholders independently of Digital. Whilst this demonstrates a positive intent to use data effectively and staff involved are generally aware of data governance requirements, the lack of a formal coordination structure has lead to duplication, inconsistencies, and reporting which does not always meet best practice standards.

The matters requiring management attention include:

- The Trust does not have comprehensive, organisation wide guidance on the appropriate use and presentation of data, and there is no consistent training framework to support staff in applying these standards.
- The processes for developing, verifying, and presenting reports vary considerably, and are often undocumented. This has led to a fragmented and decentralised reporting landscape. In the absence of a central coordination structure, reports have been shared externally without independent review.
- Information produced outside Digital sometimes falls short of established standards and does not always comply with best practice such, as the Office for National Statistics (ONS) guidance.
- Internal validation, quality assurance and version control processes remain inconsistent across departments. This has led to unverified or incomplete data being shared with senior stakeholders.
- Assurance over data accuracy and completeness cannot always be maintained, particularly where data sources outside Digital are used or where reports and extracts are altered post-production. The current decentralised approach also complicates efforts to maintain a single, authoritative “source of truth.”

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

Scope & Assurance Summary

Objectives

		Related Findings	Assurance
1	The Trust has guidance in place for all staff on the management and appropriate use of data.	1	Reasonable
2	Information products produced outside of Digital comply with relevant standards and best practice, ensure security of information and appropriately meet user needs.	2	Reasonable
3	Information products produced outside of Digital promote the effective use of data and maintain appropriate data quality throughout their lifecycle.	3	Limited

Management Actions

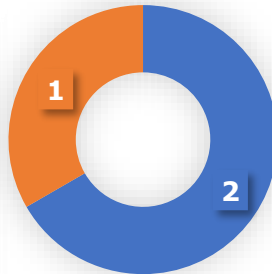


High Priority



Medium Priority

Theme



■ Information, Data
Quality & Data
Accuracy

■ Policies &
Procedures

Risk Types

Public Perception & Reputational Risk

Findings & Agreed Action Plan

Objective 1: The Trust has guidance in place for all staff on the management and appropriate use of data.	Reasonable
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The Welsh Ambulance Services University NHS Trust (WAST) has established a number of guidance documents and frameworks governing the management and use of data, primarily within its Digital functions. These include the Information Governance (IG) Policy, which provides clear guidance on how data should be validated, managed, and presented across the organisation. Key documents such as the Official Statistics Step-by-Step Guide, the Ambulance Quality Indicators Technical Guidance Document, and the Monthly Official Statistics Pre-Release Guidance provide direction on data quality, consistency, and reporting processes.

While the existing documentation provides strong technical and procedural direction for data professionals, their applicability across the wider Trust is limited. Apart from the IG Policy, most guidance is primarily tailored to specialist teams, with minimal evidence of organisation-wide standards or training to ensure consistent understanding and compliance among all staff. Departments outside the Digital directorate produce their own reports and analyses, and employ data analysts who confirmed they do not follow Insight and Data Services (IDS) specific guidance. Instead, they often rely on informal or peer-led processes for managing and validating data. This issue was highlighted in a paper produced by the Director of Digital, which stressed the need to move to a model based on formally validated data points delivered into the enterprise data warehouse, rather than relying on derived or ad hoc logic.

We noted a positive culture of data responsibility among staff interviewed outside of Digital, with general awareness of data protection obligations under General Data Protection Regulation (GDPR) and the Data Protection Act. Staff know when to seek specialist advice, particularly from the Data Protection Officer, which helps mitigate compliance risks. However, there remains an absence of a comprehensive, Trust-wide data governance framework that defines clear standards for all employees in relation to data handling, presentation, and storage (See **Key Finding 1**).

Training on data management is largely informal and varies by department, with no mandated or structured programme in place. The Digital Team plans to strengthen oversight through initiatives such as a proposed central data verification process and the introduction of a “verification stamp” to assure data quality before release. However, this work is still in progress, and no completion date has been provided. We also note the intent within the paper to enable professional oversight by Digital over the use and presentation of data across the organisation, along with increased training and up-skilling of staff (See **Key Finding 1**).

Finally, while there is no clear record of all information products produced across the Trust, the Information Asset Register (IAR) provides a record of information assets, including reporting and dashboards, which enables a level of visibility to be maintained.

Key Findings		Risk & Impact	Agreed Management Action
1	Lack of Consistent Guidance and Staff Training on Data Use The Trust does not have comprehensive, organisation wide guidance on the appropriate use and presentation of data, and there is no consistent training framework to support staff in applying these standards.	The absence of organisation-wide guidance and a consistent training framework may lead to inconsistent data practices, non-compliance with standards, and inaccurate reporting, increasing the risk of poor decision-making and reputational harm.	Agreed Action: - Develop organisation-wide data standards (i.e. the rules) for key variables and metrics to support consistent use and presentation, aligned with best practice. - Document these data standards in a central and accessible data dictionary (i.e. glossary) for use across the organisation. - Introduce training checklist for staff involved in data handling and reporting to evidence compliance (e.g. against IG and Data Quality requirements).
			Expected Evidence of Implementation: - First version of data dictionary and guidance made available on WAST intranet. - Checklist of required training and links to available materials made available on WAST intranet, and a locally held record demonstrating completion for staff who regularly engage in analytical activities to be shared to IGSG for oversight. - Evidence of communication and accessibility of dictionary guidance and training checklist via formal Digital Directorate Notice.
		Medium Priority	
	Theme: Policies & Procedures	Control Operation	Officer: Assistant Director of Digital Services: Data & Analytics Target Implementation Date: 1) October 2026 - Initial Data Dictionary 2) October 2026 - Training checklist developed and initial record of compliance to IGSG 3) October 2026 - Digital Notices on Siren

Objective 2: Information products produced outside of Digital comply with relevant standards and best practice, ensure security of information and appropriately meet user needs.

Reasonable

A wide range of information products, including dashboards, forecasts, and reports, are produced outside the Digital Team, particularly within the Operational Delivery Unit (ODU), Commissioning & Strategy, and Clinical Directorates. Because this information is developed and produced within the departments, they generally reflect a clear understanding of operational needs and objectives, making them valuable and demonstrating a strong commitment to supporting service delivery.

However, at present, there is no formal, Trust-wide framework governing report design, organisational style, presentation, compliance with standard and regulations or quality assurance. Staff tend to reuse existing templates or rely on local preferences, which supports internal departmental consistency but contributes to variation across the organisation.

Our testing showed that development, verification, and presentation processes vary considerably and are often undocumented. This has led to a fragmented and decentralised reporting landscape, described by some staff as a “cottage industry” approach to analytics. Many departments create their own dashboards and Excel-based reports independently of the Digital Directorate, with limited coordination or oversight.

In the absence of a central coordination structure, and because Digital does not routinely verify outputs produced outside its control, reports have been shared externally (including with Welsh Government) without independent review (See **Key Finding 2**). When data from other directorates is incorporated, its validity is often assumed rather than confirmed. While some teams provide clear references and source details, others do not consistently include explanatory narratives or attribution. As such, our testing showed that information produced outside Digital sometimes falls short of established standards and does not always comply with best practice such as ONS guidance (See **Key Finding 2**).

Security controls are robust where data is sourced from the Data Warehouse or Power BI environments managed by Digital. However, data stored or processed outside these systems, such as spreadsheets developed by operational teams, sits outside Digital’s governance, creating potential risks to information security and data integrity. (See **Key Finding 2**)

Key Findings		Risk & Impact	Agreed Management Action
2	Fragmented Reporting Landscape and Non-Compliance with Standards The development, verification, quality assurance and presentation processes vary considerably and are often undocumented. This has led to a fragmented and decentralised reporting landscape. Our testing showed that information produced outside Digital sometimes falls short of established standards and does not always comply with best practice such as ONS guidance.	The absence of standardised, documented processes and central oversight increases the likelihood of inaccurate or inconsistent reporting, unverified data being shared externally, and non-compliance with governance and best practice standards—potentially leading to poor decisions, reputational harm, and regulatory challenges.	Agreed Action: • [Management actions as per Key Finding 1 will also help address this risk of non-compliance in Finding 2] • Agree list of externally shared reports which require central oversight and review before publication – i.e. the list of reports which will require management and QA by the Digital Directorate. • Provide design principles to ensure consistency and quality in reports and dashboards.
		Medium Priority	Expected Evidence of Implementation: • Documented list of regularly shared reports, with identified information asset owners logged on the organisation-wide Information Asset Register or Data Sharing Register (as appropriate). Evidence should be given to IGSG via the monthly Highlight Report, demonstrating that all externally shared reports have oversight by a Digital Directorate team / staff member. • Published template document (including brand palette) for self-development of dashboards and evidence of accessibility for staff.
	Theme: Information, Data Quality & Data Accuracy	Control Operation	Officer: Head of Information Target Implementation Date: 1) August 2026 - List of external reports with owners logged on IAR / Data Sharing Register 2) July 2026 – PowerBI Design Template

Objective 3: Information products produced outside of Digital promote the effective use of data and maintain appropriate data quality throughout their lifecycle.

Limited

There is clear evidence of strong analytical capability and initiative across the Trust, with several departments developing bespoke reporting tools to meet operational needs. Examples include advanced Excel and Power BI solutions produced by the Operational Delivery Unit and senior paramedics. These demonstrate a commitment to data-driven decision-making and innovation within local teams.

However, this activity often occurs without formal coordination or oversight from Digital, resulting in inconsistent data standards and potential duplication of effort. While most teams draw their data from the central Data Warehouse, some information products rely on manual datasets or local sources, increasing the risk of conflicting figures and undermining confidence in reported outcomes. While some departmental practices have been externally reviewed, internal validation, quality assurance and version control remain inconsistent. This has led to unverified or incomplete data being shared with senior stakeholders, including the Welsh Government. In some cases, two reports present different figures for what appears to be the same measure, without explanation of the variance (see **Key finding 3**).

Digital provides the technical infrastructure and data warehouse for data reporting but has limited visibility of outputs developed elsewhere. Consequently, assurance over data accuracy and completeness cannot always be maintained, particularly where data sources outside of Digital are used or where reports and extracts are altered post-production. The current decentralised approach also complicates efforts to maintain a single, authoritative “source of truth.” (see **Key finding 3**).

Positive steps are being taken to improve governance, such as exploring controlled access through semantic data layers and renewed discussions on the need for greater central oversight and strengthening coordination. We also note an aspiration within Digital to develop a data verification “stamp” to demonstrate compliance with data governance and quality standards.

Key Findings		Risk & Impact	Agreed Management Action
3	Lack of Central Oversight for Data Reporting Digital provides the technical infrastructure and data warehouse for data reporting but has limited visibility of outputs developed by other areas. Consequently, assurance over data accuracy and completeness cannot always be maintained, particularly where data sources outside of Digital are used or where reports and extracts are altered post-production. The current decentralised approach also complicates efforts to maintain a single, authoritative “source of truth.” As there is no central coordination structure, reports have been shared externally without independent review and with unverified or incomplete data being shared with high-level stakeholders.	Decentralised reporting and lack of central oversight increase the risk of inaccurate or incomplete data being shared internally and externally. This can lead to misinformed decisions, reputational damage, and weakened data governance due to the absence of a single authoritative source of truth.	Agreed Action: - Following a discussion with ELT in April 2026, it was agreed that it would not possible for Digital to take on assurance of all reporting from WAST whilst analytical practices remain decentralised. It was agreed for an interim period, a Community of Practice (COP) for data and analytics professionals would be established internally to help build resilience, best practice, and professionalisation. This COP will aim to bring together the professionals under some central governance, with a clear operating model, but maintain decentralised ownership of reporting. As the COP itself may take time to embed, the action agreed here is for the COP plan to be developed and presented back to leadership. - Additionally, IDS will develop a certification “stamp” to add to reports and publication to demonstrate level of assurance on the data accuracy and source, and help reduce risk of misinformation.
			Expected Evidence of Implementation: - Presentation of the COP plan to appropriate leadership forum (e.g. Digital Leadership, IGSG or ELT) - Evidence of an approved IDS stamp being utilised on a key report or dashboard
		Theme: Information, Data Quality & Data Accuracy	High Priority
		Control Operation	

Appendix A: Assurance Opinion & Prioritisation of Findings

Assurance Opinion

	Substantial	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	Unsatisfactory	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Advisory	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

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The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of the Welsh Ambulance Services University NHS Trust. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Public Sector Internal Audit Standards

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Emerging Technology Adoption

Final Internal Audit Report

Welsh Ambulance Service University NHS Trust



Reasonable Assurance

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Review Reference

Fieldwork

Executive Sign Off

Audit Committee

Executive Lead

Audit Team

WAS-2526-14

January 2026 - June 2026

18 June 2026

September 2026

Jonny Summat, Director of Digital

Osian Lloyd, Head of Internal Audit

Martyn Lewis, IT Audit Manger

Executive Summary

Purpose

To assess the robustness of the processes in place to ensure the effective, safe, and well-governed use of new and emerging technologies, such as Artificial Intelligence (AI) and automation.

Overview

New and emerging technology such as AI and automation, offer significant opportunities to improve service delivery through increased efficiency and enhanced use of data. The Trusts Digital Plan (2024-2029) contains a key theme of "Digital Pioneers", which is dedicated to driving innovation and embracing these technologies to enhance services. This ambition is reflected within the Trust's Integrated Medium-Term Plan.

We have concluded **reasonable assurance** on this area. The Trust is at the early stage in its adoption of AI and automation, with a clear strategic intent to expand the use of these technologies. While a number of areas require further development, particularly in relation to the formalisation, consistency, and scalability of governance frameworks, there is evidence that core controls are in place and operating. This includes emerging governance structures, controlled access to AI tools, established processes for automation development, and active oversight through relevant groups.

Current use of AI and automation remains relatively limited and is being managed proportionately. As such, the control environment is considered adequate for the current level of activity. However, the findings within this report highlight that further strengthening is required to ensure that governance, resourcing, and control frameworks are sufficiently mature to support the Trust's planned expansion of AI and automation. In particular, greater formalisation of policies, procedures, prioritisation frameworks, and documentation standards will be necessary to ensure risks continue to be effectively managed as usage increases..

The key matters requiring management attention, primarily relating to the formalisation and scalability of controls, are set out below:

- At present, there is limited dedicated resource to support the development and use of AI or automation. No formally established team exists, with only one developer supporting automation and limited capacity to develop AI capabilities.
- The AI Policy has not yet been formally approved or issued. While interim guidance is in place, this is limited in scope and does not fully address key risks or acceptable use. Until formal governance processes are approved, communicated and embedded, there is a risk that staff may use AI tools without appropriate assessment and approval.
- There are no standard operating procedures in place for developing automated processes, and no formal guidance is available for the wider organisation.
- There is no formal prioritisation framework for automation requests. While decisions are made in practice, the absence of documented criteria reduces transparency and clarity over how resources are targeted and aligned to organisational priorities.
- There are no standard templates for documenting the design of automated processes. While current documentation captures some key elements, it does not fully document process logic, data flows, user approval of design and testing, or formal approval prior to deployment.
- Although departments are advised to maintain continuity arrangements for automated processes, there is no formal requirement to document these arrangements before an automation goes live.
- The register of automated processes includes details of target systems and required permissions, supporting visibility of dependencies. However, this information is not consistently completed, and in the absence of detailed design documentation, this limits the Trust's ability to fully identify and manage dependencies between automated processes and the wider technical environment.

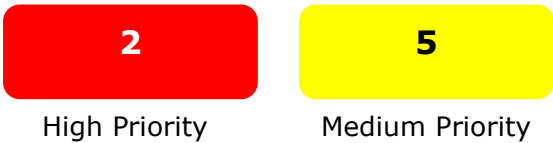
Full details of matters arising are detailed within the Findings & Agreed Action Plan. The following opportunity for enhancement has been identified that does not impact the overall opinion and is highlighted for management information:

- Defining expected run times during testing and incorporating automated timeouts within process flows would reduce the risk of automation failures adversely impacting operations.

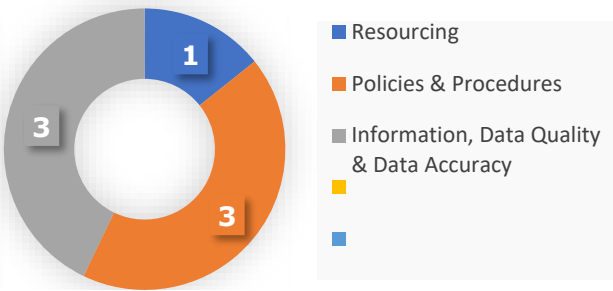
Scope & Assurance Summary

Objectives	The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.	Related Findings	Assurance
1	The use of evolving technology is included within organisation plans, with appropriate resources available to develop their use.	1	Reasonable
2	Appropriate controls and guidance are in place for the use of technology which protects information, accounts, and ensures that models are accurate, free from bias and protect information.	2, 3	Limited
3	An appropriate process is in place to control the creation of automated processes and the resource use, with an assessment process to ensure only suitable processes are automated and benefits are defined and realised.	4	Reasonable
4	Appropriate processes are in place to fully document the design of automated process and test the final product with the operation of new technology monitored to ensure they operate as expected.	5	Reasonable
5	An appropriate process is in place to ensure that changes to the environment in which automated processes operate are assessed for the impact, changes to automated processes are recorded and appropriate continuity planning is in place to enable the organisation to operate in the event of the failure of the technology.	6, 7	Reasonable

Management Actions



Themes



Risk Types

- Public Perception & Reputational Risk
- Legal & Regulatory Non-Compliance
- Choose an item.
- Choose an item.

Findings & Agreed Action Plan

Objective 1: The use of evolving technology is included within organisation plans, with appropriate resources available to develop their use.

Reasonable

The Trust has developed a Digital Plan covering the period 2024-2029. A key component of the Plan is the ‘Digital Pioneers’ pillar, which focuses on the adoption and integration of emerging technologies to improve service efficiency, effectiveness, and quality. The Plan promotes a culture of continuous improvement, experimentation and innovation to ensure that services evolve in-line with patient and community needs.

The Digital Plan includes key initiatives including Artificial Intelligence (AI); Use of drones; Virtual and augmented reality; and Chatbot and self-service automation. These initiatives are reflected within Digital Local Delivery Plan and subject to ongoing monitoring.

Delivery of the Digital Plan is supported by the IMTP 2025-28, with Section 7 setting out the Trust’s ‘Digital & Data Roadmap’, aligned to Strategic objective 3: *‘Being at the forefront of innovation and technology.’* The roadmap outlines similar priorities to the Digital Plan, including a dedicated Digital Pioneers focus.

The IMTP states that automation and workplace efficiency will be progressed through Digital Pioneers projects and pilot initiatives. A central proposed enabler will be the establishment of a digital innovation lab, intended to support idea generation, feasibility assessment, and prioritisation of technology proposals from across the organisation.

The use of AI and Automation is also included within the business case proposal for the 111 Digital Front End, further demonstrating the Trust’s commitment to leveraging new technologies to enhance service delivery.

However, at present, there is limited dedicated resourcing to support the development and implementation of AI or automation. There is no formally established team responsible for this area, and only one developer is in place to support automation, resulting in limited capacity to develop AI capabilities (see **Key Finding 1**). While discussions indicate that consideration is being given to the appointment of an automation manager, this role has not yet been established.

Key Findings		Risk & Impact	Agreed Management Action
1	Resourcing for AI and Automation Delivery At present, there is limited dedicated resource to support the development and use of AI or automation. No formally established team is in place, with only one developer supporting automation and limited capacity to progress AI capabilities.	The Trust may not be able to deliver the objectives as set out within the IMTP and Digital Plan, limiting the realisation of anticipated benefits and innovation.	Agreed Action: The Trust has already invested in dedicated automation capability through the recruitment of a Low Code and Automation Developer to support the development and adoption of automation technologies across the organisation. Whilst a dedicated AI and Automation function is not currently established, automation and AI initiatives continue to be progressed through existing Digital Directorate resources, governance arrangements, and programme delivery structures. Management acknowledges that demand for automation and AI capabilities is increasing and that there is a need to ensure available resources are aligned to organisational priorities. However, the Trust considers that future resourcing requirements should be informed by evidenced demand,

		strategic priorities, and delivery capacity rather than predetermined organisational structures. To support this, the Trust is establishing a Digital Oversight Group (DOG) to provide formal governance, prioritisation, and oversight of digital innovation, automation, and AI initiatives. This will provide improved visibility of organisational demand, anticipated benefits, resource requirements, and delivery capacity, enabling informed decisions regarding future operating model and resourcing requirements. The Trust will utilise the Digital Oversight Group to establish a prioritised pipeline of automation and AI initiatives, assess organisational demand, and review delivery capacity against strategic objectives. This will inform future decisions regarding the operating model, governance arrangements, and any additional resource requirements necessary to support sustainable delivery. Expected Evidence of Implementation • Approved Terms of Reference for the Digital Oversight Group • Prioritised pipeline of automation and AI initiatives • Evidence of governance oversight and prioritisation decisions • Review of automation and AI demand, capacity, and resource requirements through established governance processes
Theme: Resourcing	High Priority Control Design	Officer: Wyn Morris, ICT Service Desk Manager Target Implementation Date: 31st December 2026

Objective 2: Appropriate controls and guidance are in place for the use of technology which protects information, accounts, and ensures that models are accurate, free from bias and protect information.

Limited

There is currently limited formal guidance available to support the safe and appropriate use of AI within the Trust. The Trust does not currently have an approved AI Policy in place. While discussions have taken place with Digital Health & Care Wales (DHCW) regarding the adoption of an All-Wales AI policy, the Trust has concluded that the proposed national approach would not be suitable for its specific operational needs. Our review of other NHS Wales organisations identified that, at present, only Velindre NHS Trust has an approved AI policy in place.

The Trust is in the process of developing its own AI policy. The most recent draft (dated November 2025) was supplied to us; however this has not yet progressed through the Trust’s formal approval process. In the absence of a formal policy, interim digital guidance was issued in January 2025 on the general use of AI for work, and in April 2025 to support the safe use of Microsoft Copilot. While these provide staff with some direction, the guidance is limited in scope and does not fully address wider AI-related risks, including data protection, bias, model accuracy, and acceptable use. It does not set out a clear mechanism for staff to assess, approve, and monitor the use of AI tools (see **Key Finding 2**).

Uncontrolled or unguided use of AI increases the risk of data leakage and reliance on inappropriate or inaccurate models. The Trust has acknowledged this risk, reflected by the inclusion of AI-related risks within the risk register, with oversight provided through the Information Governance Steering Group.

At present, AI usage within the Trust is limited. An AI Steering Group has been established to monitor, guide and provide oversight over the use of AI tools. Our review identified that the group maintains a log of AI implementations and use cases and monitors the AI related deliverables within the IMTP. In the absence of a formal governance framework, the group is trialling the use of a structured decision-making and problem-solving approach to assess AI proposals against seven pillars of responsible AI use.

The use of copilot is controlled, with a formal request and approval process in place. Requests for access are recorded and assessed prior to approval. Monitoring arrangements are also in place through Microsoft Purview, and firewall controls enable tracking of access to public AI, with high-risk sites restricted.

The development of automation is restricted to digital staff. While each development is subject to a Data Protection Impact Assessment (DPIA), there is limited formal guidance on the design and development of automation solutions. There are no standard operating procedures (SOPs), standard templates for documenting automated processes, or defined governance requirements. While the current restricted use enables visibility and direct management of automation, this approach is unlikely to remain sustainable as automation adoption increases across the Trust (see **Key Finding 3**).

Key Findings		Risk & Impact	Agreed Management Action
2	AI Policy and Governance Framework The AI Policy has not yet been approved or implemented. Interim guidance is in place but does not comprehensively address AI risks or define acceptable use. There is no formal mechanism for staff to assess, approve or govern the use AI products.	Increased risk of data leakage and the use of inappropriate, biased or inaccurate AI models, potentially leading to regulatory, reputational, or operational impacts.	Agreed Action: The Trust will finalise, approve, and implement the Artificial Intelligence (AI) Policy and supporting governance framework, building upon the controls and governance arrangements already established through the Artificial Intelligence Steering Group (AISG) and wider Information Governance structures. This will include:

			• Formal approval and publication of the AI Policy • Communication and awareness activity to support staff understanding of AI risks, responsibilities, and acceptable use • Establishment of a standardised process for the assessment, review, and approval of AI technologies and use cases • Definition of roles, responsibilities, and governance arrangements for AI oversight • Integration of AI-related risks and assurance activities within existing governance and risk management processes • Development of supporting guidance, standards, and implementation materials to support the safe, ethical, and compliant use of AI technologies across the organisation These arrangements will ensure that AI technologies are subject to appropriate governance, risk assessment, oversight, and assurance prior to implementation and throughout their operational lifecycle.
			Expected Evidence of Implementation: - Approved AI Policy. - Evidence of communication and staff awareness. - Established governance and approval processes.
			Officer: Leanne Smith, Assistant Director of Digital Services: Data & Analytics Target Implementation Date: 31st December 2026
	Theme: Policies & Procedures	Control Design	
3	Automation Development Standards and Guidance There are no SOPs, standard templates or formal guidance for the development of automated processes. Currently controls rely on restricted access rather than formalised governance.	Automated processes may be inconsistently designed, increasing the risk of operational failure, control weaknesses, or non-compliance with governance and data protection requirements.	Agreed Action: The Trust recognises the value of establishing a more formal and consistent approach to automation governance as the use of automation technologies continues to expand across the organisation. Whilst a range of governance and assurance activities are already undertaken as part of automation delivery, including design documentation, testing and validation, DPIA assessment, information governance review, and stakeholder engagement, these processes have evolved over time and

		are not currently supported by a single, standardised framework, set of templates, or documented procedures. To support the continued growth of automation and digital innovation activity, the Trust is currently developing a standardised automation intake and governance solution. This will provide a consistent mechanism for the submission, assessment, prioritisation, approval, and documentation of automation opportunities, whilst ensuring appropriate governance, security, and information governance considerations are incorporated throughout the lifecycle. This work will support the introduction of standard operating procedures, templates, documentation standards, and approval processes, providing a clear and proportionate governance framework for future automation activity. The Trust will implement a standardised automation governance framework through the development of the automation intake and governance solution. This will include: • Standard operating procedures and guidance documentation • Standard templates and documentation requirements • Defined approval, security, and information governance requirements • Consistent assessment and governance processes for automation requests • Alignment with Digital Oversight Group governance arrangements
		Expected Evidence of Implementation: • Approved SOPs and supporting templates • Standardised automation intake and governance process • Evidence of consistent documentation for new automation initiatives • Defined and implemented approval processes • Governance records demonstrating oversight and decision-making
	Medium Priority	Officer: Kara Walsh, ICT Service Desk Manager Target Implementation Date: 31st December 2026
Theme: Policies & Procedures	Control Design	

Objective 3: An appropriate process is in place to control the creation of automated processes and the resource use, with an assessment process to ensure only suitable processes are automated and benefits are defined and realised

Reasonable

Automation capability within the Trust is delivered by Blue Prism and Power Automate (PA). However, use of Blue Prism has been limited in recent years, with no new developments undertaken, despite ongoing licensing costs.

The Trust maintains an inventory of automated processes currently in operation. Development of Power Automate solutions is restricted to the Digital Services directorate, while Blue Prism automations are provided by an external contractor due to limited in-house capacity. Requests for automation are submitted to Digital Services, and a significant number of potential automation opportunities has been identified across the Trust. However, due to current resource constraints, only a subset of requests can be progressed. A backlog has developed which, at current capacity, is projected to take until November next year to clear.

The automation request process includes submission of a standard form, capturing key information including the process to be automated and the current resource requirements (staff time and effort). This provides a documented baseline against which potential and realised benefits can be assessed.

Assessment of automation requests is undertaken by Digital Services staff based on professional knowledge and experience. However, there are no formal procedures or documented criteria which would set out the basis for prioritisation. In practice, priority is given to requests from senior management, higher-risk areas, and those expected to deliver significant value. While this approach provides some direction, it lacks transparency and consistency, limiting assurance that resources are being optimally allocated to maximise organisational benefit (see **Key Finding 4**).

We note that a Digital Oversight Group is in the process of being established, with one of its intended roles being to ensure digital initiatives, including automation, are prioritised appropriately. Once operational, this should improve clarity and formalisation of prioritisation processes, including a potential introduction of a structured assessment and scoring methodology.

The current request process captures key information on the "as is" process, rationale for automation, and baseline resource usage (including time and effort). This enables the Trust to assess relative value, target automation effort effectively, and demonstrate realised benefits. Some tracking of realised benefits is in place, particularly from the Blue Prism automations, and these are being formally reported.

Key Findings		Risk & Impact	Agreed Management Action
4	Prioritisation and Governance of Automation Requests There are no formal procedures or documented criteria in place which set out the basis for prioritisation of automation requests, resulting in limited transparency over how decisions are made and how resources are targeted to maximise organisational value.	The Trust may not direct limited automation capacity towards the highest-value or highest-risk processes, reducing overall efficiency gains	Agreed Action: The Trust recognises the importance of ensuring automation opportunities are assessed, prioritised, and governed in a consistent and transparent manner to maximise organisational benefit and ensure available resources are directed towards the highest value activities. Whilst automation requests are currently reviewed through existing Digital governance and operational processes, the Trust acknowledges that there is an opportunity to formalise and

		and benefits realisation.	standardise the approach to prioritisation, assessment, and decision-making. To support this, the Trust is establishing the Digital Oversight Group (DOG) and developing a standardised automation intake and governance solution. Together, these arrangements will provide a structured mechanism for the submission, assessment, prioritisation, approval, and oversight of automation opportunities across the organisation. The framework will incorporate defined prioritisation criteria, including factors such as strategic alignment, risk reduction, efficiency gains, capacity release, resource requirements, dependencies, and anticipated organisational benefits. This will provide greater transparency of decision-making and ensure automation capacity is directed towards initiatives delivering the greatest value to the Trust.
			Expected Evidence of Implementation: • Approved Terms of Reference for the Digital Oversight Group • Prioritised pipeline of automation and AI initiatives • Evidence of governance oversight and prioritisation decisions • Review of automation and AI demand, capacity, and resource requirements through established governance processes
		Medium Priority	Officer: Wyn Morris, ICT Programme Manager Target Implementation Date: 31st December 2026
Theme: Policies & Procedures		Control Design	

Objective 4: Appropriate processes are in place to fully document the design of automated process and test the final product with the operation of new technology monitored to ensure they operate as expected

Reasonable

As noted within previous objectives, there are no standard templates for formally documenting the design of automated processes. Currently, process documentation is maintained in Excel and includes confirmation of testing and identification of target systems. However, it does not provide comprehensive coverage of key elements such as full logical flow of the process, data flows, formal user approval of the design, validation of testing outcomes, and formal approval prior to deployment (see **Key Finding 5**).

While the current level of automation remains relatively limited, which enables direct oversight by the Digital Services team, the absence of structured documentation and formalised processes presents an increasing risk as automation adoption expands. This risk is particularly relevant if development capability is extended beyond the Digital Services Directorate.

Appropriate environment segregation is in place, with separate development, test, and production environments. Automated processes are progressed through these stages appropriately. We note ongoing improvements in change control arrangements, including the introduction of a managed deployment pipeline, which will better track amendments and reduce the risk of unauthorised changes within the production environment.

Processes are in place to monitor the operation of automated solutions. For Blue Prism, this is supported through its command centre, which enables live monitoring of processes. For Power Automate, monitoring is undertaken through a combination of manual review and use of the Power Platform dashboard.

There are established alert mechanisms for process failures, with automated notifications (e.g. email alerts) triggering when issues occur. Consideration is given as part of the development process of where to build in alerts; however, this is not supported by formal guidance and relies on developer judgement and experience (see **Key Finding 5**).

Current monitoring arrangements are largely reactive, with issues identified after failures occur. There is currently no proactive monitoring or warning in place to identify processes that are stalled, running longer than expected, or consuming excessive system resources. While this risk is currently mitigated by the small scale of automation activity, it is likely to increase as usage grows. Incorporating expected run times during testing and embedding timeout controls within automation logic would help mitigate this risk (see **Key Finding 5**).

Key Findings		Risk & Impact	Agreed Management Action
5	Automated Design, Documentation and Approval There are no standard templates for documenting the design of automated processes. Existing documentation does not fully capture process logic, data flows, testing validation, user approval, or formal approval prior to deployment.	Automated processes may not operate as intended, resulting in processing errors, data integrity issues, service disruption, or failures that are not promptly detected or effectively managed.	Agreed Action: The Trust recognises the importance of ensuring automation solutions are designed, tested, approved, and monitored in a consistent and proportionate manner. Whilst design documentation, testing activities, user validation, DPIA assessment, and governance reviews are already undertaken as part of automation delivery, these arrangements have evolved over time and are not currently supported by a single, standardised framework applied consistently across all automation activity. To support the continued growth of automation and digital innovation, the Trust is developing a standardised automation intake and governance solution, alongside the establishment of the Digital Oversight Group (DOG). These arrangements will provide a structured and consistent approach to the design, assessment, approval, implementation, and monitoring of automation initiatives. The framework will introduce standard templates, documentation requirements, approval processes, and assurance controls, whilst maintaining a proportionate approach based on the complexity, scale, and risk profile of the automation being implemented.
		Medium Priority	Expected Evidence of Implementation: • Approved templates and documented procedures • Completed design and testing documentation for new automations • Evidence of formal approvals prior to deployment • Monitoring and alerting standards in place and applied
	Theme: Information, Data Quality & Data Accuracy	Control Operation	Officer: Kara Walsh, ICT Service Desk Manager Target Implementation Date: 31 st December 2026

Objective 5: An appropriate process is in place to ensure that changes to the environment in which automated processes operate are assessed for the impact, changes to automated processes are recorded and appropriate continuity planning is in place to enable the organisation to operate in the event of the failure of the technology.

Reasonable

The automation of a manual processes enables the release of staff capacity within operational departments, this time can then be reallocated to new tasks. However, it is recognised that automated solutions are inherently sensitive to changes in their operating environment, including updates to underlying systems, applications, interfaces and platforms. Frequent system updates or configuration changes create a risk that automations may fail, leading to a continuous cycle of rework and maintenance. In the case of a failure of automation there may be a need for a temporary return to manual processes.

A Digital Change Board in operation within Digital Services, with representation from the ICT Service Desk Manager, which helps in the identification of system changes that may impact automated processes. However, this process is reliant on individual awareness of automations dependencies and may not consistently identify all potential impacts.

The Trust maintains a record of automated processes, including details of target systems and required permissions, which enables visibility over environmental dependencies. However, this information is not consistently completed and, combined with the absence of detailed process design documentation, this further limits the Trust's ability to fully understand and manage dependencies between automated processes and the wider technical environment (see **Key Finding 7**).

Automation activity within the Trust is currently at an early stage. While Digital Services highlight the need for departments to have continuity arrangements in place to manage potential automation failure, there is no formal requirement for these plans to be documented, reviewed, or approved prior to going live. As a result, there is limited assurance that departments are appropriately prepared to maintain service delivery in the event of automation failure (see **Key Finding 6**).

Key Findings		Risk & Impact	Agreed Management Action
6	Continuity Planning for Automated Processes Although departments are advised to maintain continuity arrangements for automated processes, there is no formal requirement to document, validate or approve these arrangements prior to deployment.	Failure of automated processes may disrupt service delivery and require unplanned or unsupported reversion to manual processing, potentially impacting performance and service quality.	Agreed Action: The Trust recognises the importance of ensuring appropriate continuity arrangements are considered as part of the development and implementation of automated processes. Responsibility for the development, maintenance, and approval of Business Continuity Plans (BCPs) and Business Impact Assessments (BIAs) remains with the relevant service area, supported through the Trust's Emergency Preparedness, Resilience and Response (EPRR) arrangements. Continuity and resilience considerations are already incorporated within existing governance processes, including through the DPIA process completed for automation initiatives, which requires consideration of business continuity and disaster recovery arrangements. In addition, service owners are expected to consider operational fallback

			arrangements and service continuity requirements as part of the automation design and implementation process. However, the Trust acknowledges that there is an opportunity to strengthen the consistency with which these considerations are formally documented, evidenced, and acknowledged prior to deployment. To support this, the Trust is developing a standardised automation intake and governance solution, alongside the establishment of the Digital Oversight Group (DOG). These arrangements will ensure continuity and operational resilience considerations are explicitly captured as part of the assessment, approval, and implementation process for automation initiatives.
			Expected Evidence of Implementation: • Standardised automation intake and assessment documentation incorporating continuity requirements • Evidence of service owner acknowledgement and approval prior to deployment • Confirmation of departmental ownership of relevant BCP and BIA arrangements
			Medium Priority
	Theme: Information, Data Quality & Data Accuracy	Control Operation	Officer: Kara Walsh, ICT Service Desk Manager Target Implementation Date: 31st December 2026
7	Management of Automation Dependencies and Change Impact Records of automated processes include target systems and required permissions which enables tracking of environmental dependencies. However, this information is not consistently completed, and there is no formal mechanism to identify, document and assess dependencies between automated processes and their operating environment.	Changes to applications, platforms, or configurations may cause automated processes to fail unexpectedly, leading to processing errors, delays, or service disruption.	Agreed Action: The Trust will incorporate dependency management and change impact assessment requirements into the automation governance framework and associated intake process. This will include: • Identification and documentation of system, application, infrastructure, and permission dependencies • Recording of automation owners and key stakeholders • Assessment of potential change impacts during design and implementation activities

			• Consideration of dependencies as part of governance and approval processes • Governance oversight through the Digital Oversight Group These requirements will be embedded within the Trust's automation intake and governance solution to improve visibility of dependencies and support the proactive management of changes affecting automation services.
			Expected Evidence of Implementation: • Completed and maintained dependency records • Documented change impact assessment requirements • Standardised automation documentation and governance processes • Evidence of governance oversight of changes affecting automation
		Medium Priority	
Theme: Information, Data Quality & Data Accuracy	Control Operation		Officer: Kara Walsh, ICT Service Desk Manager Target Implementation Date: 31st December 2026

Appendix A: Assurance Opinion & Prioritisation of Findings

Assurance Opinion

	Substantial	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	Unsatisfactory	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Advisory	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Disclaimer

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Welsh Ambulance University NHS Trust, and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

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Gwasanaethau Ambiwylans Cymru
Welsh Ambulance Services
University NHS Trust

Agenda Item No.

13

REPORT TITLE

Digital Reporting

MEETING

Name of meeting	Finance & Performance Committee
Date of meeting	21 July 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Jonny Sammut, Director of Digital Services
Author(s) of report	Leanne Smith, Kimberly Abraham and Digital Leadership

PURPOSE OF REPORT

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

REPORT SUMMARY

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

1. This report brings to the committee updates relating to activities of the Insight & Data Services (IDS), ICT, Digital Transformation & Innovation, and the Clinical Digital Unit functions, aligned to the IMTP deliverables, Local Directorate Plan for 2026-27, and the Strategic Digital Plan 2024-29 (see the **Annex 1** for metrics and project status).

Alerts

2. **Workload & Prioritisation:** The Digital teams are still involved in a significant number of projects and delivery activities, often with competing priorities and limited specialist capacity to facilitate all organisational needs, and new requests received regularly throughout the year. Part of the remit of the new Digital Oversight Group (DOG) - which will launch in Q2 (see paragraph 6) – will be to review new incoming requests against capacity and requirements, and balance priorities for the different Digital professions. In the meantime, a view of the Data & Analytics specific projects was taken through to CMT Board in early July, to support a decision around reducing volume of in-year commitments and providing a more realistic set of focussed projects for the team.

Highlights

3. We continue to make progress on recruitment for core roles across the directorate:
 - The **Digital Transformation & Innovation** team have now appointed the Digital Adoption Facilitator who is due to start with the team mid-July. This role will be key to achieving key IMTP milestones linked to embedding co-design and person-centred digital adoption in our directorate.
 - An appointment has been made to the new **Digital Business Manager** post, with the individual joining the Directorate in September.
 - **Clinical Digital Unit** Over the past month, the CDU has focused on a comprehensive scoping exercise to identify and assess all digital systems and applications that may require a Clinical Safety Case under two national standards: DCB0129 (i.e. a risk assessment by the health IT system manufacturer) and DCB0160 (i.e. a risk assessment by the implementing healthcare organisation). This work has involved reviewing existing systems, mapping clinical workflows, engaging with system owners, and evaluating the potential impact of digital solutions on patient safety. The objective is to establish a clear understanding of the Trust's clinical safety compliance landscape, ensuring that appropriate governance, hazard management, and assurance processes are in place for all systems that support or influence clinical decision-making and patient care. This proactive approach will provide greater assurance of regulatory compliance, support future digital developments, and strengthen the Trust's overall clinical safety governance framework.



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- **Digital 111 Online (Digital Front End)** Recruitment to the core leadership team is progressing, with interviews for the Head of Service and Product Manager roles scheduled for later in July. In parallel, two additional positions have now completed the job evaluation process and are progressing to Trac for recruitment, supporting the continued development of the team and ensuring sufficient capacity to deliver the programme's key workstreams.
 - Recruitment activity continues across the **ICT team** with several appointments into current vacancies, including a new Digital Automation and Low Code developer role. A number of vacant roles are progressing through various stages of recruitment but unfortunately, several recent resignations, in ICT Contract Manager, ICT Engineer and Service Desk, will mean recruitment activity will continue for the foreseeable future. If there is a positive to be taken from the situation, it is to see staff develop and their career progress albeit outside of WAST
4. **Clinical Model Transformation (CMT):** Digital continue to support the CMT with significant contribution already made in Q1 of 2026/27 (see Annex 1 for an overview of the workstreams). Highlights from the current reporting period include:
- **Online Symptom Checkers (Digital Front End):** Progress continues on the development of the online symptom checkers. ICT has deployed the latest update to the test environment, and testing of the enhanced administration functionality is underway. Build activities for the live system servers continue to progress in line with supplier updates, while UAT conducted by operational testers remains ongoing to verify readiness for the next stage. Integration with the 999 CAD system and the address validation solution is currently being tested within the suppliers' test environment. Welsh-language translation has been completed, subject to any further amendments identified through testing.
 - **Virtual Assistant (Digital Front End):** Following the conclusion of the four-week live Agent web-chat pilot, system metrics and lessons learned feedback have been captured and are being compiled into a report to pass through CMT governance soon. Work is ongoing on the integration of WhatsApp which is expected to be trialled later in Q2. Additionally, the team have been shortlisted for a Health Services Journal Digital Award – under the category of 'empowering patients through digital'. The award ceremony is taking place later this month.
 - The **CMT Benefits** group will see Digital involved in several of the workstreams, including Call Flow Phase 3 (and various analysis investigations), Data Linkage (with the wider system), and the academic CMT Evaluation (with Edge Hill). Whilst these are priorities for the IDS team in particular, there will need to be consideration of other IMTP deliverables and Local Directorate Plans for the year, as the involvement in CMT is still a significant draw on resources from Digital.
5. **National DOS:**
- The initial draft of the Single Directory of Services Business Case has been reviewed in detail by WAST, including discussion through the Digital Leadership Group, and a coordinated



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response has been submitted to the Programme Team. WAST strongly supports the ambition for a Once for Wales Directory of Services, while recommending a model that separates cross-sector strategic governance from operational delivery through a single accountable national delivery organisation. WAST has highlighted its existing national digital delivery, information governance and NHS 111 Wales capabilities, alongside its expanding 111 Digital function and AI-enabled services, as a strong foundation for potentially supporting this role. WAST will continue to support the programme and awaits further engagement from the Programme Team.

6. **Digital Oversight Group:** There has been significant progress with planning and launching the Digital oversight Group. Governance documentation is in final stages before being approved including process flows, Standard Operating Procedures, Terms of Reference and scoring matrices. This will ensure that all approved work is agreed upon transparently and is prioritised accordingly. In addition, SharePoint pages have been drafted to sit on the Digital Services directorate homepage to highlight the new process of requesting digital support. These pages communicated what DOG is, why it is needed, and how to make a request. To support this directorate and trust-wide communications will also be published in line with DOG go-live, which is due across July/August 2026.
7. **Human-centred design with the wider digital leadership team:** The third and final human-centred design thinking workshop was held with members of the Wider Digital Leadership Group and key stakeholders from the wider trust. At this workshop, the new CAD, ePCR and 111 Online projects were used as examples of projects that require ongoing co-design and stakeholder involvement. During this facilitated workshop, groups participated in empathy mapping, communication styles and problem-solving exercises.
8. **ePCR refresh:** The wider application refresh programme continues to progress well and remains on track for deployment in Q4. WAST has now been designated as the UK's official TerraPACE reference site, a significant recognition of the organisation's digital maturity and partnership with the supplier. This status provides WAST with early access to new platform capabilities, including EPR4, the next-generation engine underpinning the application, this will enable on device AI usage to support clinicians at the point of care, by guiding them during ePCR completion, live translation services, through to post incident analysis in natural language questioning, enabling us to influence product development, shape future functionality, and realise service improvements ahead of wider market adoption. It also strengthens WAST's position as a leading organisation for digital innovation within the ambulance sector. In addition, the tenant structure has now been developed and configured to accurately reflect the workforce structures across both the Clinical and Operations Directorates, providing a robust foundation for deployment, governance, and future service development.
9. **AI Developments:** Following an in-depth discussion on skill atrophy, and the considerations of each element of the (interim) Responsible AI governance framework used within WAST,



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there are several risks which relate to the existing BAF Risk regarding AI use which are now better understood. The BAF risk will be updated to include narrative around skill atrophy risk. The AISG have also reviewed an AI e-learning module, in development with WAST's Education & Development team. This module has a strong focus on ensuring it is practical, accessible, and aligned to organisational needs and existing digital literacy approaches, and was welcomed by the group. Finally, the AI Steering group has undertaken a maturity assessment to establish the Trust's current AI maturity position and future ambition. The assessment is intended to support development of a tailored roadmap for WAST, covering governance, policy, responsible AI, ethics, bias, skills and organisational capability. The assessment exercise identified the need for clarity on the Trust's AI ambition and strategic direction to guide prioritisation, governance and investment.

10. **GRS Cloud:** GRS migration took place successfully over 12 to 13 May 2026 (dates as planned), with post migration hyper-care support provided by the vendor and WAST ICT and Resourcing teams for 2 weeks. Minor issues experienced, mostly user login related, due to data quality within ESR around Trust primary UPN [Email] information for Single Sign On requirements. Android mobile application is not yet available and under investigation by the vendor. On-premises system has been fully decommissioned. GRS Support SharePoint page will continue to evolve as required and support is now under BAU processes.
11. **eTimesheets:** A specification has been developed which will see these two projects (GRS Cloud and eTimesheets) come together. Work completed between WAST, the supplier and DHCW regarding the Microsoft Azure tenant integration – which is now functional and allows login to GRS Cloud client. The specification has been submitted to vendor and is still under review.
12. **ESN Phase 2:** In June 2026 the Operational Communication Programme Board approved the endorsement from DLG to continue on the ESN journey with ARP and align with the English Ambulance Trusts. Both ARP and the Home Office have been made aware. One ESN Phase 2 FBC will be submitted to Welsh Government in September/October, encompassing Air to Ground, handheld radios, fixed vehicle devices (radio), field services and the resources required until 2031/32 Dates have been agreed with the relevant committees for the Governance route. The ESN Phase 2 FBC will be presented to OCP Programme Board on 23 July, at the Executive Leadership Team meeting on 5 August, Finance and Performance Committee on 15 September and at the Trust Board on 24 September.
13. **Paramount Migration:** On 30 June ICT successfully migrated the 999 CAD decision support and prioritisation systems, MPDS system and ProQA Paramount, to a new infrastructure. The migration covers the Live, Test, and Development environments. The system is now hosted on upgraded hardware with enhanced capacity and performance. In addition, it utilizes high-availability databases, improving system resilience, reliability, and overall service continuity.

Lowlights



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14. Support continued for the **Clinical Model Transformation**, although some challenges regarding data flows and reporting are still present:

- **The Integrated Clinical Call Queue (ICCQ):** despite good progress and a successful go-live, ongoing investigations have since revealed some data flow and measurement issues, with external 111 performance reporting remaining paused temporarily while data validation takes place relating to the “time to start triage” and “consult & close rate” metrics.
- **CMT Phase 1 and 2 reporting issues:** additionally, there are issues with other metrics and identification of data, for example, a null priority was being applied by the CAD system to some 999 incidents. A fix was implemented to update the default priority to RCS1, but it should be noted this fix has not been applied retrospectively, so some historical data remains unchanged. Another example is the ongoing work to validate 999 RICS metrics – until these metrics are assured, some internal reports are affected.

15. **CAD Replacement:** The Operations and Digital teams undertook a Design thinking workshop during June 2026 where human-centered design was used to start capturing the future CAD requirements. A formal project will be need to be established and an approach will be made to Planning & Performance to allocate a project manager to commence as soon as possible.

16. **Data Sharing:** An efficient and coordinated approach to national data sharing with system partners across NHS Wales is still reliant on the central work of Welsh Government and DHCW. To allow data to flow into the National Data Resource (NDR) and be shared compliantly, a resolution to the national legislative issues, and clarity on roles and responsibilities of data controllers and processors is required. WAST’s Data Protection Officer has been part of national work by the IG leads group (IGMAG) in proposing the next steps to enable data sharing across Wales.

RECOMMENDATION(S)

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

The Finance & Performance Committee is requested to:

1. Acknowledge the contents of the paper and determine if this provides assurance on the progress of the Digital Plan activities, IMTP commitments and CMT involvement of the Digital Directorate teams.

ADDITIONAL PAPER(S)

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

The Finance & Performance Committee is requested to receive the following:

Annex 1 Digital Reporting July 2026 Metrics



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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

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

RISK(S) THIS REPORT MITIGATES

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

BAF Risk: 671 Inappropriate use of AI Technologies

BAF Risk 623 Failure to comply with Data Protection Legislation (now managed locally by Digital Directorate)

BAF Risk 690 SAR and disclosure of Records compliance

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

☒ Safe	☒ Timely	☒ Effective
☒ Efficient	☒ Equitable	☒ Person Centred

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

☐ Leadership	☒ Workforce	☐ Culture
☒ Information	☒ Learning Improvement & Research	☐ Whole Systems Approach

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

☐ A socially responsible and inclusive employer	☒ An innovative and sustainable organisation	☒ A pro-active, accessible and equitable care provider
☒ n/a	☐ n/a	☐ n/a

IMPACT ASSESSMENTS FOR CONSIDERATION

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

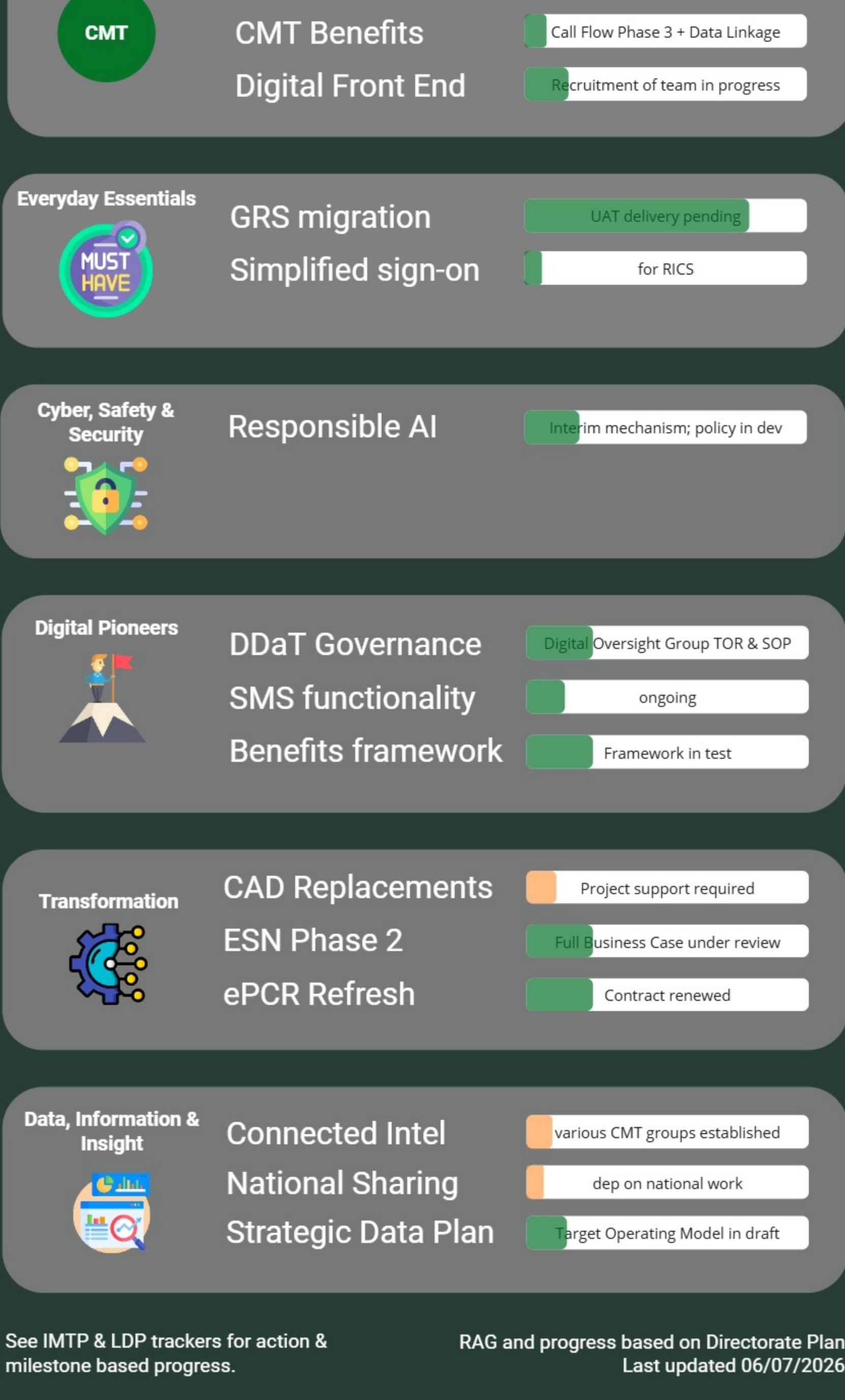
Does this paper require an impact assessment	☒ No ☐ Yes
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If yes, what impact assessment is attached

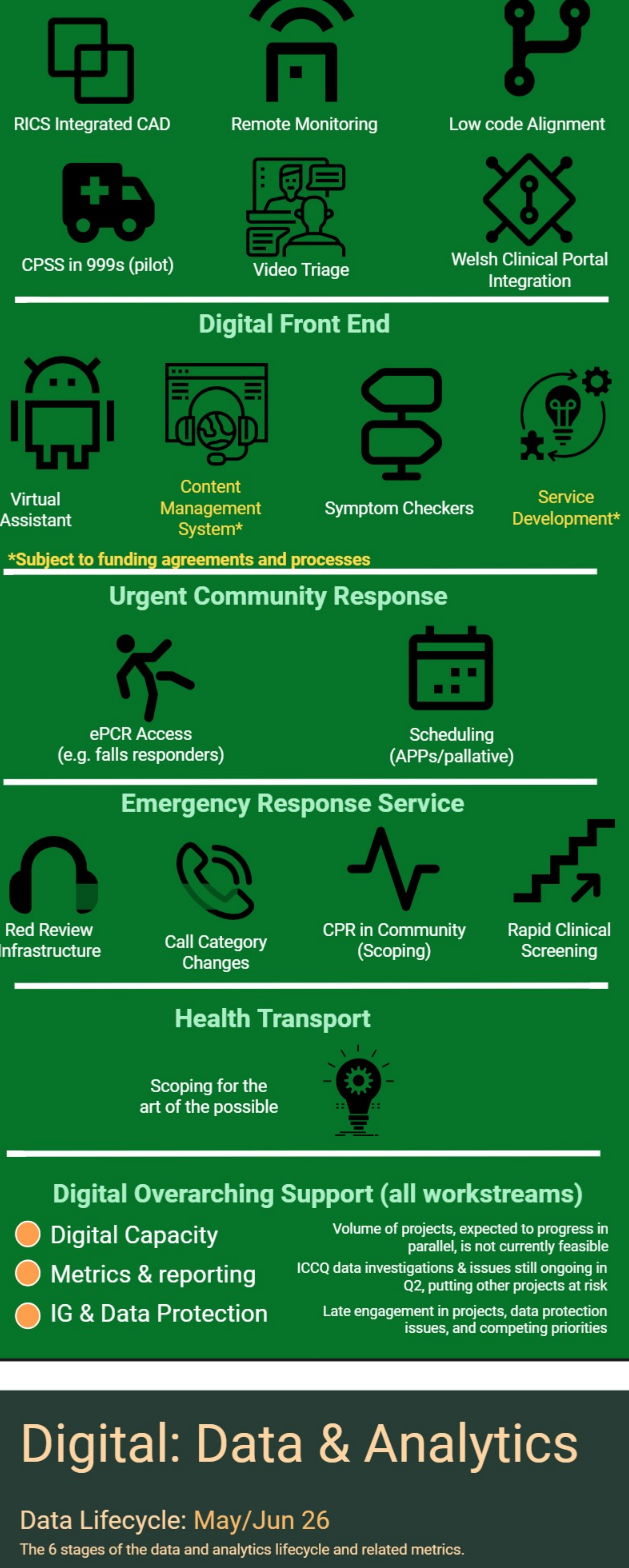
APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
TBA	Digital Leadership Group (sign-off)

Digital Contribution 26/27



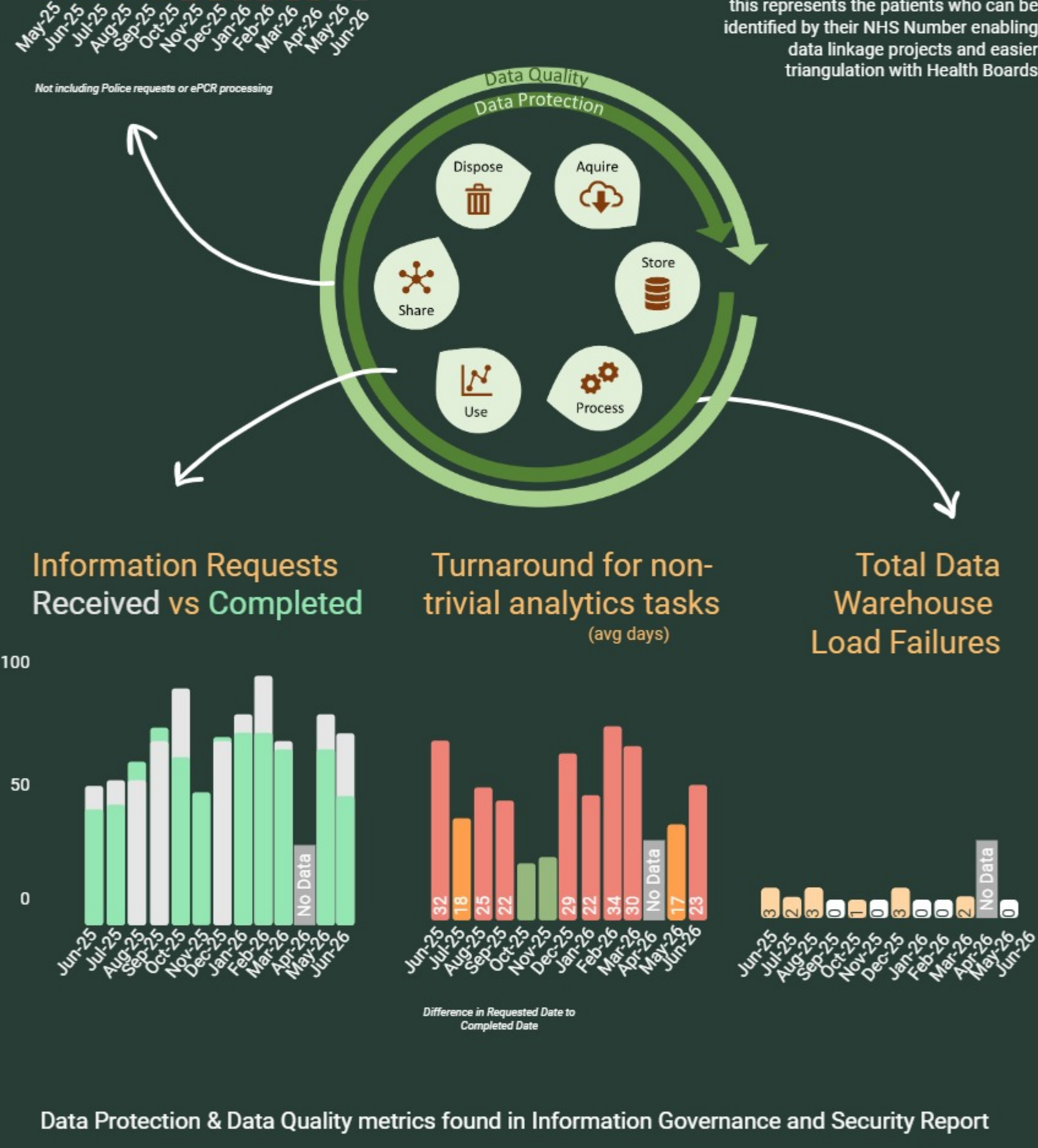
CMT Digital Contribution 25/26



Digital: Data & Analytics

Data Lifecycle: May/June 26

The 6 stages of the data and analytics lifecycle and related metrics.



Data Protection & Data Quality metrics found in Information Governance and Security Report

Digital: ICT Systems

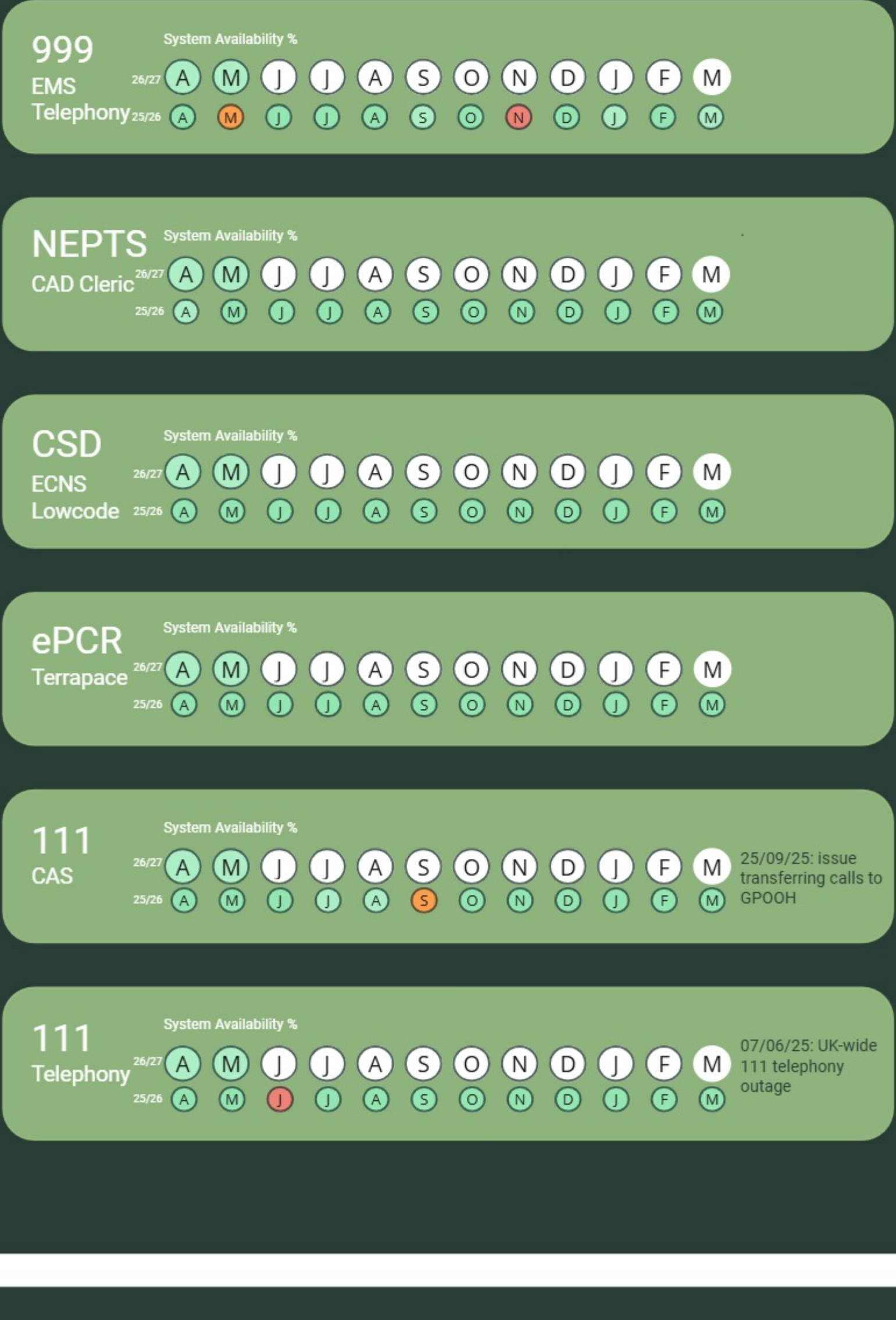
Data for May 2026 unavailable at the time of writing the report

System availability metrics

Each circle represents availability per month. N.B. these are not reflective of SLAs, and do not yet differentiate supplier issues & resolutions

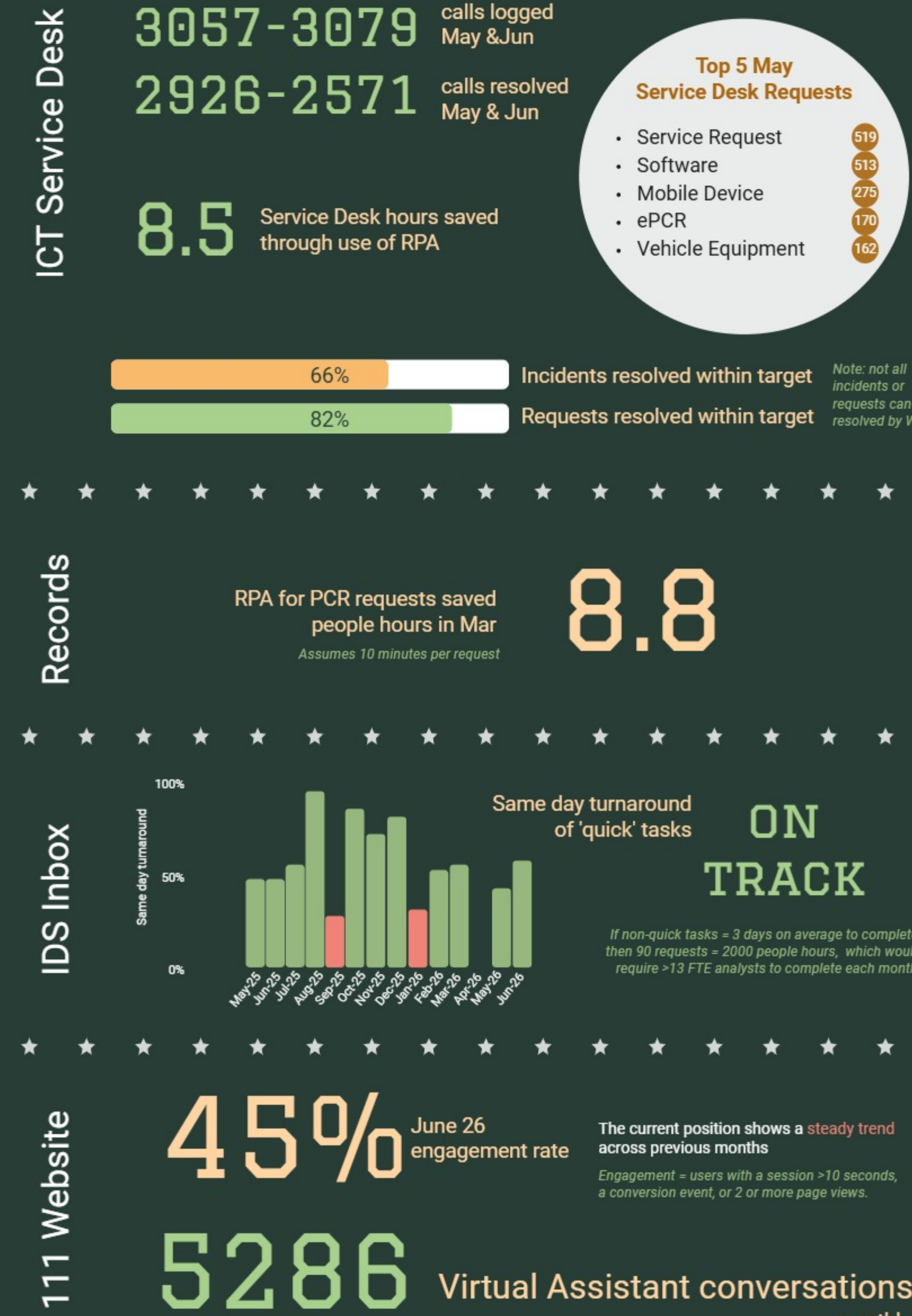
Definitions based on industry standards

- <4.32 mins downtime: >99.99%
- >4.32 and <43.8 mins: >99.9%
- >43.8 mins downtime: <99.9%



Digital: Service Provision

Quality, efficiency, and stakeholder feedback: May/June 26





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Agenda Item No.

14

REPORT TITLE

Information Governance Progress Report

MEETING

Name of meeting	Finance & Performance Committee
Date of meeting	21 July 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Jonny Sammut, Director of Digital Services
Author(s) of report	Dr Leanne Smith, Assistant Director of Digital Services: Data & Analytics

PURPOSE OF REPORT

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

REPORT SUMMARY:

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

1. This report brings to the committee an update on the Information Governance (IG) activities of the Trust and related areas, including Information Security, Records Requests and Management, Freedom of Information, and Data Quality. Information Governance Highlight Reports are presented monthly to the Information Governance Steering Group (IGSG)



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chaired by the Trust's Senior Information Risk Owner (SIRO, and Director of Digital Services). The IGSG reports via AAA to the Executive Leadership Team (ELT).

2. This paper covers data and intelligence from the period of **1 April 2026 to 30 May 2026**, and the topics discussed at the **May** and **June** meetings of IGSG.

Alerts

3. **Cyber:** The Trust's cyber position is improving, but the overall risk remains high because some important controls are not yet fully in place. Good progress has been made on stronger sign-in controls, recovery testing, patching and reducing device exposure. However, further investment and action is still needed to improve visibility of systems and devices, monitor key access risks and reduce the likelihood of disruption to services
4. **Data Breach:** Following a recent cyber security incident with a vendor of a core WAST system, and a resultant data breach, WAST IG and Cyber teams have worked closely to complete the relevant incident reviews and reporting for IGSG oversight. The incident was linked to weaknesses in the third-party system's security controls, including an outdated internet-facing firewall and absence of multi-factor authentication (MFA). WAST data was confirmed as being affected and the Information Commissioner's Office (ICO) was notified along with notifications to affected data subjects (in this case, a number of WAST staff). The ICO have requested additional information regarding the breach in relation to type of data and volume of data subject affected, however, a definitive root cause has not yet been established – WAST have written to the supplier's CEO expressing dissatisfaction with the company's response to the breach. The incident has highlighted wider organisational considerations around third-party supplier assurance, business continuity, contract management and the availability of appropriate assurance documentation.
5. **Prohibition of Destruction:** A 'prohibition of destruction notice' has been issued for all records related to the inquiry into grooming gangs, requiring WAST to retain relevant records from January 1996 to March 2029. All relevant stakeholders, including the Records Teams and Denbighshire County Council (who provide archive storage facilities), have been notified. Additional work will continue to confirm technical arrangements to prevent destruction of records including litigation holds and e-discovery holds. A report on this will be brought back to a future IGSG meeting.
6. **Records Request Compliance & The Records Recovery Taskforce:** Records request disclosure processes and compliance remains an area of active management following a previously identified risk, historic complaints, and recent breaches of response timescales. A taskforce was established, and has successfully completed an initial eight-week recovery period, with improvements across compliance, efficiency, quality assurance, process improvement and people / change themes. For example new Standard Operating



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Procedures, template letters, and decision-support tools are now in place. The collaborative approach has strengthened oversight and introduced improvements to working practices. Progress against the recovery plan has supported a proposed reduction in the relevant BAF risk score from 16 to 12 (target of 8), with further reductions anticipated as remaining actions are completed and embedded. With the support of the IGSG, the taskforce will continue for a further eight weeks to support transition into business as usual. A closure report and transition plan will then be presented back to IGSG, cross-referencing relevant BAF risk and IG audit actions, setting out the delivery trajectory and identifying any residual risks requiring continued oversight.

Highlights

7. **FOI Performance:** An FOI policy has been drafted and approved for trust-wide consultation, but consultation is delayed due to the development of an FOI EIR handbook. FOI compliance improved from March to April, with 17 FOI requests received and closed in April; 41.2% were responded to within the statutory 20 working day timeframe, while nearly 59% exceeded the deadline. For May, compliance reached about 55% with the month not yet complete, indicating a positive trajectory. Discussions are ongoing about improving redaction processes and procedures for FOI requests, with plans for software demos and further process enhancements.
8. **DPIA Backlog:** all backlog DPIAs have now been risk assessed, enabling a prioritised plan focusing first on high-risk, live items. Each Directorate will be asked to nominate a representative to review their DPIA backlog list, integrating operational priorities with the IG risk-based approach. DPIA training materials are ready, with a Q&A session scheduled and a new DPIA template being integrated. Coordination with Business Managers is planned to streamline prioritisation and address both new and outstanding DPIA needs.
9. **Data Breach Log:** with the recent recruitment of a third Data Protection Compliance Manager into the IG team in Digital, a pre-planned data breach management improvement project can now progress at pace. This project includes development of a new procedure and enhanced communications (e.g. short videos for accessibility). The data breach log is already well maintained, with incidents tracked, remedial actions implemented, and ICO notifications handled promptly.
10. **IG Risks & Issues Log:** An IG risk and issues log has been established to strengthen earlier identification, ownership, and oversight of IG risks across the organisation. The log supports a risk-based approach to IG management, ensuring emerging and existing risks identified through IG activity are captured, reviewed and appropriately aligned to local or corporate risk registers, rather than duplicating existing risk frameworks. This provides improved visibility, escalation, and assurance that information governance risks are actively managed and embedded within established governance arrangements.



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11. **AI Steering Group:** Guidance for using Copilot in AAA reporting was reviewed by the AI Steering Group, with endorsement for this to be implemented across the Trust. The AI Steering Group have also conducted a maturity assessment exercise, the results of which were planned to be used to inform a Board Development Session on Digital Maturity, however, this session has been postponed until Q3 following recent operational pressures on the service. In the meantime, the AI ambition, strategy, maturity and risk discussions continue at AISG, with a recent deep dive into "Skill Atrophy", and the impact of AI tools already in use (such as Copilot) on WAST's workforce skill and capacity.
12. **Information Asset Management Group:** following a brief hiatus, the IAMG group resumed regular meetings with an emphasis on priorities for 2026/27 and toolkit initiatives. The Terms of Reference were refined to focus on three key areas in response to earlier feedback. Meeting frequency was adjusted from monthly to bi-monthly, enabling more time for actions to be completed between sessions. The group collectively agreed to establish a more comprehensive work plan, which will be submitted back to IGSG for oversight and appropriate balance. Furthermore, the group's work plan will be incorporated into the DDaT governance framework annual schedule, to ensure alignment and visibility across all workstreams.
13. **Mandatory IG training:** compliance remains consistently above target, around 92% when accounting for staff on long-term sick leave and maternity, meeting minimum expectations of the NHS Wales IG Toolkit. This position has now been sustained throughout 2025/26 and Q1 of 2026/27. This will continue to be monitored closely.

Lowlights

14. **Data Breach Log:** four breaches on the log remain open, with two requiring specific escalation. Notably, the system related to the breach mentioned in paragraph 4, and secondly, outstanding IG actions following previous device provisioning. Additionally, completion of a report into a long-standing data loss breach is still outstanding.
15. **SOEs in SARs and AHRs:** Sequence of Events (SOEs) are automated, system-generated audit logs that record every action related to an incident, often resulting in lengthy documents with only a small portion of information directly relevant to a patient. They are not considered clinical health records, but may contain some personal data. If requested under a Subject Access Request (SAR), only-patient relevant lines are shared, requiring extensive redaction to exclude third-party information and potentially sensitive operational and system details. IGSG are working to review this process, with the need for clear and consistent arrangements and legal validation, and a way to reduce the administrative burden through



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automation if appropriate. National peer groups, IGMAG and NIIAG, are being approached for their views and professional support.

16. **NIIAS Audits:** NIIAS is the audit monitoring solution used across NHS Wales to support the identification and investigation of potentially inappropriate access to patient records. Following a period of reduced monitoring activity due to technical and capacity issues, robust monitoring has now resumed, with five potential breaches identified over the previous two months. The IGSG has reinforced the importance of timely engagement across the organisation, with further reinforcement at Executive and Directorate level to support prompt investigation and management of alerts to regulators. Work is also underway to improve reporting and validation processes, reducing unnecessary resource impact and strengthening the overall process.

RECOMMENDATION(S)

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

The Finance & Performance Committee is requested to:

1. Consider the contents of the paper and whether this gives assurance on the progress of the Trust's Information Governance arrangements and related specialist activities for Data Quality, Records Management, Freedom of Information requests and Information Security.

ADDITIONAL PAPER(S)

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

N/A

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

- | | |
|---|--|
| ☒ SO1: Providing the right care or advice, in the right place, every time | ☐ SO2: Enabling our people to be the best they can be |
| ☒ SO3: Being at the forefront of innovation and technology | ☐ SO4: Developing services in collaboration |
| ☒ SO5: Being quality driven and clinically led | ☐ SO6: Delivering exceptional value |



RISK(S) THIS REPORT MITIGATES

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

BAF Risks:

- 623 – Failure to comply with data protection legislation (no longer on BAF, managed by Directorate)
- 260 - Significant and sustained cyber attack resulting in denial of service and loss of critical system
- 671 – Unauthorised or inappropriate use of AI technologies
- 690 – SAR and disclosure of Records compliance

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

☒ Safe	☐ Timely	☒ Effective
☐ Efficient	☐ Equitable	☐ Person Centred

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

☒ Leadership	☐ Workforce	☐ Culture
☒ Information	☐ Learning Improvement and Research	☒ Whole Systems Approach

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

☐ A socially responsible and inclusive employer	☐ An innovative and sustainable organisation	☐ A pro-active, accessible and equitable care provider
☐ n/a	☐ n/a	☐ n/a

IMPACT ASSESSMENTS FOR CONSIDERATION

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

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

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
07 July 2026	Content taken from May and June 2026 IGSG Highlight Reports and AAAs
09 July 2026	Reviewed by Digital Leadership Group



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Agenda Item No. 15

REPORT TITLE

Internal Audit Report – High Risk Records Policy - ARAC Feedback

MEETING

Name of meeting	Finance and Performance Committee
Date of meeting	21 July 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Lee Brooks, Executive Director of Operations
Author(s) of report	AnnaMaria Williams, Corporate Governance Officer

PURPOSE OF REPORT

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

REPORT SUMMARY

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

1. The Audit Risk and Assurance Committee (ARAC) received and discussed the **High Risk Records Policy** Internal Audit Report at its meeting on 23 June 2026. This report summaries the discussion from that meeting in reference to this report.
2. Felicity Quance, NWSSP Internal Audit, presented the High Risk Records Policy Internal Audit Report, which received an overall rating of **reasonable assurance**. Members noted that the



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high risk records policy played an important role in supporting staff safety and operational decision-making, with effective alert mechanisms in place within the Computer Aided Dispatch (CAD) system and appropriate information-sharing arrangements with partner organisations. However, the audit identified weaknesses arising from reliance on manual processes, inconsistent application of controls and limited governance oversight. Concerns were noted regarding overdue annual reviews of high risk records, inconsistent record management practices and the absence of a formal reporting framework. Seven recommendations were agreed with management, comprising three high-priority and four medium-priority findings, with members noting that a planned digital solution was expected to address many of the issues identified.

3. Judith Bryce welcomed the audit findings and thanked Internal Audit and Trade Union colleagues for their contribution to the review. Judith acknowledged the areas identified for improvement, particularly in relation to governance, oversight and manual processes, and expressed confidence that the recommendations could be addressed through the forthcoming revision of the high risk record policy, implementation of a new digital high risk record system and strengthened reporting arrangements. Members noted that these developments would improve record management, oversight and assurance processes across the organisation.
4. The Chair sought assurance regarding the proposed digital high risk record app and its ability to address the issues identified by the audit. Judith advised that the app would significantly strengthen and streamline the management of high risk records through improved recording, review, reporting and governance arrangements, replacing existing manual processes. Felicity added that Internal Audit had been provided with a demonstration of the app and noted that its built-in controls would improve data completeness, record management and compliance with policy requirements, addressing many of the weaknesses identified during the audit.
5. Members welcomed the proposed actions to address the audit findings and expressed reassurance regarding the planned transition from paper-based processes to a digital solution. Members also welcomed the proposed governance and oversight arrangements being developed to support the implementation and ongoing management of the system.

RECOMMENDATION(S)

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

The committee is asked to:

- (a) note the discussion and feedback from ARAC
- (b) review the report, noting the agreed management actions and mitigations of risk in the area of the report



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The committee will have an opportunity to monitor the closure of these actions and scrutinise impact of those actions in response to audit recommendations via tracker reports and future assurance reporting on this issue.

ADDITIONAL PAPER(S)

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

The Committee is requested to receive the following:

- **Annex 1** High Risk Records Policy Internal Audit Report

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

☒ SO1: Providing the right care or advice, in the right place, every time	☒ SO2: Enabling our people to be the best they can be
☐ SO3: Being at the forefront of innovation and technology	☒ SO4: Developing services in collaboration
☒ SO5: Being quality driven and clinically led	☒ SO6: Delivering exceptional value

RISK(S) THIS REPORT MITIGATES

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

n/a

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

☒ Safe	☒ Timely	☒ Effective
☐ Efficient	☒ Equitable	☒ Person Centred

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

☒ Leadership	☒ Workforce	☐ Culture
☒ Information	☐ Learning Improvement & Research	☒ Whole Systems Approach



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WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

☒ A socially responsible and inclusive employer

☐ n/a

☒ An innovative and sustainable organisation

☐ n/a

☒ A pro-active, accessible and equitable care provider

☐ n/a

IMPACT ASSESSMENTS FOR CONSIDERATION

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

Does this paper require an impact assessment

☒ No

☐ Yes

If yes, what impact assessment is attached

APPROVAL/SCRUTINY ROUTE

Date

23 June 2026

Person/Group/Committee

Audit, Risk and Assurance Committee

High Risk Record Policy

Final Internal Audit Report

2025/26

Welsh Ambulance Service University NHS Trust



Reasonable Assurance

Contents

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Review Reference

Fieldwork

Executive Sign Off

Audit Committee

Executive Lead

Audit Team

WAS-2526-12

March - May 2025

12 June 2026

June 2026

Lee Brooks, Executive Director of Operations

Osian Lloyd, Head of Internal Audit

Felicity Quance, Deputy Head of Internal Audit



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Partneriaeth
Cydwasaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services
Partnership
Audit and Assurance Services



Executive Summary

Purpose

This review assessed the mechanisms in place to record and store information in relation to High Risk Records (HRRs), including how information is acted upon to inform operational responses to requests for assistance and support the safety and security of staff and service users.

Overview

HRRs are designed to alert staff to situations where increased caution is required, enabling informed decision-making and the implementation of appropriate protective measures. These records play a critical role in supporting safe and effective service delivery while reducing the risk of harm.

The High Risk Record Policy is intended to provide a structured framework for the identification, recording and management of risks relating to staff safety, patient care, and service delivery, supporting compliance with statutory, regulatory and information governance requirements.

We have concluded reasonable assurance on this area. Key systems and processes are in place to support the operational use of HRRs, and there is evidence that risk information is effectively captured and made available to inform decision-making at the point of response. In particular:

- HRRs are clearly visible within the CAD system, enabling call handlers to identify risks promptly.
- Alerts are used to inform operational decision-making, supporting staff safety and patient care.
- Proportionate information sharing arrangements are in place with partner organisations.
- Work is underway to strengthen processes, including the development of a digital HRR submission solution.

However, a number of control weaknesses were identified which require management attention:

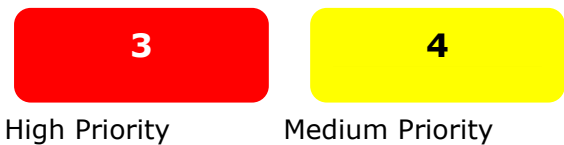
- The Policy does not define reporting or escalation arrangements, and there is currently no formal reporting of HRRs to a governance forum.
- The HRR process remains largely manual, with a need for digitalisation to improve completeness, consistency, and auditability.
- HRR documentation is not centrally stored, increasing the risk of loss or incomplete audit trails.
- Instances of inappropriate records and inconsistent use of documentation were identified.
- Notification letters to service users are not consistently issued following the creation of a HRR.
- A backlog of HRRs requiring annual review was identified, indicating that records are not consistently maintained or removed in line with policy.

Full details of matters arising, together with management actions and implementation plans, are set out in the Findings & Agreed Action Plan section of this report.

Scope & Assurance Summary

Objectives The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.		Related Findings	Assurance
1	There is a policy in place which clearly defines roles, responsibilities, and governance arrangements across the Trust	1	Reasonable
2	There are appropriate processes in place for requesting, authorising, recording and maintaining High Risk Records	2,3,4,5,6	Limited
3	High Risk Records are used effectively to inform responses and trigger timely protective actions and escalation, with mechanisms to alert staff promptly and training to ensure appropriate identification and response.		Reasonable
4	Appropriate access controls, audit trails, and retention/disposal procedures are in place to safeguard confidentiality, and that information sharing with public authorities is lawful, and compliant with data protection standards.	6	Reasonable
5	Monitoring mechanisms, including regular audits, are in place to provide assurance that the Trust fulfils its statutory and organisational responsibilities for managing High Risk Records.	7	Limited

Management Actions



Themes



Risk Types

- Public Perception & Reputational Risk
- Legal & Regulatory Non-Compliance
- Quality or Safety Issues

Findings & Agreed Action Plan

Objective 1: There is a policy in place which clearly defines roles, responsibilities, and governance arrangements across the Trust.	Reasonable
A review of the Trust’s SharePoint site confirmed the existence of a High Risk Record Policy (approved by the Finance and Performance Committee July 2020; with a review date of July 2023), which outlines its approach to identifying and managing high-risk information relating to patients or members of the public, with the aim of protecting both staff and service users. The policy outlines a number of key areas including the definition of high-risk records, categories of high-risk alerts, processes for requesting alerts, maintenance of the high-risk register, and detailed descriptions of six alert types. It also clearly defines roles and responsibilities across all organisational levels, including the Chief Executive, Board Secretary, Executive Directors, Policy Leads, Departmental Leads, Line Managers, and all staff. However, the policy does not set out arrangements for reporting on high-risk records or for the escalation of issues to an appropriate Committee or governance forum. During the audit, a revised draft version of the High Risk Record Policy was provided. This draft introduces a number of enhancements when compared to the current policy. These include updated alert categories, notably the addition of a seventh category relating to infectious or communicable diseases; the implementation of a digitised process supported by the High Risk Records App; and strengthened information governance and audit arrangements, including the proposed introduction of an annual audit Notwithstanding these improvements, the revised draft policy does not address the gap identified in the current policy in relation to reporting or escalation. Specifically, it does not define arrangements for the routine reporting of high-risk records or for escalation to an appropriate committee or governance forum (see Key Finding 1 and <i>objective 5</i>).	

Key Findings		Risk & Impact	Agreed Management Action
1	Gaps in Governance, Reporting and Escalation within the High-Risk Record Policy The High-Risk Record Policy (both current and draft versions) does not include defined reporting or escalation arrangements to an appropriate committee or governance forum.	High Risk Record issues may not be effectively monitored, escalated, or consistently understood across the Trust, limiting governance oversight.	Agreed Action: The High-Risk Record Policy will be updated to include clear governance, reporting and escalation arrangements. This will set out the governance forum responsible for oversight, the frequency and content of routine reporting. The policy will also be supported by a communication plan to raise awareness of the revised arrangements across relevant teams.
		Medium Priority	Expected Evidence of Implementation: • Approved updated HRR policy. • Evidence of communication/awareness activity. • Evidence of reporting of High-Risk Records through local business meetings and the Senior Operations Team (SOT) via Triple A reporting.
	Theme: Policies & Procedures	Control Design	Officer: Assistant Director of Operations, Coordination & Integrated Care Target Implementation Date: December 2026

The High Risk Record (HRR) process is initiated when a potential high-risk individual or location is identified. There are six defined alert categories: Staff Safety Risk, Children in Special Circumstances, Medical Need, Frequent Callers, Access and Information, and Specialist Sites. A seventh category relating to infectious or communicable diseases has been introduced within the draft policy.

HRRs may be raised by a range of sources, including Trust staff, healthcare professionals, safeguarding teams, patients or caregivers, and external organisations, often following incidents such as violence, safeguarding concerns, or identification of specific clinical or access needs.

The formal process requires completion of a High Risk Record Information Report Form (HRRIRF), capturing key information including patient details, risk description, and review date. Temporary alerts may be applied for up to 14 days pending receipt of documentation; however, we note that this has been extended in practice to 30 days due to delays in submission because of operational pressures. Where information is not received within this timeframe, no record is included on the Computer Aided Dispatch (CAD) system. This control was confirmed through testing, with one of our sample identified as a temporary record that was subsequently removed due to the absence of a completed HRRIRF. Once validated, HRRs are recorded on the CAD system for a standard 12-month period and are subject to periodic review.

The process is largely manual, with forms submitted via email and stored in Outlook folders before being uploaded to CAD. A digital solution (High Risk Records App) is currently in development to improve efficiency and data quality.

To assess compliance, we selected a sample of 40 HRRs from records added, amended and removed during 2025 (20 added, 10 amended, 10 removed). Testing of newly created records identified that:

- Two HRRIRFs could not be located, indicating possible deletion (see **Key Finding 2**).
- One record did not meet HRR criteria and related to a separate operational issue (defibrillator maintenance), resulting in an inappropriate system alert. The record applied a street indicator affecting all calls in the area and remained in place after the issue had been resolved; it was subsequently removed during testing (see **Key Finding 3**).
- Two instances of incomplete documentation were identified, including a missing page. Incomplete forms are not returned for completion; instead, missing information is inferred by the EMS team (see **Key Finding 4**).
- A non-standard HRRIRF template was used in one case.

The policy requires that individuals subject to an HRR are notified via a standard letter, with a template included in the appendices. However, when evidence of notification letters was requested for the sample of 20 newly added records, only one instance was identified from the 16 cases received, indicating that this requirement is not being consistently applied (see **Key Finding 5**).

The policy also requires annual review of all HRRs. At the time of review, 361 records had surpassed their required review date. Although reminders should be issued four weeks in advance, this has not occurred for approximately for 12-16 months due to resourcing pressures. Testing of amended records found appropriate updates; however, only one of ten cases evidenced completion of the required review form (see **Key Finding 6**).

No issues were identified in relation to records removed from the CAD system, with appropriate rationale documented.

Key Findings		Risk & Impact	Agreed Management Action
2	Inadequate Storage and Retention of HRR Documentation High Risk Record Information Report Forms are submitted to a shared email inbox and stored within Outlook folders. During testing, two forms could not be located, indicating potential deletion and lack of secure document retention.	HRR documentation may be lost or not retrievable, leading to non-compliance with records management requirements and reduced audit trail.	Agreed Action: Implementation of the High-Risk Record App as the standard mechanism for submission and storage of High-Risk Record documentation, replacing reliance on email inboxes and Outlook folders. The new process will provide a centralised and secure repository for supporting documentation, with defined access controls, retention arrangements and improved traceability between submitted information and the corresponding CAD record.
			Expected Evidence of Implementation: • Communication of the High-Risk Record App. • Redacted screen shots of the SharePoint site demonstrating the High-Risk Record App in operation. • Approved updated policy.
		Medium Priority	
	Theme: Information, Data Quality & Data Accuracy	Control Operation	Officer: Judith Bryce, Assistant Director of Operations Target Implementation Date: December 2026
3	Weaknesses in Validation of High Risk Records Testing identified an instance where a High Risk Record was created for an issue that did not meet defined HRR criteria (defibrillator maintenance). The alert applied a broad system flag without appropriate justification or supporting documentation.	Inappropriate records may be created, reducing data accuracy and resulting in misleading or unnecessary alerts.	Agreed Action: The implementation of the High-Risk Record App will include mandatory fields, standardised approval steps and validation checks to support consistent review of submissions before a record is added to CAD. Supporting guidance will also be updated to clarify decision-making and authorisation requirements.
			Expected Evidence of Implementation: • Approved policy and supporting guidance defining HRR criteria. • App workflow showing mandatory fields and validation controls.
		Medium Priority	
	Theme: Information, Data Quality & Data Accuracy	Control Operation	Officer: Judith Bryce, Assistant Director of Operations Target Implementation Date: December 2026

4	Manual and Inconsistent HRRIRF Submission Process The current High Risk Record Information Report Form process relies on a manual Word-based template to capture and submit requests. Testing identified instances of incomplete and inconsistent submission, including missing information and use of non-standard forms, highlighting weaknesses in data capture and validation.	Incomplete or inconsistent information capture reduces data quality, auditability, and effective oversight.	Agreed Action: The current manual Word-based High Risk Record Information Report Form process will be replaced with a standardised digital submission process through the High-Risk Record App. The revised approach will require use of a single approved template, supported by mandatory fields and consistent workflow stages, to improve completeness, consistency and auditability of information submitted for review.
			Expected Evidence of Implementation: - Digital form/system in use - HRR App. - Evidence of fully completed submissions Screenshots. - A copy of the How To guide.
	Theme: Information, Data Quality & Data Accuracy	Medium Priority Control Design	Officer: Judith Bryce, Assistant Director of Operations Target Implementation Date: December 2026
5	Failure to Notify Individuals of High Risk Record Inclusion The policy requires that individuals are notified when a High Risk Record is applied, with a template included in the appendices. Testing of newly created records found that this is not being consistently applied, with evidence of notification identified in only one of 16 cases.	Failure to notify individuals may result in non-compliance with data protection requirements and reduced transparency.	Agreed Action: The revised policy and implementation process will clarify when notification is required, assign responsibility for issuing and recording the notification, and introduce monitoring to provide assurance that this requirement is being consistently applied.
			Expected Evidence of Implementation: - Approved policy and How to Guide. - Screenshots of App "letter sent". - Copy of reports through the governance routes (SOT).
	Theme: Quality, Safety & Patient Experience	High Priority Control Operation	Officer: Assistant Director of Operations, Coordination & Integrated Care Target Implementation Date: December 2026

6	Ineffective Review and Maintenance of High Risk Records The policy requires annual review of all HRRs. A significant number of HRRs (361) had surpassed their required review date. Although reminders should be issued four weeks in advance, this has not occurred for approximately for 12-16 months due to resourcing pressures. Testing of amended records found appropriate updates; however, only one of ten cases evidenced completion of the required review form.	Outdated or inappropriate records may remain active, potentially impacting decision-making and patient safety.	Agreed Action: The High-Risk Record App will provide automated notifications to system leads 4 weeks prior to the 12-month timeframe to prompt system leads to complete a review of the high-risk records, with appropriate escalation in the event of a review not being undertaken. SOT will review compliance reporting from the App, with assurance provided through the Senior Leadership Team (SLT).
			Expected Evidence of Implementation: • Screenshots of automated notification and How To guide. • Copies of reports through the governance routes (AAA reporting from SOT to SLT) on High-Risk Record compliance.
	Theme: Quality, Safety & Patient Experience	High Priority Control Operation	Officer: Judith Bryce, Assistant Director of Operations Target Implementation Date: December 2026

Objective 3: High Risk Records are used effectively to inform responses and trigger timely protective actions and escalation, with mechanisms to alert staff promptly and training to ensure appropriate identification and response.

Reasonable

Review of the High Risk Record Policy and discussion with the Trust confirmed that there is no formalised training module specific to HRRs. Responsibility for staff awareness rests with line managers, who are expected to provide guidance during induction.

Management advised that, operationally, when a call is received from an individual or location associated with an HRR, call handlers are alerted via on-screen prompts within the CAD system. These prompts replicate the information extracted from the HRRIRF. Review of the example screen prompts provided confirmed that HRRs are clearly flagged through an amber-highlighted warning tab. Selecting this tab provides call handlers with relevant risk information, including the alert category and supporting narrative describing the nature of the risk.

This information is used to inform call handling and response decisions, with actions varying depending on the alert category. For example, staff safety risks may prompt the allocation of additional crew or a request for police support; medical alerts or advanced care plans may influence clinical decision-making and convey specific patient management instructions; and access or location-based risks may inform route planning or highlight hazards at the scene.

In terms of communication to responding crews, certain categories of warnings are automatically populated within the dispatch allocation screen. However, for some categories, such as medical alerts and advanced care plans, warnings are not automatically populated due to the volume and complexity of information. In these cases, the Response Coordinator is required to manually input the relevant details. For vehicles equipped with the National Mobilisation Application (NMA), this information is subsequently relayed audibly to crews alongside call information.

While direct observation of live calls and the communication of HRR information to responding crews was not undertaken, this was a deliberate decision as it was considered unlikely that a relevant HRR-related call would occur during the audit observation period, rather than due to a lack of access to the process.

Objective 4: Appropriate access controls, audit trails, and retention/disposal procedures are in place to safeguard confidentiality, and that information sharing with public authorities is lawful, and compliant with data protection standards.

Reasonable

A review of user access arrangements identified that a large number of staff have access to the CAD system, reflecting the operational requirement for clinical contact centre personnel. Access is tiered, with different permission levels applied. For example, Operations Managers (OMs) are able to add temporary HRRs prior to completion of the formal HRRIRF.

Analysis of the user access report confirmed that users assigned to “Top User Profile” categories (e.g. Admin and Duty Manager) have the ability to add, edit and remove HRRs. Filtering of this profile identified approximately 175 users with these enhanced access rights.

It was noted that user accounts are intended to be automatically suspended following three months of inactivity. Following discussions with the ICT team, we were advised that a monthly audit is undertaken to identify accounts that have been inactive for three months, as well as those not used within three months of creation. As the Trust does not have the capability to permanently delete accounts, a significant number of disabled and duplicate accounts—often arising from typographical errors—remain on the system in a dormant state.

Detailed testing of role-based access permissions (e.g. the ability to add, amend or remove HRRs) was not undertaken as part of this review. The audit focused on high-level access arrangements and user populations, rather than a comprehensive review of system access controls. We are aware that periodic monitoring is undertaken through the National Intelligent Integrated Audit Solution (NIIAS), an automated tool used to track staff access to patient records and identify potential inappropriate access; however, the operation and effectiveness of these controls were not tested as part of this review.

In addition, as highlighted under Objective 2 (see **Key Finding 6**), a significant number of HRRs had exceeded their review date. This indicates that retention and disposal controls are not consistently applied in practice, increasing the risk of records being retained beyond their intended period.

Discussion with the Data Protection Officer confirmed that the Trust follows the Joint Emergency Services Interoperability Principles (JESIP), which provides guidance for information sharing with partner organisations, such as the police. It was noted that, in relation to HRRs, information sharing is proportionate, in line with Information Commissioner’s Office guidance: *Data sharing in an urgent situation or in an emergency*) with only relevant risk information disclosed and patient medical details withheld where not required.

In addition, Information Governance expertise is incorporated into policy development, with an Information Governance lead included in the Task and Finish Group responsible for the development of the updated High Risk Record Policy.

Objective 5: Monitoring mechanisms, including regular audits, are in place to provide assurance that the Trust fulfils its statutory and organisational responsibilities for managing High Risk Records.

Limited

As identified in Objective 1, the High Risk Record Policy does not include defined reporting or governance arrangements. This gap in policy design is reflected in practice, as confirmed through discussions with the Trust, which advised that there is currently no designated group or committee through which HRRs are routinely reported or escalated.

A review of the Trust Board and Sub-Committee structures did not identify any forums where HRR activity, risks or trends are formally reported, monitored or subject to scrutiny (see **Key Finding 7**). As a result, there is limited visibility at a corporate level, reducing the Trust's ability to gain assurance that HRRs are being effectively managed, risks are being identified and addressed in a timely manner, and statutory and organisational responsibilities are being met.

It was recognised that there may be some indirect oversight through related organisational reporting streams, for example frequent callers and violence and aggression reporting through Health and Safety, Operations and People and Culture governance arrangements.

Key Findings		Risk & Impact	Agreed Management Action
7	Reporting and Governance Oversight The High Risk Record Policy does not define formal reporting or governance arrangements. There is currently no defined committee or forum through which HRRs are routinely reported, monitored or escalated. Review of Board and Sub-Committee structures confirmed that HRR activity is not subject to formal oversight or scrutiny.	High Risk Records may not be adequately monitored, challenged, or escalated, reducing oversight and increasing the risk that significant issues are not identified or addressed promptly.	Agreed Action: Formal reporting and governance routes for HRR reporting and compliance will be established; This will be reported monthly through SOT with assurance into SLT.
			Expected Evidence of Implementation: SOT and SLT papers and AAA reporting.
	Theme: Reporting	High Priority Control Operation	Officer: Judith Bryce, Assistant Director of Operations Target Implementation Date: December 2026

Appendix A: Assurance Opinion & Prioritisation of Findings

Assurance Opinion

	Substantial	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	Unsatisfactory	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Advisory	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Disclaimer

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Non-Executive Directors or officers including those designated as Accountable Officer. They are prepared for the sole use of the Welsh Ambulance Services University NHS Trust and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of the Welsh Ambulance Services University NHS Trust. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.



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



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Agenda Item No. 16

REPORT TITLE

Risk Management and Board Assurance Framework Report

MEETING

Name of meeting	Finance & Performance Committee
Date of meeting	21 July 2026
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

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

PURPOSE OF REPORT

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

REPORT SUMMARY:

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

1. The purpose of the report is to provide assurance in respect of the management of the Trust's principal risks, specifically the eight risks that are relevant to this committee's remit.
2. The summary of these risks is set out in Annex 1, and the more detailed Board Assurance Framework (BAF) is in the reading room. This 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.

3. Members can take assurance that each of the principal risks have been reviewed since the last meeting and in line with the agreed schedule detailed at Annex 3 with continual and dynamic focus on the highest rated risks scoring 15-25.
4. **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* remains static at a score of 20 (4x5) due to the escalated world conflicts and recent increase in targeted cyber-attacks against NHS organisations. 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 and is not included in Annex 4.
5. **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.
6. **Risks 542** *Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan*, current score 16 (4x4), is under active review. Work is ongoing to reframe the risk in line with the Welsh Government STB and the Trust's revised risk presentation approach, which will including the articulation of new and emerging risks. A timeline for this programme of work is in development, reflecting the resources available to support it. The revised risks will clearly distinguish between internal and external controls, assurances and gaps; set out those matters the Trust directly manages and those it monitors; and describe assurance across the three lines of defence.
7. **Risk 671** *Unauthorised or Inappropriate use of AI technologies* remains static at a score of 16 (4x4) with a target of 8 (2x4). Substantial work is ongoing in relation to AI governance arrangements, oversight by the AI Steering Group, Copilot training, and development of a policy and e-learning.
8. **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). The ELT acknowledged that all internal actions have been explored and agreed to tolerate the risk at this level for this review period.
9. **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* remains static at a score of 12 (3x4) during this period; however, a full refresh of the risk is underway.
10. **Risk 139** *Failure to Deliver our Statutory Financial Duties* has increased from a score of 8 (2x4) to 12 (3x4) in line with the financial position for 2026/27 and delivery of the plan being

reliant on £9m savings, with £1.2m not yet identified, and wider cost pressures such as an increase in fuel costs.

11. A new **Risk 690** *SAR and Disclosure of Records Compliance* has been developed and approved for inclusion on the Corporate Risk Register, by the ELT, at a score of 16 (4x4) with a target of 8 (2x4).
12. The ELT risk management session scheduled for 8 July 2026 has been postponed until August 2026; however, members can take assurance that risk reviews have been completed by risk owners in line with the agreed schedule detailed at Annex 3 with continual and dynamic focus on the highest rated risks scoring 15-25. This has identified several matters that will be progressed through the next reporting cycle. These include a proposed reduction to new Risk 690, further work to reframe Risk 100 into two separate risks, the continued review of Risk 542, and ongoing development of governance arrangements for Risk 671. As these matters have not yet been formally approved by the ELT, they are not reflected in the Board Assurance Framework presented to committee at this meeting.
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.

RECOMMENDATION(S)

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

The Finance & Performance Committee is requested to:

1. Consider contents of the report including:
 - a. The controls in place against the risks.
 - b. The actions described to further mitigate the risks.

ADDITIONAL PAPER(S)

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

The Finance & Performance Committee is requested to receive the following:

1. Annex 1 – Principal Risk Summary
2. Annex 2 - Board Assurance Framework (in reading room)

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

RISK(S) THIS REPORT MITIGATES

Where relevant note the local, directorate, corporate or BAF risk number
As above, this paper goes to mitigations against finance and performance related risks.

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

IMPACT ASSESSMENTS FOR CONSIDERATION

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

APPROVAL/SCRUTINY ROUTE

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

Annex 1 – Principal Risk 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) 
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 (5x4) 
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	Executive Director of Finance & Corporate Resources	16 (4x4) 

CORPORATE RISK REGISTER

RISK ID	NEW RISK TITLE	NEW SUMMARY DESCRIPTION	EXECUTIVE OWNER	RISK SCORE
		RESULTING IN negative environmental and social impacts causing and reputational damage		
671 FPC	Unauthorised or Inappropriate use of AI technologies	IF staff use Gen-AI tools such as ChatGPT, Co-Pilot or other AI enable platforms outside of approved organisational channels or without appropriate governance THEN information passed into, accessed by, or returned by the AI tools may breach information security and data protection controls, and use of the output may breach transparency, medical device, equality, Welsh Language and ethical requirements RESULTING IN potential breach of confidentiality and data protection law, data, damage to Trust, and non-compliance with other legislation, regulation and standards.	Director of Digital Services	16 (4x4) 
690 FPC NEW	SAR and Disclosure of Records Compliance	IF records requests from patients, the public or staff are not processed consistently or correctly THEN inappropriate withholding of information or disclosures may occur RESULTING IN harm to data subjects and financial or reputational damage to the Trust	Director of Digital Services	16 (4x4) 
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	Executive Director of Operations	15 (3x5) 

CORPORATE RISK REGISTER

RISK ID	NEW RISK TITLE	NEW SUMMARY DESCRIPTION	EXECUTIVE OWNER	RISK SCORE
		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.		
100 FPC	Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience.	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 and staff and key outcomes within the IMTP not being delivered	Executive Director of Strategy Planning & Performance	12 (3x4) 
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	12 (3x4)  8 (2x4)