Bundle Finance and Performance OPEN 18 November 2025

Agenda attachments

ITEM 00 FPC Agenda - 18 November 2025 - Open

0 09:30 - OPENING ITEMS

1 Chair's Welcome, Apols and Quorum

2 Declarations of Interest

ITEM 02 Board Member Register of Interests - Updated 21 October 2025

3 Minutes of the Last Meeting: 16 September 2025

ITEM 03 2025-09-16 Draft OPEN FPC Minutes

4 Action Log & Matters Arising

Item 4.1 FPC AAA 16 September 2025
Matters arising. Regarding an action from the QuEST Committee - Patient Story:
(Alison Clarke had contacted the previous Chief Executive and spoken to him regarding her concerns about NEPTS and her transfers to hospital appointments)
The PTR Report and Alison Clarke's lived experience highlighted the ongoing high demand for NEPTS, which continues to generate complaints about unmet patient needs. Despite QPSE support through emotional mapping, enhanced data visibility, and efforts to encourage on-the-spot resolution, complaint levels have not declined. Members discussed the impact on patient care and have asked the Finance and Performance Committee (FPC) to review current actions and plans to improve service delivery, particularly around eligibility criteria and the challenges patients face due to cancellations and limited capacity.

ITEM 04 Action Log

ITEM 04.1 FPC AAA 16 September 2025

4.1 FOR APPROVAL, ASSURANCE AND DISCUSSION

5 09:40 - Operations Update - Q2

ITEM 05 Operations Quarterly Report for Committees 2025-26 Q2

6 10:00 - Financial Position for Month 6, 25/26

Financial Position for Month 7, 25/26 - Presentation

ITEM 06 Finance Report Month 6 25-26 Final

ITEM 06.1 Month 06 2025-26 - Welsh Ambulance Services NHS Trust - Monitoring Return - Final

7 10:20 - Financial Sustainability Programme Governance Group Meeting Update

ITEM 07 Financial Sustainability Programme Update

8 10:40 - Monthly Integrated Quality Performance Report

ITEM 08 MIQPR SBARN FPC August September 2025

ITEM 08.1 MIQPR FPC August September 2025

8.1 10:55 - COMFORT BREAK

9 11:10 - Digital Reporting

ITEM 09 Digital Reporting Nov 2025

ITEM 09.1 Appendix 1 - Digital Reporting November 2025 - Metrics

10 11:20 - Information Governance Report

ITEM 10 Information Governance Reporting Nov 25

ITEM 10.1 Appendix - Information Security & Governance KPI Report Oct25

11 11:30 - Internal Audit: IMTP Development Practices (Q1 -Q2)

ITEM 11 IMTP Development Process Internal Audit Report 2025-2026

ITEM 11.1 WAST-2526-07 IMTP Development Process Final Internal Audit Report

12 11:40 - Integrated Medium Term Plan (IMTP) Progress Report (To include CMT update)

12.2 Developing the 2026/27 Integrated Medium Term Plan (IMTP) (refreshed approach)

ITEM 12 FPC IMTP Q2 Assurance Paper

ITEM 12.1a CMT Programme Highlight Report Oct 2025_26

ITEM 12.1b IMTP Delivery Assurance Report Q2 2025_26

ITEM 12.1c IMTP Outcomes Update 'What Good Looks Like'

ITEM 12.2 FPC_IMTP Guidance Refresh

ITEM 12.2a Refreshed IMTP Guidance 2026.27

ITEM 12.2b CEO Roadshows 2025 Staff Feedback analysis V0.1

13 12:05 - Committee Quality and Governance Review

ITEM 13 FPC 2025-26 Quality and Governance Review
ITEM 13.1 FPC Terms of Reference 2026-27 DRAFT
ITEM 13.2 Annex 2 Changes to board and committee operating arrangements 2025-26

14 12:25 - Risk Management and Board Assurance Framework Report
ITEM 14 Executive Summary Risk Management Report FPC 181125

15 12:35 - Audit Tracker - September 2025 (2025/26 Q2)
ITEM 15 Exec Summary - Audit Tracker 25-26 Q2 Reporting (Jul-Sep25) - FPC Public 181125

16 12:45 - Policy for approval
Estates, Environmental and Facilities Management Policy
ITEM 16 Policies for Committee Approval - FPC 181125
ITEM 16.1 Estates Env Facilities Mngt Policy

16.1 CONSENT ITEMS

17 Committee Cycle of Business Monitoring and Priorities Report 2025/26
ITEM 17 Priorities and Cycle Monitoring Report Nov 2025
ITEM 17.1 CoB Monitoring Report November 2025
ITEM 17.2 CoB Monitoring Report November 2025 - Notes

17.1 12:50 - CLOSING ITEMS

18 Reflections and Summary of Decisions/Actions

19 Any Other Business

20 Date & Time of the Next Meeting: 20 January 2026

Length of Meeting:	03:25	Agenda Status:	[OPEN] FINANCE AND PERFORMANCE COMMITTEE - 18 November 2025					Deadline: 07/11/25	
Time	**Mins allotted**	**Agendum**	**Title**	**Format**	**Item for**	**Item requested by**	**Paper prepared by**	**Item presented by**	**Colleagues to cc**
			OPENING ITEMS						
09:30	00:10	1	Chair's Welcome, Apols and Quorum	Verbal	Information	Standing	n/a	Chair	n/a
		2	Declarations of Interest	Verbal	To State Conflicts	Standing	n/a	Chair	n/a
		3	Minutes of the Last Meeting: 16 September 2025	Paper	Approval	Standing	n/a	Chair	n/a
		4	Action Log & Matters Arising	Paper	Discussion	Standing	n/a	Chair	n/a
		4.1	16 September 2025 Committee AAA Report (alerts)	Paper	Discussion	Standing	n/a	Chair	Trish Mills
			FOR APPROVAL, ASSURANCE AND DISCUSSION						
09:40	00:20	5	Operations Update - Q2	Paper	Assurance	Standing	Ops	Lee Brooks (Judith Bryce)	Judith Bryce Toni-Marie Norman
10:00	00:20	6	Financial Position for Month 6, 25/26 Financial Position for Month 7, 25/26	Paper Presentation	Assurance	CoB	FinCor	Ed Roberts	Ed Roberts
10:20	00:20	7	Financial Sustainability Programme Governance Group Meeting Update	Paper	Assurance	Forward Planner	People	Carl Kneeshaw	Richard Baxter
10:40	00:15	8	Monthly Integrated Quality Performance Report	Paper	Assurance	CoB	SPP	Rachel Marsh	Hugh Bennett, Mark Thomas, Georgia Tizzard, Melanie
10:55	00:15		COMFORT BREAK						
11:10	00:10	9	Digital Reporting	Paper	Assurance	CoB	Digital	Jonny Sammut	Leanne Smith
11:20	00:10	10	Information Governance Report	Paper	Assurance	CoB	Digital	Jonny Sammut	Leanne Smith
11:30	00:10	11	Internal Audit: IMTP Development Practices (Q1 -Q2)	Paper	Assurance	Ad hoc	Gov	Rachel Marsh (Osian Lloyd)	Steve Owen
11:40	00:25	12	Integrated Medium Term Plan (IMTP) Progress Report (To include CMT update) 12.2 Developing the 2026/27 Integrated Medium Term Plan (IMTP) (refreshed approach)	Paper	Assurance	CoB	SPP	Rachel Marsh	James Houston Hugh Bennett
12:05	00:20	13	Committee Quality and Governance Review	Paper	Endorsement	CoB	Gov	Trish Mills	Julie Boalch, Alex Payne
12:25	00:10	14	Risk Management and Board Assurance Framework Report	Paper	Assurance	CoB	Gov	Julie Boalch	Dan King
12:35	00:10	15	Audit Tracker - September 2025 (2025/26 Q2)	Paper	Assurance	CoB	Gov	Trish Mills	Lisa Trounce
12:45	00:05	16	Policy for approval [New] Estates, Environmental and Facilities Management Policy	Paper	Approval	Ad hoc	Gov	Ed Roberts	Lisa Trounce
			CONSENT ITEMS: The items that follow are for information only. Should a member wish to discuss any of these items they are requested to notify the Chair so that time may be allocated to do so.						
12:50	00:00	17	Committee Cycle of Business Monitoring and Priorities Report 2025/26 Priorities: 1. A focus on financial sustainability. 2. A focus on Clinical Model Transformation performance. 3. A focus on organisational resilience including information security; 4. A focus on the progress of the Manchester Arena Inquiry recommendations.	Paper	Information	CoB	Cor Gov	Trish Mills	Steve Owen
			CLOSING ITEMS						
12:50	00:05	18	Reflections and Summary of Decisions/Actions	Verbal	Discussion	Standing	n/a	Chair	n/a
		19	Any Other Business	Verbal	Discussion	Standing	n/a	Chair	n/a
		20	Date & Time of the Next Meeting: 20 January 2026	Verbal	Information	Standing	n/a	Chair	n/a
12:55	**03:25**		**CLOSE**						

LEAD PRESENTERS

Name	Position
Jayne Beeslee	Chair and Non-Executive Director
Judith Bryce	Assistant Director of Operations
Julie Boalch	Assistant Director of Corporate Governance and Risk
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Trish Mills	Director of Corporate Governance/Board Secretary
Jonny Sammut	Director of Digital Services
Ed Roberts	Interim Assistant Director of Finance and Corporate Resources

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

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Left Trust
EVANS, Bethan [continued]	**Non-Executive Director** * Chair of Quality, Patient Experience & Safety Committee * Member of Finance & Performance Committee * Member of People & Culture Committee * Member of Remuneration Committee	Company Director - Hawthorn Court Property Limited	Directorships	27 April 2022		
		[Previously called My Choice Healthcare (Three) Limited, Company name changed 12.08.2022 - #13371375]	*Directorships*	*27 April 2022*		
		Company Director - Ocean Living Property Limited	Directorships	22 July 2022		
		Company Director - Hawthorn Court Care Limited	Directorships	22 July 2022		
		Company Director - Glyncornel Property Limited	Directorships	01 July 2022		
		Company Director - My Choice Healthcare (Two) Limited	Directorships	01 July 2022		
		Company Director - Carmarthen Care Limited	Directorships	02 January 2024		
		Company Director - Towy Castle Property Limited	Directorships	01 September 2023		
		Company Director - Glamorgan Care Ltd	Directorships	25 October 2024		
		Company Director - The Mountains Care Ltd	Directorships	09 December 2024		
		Company Director - Alexandra House Care Ltd	Directorships	24 June 2024		
		Company Director - Alexandra House Property Ltd	Directorships	24 June 2024		
		Company Director - My Choice Healthcare Seven Ltd	Directorships	22 October 2024		
		Company Director - Danygraig Property Ltd	Directorships	10 December 2024		
		Company Director - The Mountains Property Ltd	Directorships	09 December 2024		
HITCHON, Estelle	**Director of Partnerships and Engagement**	Member of Academi Wales Expert Panel	Position in Charity or Voluntary Organisation	15 July 2024		
		Independent Governor (Non-Executive Director), Coleg Sir Gar/Coleg Ceredigion	Non-Financial Personal	01 January 2025		
HUTCHINGS, Hayley	**Non-Executive Director** * Member of the Remuneration Committee * Member of the Academic Partnership Committee * Member of the People and Culture Committee	Employed at Swansea University, Professor of Health Services Research	Financial Interest	17 June 1995	31 May 2025	
		Emeritus Professor, Swansea University	Non-Financial Professional	31 May 2025		
		Consultancy (temporary cover for the Director of Operations - Clinical Trials Unit) at Wolverhampton University	Financial Interest	10 October 2025	31 December 2025	
JACKSON, Ceri	**Non-Executive Director & Vice Chair of the Trust Board** * Chair of the People and Culture Committee * Member of the Charity Committee * Member of Audit Committee * Member of Quality, Patient Experience & Safety Committee * Member of Remuneration Committee	Management Consultant primarily working in third sector	Interest in Companies and Securities	01 May 2019		
		Associate Director of SamKat Consulting Ltd in my capacity as self-employed management consultant	Directorships	01 June 2021		
		Charity Trustee - Stroke Association Trustee, Chair Wales Advisory Group.	Position in Charity or Voluntary Organisation	08 October 2020		
		Charitable Company - Stroke Association - Company Director	Directorships	08 October 2020		
KNEESHAW, Carl	**Director of People**	Chartered Fellow of Chartered Institute of Personnel and Development	Personal or Departmental Sponsorship	April 2020		
		Fellow of Institute of Leadership	Personal or Departmental Sponsorship	October 2020		
		Safeguarding Lead for local outreach charity, Brunstad Christian Church – Huntworth, Bridgwater, Somerset	Position in Charity or Voluntary Organisation	September 2018		
LEWIS, Angela	**Director of Culture Change**	Nil Declaration				
MARSH, Rachel	**Executive Director of Strategy, Planning and Performance**	Nil Declaration				
MILLS, Patricia (Trish)	**Director of Corporate Governance/ Board Secretary**	Nil Declaration				
PARRY, Hugh	**Trade Union Partner**	Nil Declaration				
ROBERTS, Edward	**Interim Finance Director (from 09 September 2025)**	Nil Declaration				
ROWAN, Hannah	**Non-Executive Director** * Chair of Academic Partnership Committee * Member of Charity Committee * Member of People & Culture Committee * Member of Remuneration Committee	Director, St Martin's Associates (Business consulting and coaching)	Directorships	04 April 2022		
		Non -Executive Director Qualifications Wales (regulator for all non degree qualifications in Wales)	Any Other Interest	01 April 2021		
		Trustee MAE Cymru (Christian charity which champions gender equality in church of Wales)	Position in Charity or Voluntary Organisation	13 November 2021	November 2023	
		Elected member, The governing body of the church in Wales (Parliament of church in Wales - voting member)	Any Other Interest	01 April 2021		
		Relative (Parent) is a Non-Executive Director for Social Care Wales	Any Other Interest	01 April 2017		
SAMMUT, Jonathan (Jonny)	**Director of Digital Services [appointed 26.09.2023]**	Fellow of the British Computer Society – FBCS	Any Other Interest	04 March 2024		
		Panel Member of the UK CIO Advisory Panel – Digital Health	Any Other Interest	05 July 2023	2 June 2025	
		Federation of Informatics Professionals - Leading Practitioner	Any Other Interest	25 April 2024		
		Chair of BCS Hub Wales	Any Other Interest	20 June 2025		
		Co-opted into the BCS Community Board	Any Other Interest	12 August 2025	11 August 2026	
SWINBURN, Andrew (Andy)	**Executive Director of Paramedicine**	Strategic Advisor to College of Paramedics	Any Other Interest	01 January 2020		
TURLEY, Christopher	**Executive Director of Finance and Corporate Resources**	Treasurer of Royal Gwent Hospital League of Friends.	Position in Charity or Voluntary Organisation	01 February 2022	05 November 2024	
TURNER, Damon	**Trade Union Partner**	Nil Declaration				

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

MINUTES OF THE MEETING OF THE FINANCE AND PERFORMANCE COMMITTEE (OPEN SESSION) HELD ON 16 SEPTEMBER 2025 IN THE CARDIFF MAKE READY DEPOT AND VIA TEAMS

Meeting started at 09:30

PRESENT:

Jayne Beeslee	Non-Executive Director and Chair
Peter Curran	Non-Executive Director (Left During Item 67/25)
Rhiannon Beaumont-Wood	Non-Executive Director (Joined during Item 67/25)
Bethan Evans	Non-Executive Director

IN ATTENDANCE:

Julie Boalch	Assistant Director of Corporate Governance and Risk
Lee Brooks	Executive Director of Operations
Alex Crawford	Assistant Director of Planning and Performance (Joined during Item 68/25 and left after 69/75))
Richard Davies	Assistant Director of Capital and Estates (Joined during Item 74/25 and left after 75/25)
Colin Dennis	Chair of the Trust Board (Left after Item 74/25)
Estelle Hitchon	Interim Executive Director of Strategy, Planning and Performance and Director of Partnerships and Engagement
Jonathan Jones	Audit Manager
Carl Kneeshaw	Director of People
Trish Mills	Director of Corporate Governance/Board Secretary
Steve Owen	Corporate Governance Officer
Hugh Parry	Trade Union Partner
Alex Payne	Corporate Governance Manager
Ed Roberts	Assistant Director of Finance
Jonny Sammut	Director of Digital Services (Joined during Item 67/25)
Mark Thomas	Commissioning & Performance Manager (Left after Item 70/25)
Liam Williams	Executive Director of Quality and Nursing

APOLOGIES:

Osian Lloyd	Head of Internal Audit
Rachel Marsh	Interim Chief Executive
Chris Turley	Executive Director of Finance and Corporate Resources
Damon Turner	Trade Union Partner

65/25 PROCEDURAL MATTERS

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

Minutes: The minutes of the open session held on 21 July 2025 were considered by the Committee and confirmed as a correct record subject to a minor amendment on the sub heading to Item 47/25. Month 4 year to read 2025.

Matters Arising: None

Action Log: Action 53/25: In terms of the QPMF benefits map and the benefits measures it was agreed that the QPMF Steering Group would consider this in further detail. It was agreed an update would be provided at the next meeting following discussion at the QPMG Steering Group. The QPMF Steering Group further considered this on 4 September. Whilst some amendments were agreed, both Hugh Bennett and Trish Mills would benefit from a discussion with the committee chair and Peter Curran on the mapping and the best way to represent benefit going forward. A suitable date was being sourced for this meeting to take place prior to the end of September 2025. Action was to remain open until meeting confirmed.

Committee Highlight Report: The Committee highlight report dated 21 July 2025 was received.

The Committee RESOLVED TO:

(1) Approve the minutes of the Finance and Performance Committee held on 21 July 2025 subject to the minor amendment as described.
(2) Consider the Action log and noted the update as described above.
(3) Receive the Committee highlight report dated 21 July 2025.

66/25 FINANCIAL POSITION FOR MONTH FIVE 2025/26

MONTH FOUR 2025/26

The Committee noted the update as detailed in the report.

1. The Trust was now reporting a revenue year to date deficit (£246k) for month 4 2025/26.
2. In line with the balanced financial plan approved as part of the submitted 2025-28 IMTP, the Trust was currently forecasting to breakeven by the 2025/26 financial year end.
3. Capital expenditure plans continue to be progressed with plans to fully achieve in year.

4. In line with the financial plans that support the IMTP, gross savings of £2.884m have been achieved in month 4 against a target of £2.796m.
5. Public Sector Payment Policy is on track with performance, against a target of 95%, of 98.7% for the number, and 99.0% of the value of non NHS invoices paid within 30 days.

MONTH FIVE 2025/26

An update was given by Ed Roberts who provided the Committee with the following details:

1. The month 5 reports were submitted to Welsh Government by the submission date of Thursday 11September 2025.
2. The cumulative year to date (at Month 5 end of August 2025) revenue financial position reported was an overspend against budget of £0.229m (in month performance delivered a surplus of £17k).
3. The I&E forecast for 2025/26 was still one of breakeven, but this continued at a higher risk of delivery.
4. The Capital plan was being progressed and current planned expenditure of £30.190m was forecast to be fully spent by the end of the financial year.
5. In line with the financial savings plans (£8.5m) that supported the IMTP, gross savings of £3.582m have been achieved against a year-to-date target of £3.486m, hence an overachievement of £0.097m.
6. Public Sector Payment Policy was on track with cumulative performance to month 3 (as this was reported quarterly), against a target of 95%, of 98.7% for the number of non-NHS invoices paid within 30 days.

The key assumptions underpinning the year-to-date financial performance, remain broadly in line with that within the 31 March 2025 approved IMTP/Trust Board financial plan and budget set, in particular, those in the initial plan were as follows:

1. The ability to deliver a minimum of c£8.500m in savings and efficiencies in year. This equated to c2.7% of the Trusts discretionary income.
2. 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. These included any costs, capital or revenue, emerging from the recommendations of the Manchester Arena Inquiry.
3. Despite an element of additional funding provided, some cost elements were still hard to predict through the 2025/26 financial year (and beyond) and may remain volatile.
4. The ability to manage in year cost pressures as they arrive, within the small contingency the Trust continues to hold, as per the IMTP / 2025/26 financial plan.
5. Income assumptions in opening financial plan were fully funded via commissioners and Welsh Government (2025/26 pay awards increases).

The committee discussed the use of vacancy delays as a method for achieving non-recurrent savings. While holding vacancies can generate short-term financial benefits, these were not always sustainable due to ongoing staff turnover. A natural recruitment lag of around three months typically contributes to these savings without impacting organisational capacity unless deliberately planned.

Carl Kneeshaw added that some current vacancies were linked to skill mix reviews rather than savings measures, with plans in place to reduce them, although some will continue into the next financial year. The recruitment control panel ensures vacancies were assessed against organisational priorities, risk and statutory duties before being filled.

Members acknowledged the financial value of vacancy management but emphasised the need to balance this with service delivery and workforce pressures.

The Chair requested additional details regarding the distribution of capital expenditure throughout the year. Ed Roberts explained that due to the annual allocation process for capital funding, planning typically begin as early as possible, but full approval from the Welsh Government (WG) was required before proceeding. Discussions were ongoing with WG concerning next year's fleet expenditure. A staggered approach was being considered to secure funding earlier, which would allow for an accelerated purchase of vehicles and enable their preparation for conversion at an earlier stage. This process was implemented last year and was expected to continue this year, resulting in increased spending on vehicles in quarter three. Furthermore, most of the Estates expenditure will occur in quarter four due to the schedule of construction activities and when significant costs, such as planning and architectural fees, were typically incurred.

Following a query in terms of the financial risk regarding the cost involved with the impact of regarding ambulance delays, Ed Roberts advised it was anticipated that the risk will likely be reduced around month six if trends continue. The associated risks involved assigning additional staff to A&E and managing handovers, as well as potentially increasing overtime if necessary. A staggered approach was being considered, with the aim of receiving funding indications earlier to facilitate the purchase of vehicles and prepare them in advance for conversion. The shared information across NHS Wales suggested that most health boards were aiming to return to break even by quarter three and four, with figures indicating an average shift from a £2 million monthly deficit to nearly a £4 million surplus. For now, the risk level remained unchanged, but it may decrease as the end of the year approaches and investment decisions are made based on current workforce capacity.

The Committee RESOLVED To:

1. **Note and gain assurance in relation to the Month 4 revenue financial position and performance of the Trust as at 31st July 2025.**
2. **Note the delivery of the 2025/26 savings plan, and the context of this within the overall financial position of the Trust.**
3. **Note the capital programme for 2025/26.**
4. **Note the Month 4 Welsh Government monitoring returns submission included within *Appendices 1 – 2* (as required by WG).**

67/25 PHASE 2 GO-LIVE OF CLINICAL MODEL TRANSFORMATION

Lee Brooks introduced the phase two assurance for the Ambulance Performance Framework, describing it as a pivotal step in transforming the Trust's response to the people of Wales. This phase builds on the successful launch of phase one, which began in July and introduced new emergency categories and a shift from time-based targets to clinical outcomes.

Lee Brooks reminded the Committee that several pathway changes had already been deployed, including the introduction of clinical navigators and rapid clinical screening, which started in November of the previous year. These changes were designed to better direct unscheduled activity into planned care and support the new framework. Lee Brooks drew out further details of Phase Two as outlined below:

Phase two focused on the amber and green categories, which accounted for about 70% of 999 incidents. These categories previously lacked formal time standards and have been subject to increasing delays due to rising activity and handover pressures. The Welsh Government (WG) led review found the old framework unfit for purpose, leading to the current changes.

Three new response categories were being introduced:

1. Orange (Time Sensitive): For cases like stroke and STEMI, focusing on rapid arrival of specialist care.
2. Yellow (Assess and Respond): For cases needing further clinical assessment, often in the community.
3. Green (Planned): For cases suitable for remote or community-based management, such as palliative care or urinary tract infections.

Each category will be supported by tailored measures, including median and 90th percentile response times and clinical quality indicators, aligning with best practices and bringing Wales in line with other UK nations.

Implementation & Governance:

1. The deployment was being led by a task and finish group, now chaired by Kerry Griffiths. The group has developed data definitions and submitted them to the commissioner on time.
2. Impact assessments, Quality Impact Assessment (QIA) and Equality Impact Assessment (EqIA) were being developed and will be submitted to the Trust Board after scrutiny by the QuEST Committee.
3. Operational readiness includes Computer Aided Dispatch (CAD) system changes, Standard Operating Procedure (SOP) reviews, and staff training. Lessons from phase one were being incorporated, and staff feedback was being gathered to inform phase two.
4. Communications and staff engagement were ongoing, with positive feedback from staff about their readiness for phase one.

Financial and Technical Dependencies:

1. There were no direct financial implications for phase two, but there was a related ambition for a single CAD instance to support remote integrated care, with capital funding recently approved and delivery expected in the spring.
2. The main risk is the dependency on the CAD supplier (MISI), but current milestones are being met, and development is proceeding at risk while final details are agreed.

Monitoring, Risks, and Timeline:

1. Implementation will be closely monitored, with regular updates to Welsh Government and internal reviews, as was done in phase one.
2. The Cabinet Secretary has requested implementation by the start of December. If this cannot be achieved, the organization would seek to delay until after winter, but the public announcement creates an obligation to aim for the December date.

Clinical outcomes for the measures referenced were still evolving. However, a persistent challenge remains due to the lack of a unified medical record system across the wider healthcare landscape. The Trust continues to rely on available data sources, primarily the electronic Patient Care record (ePCR) and proxy measures for quality, as well as being alert to reports via the concerns and Putting Things Right processes.

Phase 2 introduces new screening codes Rapid Clinical Screening (RCS1-3) alongside RCS0 to help prioritise calls with high risk markers during the pilot. Initially, RCS codes will be adapted from Amber 1, Amber 2, and Green code sets, with further updates planned as the new model is established.

Based on the approach used in Phase 1, the communications strategy will be implemented in a similar manner for Phase 2. Key materials were currently under review and being updated, using a hybrid method that employed various communication tools and collateral to maximise reach.

Two high-level risks, each with a score of 16 or more, have been identified: challenges from an external supplier delivering Computer Aided Dispatch (CAD) changes, and potential time constraints in setting up internal reporting. Both were under close and proactive management. A meeting has been held with the supplier MIS, with an agreed way forward on the commencement of the development milestones.

The Cabinet Secretary has approved the changes and requested implementation by 01 December 2025. While the Trust recognised this coincided with the peak activity period, it was currently on track for a 01 December launch; if delays arose, the Trust would propose postponing until 01 February 2026. Nonetheless, the Cabinet Secretary has set 01 December as the official go-live date, which the Trust was obligated to meet.

Liam Williams stated that the Clinical Advisory Group (CAG) was reviewing information related to quality, safety, and clinical delivery. In phase 1, this data will inform the quality impact assessment for phase two. The CAG will recommend any changes to the Quality Impact assessment (QIA) based on lessons learned and critical analysis. These recommendations will be reviewed by the Clinical Quality Governance Group in the coming week, ensuring all necessary adjustments were addressed.

A question was raised regarding the Orange Now category and whether there were effective mechanisms in place to accurately measure outcomes across organisational boundaries. Lee Brooks advised that work was underway with Digital Healthcare Wales towards having more access to data across boundaries but there was more to do.

The Committee sought confidence levels in terms of the challenging implementation date. Executives expressed confidence that the changes to the CAD remained on track for go-live. The statement of works has been central to recent discussions, with the next milestone on the 08 October offering a further opportunity to confirm readiness. A go-live checklist will be in place as it was for phase one.

Lee Brooks added that the Trust was not seeking additional investment for this initiative; the approach to Clinical Model Transformation has always focused on optimising current resources. Members discussed the associated opportunity costs and the need to ensure appropriate use of resources, including fleet, with the delivery of these changes.

The Chair noted that one key concern was the progression to phase two without first evaluating both the delivery and clinical risks arising from phase one. The Committee was assured that external evaluation was being finalised based on the model being designed as a single, integrated approach. The timeline recognised Welsh Government requirements, and the evaluation will also share insights throughout the pilot, and complements the clinical flows implemented since November 2024.

Members endorsed the paper for onward submission to the October Extraordinary Trust Board meeting in October and noted that this was subject to the QIA and EqIA being reviewed at an extraordinary meeting of the Quality, Patient Experience and Safety Committee (QUEST), which was to be arranged.

The Committee RESOLVED To:

1. **Note that the QIA and EQIA are being developed, and each shall be subject to the appropriate quality governance mechanisms, and both shall accompany this paper at the time of final approval being sought from the Trust Board. The committee is asked to note that it may be necessary to make minor adjustments to this paper ahead of its final submission to Trust Board on 23 October 2025 following the internal review process. It is requested that the committee allow for minor changes to this assurance paper prior to submission to Trust Board, providing any change does not materially alter the direction or outcomes.**

2. **Endorse onward submission to Trust Board, confirming that the Committee is assured that the organisational preparedness meets with the appropriate requirements to implement the changes safely and effectively.**
3. **Endorse that the Ambulance Performance Framework (phase 2) proceed to implementation, with oversight of implementation be provided by the Clinical Model Transformation Board.**

68/25 MONTHLY INTEGRATED QUALITY PERFORMANCE REPORT

Mark Thomas outlined the main points of the report:

1. 111 call handling performance has stabilised post-delivery of the new 111 CAS, but the service did not achieve the 5% abandonment rate in July 2025 and is unlikely to do so within the existing commissioned financial envelope i.e. capacity (including efficiencies) is not sufficient to meet demand.
2. The Trust's overall sickness percentage was 7.82% in July 2025, up on the 7.49% recorded in June 2025, which was in line with seasonal factors. Actions within the IMTP concentrate on staff well-being with an aim to reduce this level to the IMTP ambition of 6%.
3. Phase 1, The new Purple Arrest and Red Emergency categories went live, as planned, on 01 July 2025. This is the first scorecard to include these new categories.
4. Amber response times continue to have a known impact on avoidable patient harm and are still higher than ideal. But there were ongoing response model changes being implemented to the trusts, wider Clinical Model Transformation programme.
5. Ambulance care - Oncology performance in July 2025 was 75.56%, achieving the 70% target. Renal performance remained just above target, achieving 70.72% and advanced discharge & transfer journey performance increased marginally to 83% (95% target), this will primarily be an issue with capacity.
6. Hours Produced: The Trust produced 119,098 Ambulance Response unit hours during July 2025 and delivered an emergency ambulance unit hours production (UHP) of 90%, remaining below the 95% target.
7. the Trust's overall sickness percentage was 7.82% in July 2025, up on the 7.49% recorded in June 2025, which is in line with seasonal factors. Actions within the IMTP concentrate on staff well-being with an aim to reduce this level to the IMTP ambition of 6%.

Members noted there was a notable decline in complaint response times in July. However, as mentioned in the report, a Putting Things Right recovery Plan was being implemented. The Committee can be assured that this matter was being closely monitored by QuEST Committee, with comprehensive information sharing and transparent discussions being held with executives.

Regarding 111 response times, data indicated a decline during the summer months. This highlighted a gap between demand and capacity and raised questions about the nature of investments made in the 111 service. Lee Brooks commented the Trust was observing the results of the roster review, and current performance was, although not achieving the target, exceeding the predictions from the current modelling.

Members asked what the opportunities were to improve the compliance rates in terms of the clinical outcomes. Lee Brooks added that the Trust was prioritising discussions about quality and outcomes. There was an increasing interest in the results of actions especially since the Trust started measuring key factors like response time and access to public defibrillators. He believed this focus will persist, particularly within the Operations Directorate, shifting attention from simply responding quickly to ensuring effective clinical outcomes.

Members inquired about sickness levels and when were they last near 6%, and whether the plan could realistically achieve that goal. Lee Brooks noted that the rate was closest just before the pandemic but then increased significantly. He suggested that current trends were likely due to the typical rise in sickness during the summer holiday period and expected rates to decrease as autumn arrived, with another increase anticipated in winter.

Following a discussion on the clarity of the Statistical Process Control charts within the MIQPR, it was agreed that Jonny Sammut would collaborate with Mark Thomas to explore ways to enhance the presentation of the visuals in the report for improved clarity. Estelle Hitchon noted that she has progressed discussions regarding possible adjustments to the presentation of the MIQPR.

The Committee RESOLVED To:

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

69/25 REVIEW OF AMBULANCE SERVICE INDICATORS

Members received the Ambulance Service Indicators (ASIs) noting the focus on quality elements of service delivery. The importance of how this data informs planning, resource allocation, population health and prevention strategies was highlighted by Mark Thomas. It was noted that the ASI are published monthly by the Joint Commissioning Committee (JCC) and set out the Trust's performance across the five sept 999 patient pathway.

The ASI included the recent major change in incident categorisation which introduced the Purple (Arrest), Red (Emergency) and Rapid Clinical Screening Zero (RCS0). The ASI are not formally reported to the Committee, however many of them are incorporated into the MQIPR. Estelle Hitchon noted that future planning should consider which ASI data is most useful for performance scrutiny and resource allocation.

The Committee RESOLVED To consider the Ambulance Service Indicators and that they provided sufficient assurance with regards to the wider reporting to the Committee via the Trust's MIQPR.

70/25 INTEGRATED MEDIUM TERM PLAN (IMTP) PROGRESS REPORT

Alex Crawford updated the Committee on the Integrated Medium Term Plan (IMTP) Delivery and Assurance Report for Q2 2025/26.

Detailed feedback from WG on the plan has now been received and will be distributed more widely within the Trust. Overall, the feedback was positive but also highlighted areas where delivery confidence was lower, such as population health initiatives that have been challenging to initiate. These observations aligned with those noted in this report and reflected areas for potential progress in the current planning cycle.

The report also emphasised that the number of accountability conditions this year was significantly higher than in previous years. Last year, there were three or four accountability conditions, whereas this year there were approximately ten. Many of these conditions were applicable across NHS Wales, but there were several that were specifically tailored to the Trust.

Alex Crawford added that the paper's main focus was the CMT programme, currently at a cautionary (yellow) status due to ongoing work. The digital front end has improved from amber to green, showing strong progress, especially in integrated care services, though some CAD requirements kept it at amber. For EMS services, phase one of the Ambulance Performance Framework was delivered in July, and preparations for phase two in urgent care response are underway.

Urgent care remained at a yellow status, but scheduling improvements were in progress, along with utilisation of mental health vehicles. Health transport activity was minimal, with most ambulance care managed under operations. Transfer and discharge remained challenging due to Health Board needs, but national programmes like urgent care and Six Goals aimed to address this, alongside initiatives like Wait 45.

The rapid pace of change was noted in strategic updates and planning reflects consolidation and benefit realisation. The report also reviewed the Cabinet Secretary priorities, with milestones outlined in Appendix 2 aligning closely with the CMT programme.

The Committee inquired about the current status of the transfer and discharge service, which was presently on hold. Alex Crawford advised there was an urgent need for discussion on discharge and hospital flow, as recent workshops have raised concerns about the Trust's ability to support patient movement. The challenges affecting transfer and discharge were similar to daily EMS issues, such as handover delays. Upcoming changes with regionalised services and work on the Wait 45 will impact these processes. Estelle Hitchon added that the Executive Team was actively reviewing the IMTP to determine which items should continue, be deferred, or stopped, especially for those not considered immediate priorities. They were considering whether to extend deadlines or park some items for now, recognising that not all planned work can be delivered due to the current volume and shifting priorities. Estelle emphasised the importance of understanding the actual workload behind each objective and being more selective in future planning, as unexpected priorities often arise during the year

The Committee RESOLVED To:

1. **Note the CMT programme interim Q2 position.**
2. **Note the specific update on Directorate led deliverables for SO5.**
3. **Note the interim Q2 position for the Cabinet Secretary's priorities.**

71/25 DIGITAL REPORTING

Jonny Sammut updated the Committee on the following points:

1. Recruitment into Digital was progressing well. There were currently a total of 23 roles that Digital were actively recruiting into in 25/26 - made up of core baseline vacancies, posts from 24/25 investment, and new posts from 25/26 investment.
2. Audit Wales Digital Transformation Review: Board Self-Assessment. Trust Board were invited to share feedback, and the self-assessment has been submitted on behalf of the Trust.
3. The Trust has received 70 evaluation feedback forms as part of the Copilot pilot which have been developed into requirements for an ongoing education package.
4. The refresh of the Electronic Patient Care Record (ePCR) application has been formally approved and is now in active development.

5. As part of the National Data Resource (NDR) Programme, an all-Wales Joint Controller Agreement was signed by the Trust in August, the first step of a series of Information Governance assurances and requirements to enable compliant use of this DHCW managed platform.

The Committee RESOLVED To note the contents of the Digital Report.

72/25 INFORMATION GOVERNANCE REPORT

Jonny Sammut highlighted key updates, which included alerts regarding ongoing review of the data breaches log, a new corporate Artificial Intelligence (AI) risk and an AI steering group in development. He added there was a records management plan in place for the physical records, and a developing plan for online records management.

Members commended the highest ever Information Governance mandatory training rate (89.61%) and the ongoing cyber improvement work. The Committee noted a temporary rise in dormant accounts, and the plan to reduce them. It was also noted that both physical and online records management were challenging given their volumes.

The Committee RESOLVED To note the Information Governance report.

73/25 INTERNAL AUDIT REPORT: MANCHESTER ARENA INQUIRY

Lee Brooks presented the Manchester Arena Inquiry (MAI) internal audit report which looked at the governance and reporting arrangement established, including a validation exercise to support the closure of action and received substantial assurance. It was noted that this report had been received by the Audit, Risk and Assurance Committee and that the summary from the discussion at that committee was included here for transparency.

The assurance opinion given by Internal Audit for this review was 'substantial'. The Committee welcomed the work involved and the team was commended on the positive outcome. It was noted that a more detailed discussion on the MAI submission to Commissioners and the delays to the timeline thereof were due to be discussed in the closed session of this meeting.

The Committee RESLOVED To note the receipt of the Internal Audit Report on the Manchester Arena Inquiry, the assurance opinion for which was 'substantial' assurance.

74/25 ENVIRONMENT, DECARBONISATION AND SUSTAINABILITY UPDATE

Richard Davies, in updating the Committee advised them that WG were reviewing the Strategic Delivery Plan, which will impact the Decarbonisation Action Plan.
Key challenges included the Electric Vehicle charging rapid charging network due to market instability.

Members were assured with the Trust's re-accreditation of ISO 14001 Environmental Management which was commended by the Committee. This reflected the team's commitment to high standards in environmental management. The update was received and there were no questions or concerns.

The Committee RESOLVED to note the update on the work being undertaken in support of the Trust's Environment, Decarbonisation and Sustainability work programme and the update on the Trust's Decarbonisation Plan.

75/25 ESTATES BACKLOG ANNUAL REPORTING

Richard Davies updated the Committee advising them there has been a continued reduction in backlog costs due to targeted investment in priority areas, such as roof replacements and successful capital and Estates Facilities Advisory Board funding bids.

Richard Davies added that physical condition surveys were completed every 5 years and updated annually after completion of essential works, or because of disposal.

Ed Roberts acknowledged Richard and the team for their efforts in addressing the backlog. One major aspect involved Llanfairfechan, specifically regarding the closure and relocation to Ty Elwy, which resulted in substantial deferred maintenance for that facility.

The Committee RESOLVED To note this update and the 2024/25 Estates Condition and Backlog Maintenance Report.

76/25 RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK REPORT

The committee received the Risk and Board Assurance Framework report noting that all risks have undergone their quarterly review, with no material changes to scores.
The inclusion of a new risk on the register relating to the use of Artificial Intelligence (AI) tools was noted and the Risk 542 Decarbonisation is in development and will likely be presented at the January 2026 meeting on the new template.

Additional risks were discussed throughout including **financial risks** and **Phase Two** of the Ambulance Performance Framework risks which are noted in the sections above.

RESOLVED: The Committee RESOLVED To

Consider contents of the report including:

a. **The controls in place against the risks.**
b. **The actions described to further mitigate the risks.**

77/25 AUDIT TRACKER

Trish Mills provided a brief overview of the Audit Tracker, highlighting that its purpose is to give assurance on the progress of tracking audit actions under the committee's remit. She specifically noted the focus on the data quality audit, mentioning that the committee wanted to closely monitor its progress. She referenced a recent report to ARAC, explained that one action (111 commissioning advisory) was closed at the meeting, and pointed out that the remaining open action relates to digital literacy, which is due next month. She also mentioned that ARAC requested assurance from the Finance and Performance Committee on the realistic delivery of revised dates for these actions.

Jonny Sammut explained that previous delays on the data quality action were due to long-term staff absence, but the data quality team is now back to full strength. He reported that architecture documents mapping systems and data flows have been updated and signed off, and he expressed confidence that the October deadline for the digital literacy action will be met, with ongoing monitoring to ensure completion.

The Committee was asked to receive assurance on the monitoring and progress of actions, and there were no objections or concerns raised, indicating that the committee was assured of the position regarding the outstanding data quality action.

The Committee RESOLVED To:

1. **Receive assurance on the monitoring of management actions to address recommendations in the Tracker, noting any revised dates for actions.**

2. **Note the progress reported against the remaining 2024/25 Data Quality Internal Audit recommendations.**

78/25 COMMITTEE CYCLE OF BUSINESS MONITORING REPORT AND PRIORITIES UPDATE

Trish Mills advised that the Committee's annual priorities were reviewed and were progressing well. The Cycle of Business Monitoring Report noted that the Value Based Healthcare Report, which was scheduled for receipt by the Committee, is the subject of a Board Development session later this month.

The Committee RESOLVED To note the update with regards to the Committee Cycle of Business Monitoring Report and Committee Priorities

79/25 REFLECTION: SUMMARY OF DECISIONS AND ACTIONS

Members reflected that the meeting was characterised by open, robust, and constructive discussion, particularly on the Ambulance Performance Framework, where additional time was deliberately allocated to ensure thorough scrutiny and effective decision-making. The meeting was seen as providing strong assurance on key issues, with an emphasis on the value of certainty, even when facing challenges, and the importance of balancing ambition with realism as the organisation continues its transformation and performance improvement journey.

Meeting concluded at 12:30

Date of Next Meeting: 18 November 2025

ACTION LOG - CURRENT
FINANCE AND PERFORMANCE COMMITTEE

Action	Date	Agenda Item	Action Note	Responsible	Due Date	Progress/Comment	Status
53/25	21 July 2025	Quality and Performance Management Framework (QPMF) Logic Benefits Map	In terms of the QPMF benefits map and the benefits measures it was agreed that the QPMF Steering Group would consider this in further detail. It was agreed an update would be provided at the next meeting following discussion at the QPMG Steering Group.	Hugh Bennett	30 September 2025	**Update for 18 November 2025** The meeting was held on 7 October 2025 and a mock up of the revised benefits map was currently being considered by the FPC Chair. Update for 16 September 2025 The QPMF Steering Group further considered this on 4 September. Whilst some amendments were agreed, both Hugh Bennett and Trish Mills would benefit from a discussion with the committee chair and Peter Curran on the mapping and the best way to represent benefit going forward. **A suitable date was being sourced for this meeting to take place prior to the end of September 2025**.	Complete
67/25	16 September 2025	Phase 2 Go Live of Clinical Model Transformation	It was agreed that ahead of the extraordinary board meeting (23 October 2025), an extraordinary meeting of the Quality, Patient Experience and Safety Committee (QUEST) will be held to consider the QIA and EqIA, Trish Mills would arrange the Extraordinary QuEST meeting.	Trish Mills	6 October 2025	The QuEST Extraordinary Meeting was arranged and took place on 10 October 2025	Closed
68/25	16 September 2025	Monthly Integrated Quality Performance Report	It was agreed that Jonny Sammut would collaborate with Mark Thomas to explore ways to enhance the presentation of the visuals in the report for improved clarity.	Jonny Sammut Mark Thomas	10 November 2025	**Update for 18 November 2025** A broader update was being undertaken on the MIQPR, Jonny Sammut will provide a verbal update as to the detail at the meeting. Once the Committee is satisfied with the update, the action can be closed.	Open

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

FINANCE AND PERFORMANCE COMMITTEE
HIGHLIGHT REPORT TO BOARD

This report provides the Board with key escalation and discussion points at the last Committee meeting. A full list of items discussed appears at the end of the report to enable members to raise any questions to the Chair which have not been drawn out in the report. The papers for these meetings can be found by following this link to the Committee page on the Trust website.

Trust Board Meeting Date	25 September 2025
Committee Meeting Date	16 September 2025
Chair	Jayne Beeslee

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

Phase 2 of the Ambulance Performance Framework

1. An extraordinary public board meeting has been arranged for 23 October 2025 to consider go-live for phase 2 of the Ambulance Performance Framework. At the FPC meeting today members received an update on internal arrangements in place to implement and pilot the second phase of changes ahead of the board considering an endorsement of go-live alongside the Quality Impact Assessment (QIA) and Equality Impact Assessment (EqIA) at that October meeting. Ahead of the extraordinary board meeting, an extraordinary meeting of the Quality, Patient Experience and Safety Committee (QUEST) will be held to consider the QIA and EqIA.

2. The board will recall that on 1st July 2025, the Trust successfully implemented the Phase 1 changes to the Framework for a 12-month pilot period. This involved replacing the previous 'Red' category with a new 'Purple Arrest', 'Red Emergency' and 'RCS0' call categories. This change was undertaken to provide greater emphasis on clinical outcomes over time-based targets, with a bundle of measures related to the 'Chain of Survival'. Upon announcement of the Phase 1 changes the Welsh Government (WG) led Ambulance Target Review group reconvened to review the remaining Amber and Green categories. Following consideration of the available clinical evidence and evidence relating to what matters most to patients & staff, the review group concluded new categories were required to replace the current Amber and Green categories. These three new response categories, which will complement the phase one changes are set out below and are planned to go-live on 1 December:

Category	Descriptor	Types of Complaint
ORANGE NOW	Refers to incidents likely to need diagnostics and transport to hospital or specialist care e.g. a person in stroke or heart attack	Stroke Heart attack
YELLOW SOON	Refers to incidents where further clinical assessment to support clinician decision making (remote or face to face) is required for discharge at	Abdominal pain

	scene and/or an alternative pathway, and/or planned transport to a treating facility.	
GREEN PLANNED	Refers to incidents where there is high potential for the ambulance service to manage the care episode in its entirety or in collaboration with a community service or planned care provider.	Chest infection Palliative care Mental health Urinary tract infection

Alongside the face-to-face response categories, Rapid Clinical Screening already in place will be supported by the addition of RCS1, RCS2, and RCS3 as well as RCS0.

3. There was constructive and wide-ranging discussion on the arrangements for go-live for phase two, and the following points are of note for board's attention:

   (a) Clinical outcomes for the measures referenced are still evolving. However, a persistent challenge remains due to the lack of a unified medical record system across the wider healthcare landscape. WAST continues to rely on available data sources, primarily the ePCR and proxy measures for quality, as well as being alert to reports via the concerns and Putting Things Right processes. The recent signing of a Joint Controller Agreement with Health Bodies and DHCW marks a positive step towards securing pathway based data analysis that demonstrates clinical impact and patient outcomes. Members emphasised the importance of transparency and a shared ambition to improve patient outcomes.
   (b) A staff survey has been issued to gather feedback on the changes introduced during phase one. This input will help assess organisational and staff readiness for phase two.
   (c) Executives expressed confidence that the changes to the CAD remain on track for go-live. The statement of works has been central to recent discussions, with the next milestone on 8 October offering a further opportunity to confirm readiness. A go-live checklist will be in place as it was for phase one.
   (d) Although no additional financial investment is being sought for the Clinical Model Transformation (CMT) (noting internal capital allocation for the single instance of CAD for the Remote Integrated Care Service), members discussed the associated opportunity costs and the need to ensure appropriate use of resources, including fleet. Data parameters are currently being developed to support future reviews of demand, capacity and skills mix following the pilot.
   (e) A query was raised about progressing to phase two without first evaluating both the delivery and clinical risks arising from phase one. Committee was assured that external evaluation was being finalised based on the model being designed as a single, integrated approach. The timeline recognised Welsh Government requirements. The evaluation will also share insights throughout the pilot and complements the clinical flows implemented since November 2024.

4. Members endorsed the paper for onward submission to the October Extraordinary board, but that this is subject to the QIA and EqIA being reviewed by QUEST. Finalisation of these impact assessments may lead to changes, and those that are material should be drawn out for the committee members and the board.

ADVISE

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

5. Chairs of committees will meet with executives in the autumn for a discussion on **revisions to the Monthly Integrated Quality and Performance Report** (MIQPR). The potential to incorporate statistical process charts (SPC) to clearly illustrate variances and use of co-pilot to produce these was canvassed.

6. An update was provided on the **'Wait 45' initiative**. The national handover taskforce continues with WAST represented, to oversee the recommendation from an independent Ministerial Advisory Group that no ambulance handover should exceed 45 minutes by 1 October. Although handover delays are reducing, 12,565 hours were still lost during July 2025. Examples of prolonged waits at Emergency Departments were shared, including instances of 19 and 29 hours this last week although all Health Boards have reported reductions. The Wait 45 initiative aims to reduce lost handover hours to a level that aligns with EMS rosters and enables improvements in performance and patient care.

7. Members received the **Ambulance Service Indicators (ASIs)** noting the focus on quality elements of service delivery. The importance of how this data informs planning, resource allocation, population health and prevention strategies was highlighted.

8. Members **reflected** that the meeting was characterised by open, robust, and constructive discussion, particularly on the Ambulance Performance Framework, where additional time was deliberately allocated to ensure thorough scrutiny and effective decision-making. The meeting was seen as providing strong assurance on key issues, with an emphasis on the value of certainty - even when facing challenges - and the importance of balancing ambition with realism as the organisation continues its transformation and performance improvement journey.

ASSURE

(Detail here assurance items the Committee receives)

The following items will also be presented to board at their 25 September meeting however members may benefit from the following points of discussion from the committee:

9. With respect to the **financial position for months 4 and 5 2025/26.** The month 4 position was noted, and the committee took assurance from the update. The Trust is reporting a revenue year to date deficit of £246K for month 4 2025/26. The committee reflected on the risks discussed and escalated to the Board following the July meeting but heard that the Trust is currently forecasting to breakeven by the 2025/26 financial year end. This position is one of high risk of delivery, however. The cumulative year to date month 5 revenue position reported is an overspend against budget of £0.229m. The Capital Plan for month 5 is progressing with current planned expenditure in year of £30.190m. Gross savings which have been achieved are £3.582m against a year to date target of £3.486m. The primary risks at month 5 continue to be the additional costs for increased National Insurance contributions, and the increase in costs for the Welsh Risk Pool; as reported to the Board in July. The need for realistic income generation targets was emphasised for 2026/27.

The committee discussed the use of vacancy delays as a method for achieving non-recurrent savings. While holding vacancies can generate short-term financial benefits, these are not always sustainable due to ongoing staff turnover. A natural recruitment lag of around three months typically contributes to these savings without impacting organisational capacity unless deliberately planned. Some current vacancies are linked to skill mix reviews rather than savings measures, with plans in place to reduce them, although some will continue into the next financial year. The recruitment control panel ensures vacancies are assessed against organisational priorities, risk and statutory duties before being filled. Members acknowledged the financial value of vacancy management but emphasised the need to balance this with service delivery and workforce pressures.

10. With respect to the **Monthly Integrated Quality and Performance Report** (MIQPR) for July. This is the first scorecard to include the new categories of Arrest (Purple), for cardiac and respiratory arrests, and Emergency (Red). Of note for the board:

    - Members reiterated that the July hours lost to handover, whilst significantly beneath what we have seen for some years, is still resulting in avoidable harm that is difficult to currently mitigate against.
    - The Chair of QUEST noted that a PTR recovery plan in place and that QUEST will be closely monitoring that, particularly its impact on concerns response.
    - The decline in 111 response times despite expectations for improvement was raised. It was however noted that whilst not achieving target performance is better than the model suggests given the current capacity. On the resources currently in place it is unlikely that a 5% abandonment rate will be reached without further investment.

11. The Committee received the **Integrated Medium Term Plan (IMTP) Delivery and Assurance Report** for Q2 2025/26 with a key focus on the CMT which has a yellow (cautionary) status. The digital front end has moved from amber to green which was welcomed. WG had provided detailed feedback on the IMTP which was positive. That feedback drew out areas where low delivery confidence was noted, and the next report will review those areas and seek to draw through a recalibration and prioritisation of the 2025/26 plan. This was a topic of discussion at the recent executive team away day.

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

12. The **Manchester Arena Inquiry (MAI) internal audit** report looked at the governance and reporting arrangement established, including a validation exercise to support the closure of action and received substantial assurance. This was welcomed and the team commended. A more detailed discussion on the MAI submission to Commissioners and delays to the timeline thereof were discussed in closed session.

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

    - Strong digital recruitment activity
    - The launch of the 111 virtual agent "albot" with over 10,000 chats and ongoing evaluation
    - Positive submission for the Audit Wales Digital Review self-assessment, with most scores in the "agree" or "strongly agree" range.

- Data warehouse load failures are low (1–2 per month), which is within best practice
- As noted above, the NDR joint controller agreement has been signed, though further work is needed on public engagement and opt-out processes.

Members welcomed the focus on digital as transformation, not just service, and encouraged continued support for this direction.

14. The **Information Governance (IG) Report** highlighted key updates, which included alerts regarding ongoing review of the data breaches log, a new corporate AI risk and AI steering group in development, and ICO 999 survey advice under review. Members commended the highest ever IG mandatory training rate (89.61%), ongoing cyber improvement work, and a temporary rise in dormant accounts, and the plan to reduce them. Both physical and online records management are challenging given volumes. There is a records management plan in place for the physical records, and a developing plan for online records management.

15. The **Environmental, Decarbonisation and Sustainability update** was received. Welsh Government are reviewing the Strategic Delivery Plan, which will impact our Decarbonisation Action Plan. Key challenges include the EV charging rapid charging network due to market instability. Members were assured with the Trust's re-accreditation of ISO 14001 Environmental Management.

16. The **estates condition and backlog maintenance** update for 2024/25 period was received. The committee noted that there has been a continued reduction in backlog costs due to targeted investment in priority areas, such as roof replacements and successful capital and Estates Facilities Advisory Board funding bids. The positive impact of these improvements on the working environment was noted and the Estates Team were commended for their work.

17. In **closed session** members received an update on the MAI recommendations timeline, cyber KPIs, cyber audit actions and the cyber risk 260. The limited assurance 111 Website Internal Audit was also received. The closed session also received an update the forthcoming board approvals for key estate schemes in Monmouth, Matrix House and Abergavenny. All items taken in closed session were done on the basis of commercial or security sensitivity and will be reported to the open session of the board in due course.

18. The **audit tracker for Q1** was reviewed and the committee was assured that actions were on track, and all extensions of dates were appropriate and realistic.

19. The **committee's annual priorities** were reviewed and are progressing well. The cycle of business monitoring report noted that the Value Based Healthcare Report, is the subject of a board development session later this week.

RISKS

The committee received the **Risk and Board Assurance Framework report** noting that all risks have undergone their quarterly review, with no material changes to scores.

The inclusion of a **new risk** on the register relating to the use of Artificial Intelligence (AI) tools was noted and the **Risk 542** Decarbonisation is in development and will likely be presented at the January 2026

meeting on the new template.

Triangulation of the Manchester Arena Inquiry (MAI) Internal Audit Report against **Risks 594 and 641** was included noting ongoing discussions with the Joint Commissioning Committee to resolve the outstanding recommendations from the MAI Inquiry.

Additional risks were discussed throughout including **financial risks** and **Phase Two** of the Ambulance Performance Framework risks which are noted in the sections above.

In private session, Members received assurance on the detail of **Risk 260** noting that there were no material changes during this period.

COMMITTEE AGENDA FOR MEETING		
Financial position M4 and M5 2025/26	Phase 3 Ambulance Performance Framework and W45 assurance update	MIQPR
Ambulance Service Indicators	Digital reporting	Information governance report
Manchester Arena Inquiry Internal Audit Report	IMTP progress report	Environmental, decarbonisation and sustainability update
Estates condition and backlog maintenance update	Risk management and BAF	Audit tracker Q1
Committee cycle and priorities update		

COMMITTEE ATTENDANCE						
Name	**20 May 2025**	**21 Jul 2025**	**16 Sep 2025**	**18 Nov 2025**	**20 Jan 2026**	**17 Mar 2026**
Jayne Beeslee (Chair)						
Bethan Evans						
Peter Curran			[1]			
Chris Turley			Ed Roberts			
Rachel Marsh	Hugh Bennett	Hugh Bennett	Estelle Hitchon			
Lee Brooks						
Liam Williams	Wendy Herbert	Wendy Herbert				
Carl Kneeshaw						
Jonny Sammut			From 1022			
Trish Mills						
Hugh Parry						
Damon Turner						

	Attended
	Deputy attended
	Apologies received
	No longer member

[1] Peter Curran left the meeting at 10.25. Rhiannon Beaumon-Wood joined at 10.30 and was counted towards quorum.

OPERATIONS DIRECTORATE
QUARTERLY REPORT FOR COMMITTEES
2025-26 Q2 (July – September 2025)

National Operations & Support

IMTP

Manchester Arena Inquiry

We continue to await a formal outcome following our August 2024 submission on the Manchester Arena Inquiry recommendations. We have continued to engage with commissioners and completed a fifth scrutiny session in September 2025 with Health Board colleagues and JCC to answer the outstanding queries on our submission. The timeline advised is to anticipate an outcome in December 2025.

General Update

HART Drone

Our HART drone is now being utilised regularly in a training environment to ensure pilots maintain regular flying hours. In August, the drone capability was successfully demonstrated to the Senior Leadership Team, with live streaming into the ODU. The drone group is working with Information Governance to finalise the draft SOP which should enter the governance approvals before Christmas.

Volunteer Conference

The Volunteer team delivered the annual Volunteer Conference in Swansea on 27th September, celebrating the achievements and contributions from our volunteers. The event was well attended with final numbers exceeding 175 volunteers, with Executive and Non-Executive colleagues in attendance. Speakers on the day covered an exciting agenda including Human Factors in Health Care, Oncology: The Patient Journey, Response Model update and WAST Charity with the event concluded with the WAST Volunteer Award Ceremony.

EPRR Testing and Exercising

On 7th October, HART (Blue Watch) participated in *Exercise Tendley 2*, a multi-agency major incident scenario planned and delivered by South Wales Police. The exercise simulated a multi-vehicle road traffic collision involving a coach carrying high-risk football supporters and featured 40 live casualty actors, enhanced with realistic moulage provided by the BBC *Casualty* team. HART supported triage, treatment, and extrication of patients to the Casualty Collection Point (CCP), working closely with Fire and Rescue Service, Police, EMRTS, and Medserve colleagues to deliver high-quality care.

The HART Team Leader integrated effectively within the command structure, directing the team to prioritise tasks and patients. JESIP principles were actively maintained throughout—supporting shared situational awareness, coordinated decision-making, and effective joint working. JESIP is recognised nationally as best practice for interoperability between emergency services during major incidents.

Positive outcomes from the exercise included successful mobilisation and testing of SORT logistical capabilities, with SORT setting up tents for the Casualty Clearing Station in collaboration with EMRTS. The first crew on scene promptly initiated triage using ten second triage and, establishing a Forward Command Post (FCP). Debriefs on points of learning for the exercise will follow.

Resourcing, EMS Coordination and Quality

General Update

EMS Coordination

IAED Mentor Courses

In August, we commenced IAED Accredited Mentor courses for Call Supervisors and Senior EMDs across the three EMSC's, enhancing their skills and knowledge to better support our EMDs. Additionally, Managing Attendance at Work Training has been delivered to all Shift Managers and Call Supervisors, increasing their understanding and confidence in applying this policy, and supporting our people.

Yorkshire Ambulance Service (YAS)

Our support for Yorkshire Ambulance Service (YAS) concluded with WAST monitoring performance impacts daily. Since its inception in 7th April 2025, we have dealt with over twenty-two thousand calls. As a result of the monies generated from this process, alongside support of our colleagues in Yorkshire, we have been able to offer our staff overtime to support this mutual aid request. In addition, it has provided the financial means to send more staff to the Navigator conference and offer overtime so that we can facilitate the IAED mentor courses.

CMT – Clinical Model Transformation

On the 1 July 2025, the first phase of the Clinical Model Transformation project was implemented. The existing Red Category in the Dispatch Cross Reference (DCR) table was split into three new categories: Purple Arrest, Red Emergency, and RCS0. Additional codes were added for Multi Agency Incident Transfer (MAIT) and 111, and amendments were made to Cymru High Acuity Response Unit (CHARU) suitable codes. Standard Operating Procedures were updated and face to face training was delivered to EMSC Staff. It is particularly pleasing that following a survey the implementation of phase 1 has received positive feedback from EMSC staff outlining that the rationale for the need to change was explained clearly and that colleagues felt supported in understanding and being prepared for the change.

Quality Assurance Framework

A Quality Assurance Framework for Clinical Navigators has been approved. This framework will offer the monitoring, compliance and reporting processes that need to be in place to provide and assure a high-quality service. The cultural ethos and aim of audits and monitoring is to observe and applaud good practice and provide feedback for improvement where compliance and clinical advice has fallen below standards. The framework provides a shared understanding of what is required to be achieved and offers a two-way feedback mechanism to improve standards.

Operations Quality (OQ)

Organisational Change

A formal consultation process for expansion of the OQ department concluded on 05 September 2025. The department is now in the process of recruiting staff into new posts and teams which include CPSS Quality Audit, ECNS Quality Audit and Integrated Care concerns. A team of 10 CPSS auditors have been recruited and started on 01 October 2025. Training is ongoing and the department will be working with the International Academies of Emergency Dispatch (IAED) to scope out requirements to work towards Accredited Centre of Excellence status for CPSS. ECNS auditor recruitment will begin early January 2026.

Putting Things Right (PTR) Recovery Plan

Operations Quality is working closely with the PTR team to improve the Trust's PTR position as part of the PTR recovery plan. Complaint reviews have been taking place to ensure investigation scopes are proportionate and to enable the investigation team to expedite overdue complaints. Temporary investment has been provided to increase the department's QA capacity and a trajectory of improvement is in development.

Resourcing

Following a period of user acceptance testing, GRS live on premise has successfully been upgraded to v4.8 which is a prerequisite for transition to Cloud and the broader e-timesheet project. The timeline for Cloud Migration to happen in May 2026.

Resourcing have welcomed two newly appointed resourcing coordinators to the team during September, bringing us to coordinator establishment and a welcomed support to the Swansea based team as we progress preliminary work for the rostering of Integrated Care, 111 to GRS.

Emergency Medical Service

IMTP

EAP Training

EAP training continues to progress well. There are further courses scheduled for 6 October & 11 November with both courses currently have 45 staff booked on. Therefore, by the end of the current calendar year a total of 378 staff (including EMT3) will have completed the training and qualified as EAPs, with 518 completed by the end of the financial year.

As a result of considerable staff release to support this training initiative the upcoming winter UHP position is a concern, and we will continue to manage this by targeting staff release strategically to avoid overburdening any single area. Our winter structures will lead the response across the period.

APP Roster Review

The APP Roster Review is progressing, and a series of meetings have already been undertaken with Clinical colleagues and TUPs. There are many functional elements to build into new rotas which includes Primary Care, APP Navigators, Palliative Care and operational staff. Further modelling is underway to support rota build.

Improve Capacity in Rural Wales

A Task and Finish Group has been established in partnership to develop an action plan that is actionable and sustainable, improve rural recruitment and retention alongside rural capacity and resilience.

General Update

CHARU Recruitment

CHARU Recruitment is transitioning to a quarterly cycle, with no immediate barriers or additional recruitment needs anticipated.
With the commencement of external training courses, it is expected that a high proportion of candidates will succeed. However, following the completion of the upcoming external training course we will be in a position to fully understand the true CHARU position and whether there remain any shortfalls.
If shortfalls remain following all the recruitment processes (internal & external), consideration will then be given to applying acceptable solutions to increase CHARU coverage similar to the Welshpool rotational model.

Overruns

Conversations to reduce end-of-shift overruns are being advanced through ongoing collaboration with TUPs. The ambition is to operationalise the majority of identified strategies within October 2025, thereby safely improving operational efficiency and enhancing staff wellbeing.

Ambulance Care

Challenges

Transfer and Discharge Pressures

Transfer and discharge has emerged as a pressure point for Ambulance Care. As Health Boards actively strive to reduce handover times outside Emergency Departments to achieve the W45 standards, there has been a noticeable increase in journey booking requests for Discharge & Transfer. Whilst every effort is being made to accommodate all journeys, there have been occasions when demand exceeds available capacity and some journeys have been delayed until the following day. The service is focused on engaging proactively with HBs and maximising the utilisation of our discharge and transfer resources.

Capacity Management Plan (CMP)

The Capacity Management Plan continues to be a considerable challenge, with an average of 500 journeys across Wales cancelled each week. Although this figure is higher than desired, a whole systems approach has enabled a reduction in overall cancellations, particularly in areas of greatest need.

In AB and BCU Health Boards areas we have piloted initiatives to reduce CMP numbers, and these are delivering positive outcomes, including days without the CMP being activated. These intitatives include;

- Continued review of PAS improved provision to identify utilisation
- Operational oversight via OTL within control rooms.

We continue to raise awareness of these efforts both internally and externally, including with our commissioners.

Additionally, focused collaboration with PTR and PECI is ongoing to better support patients whose journeys are cancelled, and to enhance our responsiveness to concerns raised.

IMTP

NEPTS Cleric System and Hywel Dda Patient Administration System Connectivity

The link between the Cleric system and the Hywel Dda PAS is now complete and in operation. This connection facilitates cross checking of systems to identify patients who have transport booked, but are no longer attending their appointment due to cancellation, date/time change or a change in patient circumstances. In a week of operation, we have identified almost 50 journeys where a patient's healthcare appointment has changed, and they no longer require the transport that was booked. It is highly likely that a resource would have been dispatched to complete this journey without this information. Rollout to additional Health Board areas will be explored following completion of further refinement with Hywel Dda.

Roster Review Modelling

Following the pause to the review, additional modelling has been provided and two new potential roster proposals have been developed. These have passed the first phase of testing and are currently being tested with real world data by our planning and operational management team. Upon completion of the testing and, providing a viable option is identified, working parties will recommence soon.

General Update

Ambulance Care Roadshows

Throughout September, we completed our inaugural set of six Ambulance Care roadshows. The roadshows provided an opportunity for the management team to engage with colleagues across the country, through three face-to-face and three online sessions. Key

topics included the future vision for Ambulance Care, the Capacity Management Plan, the Urgent Care Service, and Roster Reviews. Each session featured an interactive Q&A, sparking valuable discussions and prompting further consideration within the team.

Feedback was overwhelmingly positive, with staff highlighting the sessions as informative and welcoming the opportunity to engage directly with the senior leadership team. The NHS Staff Survey was also actively promoted during these events.

Key engagement metrics from the six sessions:

- 110 unique attendees, with face-to-face sessions attracting higher numbers
- 75 questions were received and answered
- 92 interactions were received on the future Ambulance Care Future Vision
- In addition to informing future years IMTP content, the feedback on the Ambulance Care Vision will be incorporated into next year's IMTP and the refresh of the Trust's long-term strategy.

Further engagement events will be held in the New Year.

Integrated Care

IMTP

Senior Management OCP

The process has now been completed and will reshape the Service Manager structure, moving our Service Managers into functional, pan Wales roles:

· Service Manager for Inbound Services.

· Service Managers leading Clinical Services.

In addition, we appointed a new Service Manager post with responsibility for service improvement. This role will oversee a wider portfolio, including the Directory of Service team and a Locality Manager.

General Update

Ambulance Performance Framework

On 1 July 2025, the new Ambulance Performance Framework was launched and the introduction of RCS0 calls to Integrated Care. Another significant development was the establishment of the 'Rapid Assessment Queue,' dedicated to handling RCS0 and priority calls, with clinicians specifically assigned to these cases. Priority calls, identified by the Clinical Navigator, CSD Operations Manager, or Point of Contact, are clinically assessed as needing a faster call back. Since this queue began operating, the average time to assessment of 9 mins has been below the balancing measure of 15 mins.

Care Planning

We are refining how we manage the Care Planning queue by dividing it into three categories: remote monitoring, falls, and extended response delays over six hours during periods of high escalation. The primary focus for care planning clinicians will be on remote monitoring, supporting patients to be safely managed in the community and reducing the need for transport to an Emergency Department. To achieve this, they will work closely with Advanced Paramedic Practitioners and Health Board community teams. A new AQM (Advanced Questioning Module) has been developed and will be implemented in October to improve the documentation and data collection on activity.

Video Consultation

On the 8th of July video consultation was introduced to clinicians working on the 111 CAD system, joining those clinicians on the CSD CAD who already had access. Video consultation is designed to support the triaging process by enabling clinicians to visually assess a patient's condition. This visual interaction enhances clinical judgement and supports critical thinking, helping clinicians determine the most appropriate pathway. Since the launch, there have been 329 episodes of Video Consultation activations. Within CSD 754 video consultations were completed (this was the highest amount since records began in Sep 22). In total there were 1,083 Video consultations completed.

Simply Do Challenge

The intergrated care team, were the first team to trial the use of the "Simply Do- WIN platform". This platform is an ideas generation platform, that allows teams to submit ideas around a specific challenge. A challenge was designed, focused on gathering ideas around improving the abandonment rate of 111 specific calls. A total of 17 ideas were submitted by Call Handling Coordinators, focused on the specific challenge. The team are collaborating with the Quality Improvement Team, within the Quality Directorate, to progress some ideas into small tests of change. This was presented at the annual Quality Conference.

Pan Operations

Staff Survey

Following the Quality and Support Day held in response to the NHS Wales Staff Survey 2024, all service areas have now developed and confirmed their action plans based on the feedback received. These action plans have been reviewed and approved through the Senior Operations Team (SOT) and are now ready for submission to the People & Culture team. This marks a key milestone in our commitment to addressing staff feedback and driving meaningful improvements across the Operations Directorate.

Quality and Support Days

As part of our commitment to act on staff feedback and deliver meaningful improvements across the Operations Directorate, the good work carried out so far through the Quality and Support Days will be further built upon by holding the sessions monthly on one day across all service areas from October 2025. The dedicated sessions will provide a structured opportunity to prioritise staff wellbeing while addressing both organisation wide themes and local service specific priorities.

The content of each session will be scheduled in advance, drawing on service area action plans, staff feedback, compliance requirements, and lessons learned. Outcomes will be integrated into action plans where significant interventions are required, including actions linked to the NHS Wales Staff Survey 2024. Alongside these larger initiatives, a log of immediate local "Just Do It" improvements will be maintained to capture quick resolutions where appropriate.

While staff wellbeing will remain the central focus, the sessions will also provide a platform for timely operational priorities such as compliance, training, seasonal planning, and feedback on national programmes of work. In doing so, Quality and Support Days will ensure a consistent, visible, and meaningful approach to supporting staff and strengthening service delivery across the Directorate.

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

Agenda Item No. 6

REPORT TITLE

Financial Performance as at Month 6 – 2025/26

MEETING

Name of meeting	Finance & Performance Committee
Date of meeting	18th November 2025
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Edward Roberts (Acting Director of Finance)
Author(s) of report	Steph Taylor (Assistant Head of Capital Planning)

PURPOSE OF REPORT

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

REPORT SUMMARY:

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

1. This paper presents to the Committee the latest Financial Performance Report of the 2025/26 financial year, the reported position as at Month 6 (September 2025).

2. The Committee is asked to review, comment, note and receive assurance on the financial position and 2025/26 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 now reporting a revenue year to date deficit of £0.186m. For month 6 (September 25) the Trust is reporting a small in month surplus of £0.043m;
   - In line with the balanced financial plan approved as part of the submitted 2025-28 IMTP, the Trust is currently forecasting to breakeven by the 2025/26 financial year end;
   - Capital expenditure plans continue to be progressed with plans to fully achieve in year;
   - In line with the financial plans that support the IMTP, gross savings of £4.260m have been achieved in month 6 against a target of £4.216m;
   - Public Sector Payment Policy is on track with performance, against a target of 95%, of 98.8% for the number, and 99.1% of the value 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 6 revenue financial position and performance of the Trust as at 30th September 2025.

2. **Note** the delivery of the 2025/26 savings plan, and the context of this within the overall financial position of the Trust.

3. **Note** the capital programme for 2025/26.

4. **Note** the Month 6 Welsh Government monitoring returns 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:

1. Monitoring return submitted to Welsh Government for month 6 – as required by WG (Reading Room)

2. Monitoring return letter submitted to Welsh Government for month 6 – as required by WG

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
18 November	Finance and Performance Committee

SITUATION

1. This report provides the Committee with a summary of the revenue financial performance of the Trust as at 30th September 2025 (Month 6 2025/26), along with an update on the 2025/26 capital programme.

BACKGROUND

2. The key points to note in relation to the **delivery of the Statutory Financial Targets for 2025/26** (1st April 2025 – 30th September 2025) are that:

   - The cumulative revenue financial position reported is an **overspend against budget of £0.186m**, based on some key assumptions consistent with that within the IMTP financial plan and the Board approved budget for 2025/26. The underlying year-end forecast for 2025/26 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 **£4.260m** have been achieved against a target of **£4.216m**;

   - Public Sector Payment Policy is on track with **performance, against a target of 95%, of 98.8% for the number, and 99.1% of the value** of non-NHS invoices paid within 30 days.

3. Whilst any adverse reporting of the year-to-date financial position is not welcomed, the month 6 surplus of £0.043m does represent an improvement from that originally forecasted at month 4 and 5. This does give some positive signs for future months and the Trust's ability to further improve the month-on-month position and recover it before the year end.

4. This has in part been achieved through the delay in the timing of some elements of additional unavoidable costs, some further improvements in variable pay spends, reduced sickness absence rates and the start of some impact of reduced handover delays (albeit mostly efficiency gains rather than cost reduction). Further updates will be regularly provided through various leadership groups, Committees and Boards.

5. Given some of the above, we have again at this stage not reflected any change to the year-end forecast, which remains at breakeven and one we will continue to do

all that we possibly can to achieve. This is also in part to seek to ensure some consistency across NHS Wales in terms of how some of the external pressures continue to be treated.

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 6 are set in line with the submitted IMTP and summarised later in this report. As we go through the next few months these will continue to be scrutinised and amended accordingly, with mitigations and management plans in place. However, given that as discussed above these risks now do reflect an element of the financial shortfall.

ASSESSMENT

REVENUE FINANCIAL PERFORMANCE – MONTH 6 2025/26

7. The table below presents an overview of the financial position for the period 1st April 2025 to 30th September 2025.

Revenue Financial Position for the period 1st April - 30th September				
	Annual Budget	Year to date		
		Budget	Actual	Variance
	£000	£000	£000	£000
Income	-327,226	-161,270	-161,169	101
Expenditure				
Pay	244,214	120,756	119,864	-892
Non-pay	63,217	29,892	30,690	798
Total pay & non-pay expenditure	307,431	150,648	150,554	-94
Depreciation & Impairments / interest payable & receivable	19,795	10,622	10,801	179
Total	**0**	**0**	**186**	**186**

Income

8. Reported Income against the initial budget set to Month 6 shows an underachievement of **£0.101m**.

Pay Costs

9. Overall, the total pay variance at Month 6 is an underspend of **£0.892m**.

Non-pay Costs

10. The overall non-pay position at Month 6 is an overspend of **£0.798m**. In addition, for reporting purposes Depreciation, Impairment and interest is excluded from the above figure, overspend of **£0.179m,** hence the total overspend to budget of **£0.186m**.

Savings

11. As above, the 2025/26 financial plan identifies that a minimum of **£8.500m** of planned savings (including Income generation) are required to achieve financial balance in 2025/26, this equates to c2.7% of the Trusts discretionary income. Of this, **£6.225m** is recurrent and **£2.275m** is currently deemed non recurrent.

12. Month 6 in month performance was, plan of £0.730m and £0.678m achieved, therefore an underachievement of £0.052m (recurrent underachievement of £0.101m and non-recurrent overachievement of £0.049m), as per the below table.

	Annual	In Month			Cumulative			Forecast		
	Plan £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000
Recurrent Schemes / Themes	6,225	540	439	-101	3,078	2,883	-195	6,225	6,091	-134
Non Recurrent Schemes / Themes	2,275	190	239	49	1,137	1,377	239	2,275	2,409	134
Overall Total	**8,500**	**730**	**678**	**-52**	**4,216**	**4,260**	**44**	**8,500**	**8,500**	**0**

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

13. The split between savings, net income generation and accountancy gains as at month 6 is shown on the below table.

	Annual	In Month			Cumulative			Forecast		
	Plan £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000
Savings (Cash releasing and Cost Aviodance)	8,350	726	673	-52	4,191	4,235	44	8,350	8,450	100
Net Income Generation	150	4	4	0	25	25	0	150	50	-100
Accountancy Gains	0	0	0	0	0	0	0	0	0	0
Overall Total	**8,500**	**730**	**678**	**-52**	**4,216**	**4,260**	**44**	**8,500**	**8,500**	**0**

14. ***Appendix 1*** provides the overall detail for Month 6 by theme. This is now further split over recurring and non-recurring schemes

Financial Performance by Directorate

15. Whilst there is an overall year to date deficit reported at Month 6, there are also some small variances between Directorates, as shown in the table below, when compared to the budgets set at the outset of the financial year. Some of this is driven by staffing vacancies. These are fairly minor in nature, but they will be continued to be closely monitored.

Financial position by Directorate @ 30th September	Annual Budget	Year to date			
		Budget	Actual	Variance	Tolerance 5%
	£000	£000	£000	£000	%
Directorate					
Operations Directorate	223,226	110,567	109,772	-795	-0.7%
Chief Executive Directorate	2,163	1,122	1,121	-1	-0.1%
Board Secretary	701	343	342	-1	-0.2%
Partnerships & Engagement Directorate	636	300	299	-1	-0.2%
Finance and Corporate Resources Directorate	36,632	17,589	18,147	558	3.2%
Planning and Performance Directorate	2,956	1,404	1,372	-32	-2.3%
Quality, Safety and Patient Experience Directorate	7,394	3,642	3,533	-109	-3.0%
Digital Directorate	16,308	7,165	7,119	-46	-0.6%
People and Culture	6,503	3,135	2,950	-185	-5.9%
Medical & Clinical Services Directorate	6,524	3,054	3,079	24	0.8%
Trust Reserves	1,363	316	515	199	62.8%
Trust Income (mainly JCC)	-304,407	-148,637	-148,063	574	0.4%
Overall Trust Position	**0**	**0**	**186**	**186**	

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

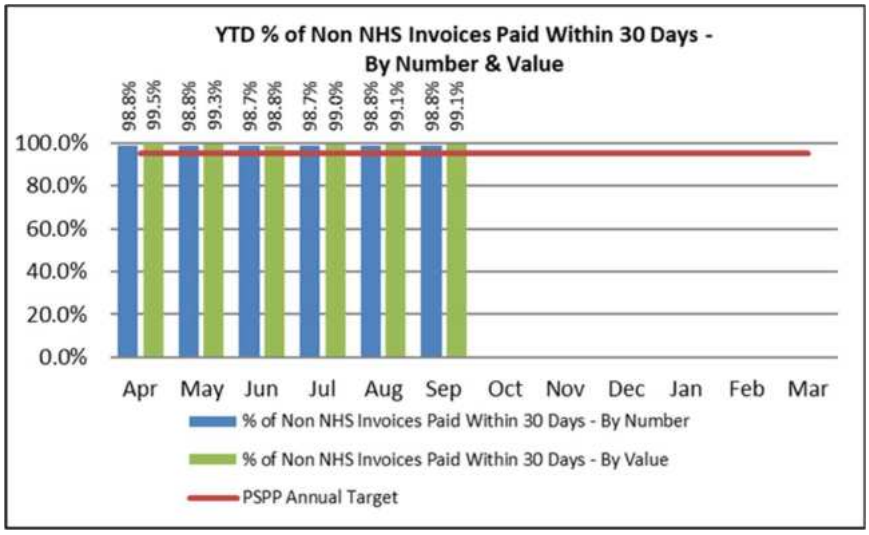
- Most directorates either underspending or broadly in line with budget plan for Month 6 except for Trust reserves, Finance and Corporate Resources and Trust income. It is through these areas that the previously highlighted main drivers of the current YTD position are reported, as follows:
- Core budgets set for **Finance and Corporate resources** at opening of the financial year are broadly balanced with the exclusion of the current cost pressure around Welsh Risk Pool (WRP) as follows.
    i. **Forecasted Increase:** The forecast spend in relation to the Welsh Risk Pool has increased by £42 million across Wales, over and above the £36 million already included in organisational plans. This leaves a balance to be covered across NHS Wales under the risk share agreement.
    ii. **Provisions and Cases:** At the end of March last year, there were £1.7 billion of provisions for 1,100 cases across NHS Wales. The increase in forecasted losses is attributed to additional court dates being opened up, possibly due to a backlog from COVID-19. This has led to more trials being booked earlier in the year, limiting the scope for settlements to move.
    iii. **Impact of Personal Injury Discount Rate:** The change in the personal injury discount rate in January was expected to shift claimant preference towards periodic payment orders rather than lump sums. However, this shift has not been observed, with some cases potentially settling for significantly higher amounts than forecasted.
- Core budgets set for **Income** at the opening of the 2025/26 financial year included two main components
  1. Income from main commissioner (JCC) for core services provision of EMS, Ambulance Care and 111 related services

2. Income from WG for the increased costs of the changes to Employers National Insurance from April 2025 which is where a cost pressure has emerged since Month 3.
    i. The rate of employer's National Insurance Contributions (NICs) increased by 1.2%, bringing it to 15%. The Employer's NI Secondary Threshold also decreased from £9,100 to £5,000.
    ii. Impact on WAST was a cost increase of c£4.69m and this was included in the opening financial plan with assumed full income coverage from WG.
    iii. Discussions in Deputy Directors of Finance in June 2025 via WG updates had flagged a potential funding shortfall of c7% (WAST risk of £0.330m) for NHS Wales organisations and hence based on this M3 ¼ of this (£0.082m) was included in the M3 financial reported position.
    iv. Further correspondence then received from WG in July 2025 identified a much larger shortfall figure of c25% (c£1.2m) based on the full NHS Wales funding allocated for Employers NI, due to UK treasury funding being far less than the public sector costs.
    v. This has resulted in the Trust only being able to invoice WG for £3.540m.

- Trust reserves due to rebasing some balance sheet provisions from 24/25 for annual leave sold.

PUBLIC SECTOR PAYMENT POLICY PERFORMANCE (PSPP)

17. Public Sector Payment Policy (PSPP) compliance to Month 6 was **98.8%** against the **95%** WG target set for non-NHS invoices by number and **99.1%** by value.



2025-26 CAPITAL PROGRAMME

18. As we are still in the relative early stages of the financial year the discretionary capital programme and resulting cashflows continue to be progressed.

19. At Month 6, the Trust's approved Capital Expenditure Limit (CEL) set by and agreed with WG for 2025/26 is **£30.190m**. This includes **£24.242m** of All Wales Approved schemes and **£5.948m** for Discretionary schemes.

20. There is no suggestion at this stage of the financial year that this value will not be spent in full.

	Actual £'000	Plan £'000
All Wales Capital Programme: Schemes:		
ESMCP - Control Room Solutions	71	421
MDVS	0	72
Special Operational Response Teams (SORT) Enhancement Equipment	0	290
Welsh Ambulance Services NHS Trust – Vehicle Replacement Programme – 2025-26	3,114	22,452
TEF - Infrastructure	48	300
TEF - Decarbonisation	21	707
Sub Total	**3,253**	**24,242**
Discretionary:		
I.T.	363	1,149
Equipment	79	250
Statutory Compliance	0	0
Estates	(110)	4,350
Other	16	180
Unallocated Discretionary Capital	0	19
Sub Total	**348**	**5,948**
Total	**3,601**	**30,190**
Less NBV reinvested		
Total Funding from WG	**3,601**	**30,190**

RISKS AND ASSUMPTIONS

21. As we progress through the financial year, 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 report, we may continue to move towards higher risks having to be reported, alongside ensuring that Trust Board and the Finance & Performance Committee remain fully appraised of such risks and any mitigating actions.

22. There are a number of risks that need to be documented within this reported financial position, which aligns to that fully described within the financial plan submitted as part of the IMTP.

23. It continues however that the risk of not achieving financial balance this financial year has significantly increased since the outset of the financial year. Whilst there continue to be further elements of mitigation that we can reasonably expect to be delivered between now and the end of the financial year, and we continue to explore any and all opportunities for more in this regard, it would not be reasonable at this stage to expect all of this to be able to be absorbed, and certainly not without some potential service impacts. This does all mean that we will then further have to deliver a reduced spend and manage existing plans to ensure that the Trust can continue to forecast a year end break even. Therefore, the Trust need to include a medium risk of this not being achievable. However, positively the Trust has again in month, based on the work detailed above, reduced this risk down to **£0.250m** from the previously reported £0.400m, also noting this risk has been reduced from a high risk at month 5 to a medium risk in month 6.

24. A medium risk has been identified following the NWSSP risk sharing paper, in which in addition to the increase already reported within the Trust's position, the paper included a potential additional figure for the Trust of **£0.213m**, this will continue to be monitored monthly when updates are provided by NWSSP.

25. A low risk has been included around any JCC additional, in year, saving request. This is currently low at present; however, this is on the basis that the Trust has had no further direct contact from the JCC on any further ask. However, the Trust acknowledges this could be an increased risk should such an in-year request be made. It remains that our current breakeven forecast assumes the current level of core funding and savings (which are significant and challenging as they stand), supported as such by the JCC in our IMTP and financial plan, and in part is following the Trust receiving no additional funding for the Band 4 to 5 technician grade re-banding.

26. Given the pressures the Trust feels every winter, the Trust has included a figure of **£1.000m** to cover any unfunded winter pressures; this has been deemed as a low risk, based on support provided from Commissioners over recent years.

27. The risk associated with the increase in handover delays (increase in overrun costs, due to HB reducing services) is included as **£1.500m** (low risk).

28. The unquantified risk associated with the Manchester Arena Inquiry has now been excluded, however specifically from a finance only lens. Subsequent recommendations, both Capital and Revenue costs have been identified and if this recommendation is to be taken forward additional funding would be required to deliver. As previously noted, this has always been less of a financial risk, as only if funding were made available would the costs transpire. However, the risks to the services are much more than financial.

29. 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 continues to be included on the Trust's Corporate Risk Register.

RECOMMENDATION

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

NEXT STEPS

31. Monitor the ongoing revenue and capital position over the remaining months of the year linking in with key stakeholders, to ensure delivery to plan.

32. Continue to closely monitor the risks and ensure plans are developed to ensure the Trust can meet its statutory duties.

Appendix 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.

Welsh Ambulance Services NHS Trust

Savings Performance by Theme 25-26

Reporting Month 6

	Annual	In Month			Cumulative			Forecast		
	Plan	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Apprentice Income	50	4	4	0	25	25	0	50	50	0
Balance Sheet Flexibility	200	50	0	-50	100	50	-50	200	200	0
Commercialisation Opportunities	100	0	0	0	0	0	0	100	0	-100
Disposals	250	20	20	0	60	60	0	250	250	0
End of Shift Overrun	100	9	9	0	54	52	-2	100	98	-2
Fuel	230	20	61	41	119	354	235	230	551	321
Interest Receivable	516	43	9	-34	258	78	-180	516	229	-287
Non Pay Local Schemes - Corporate	914	64	41	-23	382	306	-76	914	913	-1
Non Pay Local Schemes - Operations	650	54	36	-19	319	254	-65	650	585	-65
Pay Cost Management (Variable / Net Vacancies) - Operations	3,140	267	250	-17	1,736	1,679	-57	3,140	3,140	0
Pay Vacancy Management - Corporate	2,275	190	239	49	1,137	1,377	239	2,275	2,409	134
Pay Vacancy Management - Corporate 25-26	75	9	9	0	25	25	0	75	75	0
Totals	**8,500**	**730**	**678**	**-52**	**4,216**	**4,260**	**44**	**8,500**	**8,500**	**0**

Savings Performance by Theme 25-26 - Recurrent

Reporting Month 6

	Annual	In Month			Cumulative			Forecast		
	Plan	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Apprentice Income	50	4	4	0	25	25	0	50	50	0
Balance Sheet Flexibility	200	50	0	-50	100	50	-50	200	200	0
Commercialisation Opportunities	100	0	0	0	0	0	0	100	0	-100
Disposals	250	20	20	0	60	60	0	250	250	0
End of Shift Overrun	100	9	9	0	54	52	-2	100	98	-2
Fuel	230	20	61	41	119	354	235	230	551	321
Interest Receivable	516	43	9	-34	258	78	-180	516	229	-287
Non Pay Local Schemes - Corporate	914	64	41	-23	382	306	-76	914	913	-1
Non Pay Local Schemes - Operations	650	54	36	-19	319	254	-65	650	585	-65
Pay Cost Management (Variable / Net Vacancies) - Operations	3,140	267	250	-17	1,736	1,679	-57	3,140	3,140	0
Pay Vacancy Management - Corporate	0	0	0	0	0	0	0	0	0	0
Pay Vacancy Management - Corporate 25-26	75	9	9	0	25	25	0	75	75	0
Totals	**6,225**	**540**	**439**	**-101**	**3,078**	**2,883**	**-195**	**6,225**	**6,091**	**-134**

Savings Performance by Theme 25-26 - Non Recurrent

Reporting Month 6

	Annual	In Month			Cumulative			Forecast		
	Plan	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Apprentice Income	0	0	0	0	0	0	0	0	0	0
Balance Sheet Flexibility	0	0	0	0	0	0	0	0	0	0
Commercialisation Opportunities	0	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	0	0	0	0	0	0
End of Shift Overrun	0	0	0	0	0	0	0	0	0	0
Fuel	0	0	0	0	0	0	0	0	0	0
Interest Receivable	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
Pay Cost Management (Variable / Net Vacancies) - Operations	0	0	0	0	0	0	0	0	0	0
Pay Vacancy Management - Corporate	2,275	190	239	49	1,137	1,377	239	2,275	2,409	134
Pay Vacancy Management - Corporate 25-26	0	0	0	0	0	0	0	0	0	0
Totals	**2,275**	**190**	**239**	**49**	**1,137**	**1,377**	**239**	**2,275**	**2,409**	**134**

Please note figures are rounded to the nearest whole number

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

Cadeirydd
Chair: Colin Dennis

Prif Weithredwr
Chief Executive: Jason Killens

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

13th October 2025

Your ref:

Dear Andrea,

Re: SEPTEMBER 2025 (MONTH 06 2025/26) MONITORING RETURN

Please find attached the Monitoring Returns for the Welsh Ambulance Services University NHS Trust for September 2025.

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 2025.

The Trust's performance against financial targets for month 06 2025/26 is as follows: -

1. **Actual Year to Date 2025/26 (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 2025/26 being that the 2024/25 funding is, where applicable, fully recurrent, and the 2025/26 funding will include: -

- The nationally made available 1.77% uplift for core cost growth, which excludes any funding to meet the 2025/26 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.

Included within the income assumptions is the full pass through of 2024/25 pay funding and an assumed level of funding for Employers National Insurance contribution increase for 2025/26 funding (see below).

The resulting reported performance at month 6 as per Table B, is a overspend against budget / deficit of **£0.186m**

The reported total pay variance against plan as at month 6 is an underspend of **£0.892m**, set against the budgets.

The non-pay position at month 6 is a reported overspend of **£0.977m**.

Income at month 6 shows an underachievement of **£0.101m**.

Whilst an adverse financial position is not welcomed, the month 6 surplus of £43k does represent an improvement from that originally forecasted at month 4 and 5. This does give some positive signs for future months and the Trust's ability to further improve the month on month position and potentially recover it before the year end.

This has again in part been achieved through the delay in the timing of some elements of additional unavoidable costs commencing, some further improvements in variable pay spends, reduced sickness absence rates and the start of some impact of reduced handover delays (albeit mostly efficiency gains rather than cost reduction).

Given some of the above, we have again at this stage not reflected any change to our year end forecast, which remains at breakeven and one we will continue to do all that we possibly can to achieve. This is also in part to seek to ensure some consistency across NHS Wales in terms of how some of the external pressures continue to be treated, the WRP updated forecast in particular, plus noting the ongoing work by NWSSP in relation to this and to further understand the actual level of any further risk share that could eventually be incurred in relation to this in 2025/26.

2. Movement (Table A)

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

The planned FYE values in Table A, now reflect the prior month's forecast **(Action Point 5.1)**

3. Underlying Position (Table A1)

Table A1 has been adjusted to agree with Table A

4. Risk (Table A2)

The risks have again been reviewed in detail and depending on the outcome of some of the issues highlighted elsewhere in this return, we may continue to move towards higher risks, as noted above, having to be reported, alongside ensuring that the Trust Board and the Finance & Performance Committee remain fully appraised of such risks and any mitigating actions.

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

It continues however that the risk of not achieving financial balance this financial year remains a risk. Whilst there continue to be further elements of mitigation that we can reasonably expect to be delivered between now and the end of the financial year, and we continue to explore any and all opportunities for more in this regard, it would not be reasonable at this stage to expect all of this to be able to be absorbed, and certainly not without some potential service impacts. This does all mean that we will then further have to deliver a reduce spend and manage existing plans to ensure that the Trust can continue to forecast a year end break even. Therefore the Trust need to include a medium risk of this not being achievable, however positively the Trust has again in month, based on the work detailed above reduce this risk down to £0.250m from the previously reported £0.400m, also noting this risk has been reduced from a high risk at month 5 to a medium risk in month 6.

A medium risk has been identified following the NWSSP risk sharing paper, in which in addition to the increase already reported within the Trust's position, the paper included a potential additional figure for the Trust of £0.213m, this will continue to be monitored on a monthly basis when updates are provided by NWSSP.

A low risk has been included around any JCC additional, in year, saving request, this is currently low at present however this is on the basis that the Trust has had no direct contact from the JCC on any further ask. However in light of the comment contained in the month 1 reply letter, the Trust acknowledges this could be an increased risk

should such an in-year request be made. However, it remains that our current breakeven forecast assumes the current level of core funding and savings (which are significant and challenging as they stand), supported as such by the JCC in our IMTP and financial plan, and in part is following the Trust receiving no additional funding for the Band 4 to 5 technician grade re-banding**.**

Given the pressures the Trust feels every winter, the Trust has included a figure of £1.000m to cover any unfunded winter pressures; this has been deemed as a low risk, based on support provided from Commissioners over recent years.

As noted in prior months returns, the risk related to the costs associated with the Manchester Arena Inquiry, and subsequent recommendations, both Capital and Revenue costs have been identified and if this recommendation is to be taken forward additional funding would be required in order to deliver. As previously noted within the returns, whilst this is less of a financial risk as only if funding was made available would the costs transpire, the risks to the services are much more than financial.

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 included, alongside a more detailed review of this risk on the Trust's Corporate Risk Register.

Now excluded from the opportunity table, is the VAT rebate for the Microsoft licences following the latest intelligence from DHCW.

5. Monthly Profiles (Table B)

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

6. Expenditure Movement (Table B2)

Table B2 has been completed in accordance with the guidance.

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

Agency costs for month 6 totalled £0.088m. The current percentage of agency costs against the total pay figure remains very small, at 0.4%. 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 in the near future. Due to the uncertainty that remains around some ICT funding that has been received on a non-recurrent basis, as such we are having to utilise agency staff in these roles to deliver the service, therefore there remains costs going into November and December, however as mentioned above these have non-recurrent funding and couldn't be appointed on a permanent basis.

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

Year to date at month 6 the Trust is reporting planned savings (including Income generation) of £4.216m and actual savings of £4.260m.

As can be seen from Table C3, the Trust underachieved its savings target in month 6 but it still forecasting to achieve the total original savings target for the year. As detailed above, this doesn't take into account any further ask on the Trust to manage either the additional external cost pressure or reduction from assumed funding, or any additional in year ask via the JCC,

In response to the Balance sheet flexibility scheme question, this savings target is linked to a planned reduction in variable costs due to a reduction in TOIL (i.e. less overtime) so ultimately although narrative is named balance sheet flexibility it is in relation to pay reduction. **(Action Point 5.4)**

9. Income/Expenditure Assumptions (Tables D, E and E1)

These are set out in Tables D, E and E1.

The Trust can confirm that the £1.332m has been received and table E1 has been adjusted accordingly **(Action Point 5.2)**

10. Statement of Financial Position and Aged Welsh NHS Debtors (Table F & M)

At month 6 there was 3 invoices over 11 weeks, more detailed comments have been provided in the narrative section and the Trust is actively chasing these invoices. **(Action Point 5.3)**

In relation to your question regarding the Capital creditor balance and the capital cash, due to the requirements to achieve cash balance the £0.050m relates to the methodology to achieve this, noting this has been removed in prior years, for planning purposes we are assuming this will be a requirement. In relation to the capital creditor balance this is based on the assumption on prior years experiences, however from a cash point of view we have assumed worse case in regard to all amounts due requiring payment in the current financial year, or as we usually see in the first weeks of the new financial year. **(Action Point 5.5)**

11. 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	16	12	15	13	13	10	13	13	13	13	13	13	157
Other Non NHS Income	329	268	293	135	453	213	266	266	266	266	266	270	3,291
Pensions Agency	0	0	0	0	0	0	0	0	0	0	0	0	0
Vat Refund	0	435	384	0	622	381	700	400	400	400	400	400	4,522
Risk Pool Refund	1,519	0	1,020	0	8	0	0	0	0	0	0	0	2,547
Total	1,864	715	1,712	148	1,096	604	979	679	679	679	679	683	10,517

12. Public Sector Payment Compliance (Table H)

This table has been completed in accordance with the guidance. The Trust endeavours to ensure that NHS invoices along with Non-NHS invoices are paid within targets.

The quarter 2 cumulative percentage of Non-NHS invoices paid within 30 days by number was 98.8% and 99.5% by value against a target of 95%.

13. Capital (Tables I, J and K)

The capital tables have been completed in accordance with the guidance.

Works are ongoing with Programme managers to establish updated cash flows that reflect the profiles of approved projects now for this financial year, however at present schemes are progressing well, and more detailed updates will be provided as the financial year progresses.

14. 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 6 Financial Monitoring Return will be presented to the Finance and Performance Committee on 18th November 2025.

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 Edward Roberts, Acting Director of Finance and Emma Wood, Chief Executive.

15. Other Issues

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

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

Edward Roberts
Acting Director of Finance

Emma Wood
Chief Executive

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

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

Agenda Item No. 7

REPORT TITLE

Financial Sustainability Programme Governance Group Meeting Update

MEETING

Name of meeting	Finance and Performance Committee
Date of meeting	18 November 2025
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Carl Kneeshaw, Director of People Chris Turley, Executive Director of Finance & Corporate Resources Rachel Marsh, Executive Director of Strategy, Planning and Performance
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 paper provides a strategic update on the status and forward trajectory of the Welsh Ambulance Services University NHS Trust's (WAST) Financial Sustainability Programme (FSP). It outlines key developments, progress against financial targets, and the evolving governance and delivery framework designed to embed long-term financial resilience across the organisation.
2. The FSP has undergone a structural reconfiguration to enhance delivery effectiveness, now operating through three core groups: Opportunities, Commercial, and Financial Planning. These are aligned with the Service Review and Directorate Plans to ensure integrated and accountable delivery. A revised governance model is being implemented, with oversight from the FSP Governance Group and the Strategic Transformation Board (STB).
3. **Financial Position** - The Trust continues to face a significant financial challenge. The 2025/26 savings target is set at £8.5 million, with a strategic emphasis on sustainability. 73% of the target is recurrent. As of Month 6, the Trust has achieved £4.260 million against a planned £4.216 million, representing a slight year-to-date overachievement. This reflects a positive trajectory, though future delivery remains weighted towards the latter half of the year.
4. **Administrative and Support Review** - All 24 recommendations from the 2023 review have been actioned or embedded within directorate plans. The review is now formally closed, with full agreement from the Administration Community and endorsement by the FSP Governance Group.
5. **Service Review** - a Trust-wide initiative aimed at addressing financial pressures and operational complexity. It engaged over 50 service areas and generated more than 330 improvement proposals, culminating in the *State of Play Report* (October 2024). The Executive Leadership Team (ELT) approved the tiered implementation model in June 2025, recognising the need for phased delivery through IMTP planning. A fixed-term Senior Project Manager role was created to lead the programme, with Richard Baxter appointed in October 2025. A collaborative review of Directorate-level proposals is underway, supported by the Senior Project Manager and Head of Commercial Development, to prioritise initiatives based on organisational value and financial impact.
6. **Commercial Development** - A new Head of Commercial Development, Matt Dugdale, has been appointed to lead the creation of a sustainable commercial strategy. A Commercial Steering Group will be established to define strategic priorities and income generation opportunities.
7. **Supply X** - The Supply X Inventory Management System has been successfully implemented across all five Make Ready Depots (MRDs), achieving 95% catalogue coverage and delivering

measurable improvements in stock visibility, cost control, and operational efficiency. The system, tailored for ambulance-specific use, integrates with Oracle and has enhanced business continuity and stakeholder engagement. Further rollout to five additional stations is planned, though concerns remain about the resource-intensive nature of implementation. A position paper will be presented to the Financial Sustainability Programme Governance Group on 21 November 2025 to assess alignment with IMTP priorities and determine future rollout strategy.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The Finance and Performance Committee is requested to:

1. To note and take assurance from the content of the paper.

ADDITIONAL PAPER(S)

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

1. No additional papers are suggested.

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
03/11/25	Strategic Transformation Programme Board
04/11/25	Carl Kneeshaw, Director of People

1. SITUATION

1.1 This paper sets out the Financial Sustainability Programme's current position, and delivery intentions for 2025/26.

2. BACKGROUND

2.1 Following our last progress report in July 2025, the re-development of the Financial Sustainability Programme Structure is taking place.

2.2 Work has continued around the Financial Sustainability Programme Delivery Framework for 2025/26 following engagement with Executives regarding the programme delivery structure. This consists of a three-group approach encompassing Opportunities, Commercial and Financial Planning. This will sit alongside the Service Review, which will link with Directorate Plans.
While engagement with programme governance has been underway with the Executive Leadership Team, work has continued in the following areas:

- Administrative Review Action Plan – now completed.
- Engagement regarding implementation of the Service Review recommendations.
- Head of Commercial Development and Senior Project Manager for FSP appointed.
- The continuation of the roll out of Supply X across stations.

3. FINANCIAL POSITION

3.1 Overall plan (target) for 25/26 is £8.5m, of which £6.225m (73%) is recurrent and £2.275m (27%) non-recurrent. 24/25 Savings target total of £6.421m had a split of c57% recurrent and c43% non-recurrent, so a greater proportion included as recurrent is needed to make savings more sustainable.

3.2 As of Month 6, performance was a plan of £0.730m and £0.678m was achieved, resulting in an underachievement of £0.052m. Cumulative YTD performance was planned at £4.216m and £4.260m achieved, so a YTD overachievement of £0.044m.

3.3 49.6% of the annual plan has been phased in year to date as at Month 6, which is slightly less than flatline (50%), so it shows savings plans are slightly phased greater in future months. 50.1% of the 25/26 overall plan value of £8.5m has been achieved year to date.

4. ASSESSMENT

Administrative and Support Review

4.1 The Administration and Support Delivery Plan was developed following the Administration and Support Review conducted in August 2023. The review produced 24 recommendations, which have been prioritised using the MoSCoW method (Must, Should, Could, Won't).

4.2 The Assistant Director Leadership Team (ADLT) met in September 2025 to review the outstanding recommendations. We are pleased to report that, following the review of the outstanding recommendations, all recommendations have either been completed or the recommendations now sit within directorate plans.

4.3 The Lead for the Administration and Support Review and the Senior Project Manager for the Financial Sustainability Programme met with the Administration Community to provide an update on the Administration and Support Review. We are pleased to report that the Administration Community were in agreement that the outstanding recommendations were either closed down as they were deemed no longer relevant or included in local directorate plans.

4.4 The Financial Sustainability Programme Governance Group received an update on 22 October 2025 and agreed on the closure of the Administration Review.

5. Service Review

5.1 The FSP Service Review was commissioned in response to growing financial pressures, increasing service complexity, and the need for a more sustainable and integrated operating model across the Welsh Ambulance Services University NHS Trust (WAST). It was a holistic review encompassing the entire organisation.

5.2 The review engaged with over 50 service areas and analysed more than 330 improvement proposals, culminating in the comprehensive *State of Play Report* (October 2024)

5.3 The ELT approved the final report on 11 June 2025, endorsing the tiered implementation model and its governance structure. It was acknowledged that not all recommendations could be implemented simultaneously, and prioritisation would occur through directorate and IMTP planning processes.

5.4 A fixed-term (2-year) Senior Project Manager post was approved to lead programme management, coordinate delivery, support directorates, and manage risk and reporting. The continued use of the Implementation Tracker and associated tools was endorsed, with recognition that implementation must be phased.

Following successful recruitment in early September 2025, Richard Baxter was appointed and commenced the role on 1 October 2025.

5.5 A collaborative review of Directorate-level ideas is currently underway with each Directorate Director and Business Manager, supported by the Senior Project Manager and Head of Commercial Development. The aim is to identify and prioritise proposals for implementation based on organisational value and potential financial savings.

6. **Commercial Development**

6.1 The new Head of Commercial Development, Matt Dugdale, joined the organisation on 6 October 2025.

6.2 Work has commenced on drafting a commercial plan. The plan will be developed around a more sustainable approach utilising applicable ideas and profitable opportunities.

6.3 The Head of Commercial Development will now work with the Executive Director of Strategy, Planning and Performance to establish a Commercial Steering Group to develop what good looks like and a forecast of what income may be possible from commercial development.

7. **Supply X**

7.1 Following the contract agreement with Omnicell in September 2021, WAST selected the Supply X Inventory Management System for rollout across NHS Wales, beginning with five Make Ready Depots (MRDs). A dedicated working group, including stakeholders from WAST and NWSSP, oversaw the implementation. Supply X integrates with Oracle to automate stock control and optimise inventory levels and has now been successfully deployed across all five MRD sites, with full stocktakes completed. The system has been tailored for ambulance specific use, achieving 95% catalogue coverage and delivering measurable improvements in operational efficiency, cost control, and stock management. Benefits include enhanced visibility of stock, streamlined ordering, reduced waste, improved business continuity, and stronger stakeholder engagement. The rollout will continue to larger sites in the coming months, with the aim of demonstrating tangible financial impact in the next reporting period, subject to data availability.

7.2 Supply X has been rolled out to MRD stations, with a further 5 stations in the near future. It is unclear what the plan is to roll this out any further beyond the stations currently in scope.

7.3 Concerns have been raised regarding the roll out requiring a resource-intensive approach. Therefore, it is important to fully understand and appraise the current position of the project against the Trust's current priorities and competing IMTP workplan.

7.4 A position paper will be taken back to the next Financial Sustainability Programme Governance Group on 21 November 2025.

8. RECOMMENDATION

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

9. NEXT STEPS

9.1 On 11 November 25, a presentation to ELT/SLC on the work and governance arrangements for the FSP will take place. The aim is to ensure all senior leaders are reminded of their responsibilities for financial sustainability and actively engaged in FSP governance arrangements, including the Opportunities, Commercial and Financial Planning groups. An update on the Trust's financial position, as well as early indications on settlement for 25/26 will be shared, alongside group engagement on modelling activity for projected cost savings.

9.2 To continue the implementation of the new governance structure, which will involve establishing the new groups - the Commercial Development Group and the Projects Opportunities Group.

9.3 Work will also continue to progress the Service Review and Supply X.

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

Agenda Item No.	8

REPORT TITLE

Monthly Integrated Quality Performance Report – August/September 2025

MEETING

Name of meeting	Finance & Performance Committee (FPC)
Date of meeting	18 November 2025
Public or Private	Public
If private - rationale	Choose item from below

REPORT SPONSOR

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

PURPOSE OF REPORT

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

REPORT SUMMARY:

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

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

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

3. There are a few acknowledged data quality issues within the report. There is a clear executive focus on Phase 2 of the Ambulance Performance Framework, so this is the current priority, but additional capacity is being sought for the Insight & Data Services function. Some additional capacity is already in place and further positions are due to be filled following interviews which took place in early September 2025. The pressures on IDS are being actively managed through a CMT workplan.

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

5. The Trust saw 12,284 hours lost to handover during September 2025, compared to 20,693 lost hours in September 2024. This follows on from significant month-on-month reductions seen during June, July and August 2025 pan-Wales. Whilst this reduction is very welcome, it is by no means universal, and the ambition is for all health boards to reduce handover to levels which improve patient experience and outcomes, and which are sustainable.

6. 111 call handling performance has stabilised post-delivery of the new 111 CAS, but the service did not achieve the 5% abandonment rate in September 2025.

7. Ambulance Care, in particular, Non-Emergency Patient Transport Service's (NEPTS) performance is varied, with only oncology and renal journeys remaining above target in September 2025.

8. The Trust continues to focus on its people, with a range of actions in place to improve workplace experience including, for example, reducing shift overruns, whilst also continuing with the more strategic focus on the People and Culture Plan.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The FPC Committee is requested to:

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

ADDITIONAL PAPER(S)

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

1. Annex 1 - Monthly Integrated Quality and Performance Dashboard

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

RISK(S) THIS REPORT MITIGATES

Where relevant note the local, directorate, corporate or BAF risk number
223 - The Trust's inability to reach patients in the community causing patient harm and death 224 - Handover of Care Delays Outside Accident and Emergency Departments Impacts on Access to Definitive Care Being Delayed and Affects the Trust's Ability to Provide a Safe & Effective Service for Patients 160 - High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service

558 - Deterioration of staff health and wellbeing in the face of continued system pressures as a consequence of workplace experiences

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 and Research	☒ Whole Systems Approach

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

IMPACT ASSESSMENTS FOR CONSIDERATION

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

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

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
28 October 2025	Hugh Bennett – Assistant Director Commissioning & Performance
03 November 2025	Rachel Marsh – Executive Director Strategy, Planning & Performance

SITUATION

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

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

BACKGROUND

3. This Integrated Quality & Performance Report contains information on key indicators at a highly summarised level, which 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.

4. As previously agreed, the metrics which form part of this committee report are updated on an annual basis, to ensure that they continue to represent the best way of tracking progress against the Trust's plans (IMTP) and strategies. A Board development session was held in April 2025 at which the annual review was undertaken. It was noted that there will be some changes to metrics during 2025/26, aligned to the new performance framework announced by the Cabinet Secretary. No other specific changes were requested, but the Board did discuss a number of areas where it was felt development and progress could be made in terms of the MIQPR and 'what good looks like' reporting. At other levels of the organisation, work continues in terms of developing appropriate metrics which can be used to measure quality and performance against our four domains.

5. Following more recent discussions with the Chair of this committee, and with others, a session will be convened later in the autumn (now arranged) to discuss with committee chairs the format of the MIQPR for the next financial year, as the organisation and its metrics evolve.

ASSESSMENT

Our Patients – Quality, Safety and Patient Experience

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

7. **999** call answering times during September 2025 saw the 95th percentile decreasing to 18 seconds, compared to 23 seconds in August 2025. However, the 65th percentile and median performance times remained consistently good. Work is currently being undertaken on demand and capacity analysis of 999 call demand.

8. **111 call answering performance has minimally decreased over recent weeks,** with the call abandonment rate for September 2025 being 10.4%, and therefore not achieving the 5% target. 111 demand in September 2025 did see a 1.4% increase compared to September 2024. In addition, the external rostering review suggests there is a demand and capacity gap within the current funded establishment, and the Trust is therefore unlikely to reach performance without an increase in its workforce (including efficiencies). The current position with commissioners is to focus on the 111 digital front end as a way of managing demand rather than investment in call handlers.

9. **111 Clinical response:** clinical ring back times for patients with the highest priority remained above target at 99.1%. Response times for lower priority calls showed a minimal decrease , reducing to 71.4% and 65.1% for P2CT and P3CT respectively.

10. **Ambulance Response** (safety / patient experience): on 1 July 2025, the Trust's new ambulance response model was implemented, and two new response categories replaced the previous (old) Red category. The new categories are Arrest (Purple), for cardiac and respiratory arrests, and Emergency (Red), for major trauma and other incidents where patients are at significant risk of cardiac or respiratory arrest if they do not receive a rapid response. In September 2025, there were 785 purple calls to the ambulance service, around 2.31% of all calls, and 4,453 (Emerg) red calls, around 13% of all calls. The median response times for purple and red calls were 7 minutes 15 seconds and 8 minutes 36 seconds respectively, with the required range being 6- minutes.

    The Amber 1 median in September 2025 was 1 hour and 21 minutes and the Amber 1 95th percentile was 4 hours 52 minutes. The Clinical Safety Plan will

protect Arrest and Emergency demand, but Amber is where the impact of handover lost hours is most felt i.e. there is a strong correlation. Amber 1 response times have seen a significant improvement in recent months, in line with the fall in the number of hours lost to handover. However, these response times still remain too high and have a known impact on avoidable patient harm. Amber will be replaced by the Orange (Now) and Yellow (Soon) categories in quarter three of this year. The changes are designed to improve patient safety and patient outcomes by better stratifying patient demand.

11. Traditionally, the main factors which affect response times are demand and capacity (recruitment and lost hours). EMS production has been good although it dropped below 90% in September, and handover lost hours have significantly improved; with this improvement particularly feeding through into the Amber category's performance. Health Boards are implementing new actions in order to further reduce handover lost hours. The Trust's main focus is to continue to implement a material change in how it responds to patient demand by evolving its clinical model through the Clinical Model Transformation (CMT) programme. Areas of focus for 2025/26 include: -

    - Further investment into remote clinical capacity;
    - Further investment in APPs;
    - Development of the remote integrated care service (111 clinicians and CSD clinicians);
    - Continued focus on a range of responses that support non-conveyance, where it is clinically safe and appropriate to do so: Connected Support Cymru, mental health response pilot, Falls response etc.; and
    - The transformation of the various clinical model categories as per the previous paragraph.

12. As above, the level of lost hours to **handover outside Emergency Departments** remains a critical component of long waiting times and patient safety incidents. 12,284 hours were lost during September 2025; a 40.6% reduction compared to September 2024 and is the lowest monthly figure since July 2021. This follows on from significant month-on-month reductions seen during June, July and August 2025 pan-Wales. Whilst this reduction is very welcome, it is by no means universal, with Betsi Cadwaladr health board remaining high, with 7,569 hours being lost within the health board during September 2025. The ambition is for all health boards to reduce handover to levels which improve patient experience and outcomes and which are sustainable. WG has re-iterated to health boards the critical importance of improvements in this area and the reduction of all over 45-minute waits was a recommendation from the recent Ministerial Advisory Group on Performance and Productivity. The W45 initiative would see handover

lost hours reduce to approximately what the EMS rosters are designed to cope with.

13. **Ambulance Care (Patient Experience)**: Oncology performance in September 2025 was 77.79%, achieving the 70% target. Renal performance increased slightly to above target, achieving 71.21% and advanced discharge and transfer journey performance also increased to 81% (95% target), with this primarily being an issue with capacity. Same day discharge and transfer journey performance was also below the 95% target at 94%. Overall demand for NEPTS continues to increase and is now above pre-pandemic levels. The Trust has a comprehensive health transport transformation workstream in place, which includes delivering a range of efficiencies and improvements. The Trust is currently re-rostering NEPTS transport which will better align available capacity with changing demand patterns (on target). This is proving complex and difficult but will be delivered.

14. **National Reportable Incidents (NRIs) / Concerns Response**: the Trust reported three NRIs to NHS Wales Performance & Improvement in September 2025, remaining the same as August 2025, and two serious patient safety incidents were referred to health boards under the Joint Investigation Framework. In September 2025 complaint response times decreased to 56%, compared to the 60% recorded in August 2025, not achieving the 75% target. Data accuracy issues have been identified and addressed. However, a PTR recovery plan remains in place, recognising that cases continue to be complex.

15. **Clinical outcomes**: The percentage of suspected stroke patients who are documented as receiving an appropriate stroke care bundle was 88.5% in September 2025, decreasing from the previous month (90.8%), and remains below the 95% performance target. Work is ongoing to improve reporting and compliance through the ePCR system, and this improvement is clearly being seen in most of the clinical indicators. The Return to Spontaneous Circulation (ROSC) compliance rate decreased to 23.7% in September compared to 27.4% in August 2025.

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

17. In September 2025, 5,314 patients **cancelled** their ambulance (this figure excludes patients who refused treatment), which is a significant reduction on

previous levels. This reduction is likely to be the impact of switching on RCS although caution is required at this stage, as a longer run of data is required in order to properly evaluate the changes made. The Trust changed its Clinical Safety Plan in December, removing the "can't send" application, with the option remaining at the strategic commander's discretion in the new plan.

Our People (workforce resourcing, experience, and safety)

18. **Hours Produced**: The Trust produced 115,981 Ambulance Response unit hours during September 2025 and delivered an emergency ambulance unit hours production (UHP) of 89%, remaining below the 95% target (This will be a product of abstractions being above benchmark and the current vacancy factor).

19. **Response Abstractions:** EMS abstraction levels decreased minimally to 32.71% during September 2025 but remained above the 30% benchmark figure. Response sickness abstractions stood at 7.39% (benchmark 5.99%).

20. **Trust sickness absence:** the Trust's overall sickness percentage was 7.77% in September 2025, minimally down on the 7.91% recorded in August 2025, which is in line with seasonal factors. Actions within the IMTP concentrate on staff well-being with an aim to reduce this level to the IMTP ambition of 6%.

21. **Staff training and PADRs:** PADR rates did not achieve the 85% target in September 2025 and decrease slightly to 75.35%. Compliance for Statutory and Mandatory training also decreased slightly to 84.61% marginally failing to achieve the 85% target.

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

Finance & Value

23. **Financial Balance**: the reported outturn performance at Month 6 is a deficit of £0.186m with a forecast to the year-end of breakeven. The Trust is forecasting the achievement of both its External Financing Limit and its Capital Expenditure Limit.

Partnerships & System Contribution

24. The consult & close rate was 18.7% in September 2025, a slight decrease from the previous month but continuing to achieve the IMTP ambition (and Welsh Government target) of 17%.

25. Same Day Emergency Care (SDEC) centres continue to see only a low level of ambulance activity.

RECOMMENDATION

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

NEXT STEPS

For 111, key next steps include preparing for winter (forecasting, recruitment/production, respiratory offer, digital offer) and acting on the findings from the roster practice review.

For the 999-emergency care pathway, similarly, the focus is now on winter, which will include the usual business as usual preparations, but also the planned major transformation change of moving to the new Orange (Now), Yellow (Soon) and Green (Planned) categories.

For Ambulance Care, the focus will be on ensuring sufficient capacity is available for the predicted increase in planned care i.e. supporting health boards with the required transport on this, the NEPTS re-roster and options for how the Trust can reduce cancellations as a result of the Capacity Management Plan.

Welsh Ambulance Services University NHS Trust

Monthly Integrated Quality & Performance Report

August/September 2025

Annex 1 – Top Indicator Dashboard

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

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

by Commissioning & Performance Team

Section 1: Monthly Indicators / Top Indicator Dashboard

Top Monthly Indicators	Target 2025/26	Aug-25	Sep-25	2 Year Average	RAG
Our Patients					
Timeliness Indicators					
NHS111 Call Handling Abandonment Rates	< 5%	10.8%	10.4%	9.7%	R
111 Clinical Triage Call Back Time (P1)	90%	98.8%	99.1%	97.6%	G
999 Call Answer Times 95th Percentile	00:06	00:23	00:18	00:22	R
Arrest (Purple) Median	6-8 Minutes	07:15	07:15	N/A	G
Emerg. (Red) Median	6-8 Minutes	09:15	08:36	N/A	A
999 Amber 1 Median	00:18	01:25	01:21	01:36	R
Oncology Journeys arriving within 45 mins and up to 15 minutes after appointment time	70%	77.0%	77.8%	74.5%	G
Advanced Discharge & Transfer journeys collected less than 60 minutes after booked time (NEPTS)	90%	79.3%	80.6%	79.8%	R
Clinical Outcomes / Quality Indicators					
Return of Spontaneous Circulation (ROSC)	Increasing Trend	27.4%	23.7%	20.2%	G
Stroke Patients with Appropriate Care	95%	90.8%	88.5%	85.2%	A
Stroke Call to Hospital Door Times	Reduction Trend	02:27	02:09	02:24	A
ST-Elevation Myocardial Infarction (STEMI) with Appropriate Care	95%	75.9%	67.5%	60.6%	R
National Reportable Incidents reports (NRI)		3	3	4	
Can't Send & Cancelled by Patient Volumes	Reduction Trend	5,822	5,314	8,215	G
Concerns Response within 30 Days	75%	60%	56%	57%	R
Enactment of the Duty of Candour Total		0	4	5	
Our People					
Capacity					
Hours Produced for Emergency Ambulances	95-100%	90%	89%	93%	R

Top Monthly Indicators	Target 2025/26	Aug-25	Sep-25	2 Year Average	RAG
Health & Well-being					
Sickness Absence *(all staff)*	6.0%	7.91%	7.77%	7.97%	R
Mental Health Absence Rates	Reduction Trend	2.89%	2.96%	2.49%	R
Staff Turnover Rate	Reduction Trend	8.15%	8.02%	8.48%	G
Statutory & Mandatory Training	>85%	84.95%	84.61%	83.65%	A
PADR/Medical Appraisal	>85%	75.53%	75.35%	74.54%	R
Number of Shift Overruns	Reduction Trend	3,501	3,292	3,810	G
Inclusion & Engagement / Culture					
NEPTS % of Total Calls Answered in Welsh	Increasing Trend	2.00%	1.50%	1.9%	R
Value					
Financial balance - annual expenditure YTD as % of budget expenditure YTD	100%	100%	100%	100%	G
EMS Utilisation Metric (CHARU)	Increasing Trend	25.5%	26.4%	28%	G
Average Jobs per Shift (All Vehicles)	Increasing Trend	2.36	2.39	2.40	R
NEPTS on the Day Cancellations	Reduction Trend	14.7%	14.3%	13%	G
Partnerships / System Contribution					
Inverting the Triangle					
Successful Consult & Close Outcome	17.0%	19.1%	18.7%	15.7%	G
% Of Total Conveyances taken to a Service Other Than a Type One Emergency Department	Increasing Trend	9.55%	10.20%	11.1%	A
Number of Handover Lost Hours	7,500	13,160	12,284	21,093	R
NHS111					
NHS111 Dental Calls	Increasing Trend	8,920	8,852	8,000	A
Consult & Close Volumes by NHS111	Increasing Trend	2,365	1,940	1,414	A

In-Month RAG Indicates =

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

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

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

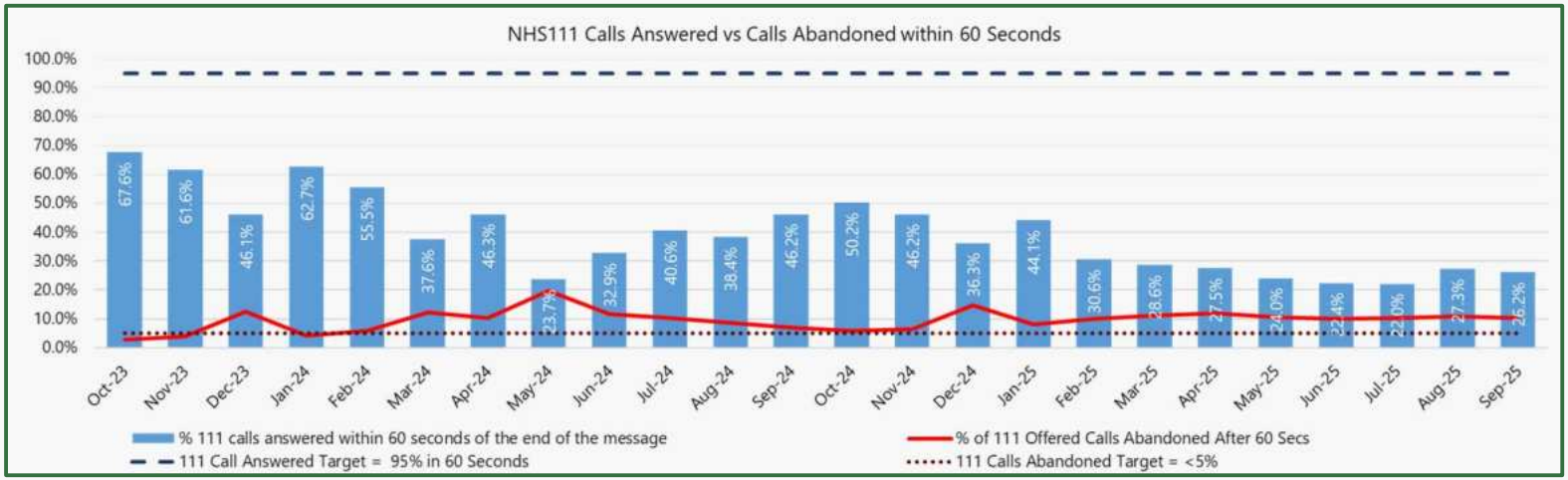
TBD: Status cannot be calculated (To Be Determined)

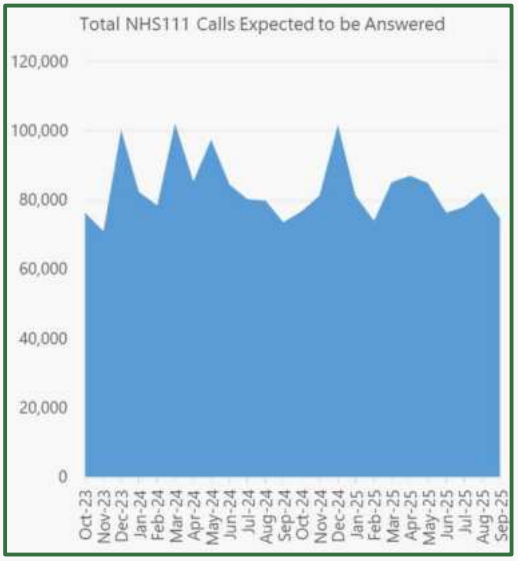
Our Patients: Quality, Patient Safety & Experience
111 Call Answering/Abandoned Performance Indicators
Influencing Factors – Demand and Call Handling Hours Produced

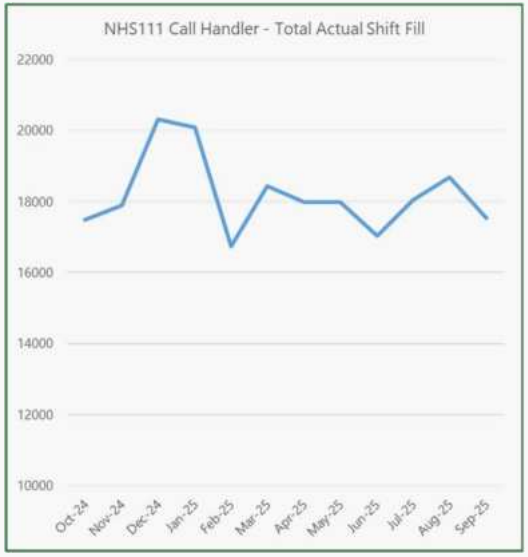
(Responsible Officer: Lee Brooks)

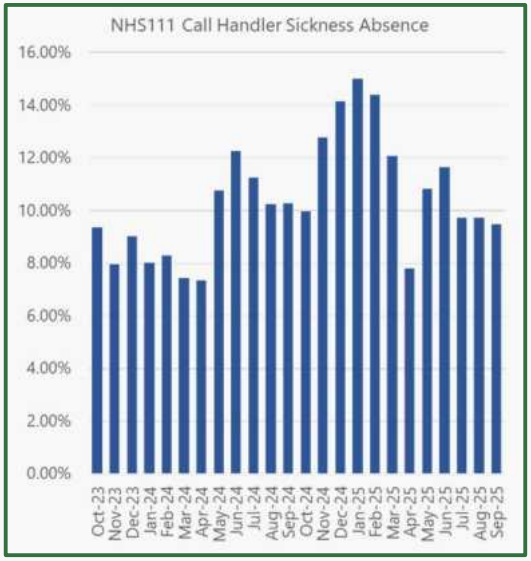
Abandonment Rate
R

FPC









Analysis

The 111-call abandonment rate decreased slightly to 10.4% in September 2025 from 10.8% in August 2025. The percentage of 111 calls answered within 60 seconds decreased from 27.3% in August 2025 to 26.2% in September 2025 and continues to remain significantly below the 95% target and the levels seen during 2024.

This call answer rate of 26.2% in September 2025 is the fourth lowest seen in the past two years and is significantly below the 65.4% recorded in September 2023. This is at a time when UHP capacity for call handlers has increased slightly and is higher than the levels produced in September 2024.

However, 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 through the summer; this includes an active recruitment plan.

A 111-re-roster review, is underway, that takes account of the increased demand the Trust is seeing; what levels of performance commissioners want and the mix of capacity and efficiencies to achieve this.

The 111-re-roster project is also considered a key response to improving sickness levels i.e. more workable patterns.

Actions are 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.

Expected Performance Trajectory

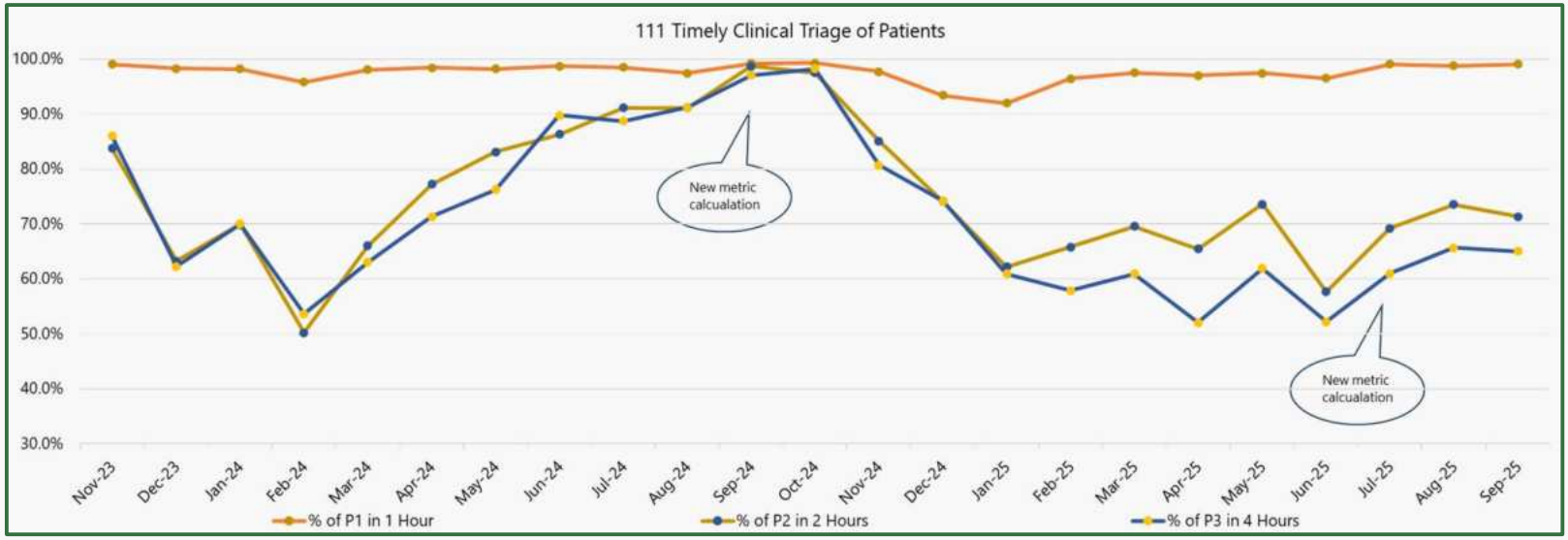
We would expect to see performance levels improve slightly during the autumn if abstraction levels continue to fall.

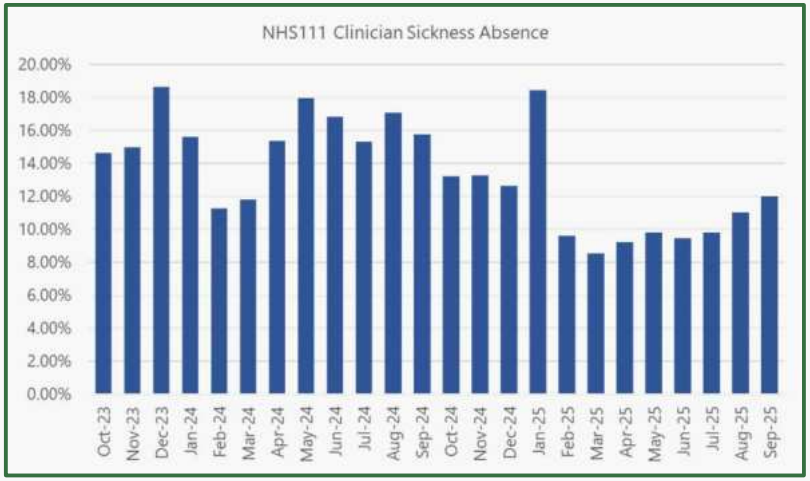
Our Patients: Quality, Safety & Patient Experience
111 Clinical Assessment Start Time Performance Indicators
Influencing Factors – Demand and Clinical Hours Produced

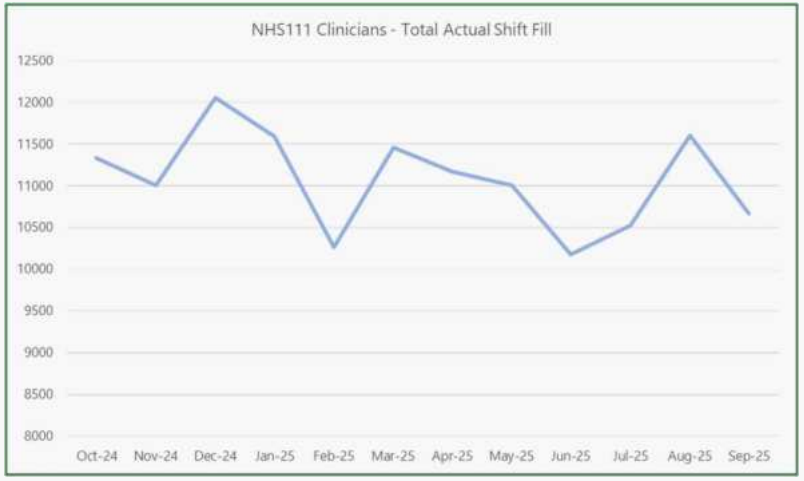
(Responsible Officer: Lee Brooks)

P1CT G

FPC







Analysis

The highest priority calls, P1CT, achieved the 90% target, recording 99.1% in September 2025.

Ring back times for lower category calls decreased slightly during September 2025, with P2CT calls at 71.4% and P3CT at 65.71%.

Number of clinician hours produced decreased during September 2025, falling from 11,604 hours in August 2025 to 10,670 hours in September 2025. This is against one less day in the month and they remain consistent with the figure produced for September 2024 (10,688).

Remedial Plans and Actions

The key actions include:

A focus on delivering the benefits of the new 111CAS.
A review to determine appropriate levels of capacity to meet increasing demand, including rostering practice (review now live).

This review also considered key to improving clinician sickness absence along with exploring rotation, as part of the Strategic Workforce Plan.

The P1-P3 metric calculation has changed. Previously it was when the Trust called back, now it is when the patient answers.

Expected Performance Trajectory

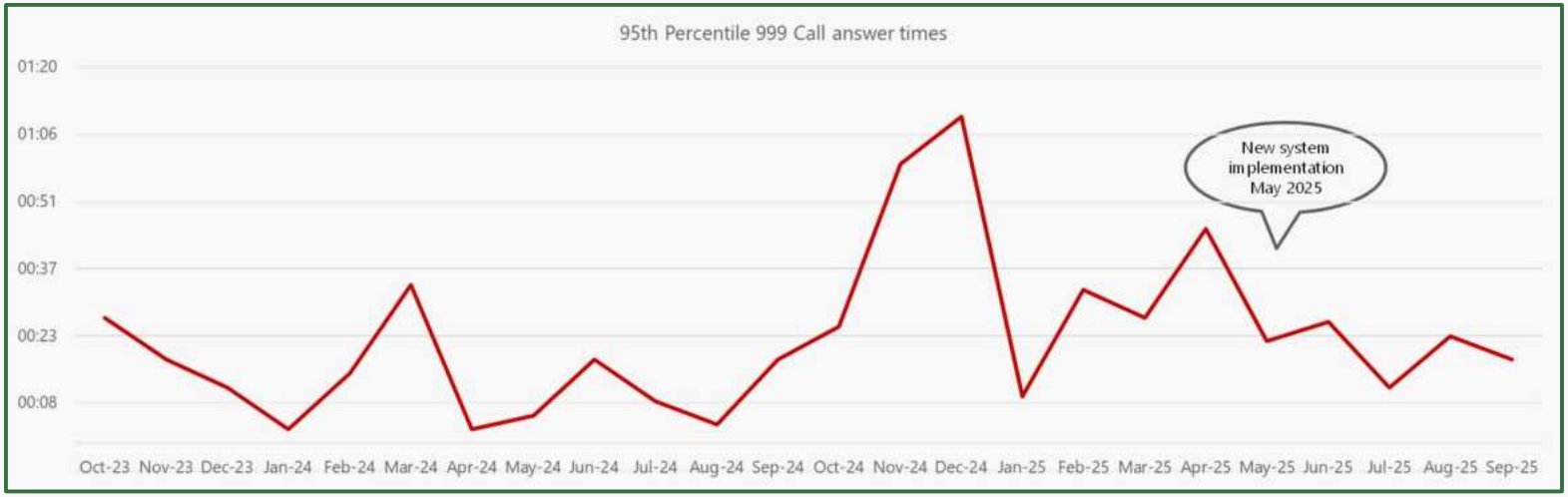
It is likely we will see performance levels improve slightly during the autumn however the external rostering review suggests there is a demand and capacity gap within the current funded establishment, and the Trust is therefore unlikely to reach performance without an increased workforce.

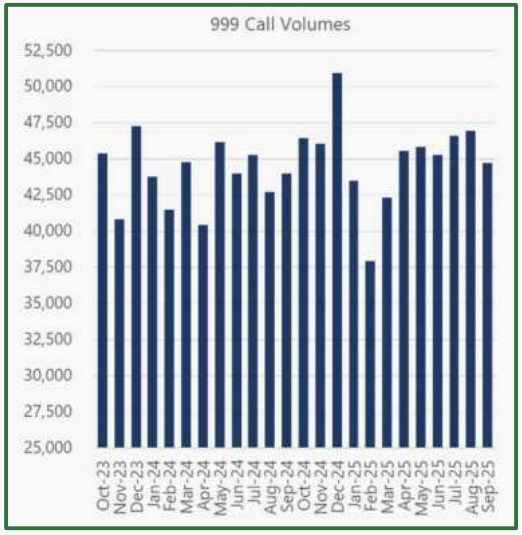
Our Patients: Quality, Safety & Patient Experience
999 Call Performance Indicators

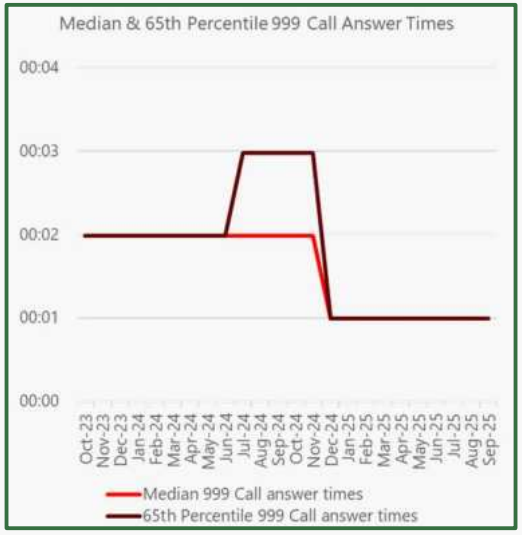
(Responsible Officer: Lee Brooks)

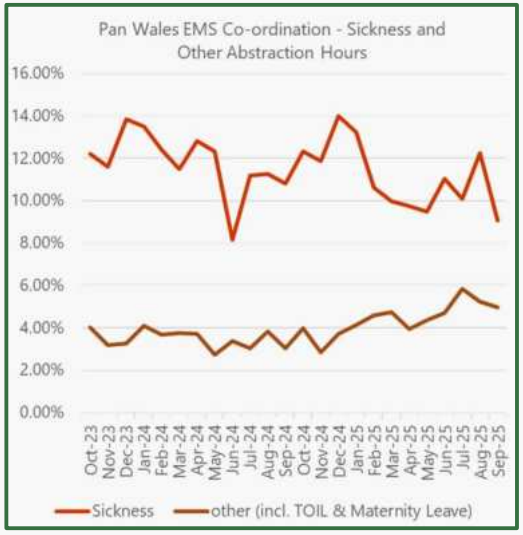
R FPC CI

Influencing Factors – Demand and Hours Produced









Analysis

The 95th percentile 999 call answering performance decreased to 18 seconds in September 2025 but remained above the 6 second target; however, the median call answer time for the 999-service has been consistently good at 1 second. The new system is now aligned with reporting and is signed off.

There was a decrease in demand during September 2025 to 44,720 calls from 46,955 in August 2025.

Call taker UHP for the month of September was at 88% and all EMSC sickness levels saw a decrease, from 12.14% in August 2025 to 9.07% in September 2025.

Remedial Plans and Actions

- Currently 2.88 above establishment with EMDs and Call Handlers at 91.88 WTE. A further training cohort will commence on November 3rd with two further courses in January and March.
- Work is ongoing to identify what is contributing to high sickness via the Managing Attendance at Work Policy and attrition via the recruitment and selection processes.

Whilst the EMSC transformation programme has concluded, there are various follow up actions:

- There is feedback from EMS that the new dispatch boundaries are adversely affecting performance, particularly within the South-East region. Further analysis of this issue is currently being undertaken.
- The Executive Director of Operations has asked for some additional modelling on EMD capacity. Capacity was not increased through the transformation programme but is an area of interest.
- There is a need to keep under review the consequences on allocators of changing/increasing resources e.g. APPs, Falls Resource etc.

Expected Performance Trajectory

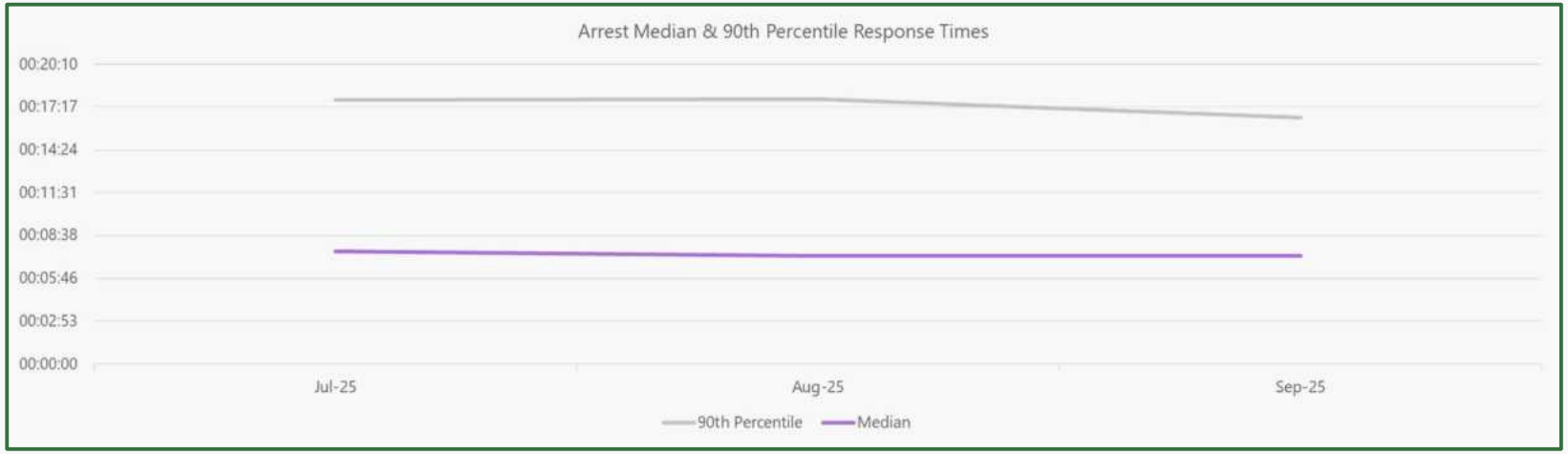
The median and 65th percentile are performing very well and are stable. Paper currently to be drafted on future resilience of EMSC i.e. winter demand v capacity (with efficiencies).

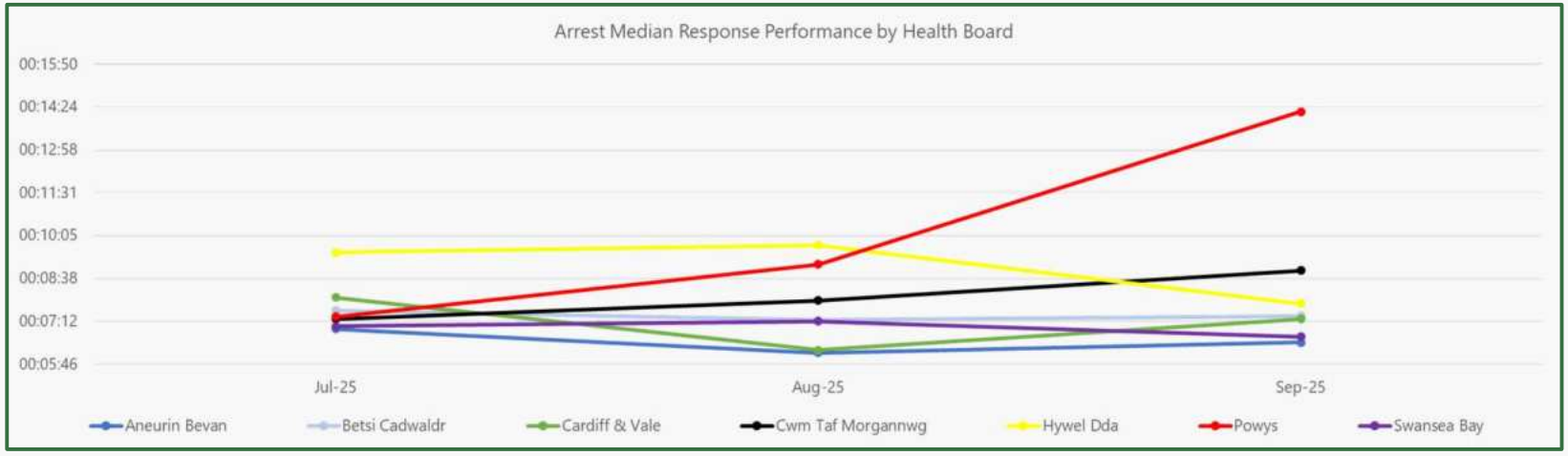
Our Patients: Quality, Safety & Patient Experience
Arrest Purple Performance Indicators

Influencing Factors – Demand, Hours Produced and Hours Lost

G CI QUEST FPC

(Responsible Officer: Lee Brooks)





Analysis

On 1 July, our new ambulance response model was implemented, and two new response categories replaced the previous (old) Red category. The new categories are Arrest (Purple), for cardiac and respiratory arrests, and Emergency (Red), for major trauma and other incidents where patients are at significant risk of cardiac or respiratory arrest if they do not receive a rapid response.

In September there were 785 Arrest calls received, making up 2.31% of all calls.

The median response times for Arrest remained at 7 minutes 15 seconds. Aneurin Bevan had the lowest median time of 6 minutes and 30 seconds, and Powys had the highest at 14 minutes and 15 seconds, although this is against relatively low numbers and in quite rural locations.

The 90th percentile response time for Arrest calls was 16 minutes 35 seconds. Swansea Bay had the lowest time of 13 minutes and 11 seconds, and Powys had the highest at 26 minutes and 48 seconds.

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

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

Influencing Factors – Demand, Hours Produced and Hours Lost

(Responsible Officer: Lee Brooks)

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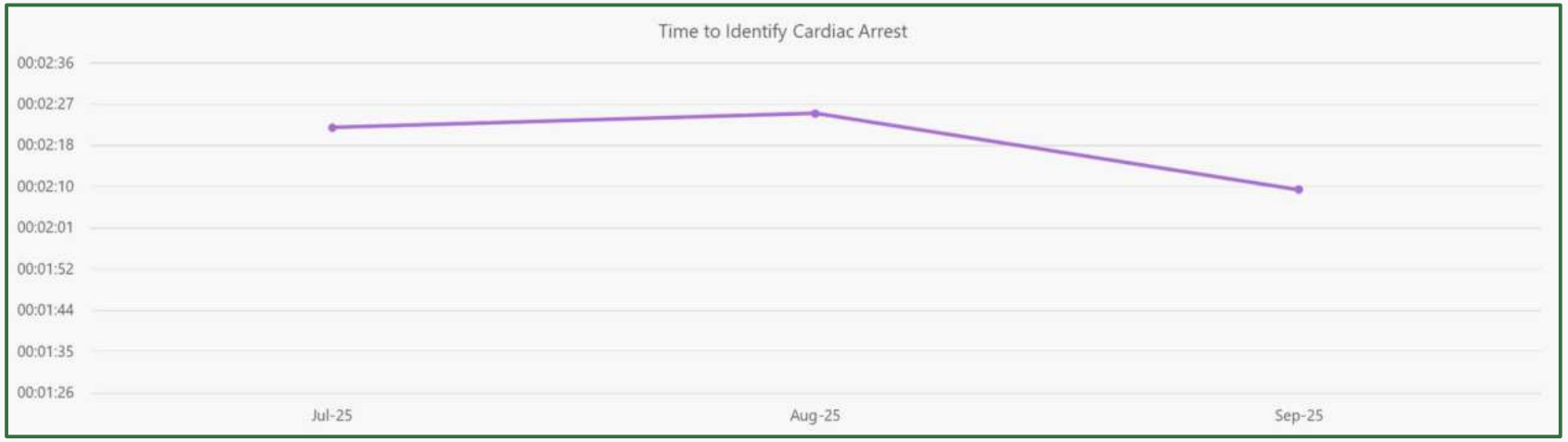

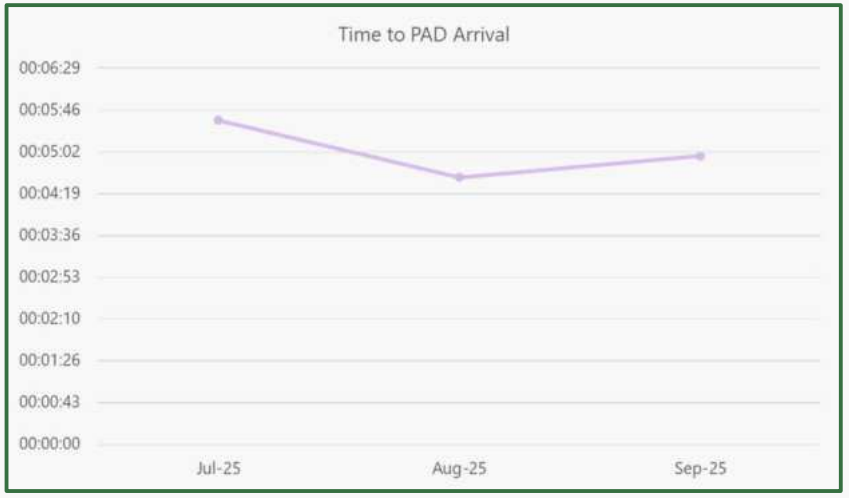

Analysis

As part of the go live on Arrest (Purple) more measures have been introduced to help better understand and manage the chain of survival.

In September 2025, the:
Average Median time to identify cardiac arrest was 2 minutes and 9 seconds.

Average Median time to commence CPR instructions was 4 minutes and 5 seconds.

Average (Median) time for a defibrillator (PAD) arrival at scene was 4 minutes and 58 seconds. An improvement from August (5 minutes and 58 seconds).

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

(Responsible Officer: Lee Brooks)

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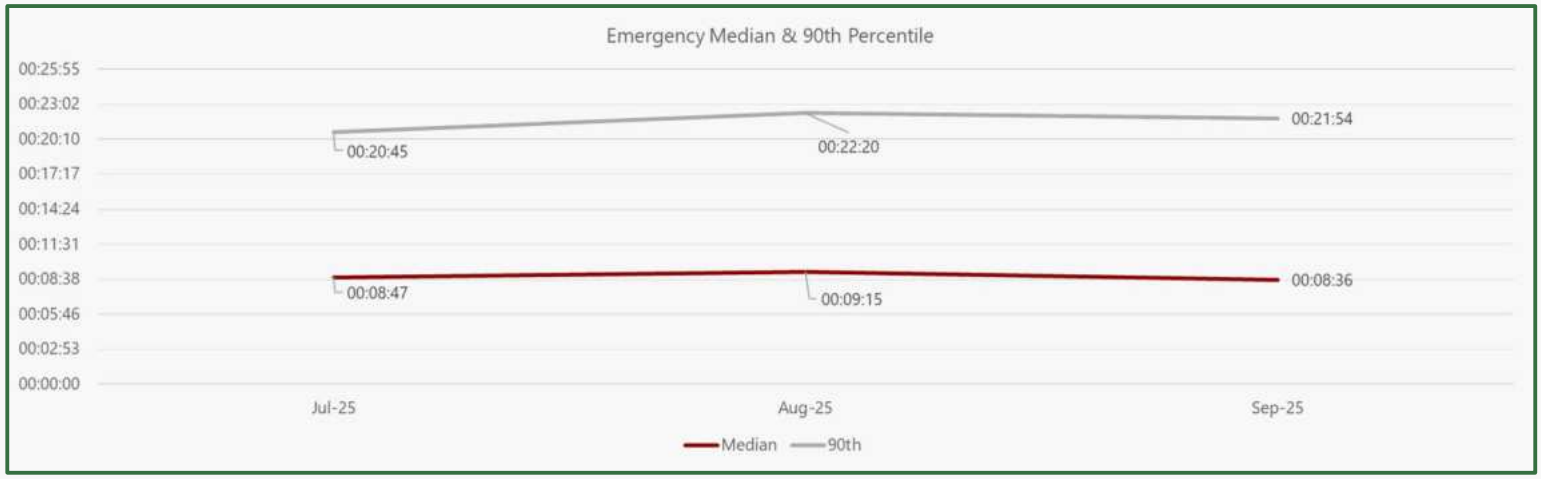
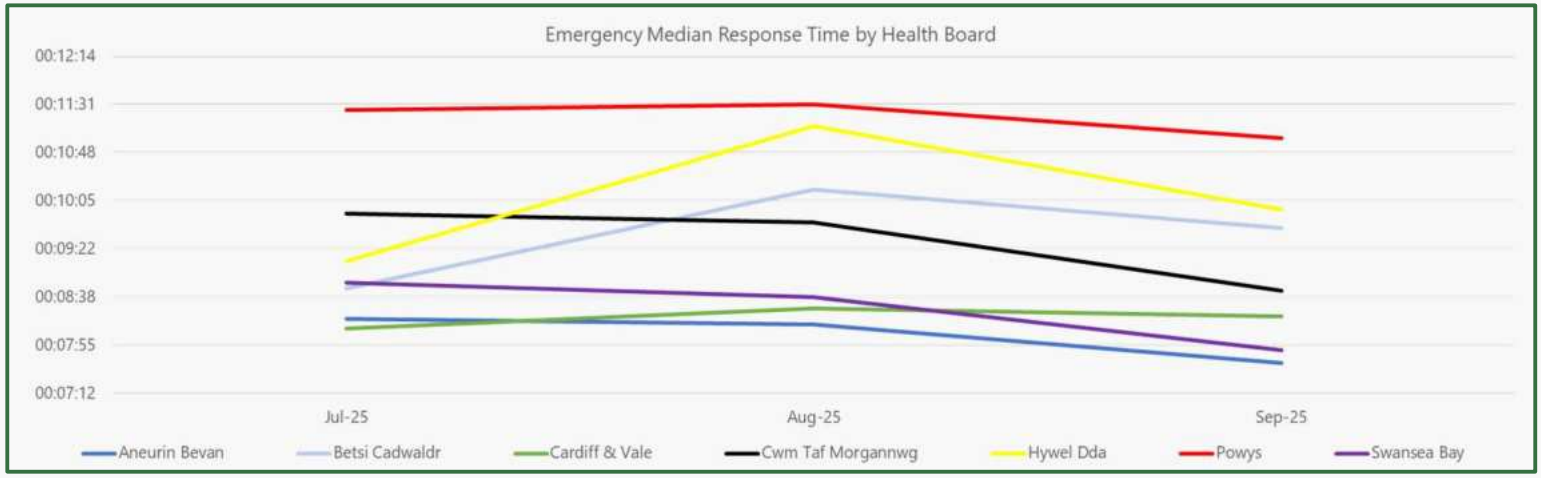




Analysis

In September 2025 there were 4,453 Emerg (Red) calls, around 13.1% of all calls.

The median response time in September 2025 for Emerg incidents was 8 minutes 36 seconds. Aneurin Bevan health board had the lowest median time of 7 minutes and 39 seconds, and Powys had the highest at 11 minutes and 1 second.

For Emerg calls, the 90th percentile response time was 21 minutes 25 seconds. Swansea Bay had the lowest time of 16 minutes and 24 seconds, and Powys had the highest at 31 minutes and 21 seconds.

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

Remedial Plans & Actions

Arrest is performing better than the Trust modelled, but Emergency performance is worse than the Trust modelled. A small divergence between them was expected, but the divergence is bigger than expected. The Trust is currently undertaking a deep dive on its month one data to look at what may be causing this.

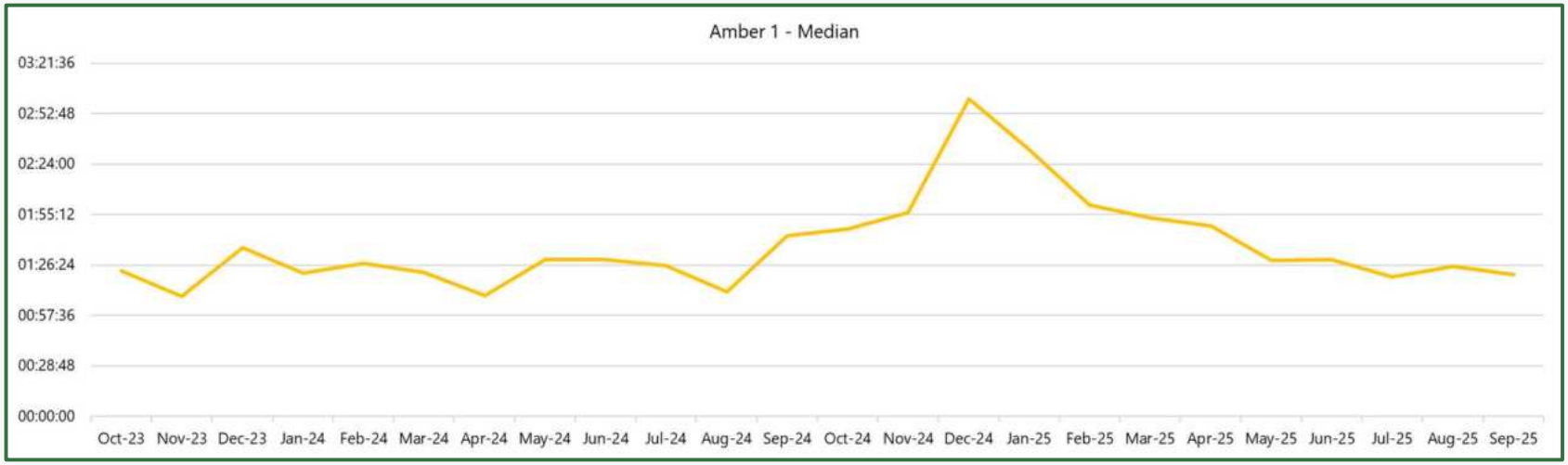
Our Patients: Quality, Safety & Patient Experience
Amber Performance Indicators

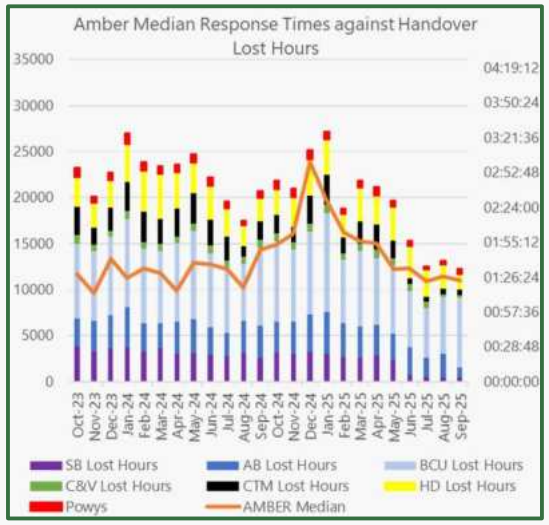
(Responsible Officer: Lee Brooks)

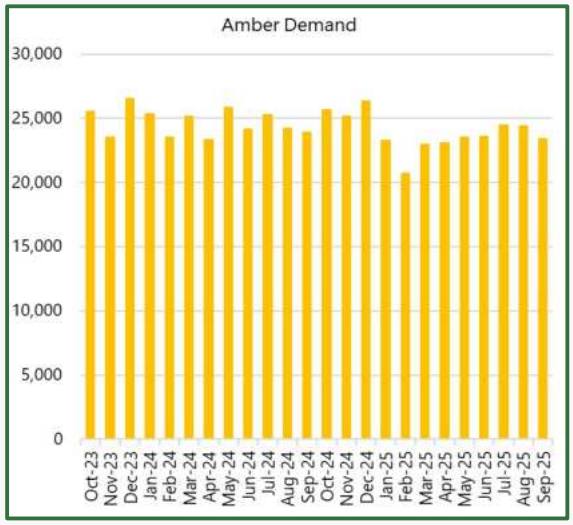
R

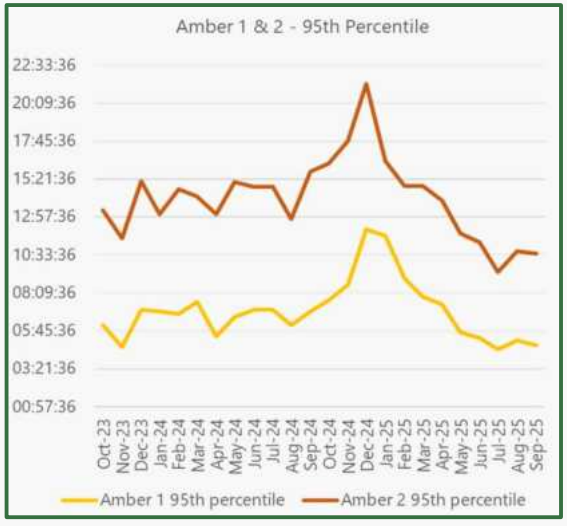
FPC CI QUEST

Influencing Factors – Demand, Hours Produced and Hours Lost









Analysis

The Amber 1 median performance time decreased during September 2025 to 1 hour and 21 minutes. The ideal Amber 1 median response time remains at 18 minutes.

The Amber 1 95th percentile also decreased during September 2025 to 4 hours 52 minutes, down from 5 hours 9 minutes in August 2025. This time remains below the 2-year average figure of 7 hours 3 minutes.

There is a strong correlation between Amber performance and lost hours due to handover delays, so if handover rates continue to remain below the 3-year average it would be expected that Amber 1 median response rates will continue to improve.

Remedial Plans and Actions

Welsh Government has recently announced further changes to the Ambulance Performance Framework that will affect the existing Amber category, which will be replaced by Orange (now) and Yellow (soon).

Expected Performance Trajectory

The Trust's commissioned level of production (its rosters) is designed to cope with 6,000 hours of handover lost hours. The Trust is now part of a WG led meeting on how handover can be reduced with a recommendation to reduce handover waits to 45 minutes. Reduced handover lost hours is a critical element of improving patient safety in this category.

Our Patients: Quality, Safety & Patient Experience

Patient Experience – Influencing Ambulance Care Indicators

(Responsible Officer: Lee Brooks)

D&T	Oncology	Welsh Calls
R	G	R

FPC

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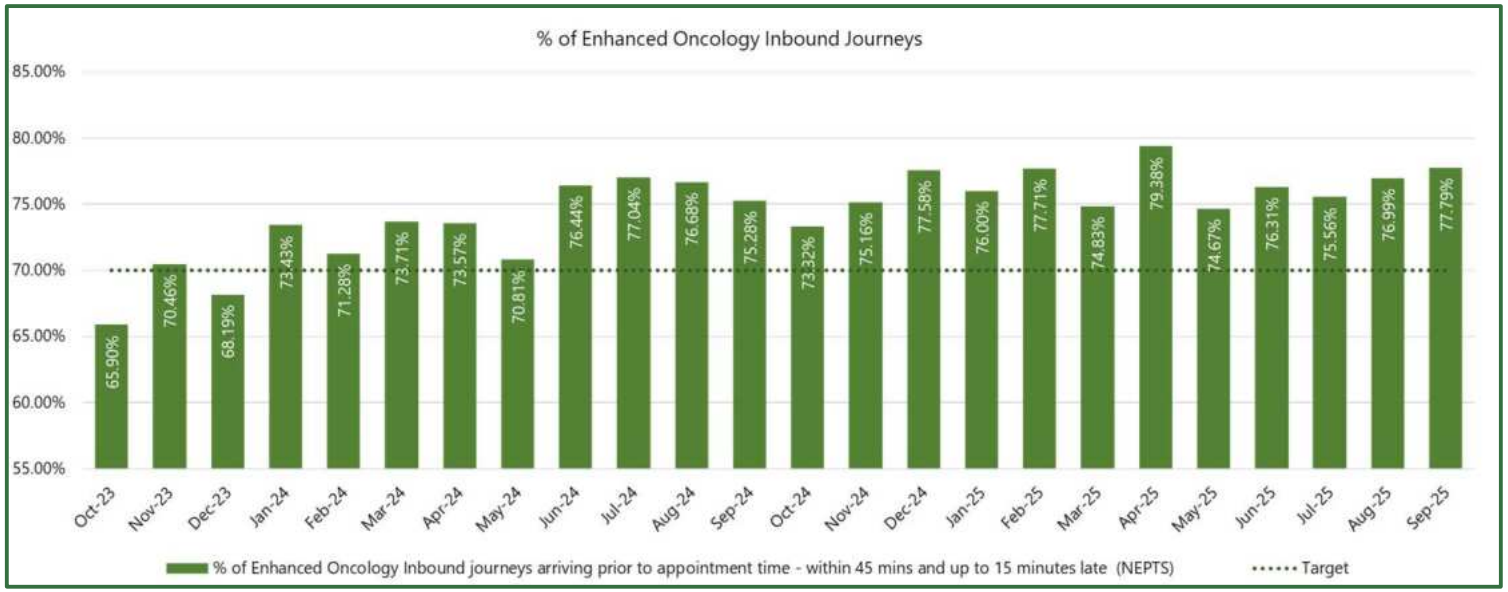
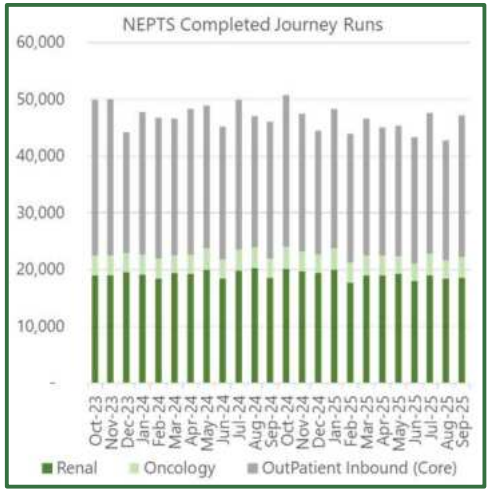
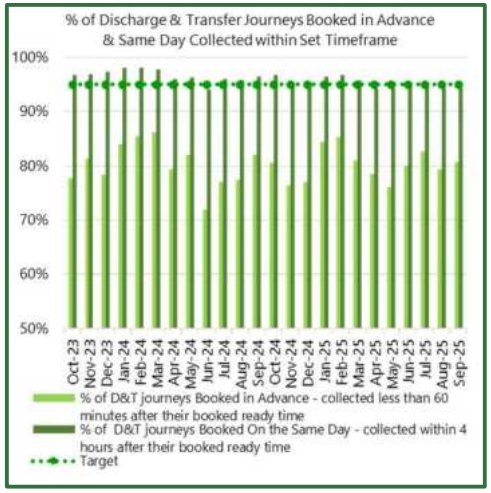
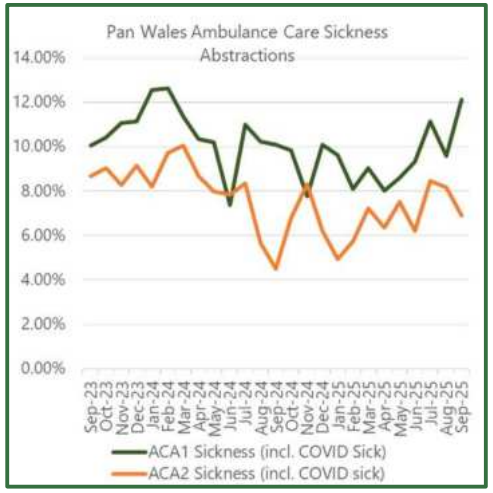








Analysis

77.8% of enhanced Oncology journeys arrived within 45 minutes prior and up to 15 minutes late of their appointment time in September 2025, once again achieving the 70% target.

Discharge and Transfer journeys booked in advance and collected less than 60 minutes after their appointment increased in September 2025 to 81% and remain below the 95% target. Discharge and Transfer journeys booked on the same day achieved 94% in September 2025, remaining just below the target (95%).

Renal journeys arriving within 30 minutes prior to their appointment time increased from 69.21% in August 2025 to 71.21% in September 2025 and marginally achieved the agreed performance standard of 70%.

Call volumes answered increased to 14,869 calls during September 2025, from 14,629 in August 2025; but the average speed of call answering improved from 7 minutes 30 seconds to 3 minutes.

ACA1 sickness remains above the 5.99% target, at 12.12% and ACA2 sickness also remains above the 5.99% target at 6.88% in July 2025.

Remedial Plans and Actions

Oncology performance continues to be in excess of the service standards nationally, however there is some regional variation to this. Work continues in the areas where performance is lower to address the underlying reasons for this. The renal hub has now transitioned to also cover oncology journeys, and we anticipate that this will positively impact upon patient experience

Performance on advanced discharges and transfers has been challenged through the quarter. This has been addressed by the team and has begun to recover. It is important to note that this measure was always deemed aspirational and requires a shift in booking practice by Health Boards for this to be achieved.

Sickness levels have seen an increase trend during the quarter, with short term sickness proving most challenging. Actions have been put in place across the service areas to increase focus on this area.

Expected Performance Trajectory

An improvement to sickness absence levels and advanced discharge and transfer is anticipated within the next quarter. Oncology performance is above the standard nationally and expected to sustain this.

Our Patients: Quality, Safety & Patient Experience
Clinical Indicators

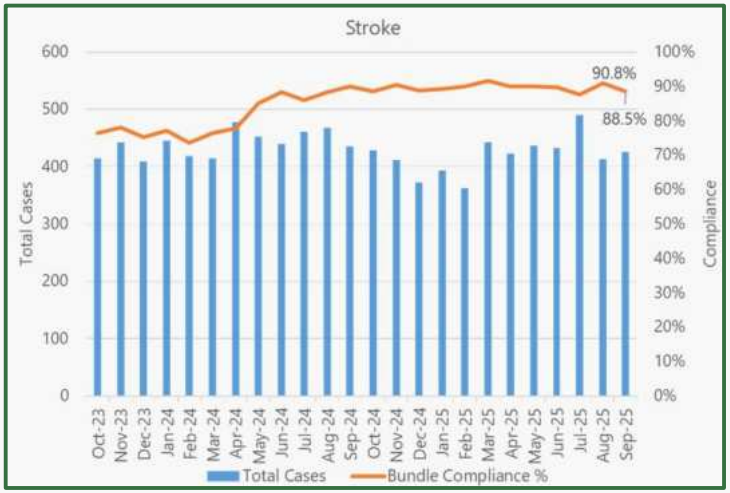
Suspected Stroke Patients with Appropriate Care, ST-elevation myocardial infarction (STEMI) with Appropriate Care and Time-Based metrics.

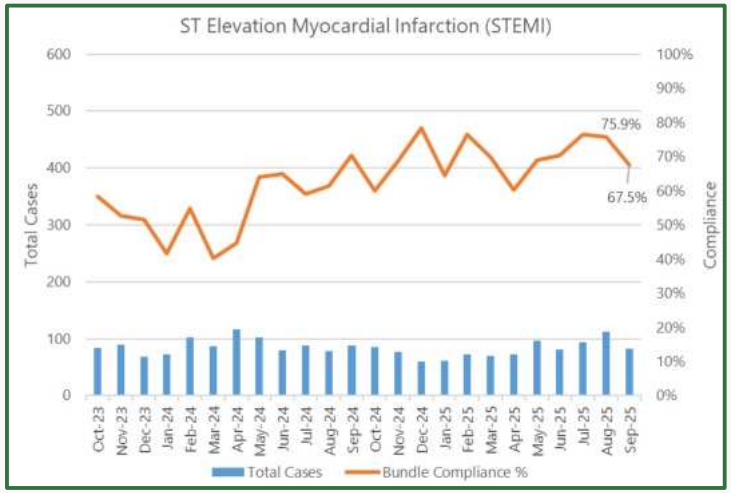
Stroke	Stroke Call to Door	STEMI
A	A	R

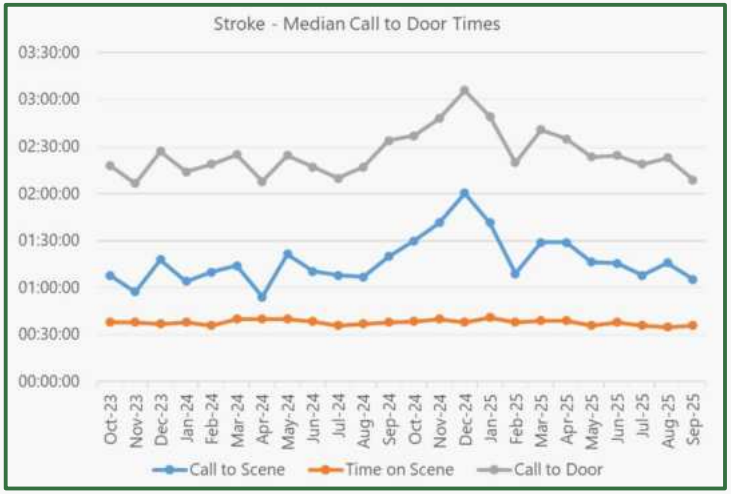
Self-Assessment: Strength of Internal Control: Moderate

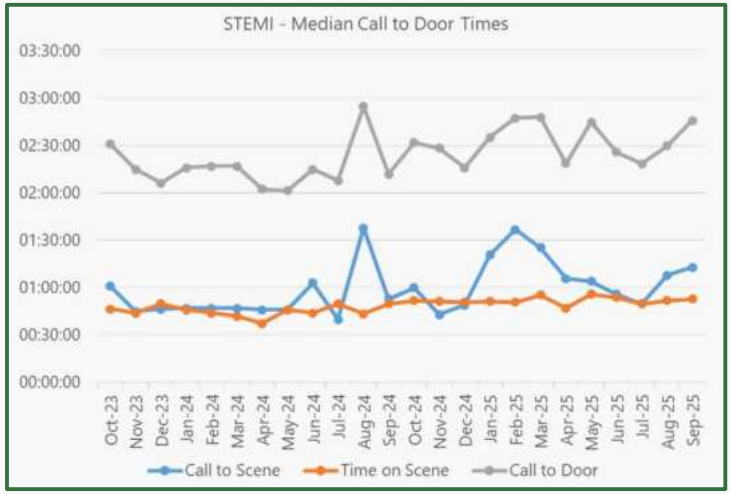
QUEST

(Responsible Officer: Andy Swinburn)









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

Stroke – 88.5% - performance has consistently remained at or above 85% since May 2024. There is a close correlation between documenting FAST (a test to detect symptoms of stroke) and care bundle compliance.

STEMI (heart attack) – 67.5%, a decrease from 75.9% in August 2025. There has been a decrease in compliance across all elements of the care bundle. The number of cases remained low (83) therefore, increasing the volatility of the compliance data so this could be natural variance.

Call to door times for Stroke – call to door times decreased marginally for stroke in September (02:09:00). All three elements of the bundle have seen consistency on time.

Call to door times for STEMI – Call to door time has increased since last month, with this being driven by a rise in call to scene times (02:46:00).

Remedial Plans and Actions
- A recovery plan implemented from April – September 2024 and remains BAU monitored through CIAG to maintain the improvements:
- Continued focus on communication with clinicians to use the bespoke electronic Patient Clinical Record fields (in addition to the narrative).
- Provided weekly non-compliant data to support Senior Paramedics conversations with clinicians to improve compliance.
- Promoted Clinical Indicators, care bundles and electronic Patient Clinical Record completion at Health Board area focussed workshops.
- Review of the ePCR interface led by the Digital Directorate.
- Ongoing development of the Tennant Structure within ePCR to facilitate clinical feedback to clinicians.

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

Our Patients: Quality, Safety & Patient Experience
Clinical Indicators

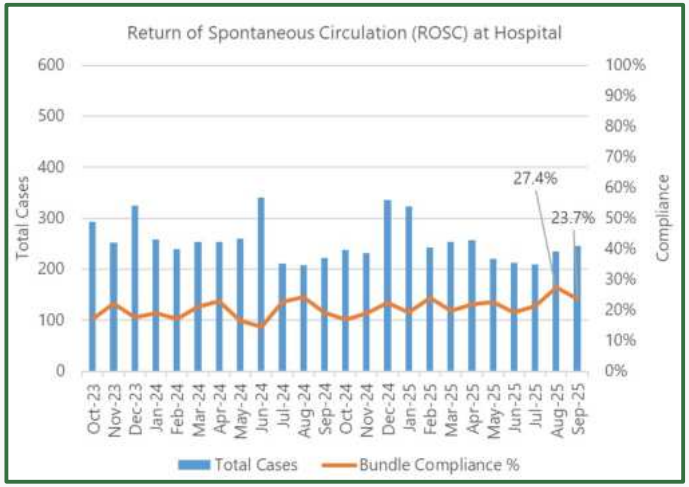
Return of Spontaneous Circulation, Hypoglycaemia, Fractured Neck of Femur (#NOF) and Time-Based metrics (#NOF)

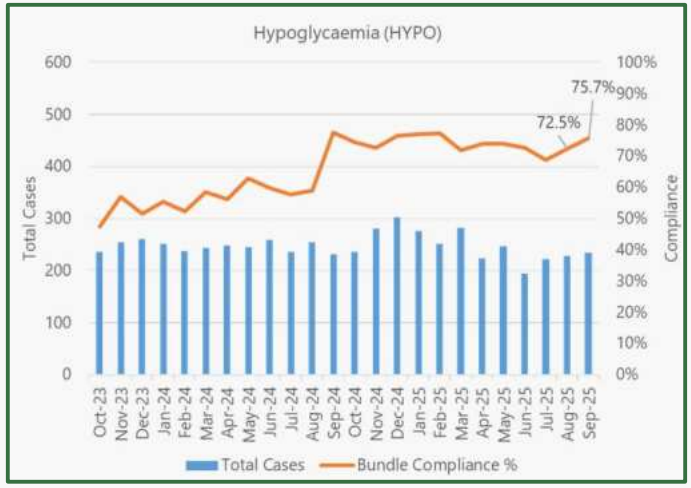
(Responsible Officer: Andy Swinburn)

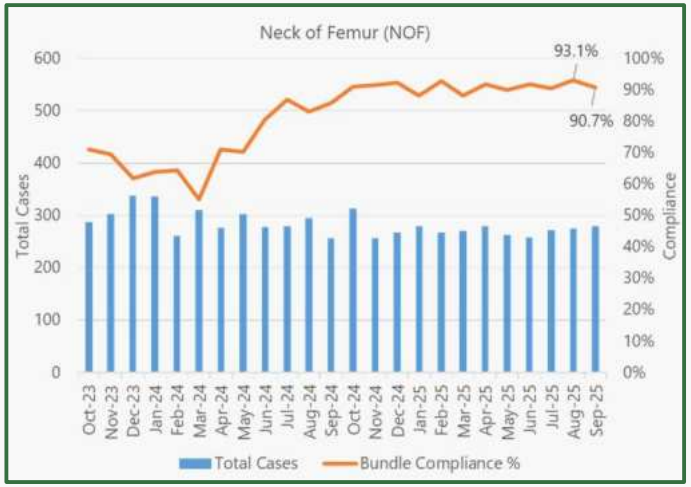
ROSC
G

Self-Assessment: Strength of Internal Control: Moderate

QUEST







#NOF Call 2 Door in development

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

Return of Spontaneous Circulation at hospital (from cardiac arrest) – 23.7%, a decrease from 27.4% in August. An update was made to the ROSC coding scripting which affected the data from July 2024. This resulted in a step change with August 2024 being the highest since ePCR was implemented. A 'nudge' to improve documentation for specific fields including outcome was implemented in October 2024. Low case numbers means a volatile percentage dataset.

Hypoglycaemia (diabetic patients with low blood glucose) – 75.7%, an increase from last month (72.5%). Compliance has remained consistency in compliance across the bundle though Q3.

Fractured Neck of Femur (hip fracture) – 90.7%, a slight decrease in performance from August (93.1%). Only a slight decrease in compliance which is evident across the care bundle.

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

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

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

Further electronic Patient Clinical Record User Interface changes are planned for the next update, scheduled for Autumn / Winter 2025 - 2026.

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

(Responsible Officer: Liam Williams)

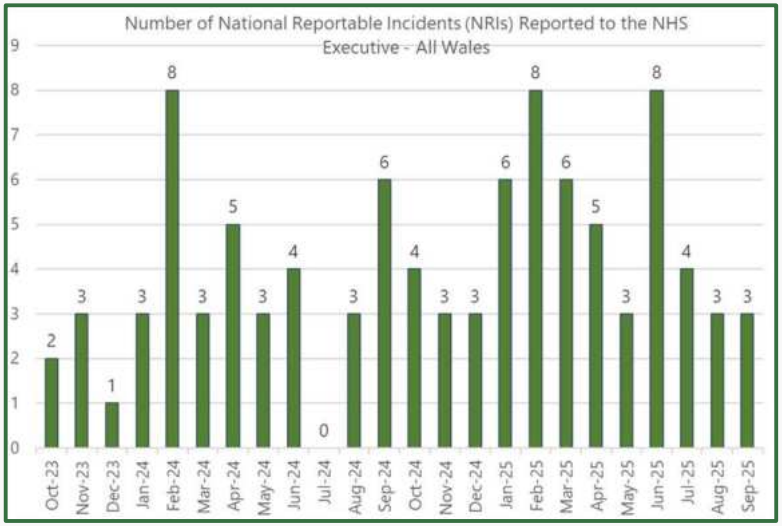
Concerns. R

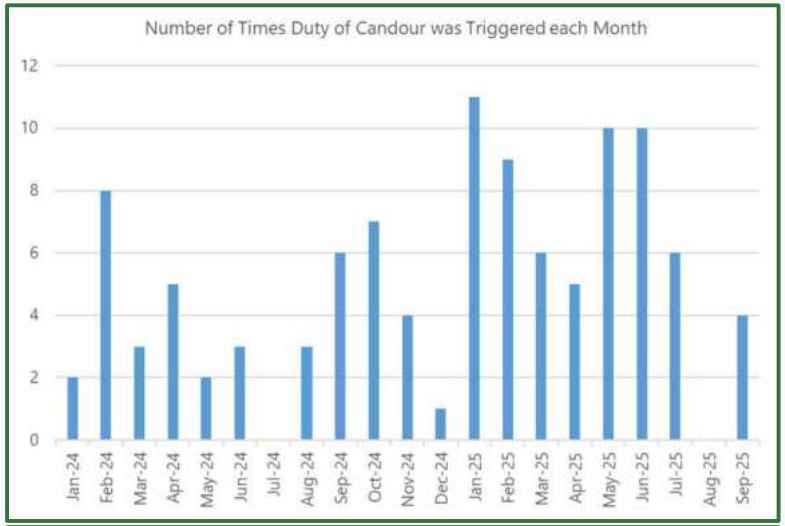
QUEST

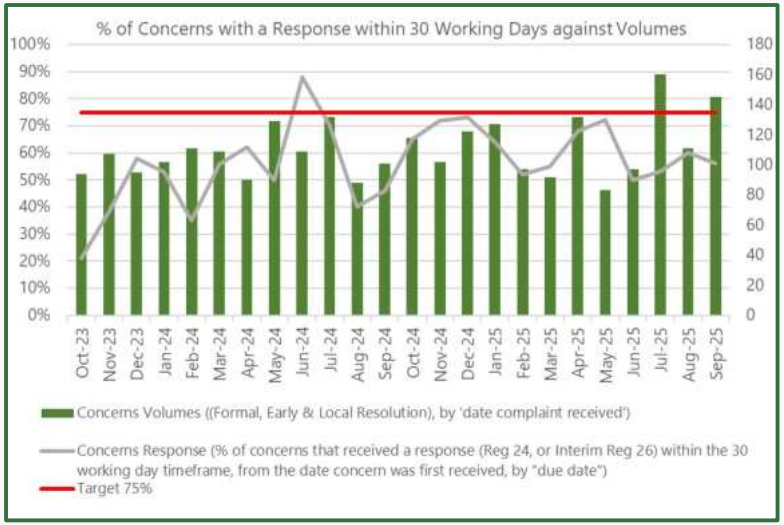
Self-Assessment: Strength of Internal Control: Moderate

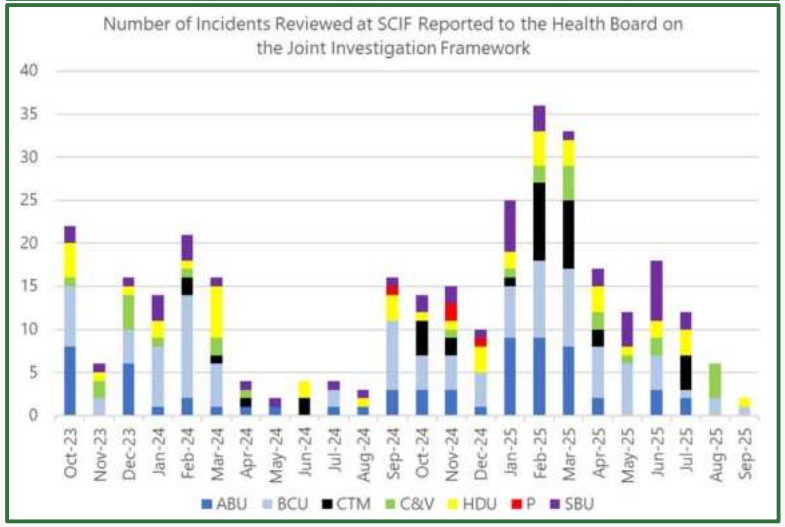
Health & Care Standard
Health - Safe Care / Timely Care

Responses Indicators









Analysis
Complaint response times are of high concern with the organisation not having achieved the target in any of the previous 15 months reported. Whilst larger numbers of complaints have been closed in the last quarter, a much-improved position in reducing open overdue complaints will be required to provide acceptable performance.

A data reporting error identified with two sets of monthly data; June and August 30 working day compliance has been over-reported. The error was identified during the development of an automated business-intelligence product.

The number of complaints received by the Trust continues at historically high levels, this is being driven by an increased volume of complaints about Ambulance Care Services.

The Serious Case Incident Forum agreed for 3 incidents to be reported as NRIs, mostly relating to call management issues.

Remedial Plans and Actions
A Putting Things Right and Legal Services Recovery Plan has been developed to address the number of overdue concerns (complaints and incidents). This is being monitored through our internal governance structure. Additional non-recurrent investment is expected to deliver the required improved at increased pace.
This lays the foundations for the long-term objective of quality and safety data sources being available to meet user need and enable effective triangulation of all Trust information.

Expected Performance Trajectory
As service areas focus on reducing the number of open overdue complaints, it is expected that the 30-working day performance will decrease, depending on the success of Recovery Plan. Support from colleagues in terms of experiential emotional mapping, data visibility and the need to focus on 'on-the-spot' resolution is underway but does not yet appear to have impacted complaint volumes.

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

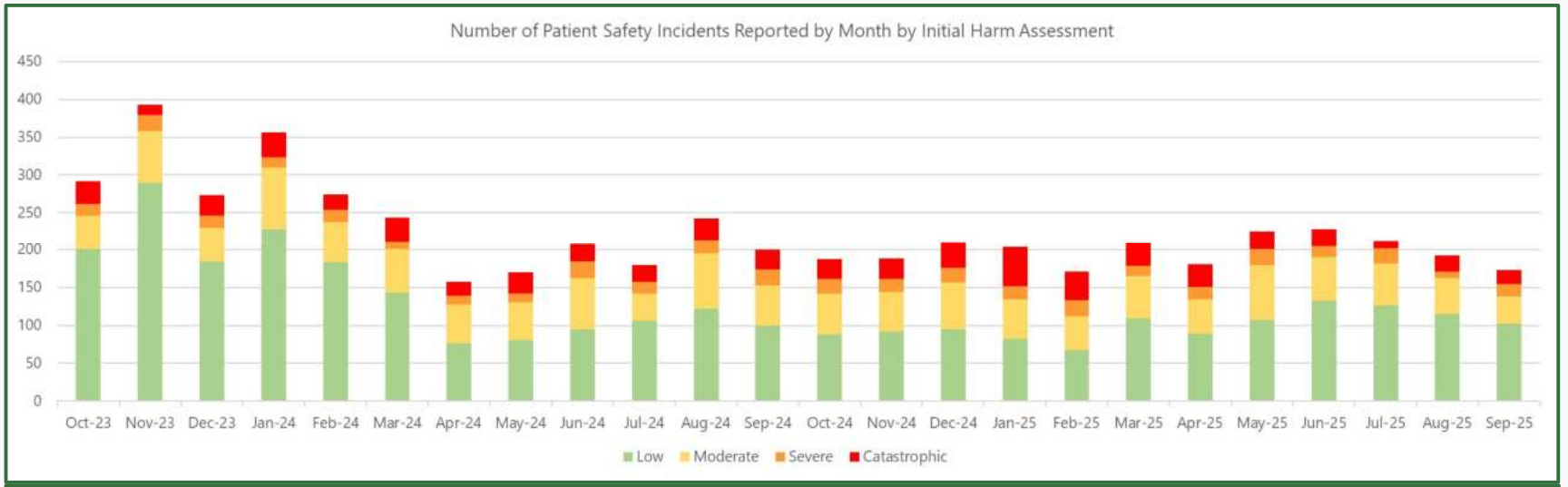
Our Patients: Quality, Safety & Patient Experience
Patient & People Safety Indicators

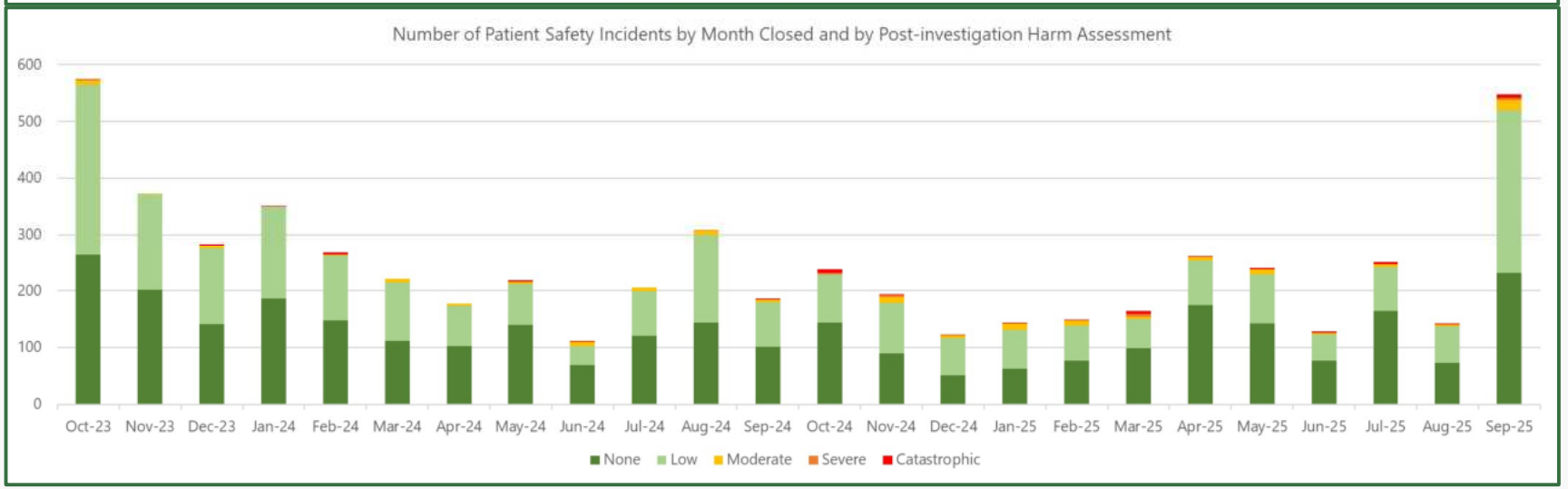
(Responsible Officer: Liam Williams)

Self-Assessment: Strength of Internal Control: Moderate

QUEST

Health & Care Standard
Health – Safe Care





Analysis
The number of investigations needing to be shared with other NHS Wales organisations has reduced in the last quarter. This appears in keeping with seasonal fluctuations however August and September have dropped beneath historical seasonal averages and there is optimism that the launch of the 'Wait 45' initiative is beginning to impact favourably on patient safety incidents caused by long community waits.

Incident reporting volumes remain stable, and the number of incidents being finalised and closed on the Datix system has increased markedly following a Senior Operations Team improvement drive in this area. Commitment to converting this to business-as-usual practice will be key to sustaining the improvements.

Closed incidents continue to demonstrate that validated levels of severe or catastrophic harm remain consistently low.

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

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

Data source: Datix

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

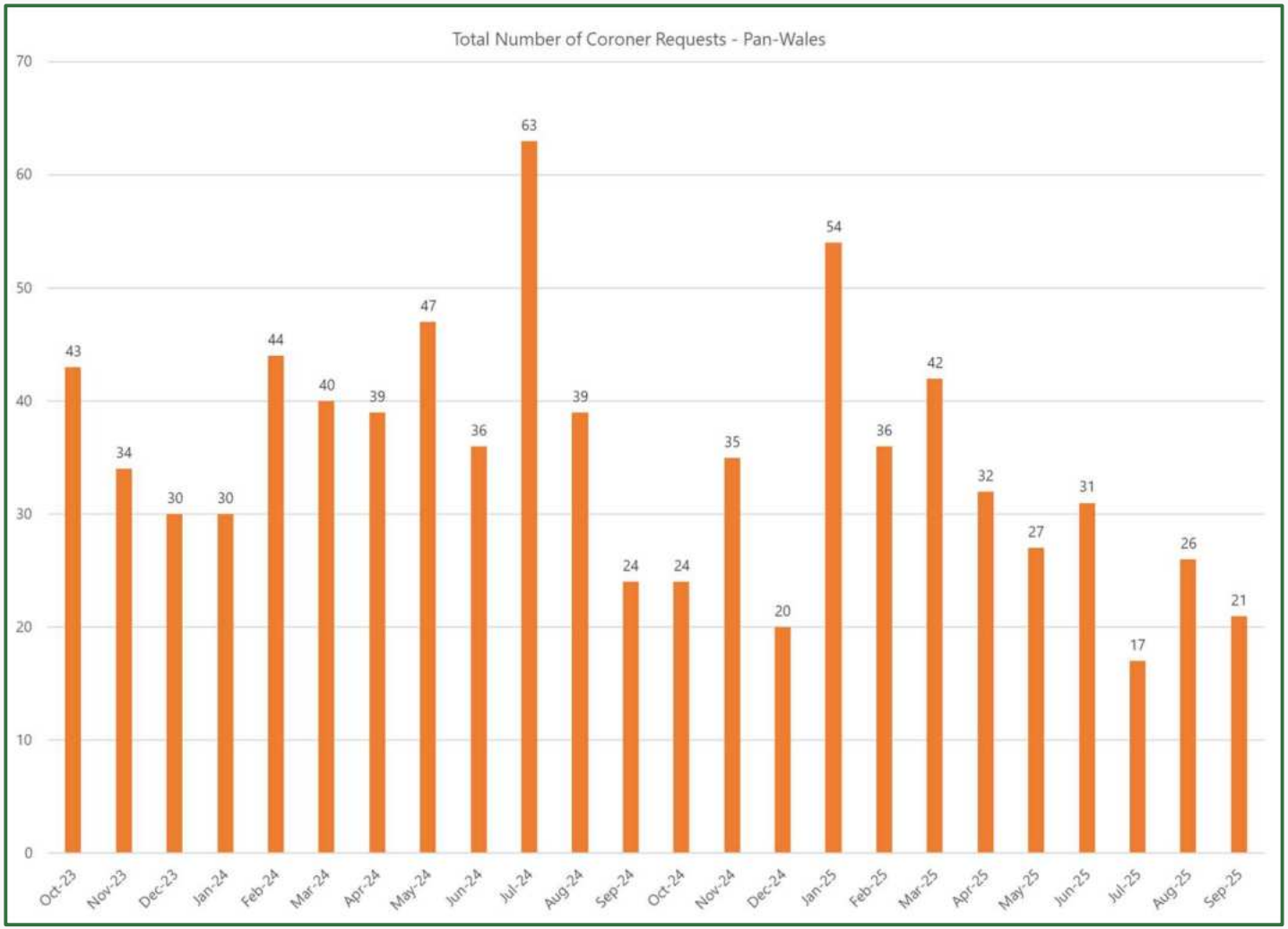
(Responsible Officer: Liam Williams)

Coroners Self-Assessment: Strength of Internal Control: Moderate

Mortality Self-Assessment: Strength of Internal Control: Moderate

QUEST

Health & Care Standard
Health – Safe Care



Mortality Reviews Data source: Internal Web Application

Analysis

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

Level 1 triage of Medical Examiner referrals proceeds at fortnightly intervals with all Q1 and Q2 cases.
143 referrals have been received from the Medical Examiner Services (MES) in the first two quarters of 2025/26.
27 cases have been triaged as requiring further review and investigation.
Enhanced analytical opportunities and improved data capture reveal the vast majority of referrals being due to community delays and inability to provide 'Timely' care.
Internal review of Q1 and Q2 referrals at Medical Examiner Learning Panel continues to identify learning relating to delays in attending in the community, alongside improvement opportunities for Advanced Care Planning and enhanced end of life care in the community.

Remedial Plans and Actions

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

Expected Performance Trajectory

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

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

(Responsible Officers: Jonny Sammut & Liam Williams)

Health & Care Standard
Health – Safe Care

Self-Assessment: Strength of Internal Control: Strong

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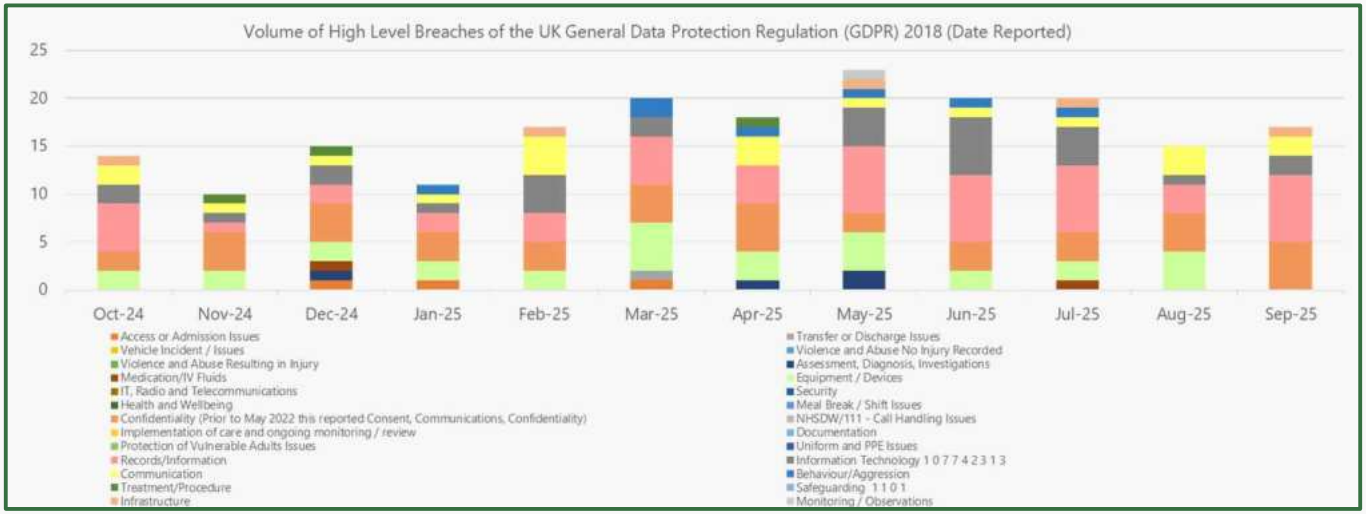
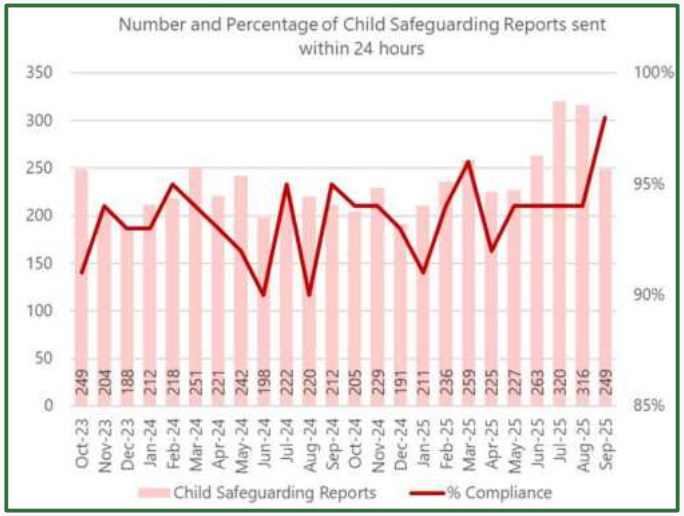
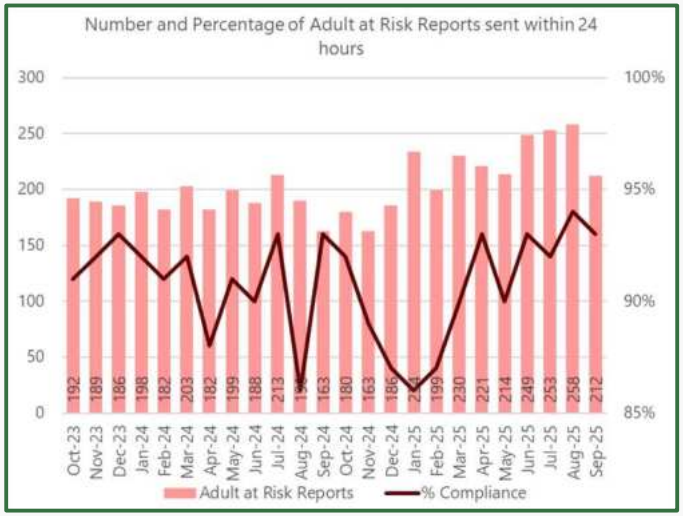






Analysis

Safeguarding: In September 2025 WAST colleagues submitted a total of 212 Adult at Risk Reports, 93% of these were processed within 24 hours. Whilst the Trust does not report on Adult Need for Care & Support reports (wellbeing); 775 reports were shared with local authorities across Wales during this reporting period. There have been 249 Child Safeguarding Reports submitted in September 2025, 98% of these were processed within 24 hours.

Data Governance: In September 2025, there were 17 information governance (IG) related incidents reported on Datix Cymru categorised as an Information Governance (IG) breach. Of these 17 breaches, 7 related to Records/Information, 5 IG/Confidentiality, 2 Communication, 2 Information Technology, and 1 Infrastructure.

Remedial Plans and Actions

Safeguarding: The Trust manages all safeguarding reports digitally via Doc-works Scribe and regular monitoring of the system by the Safeguarding Team provides a means to identify any problems with delayed reports with appropriate action taken to support WAST colleagues with using the Doc-works Scribe system and liaising with local authorities when required. Only minimal paper safeguarding reports are now received; they are used as a back-up and are sent directly to the Safeguarding Team for actioning. The Safeguarding Team monitor any paper reports received and provide direct feedback to colleagues to improve practice.

Data Governance: During the reporting period, of the 17-information governance related incidents reported on Datix, 2 incidents were reported to the Information Commissioner's Office (ICO) as they met the risk threshold. Both incidents related to inappropriate recording and disclosure of personal data. The IG Team continues to monitor, and review reported incidents where applicable.

Expected Performance Trajectory

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

Data Governance: The next iteration of the IG Toolkit has now opened for FY25/26 submissions.

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

Safeguarding Data source: Doc Works

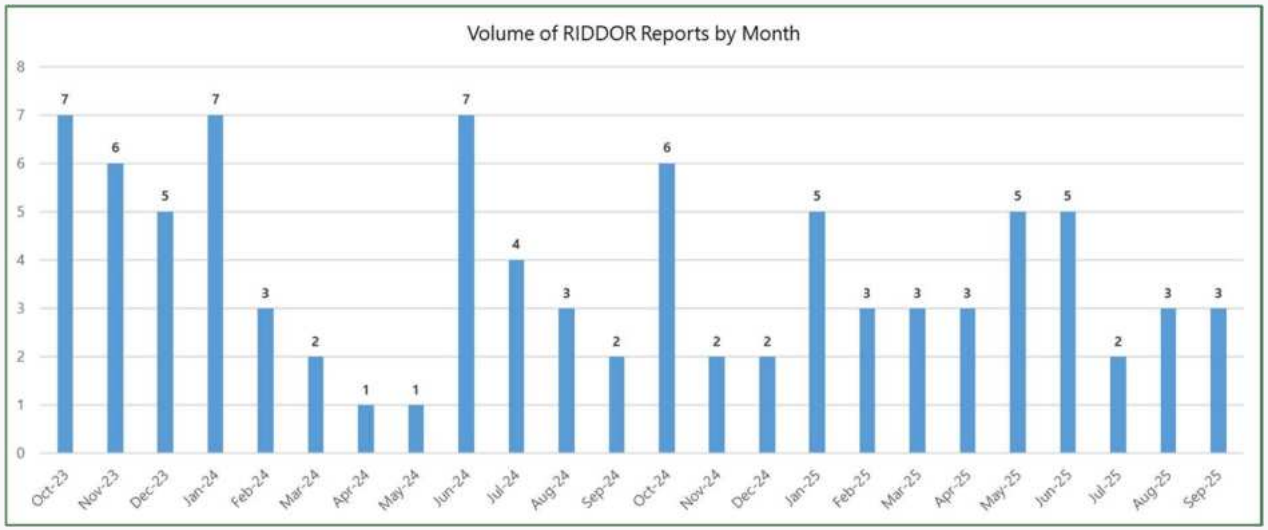
Our Patients: Quality, Safety & Patient Experience
Health & Safety (RIDDORS) Indicators

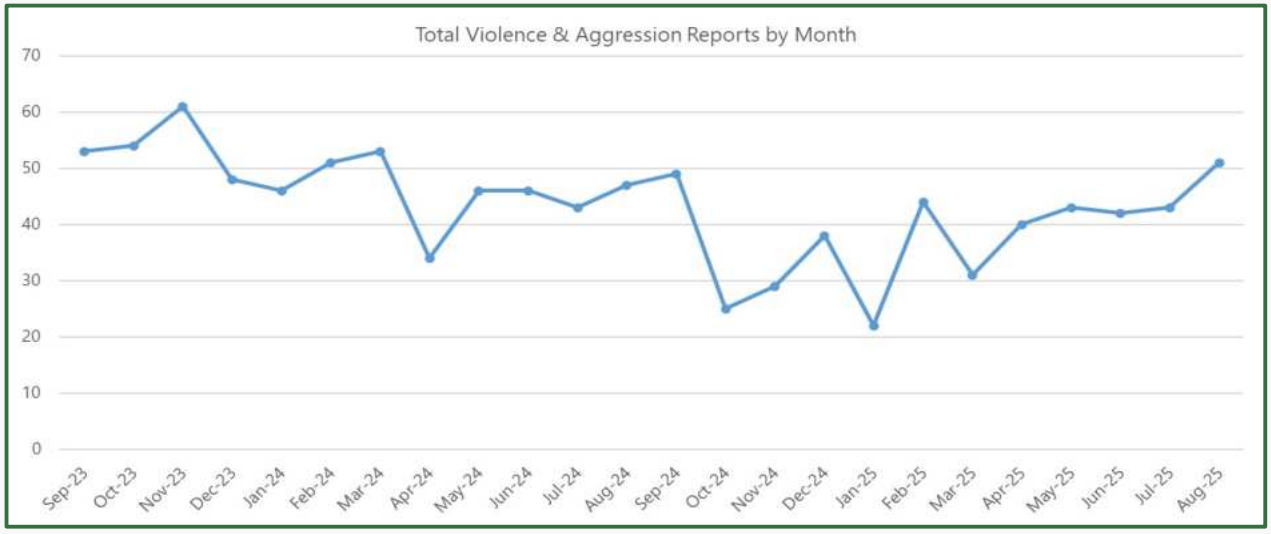
(Responsible Officer: Liam Williams)

Self-Assessment: Strength of Internal Control: Moderate

PCC

Health & Care Standard
Health – Safe Care





Analysis

RIDDOR: There were 3 incidents requiring reporting under RIDDOR during September 2025 all were for an injuries requiring over 7 days of work.

- 33% of the RIDDOR's were submitted within the HSE reporting timelines, the main reason for not reporting in time was seen to be the late reporting of incidents onto Datix
- 3 RIDDORs reported during the month were as a result of manual handling incident whilst handling patients. 1 resulted from the use of a carry chair on the stairs of a patient's home and another happened when using a lift to load a patient onto a vehicle.

Violence and Aggression:

- A total of 51 incidents have been reported of V&A in August
- There was an increase in the number of Aggressive/Threatening behaviour.
- 5 Physical Assault on staff was reported during the month with incidents of verbal assault that included swearing.

Remedial Plans and Actions

RIDDOR: The weekly Datix incident meeting continues to be used to identify RIDDOR reportable incidents. A Safety Advisor is designated to assist with the investigation to find root cause and reporting to the HSE. Consistent effort to investigate incidents by line manager is making an improvements in causation and reporting to the HSE.

Violence and Aggression: The use of appropriate Hashtags to flag incidents of verbal aggression within the Trust call centres is being progressed to provide a greater understanding of the verbal abuse experienced by staff.

Expected Performance Trajectory

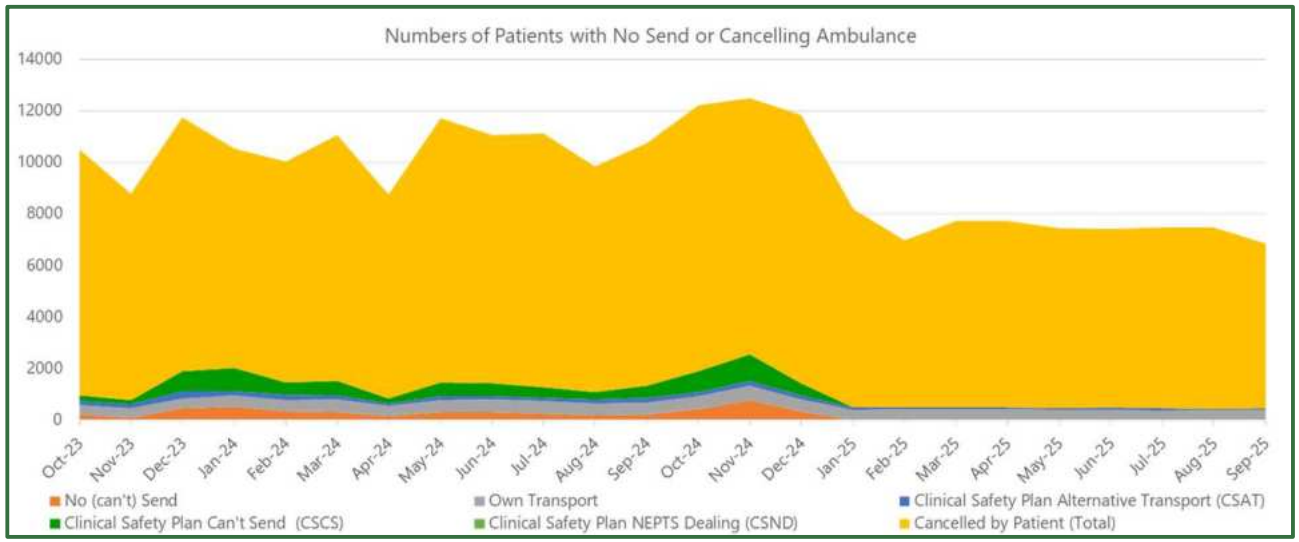
RIDDOR: The actions arising out of the recent deep dive into manual handling incidents aim to address the issues identified in the manual handling incidents this month.

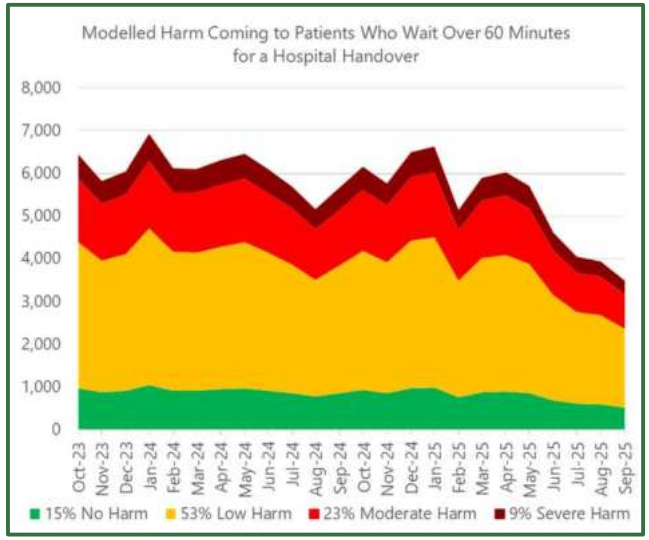
Violence and Aggression: It is expected that the number of verbal V&A incidents will increase over the next few months as a result of increased awareness of reporting mechanisms within the call centre teams.

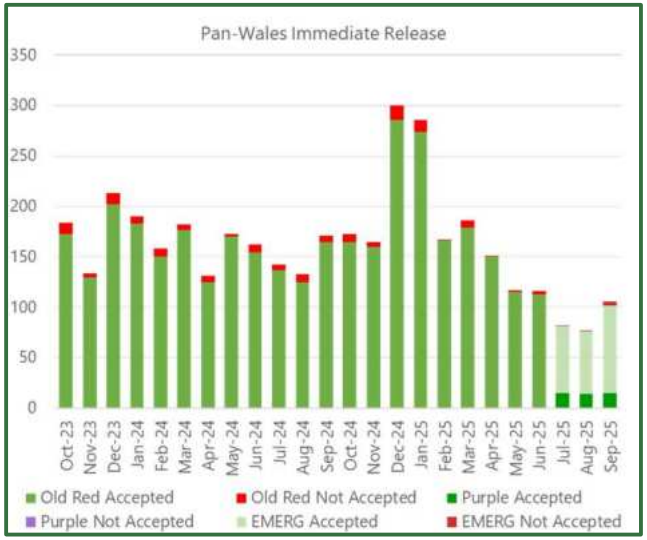
Data source: Datix

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

(Responsible Officer: Andy Swinburn) G QUEST







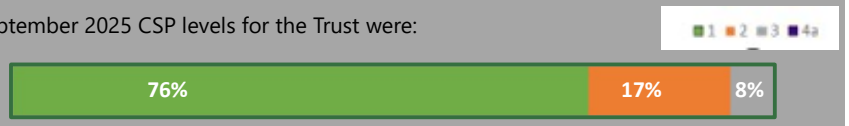
Analysis

In September 2025, 71 ambulances were stopped due to Clinical Safety Plan alternative transport (CSPT). In addition, 6,381 ambulances were cancelled by patients (including patients refusing treatment at scene) a decrease from the 7,028 in August 2025. There has been a downward trend in patient cancellations since December 2024 which the Trust believes is connected to the implementation of Rapid Clinical Screening during the winter.

There were 426 requests made to Health Board EDs for immediate release of Arrest, Emergency or Amber 1 calls in September 2025. Of these 15 were accepted and released in the Arrest category, with none not being accepted, 87 were accepted in the Emerg category, with 4 not accepted and 86 ambulances were released to respond to Amber 1 calls, but 234 were not.

The graph in the bottom left shows the estimated level of patient harm during September 2025. Of the 3,484 patients who waited outside an ED for over an hour, to be handed over to the care of the hospital, the Trust could assume that 15% (523 patients) would experience no harm, 53% (1,847 patients) would experience low harm, 23% (801 patients) would experience moderate harm and 9% (314 patients) would experience severe harm.

In September 2025 CSP levels for the Trust were:



Remedial Plans and Actions

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

Expected Performance Trajectory

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

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

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

(Responsible Officer: Liam Williams)

Self-Assessment: Strength of Internal Control: Moderate

PCC

Health & Care Standard
Health – Safe Care

September 2025		
NEPTS (267 responses)	Benchmark	Score
How long did you wait for your transport to take you home after your appointment.	85	82
Were you happy with the transport you received?	85	94
999 (3 responses)	Benchmark	Score
The 999-call taker who answered your call was reassuring.	85	100
The 999-call taker who answered your call explained what was going to happen next.	85	100
The length of time I waited for an ambulance to arrive was acceptable.	85	75
111 (21 responses)	Benchmark	Score
Do you feel your call to 111 Wales was helpful?	85	79
Did you follow the advice given to you by NHS 111 Wales?	85	86
Would you consider using NHS 111 Wales again?	85	100
WAST Overall - Friends & Family Test How was your overall experience with the service today?	Ranked from very poor to very good.	
o Ambulance care	90.95% Good	5.24% Poor
o Integrated Care (NHS 111 Wales Telephone line only)	85.71% Good	14.29% Poor
o EMS (including CSD)	100.00% Good	0.00% Poor
o NHS 111 Wales Online	56.25% Good	43.75% Poor
	* Where totals above do not add up to 100%, this is because a 'Do Not Know' answer was given, these are excluded from overall total.	

Analysis

In September PECI did not attend any engagement opportunities in the community. This was due to a lack of capacity within the Team, we are currently carrying four vacancies and have only one part time Engagement Coordinator currently within the Team.

The Team are also being impacted by an OCP which has been announced but not officially started. The impending OCP means we are unable to back fill into vacant posts. The OCP is also creating some uncertainty within the Team about future responsibilities to carry out engagement activities. As such we have not committed to attend any engagement events until the OCP is complete.

Throughout September we continued to make available 4 patient experience surveys covering the Trust's main service delivery areas. Engagement and survey outcomes remain largely consistent and tell us that people continue to be very concerned about response times in the community and frustrated at hospital handover delays.

- 111 callers have told us that they experienced long waits for call backs.
- NEPTS users told us that overall, they continue to be happy with the transport they receive but experience delays when waiting for their transport home following their appointment.

Remedial Plans and Actions

Work is underway to enact the findings of the service review in relation to public and patient engagement.

The ICO responded to our DPIA with 7 recommendations which were presented to IGSG who gave permission to continue working on the recommendations.

Expected Performance Trajectory

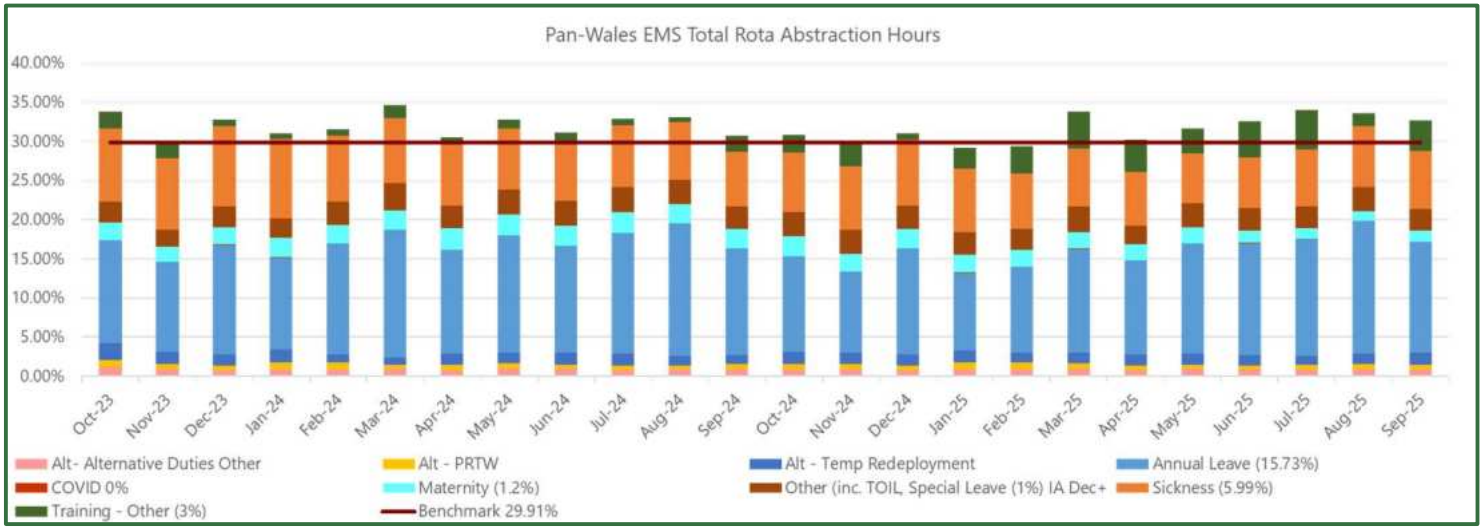
Vacancies and the work to enact the recommendations of the service review will have some impact on team capacity over the coming months.

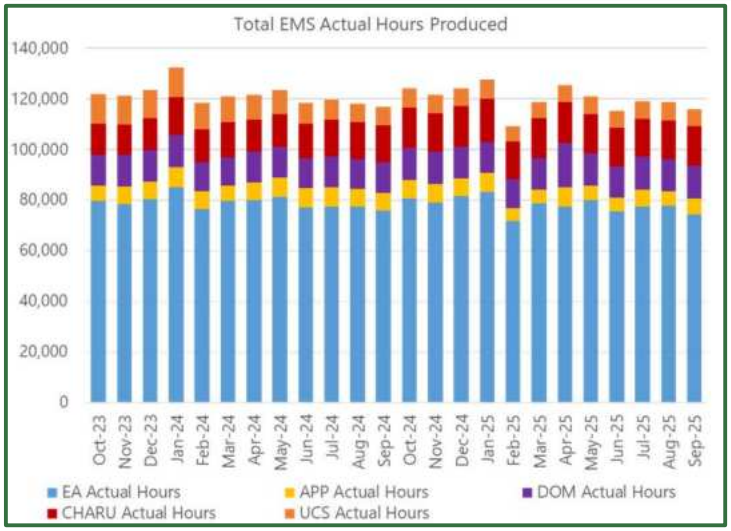
Our People
Capacity - Ambulance Abstractions and Production Indicators

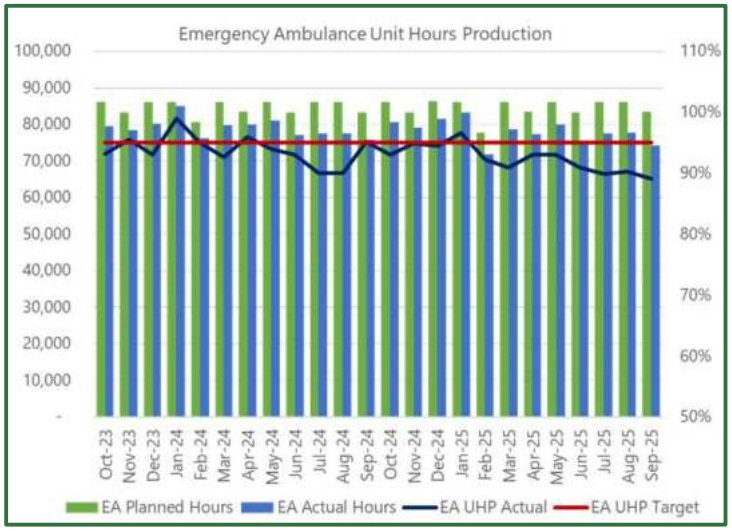
(Responsible Officer: Lee Brooks)

EA Production
R

CI PCC FPC







Analysis

Monthly abstractions from the rosters are key to managing the number of hours the Trust produces, as are the total number of staff in post. September 2025, saw total EMS abstractions (excluding Induction Training) of 32.71%. This was a minimal decrease on the 33.65% recorded in August 2025 and remains above the 29.91% benchmark. The highest proportion of abstractions was due to annual leave at 14.24% followed by sickness at 7.39%.

The total EMS hours produced is a key metric for patient safety. The Trust produced 115,981 hours during September 2025; a slight decrease compared to the 118,986 hours produced during September 2024. The Trust is still delivering good levels of production.

Emergency Ambulance Unit Hours Production (UHP) achieved 89% in September 2025 which equated to 74,307 Actual Hours.

In September 2025 CHARU UHP was 88% against the full roll out requirement.

Remedial Plans and Actions

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

Expected Performance Trajectory

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

Our People
Capacity - Sickness Absence Indicators

(Responsible Officer: Carl Kneeshaw)

Sickness	Mental Health
R	R

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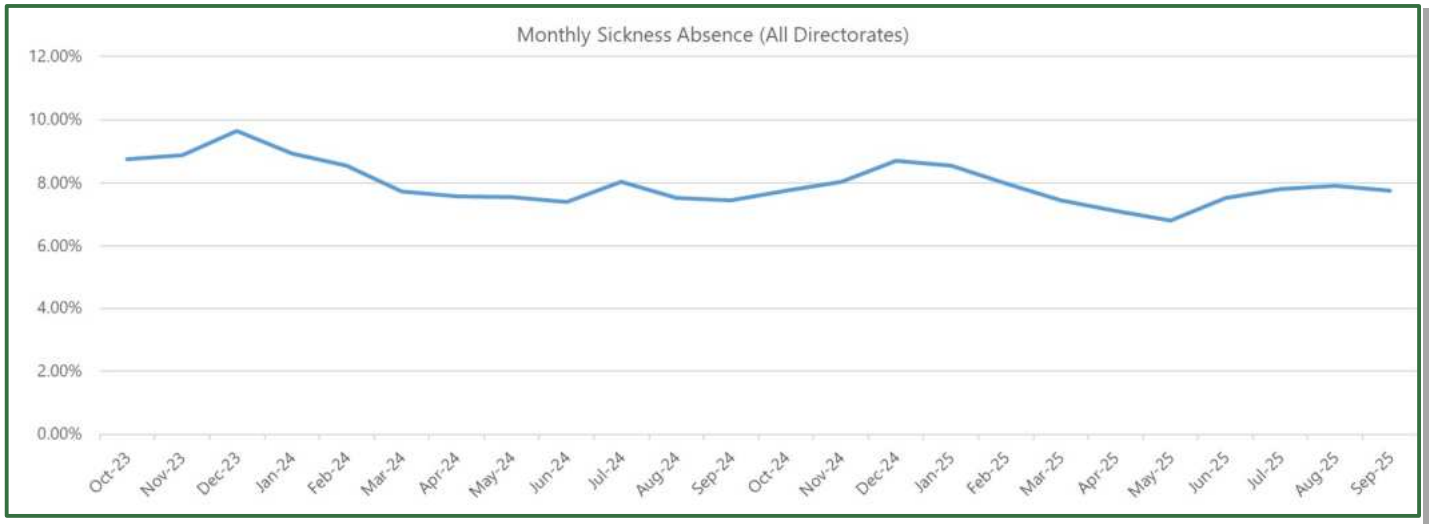
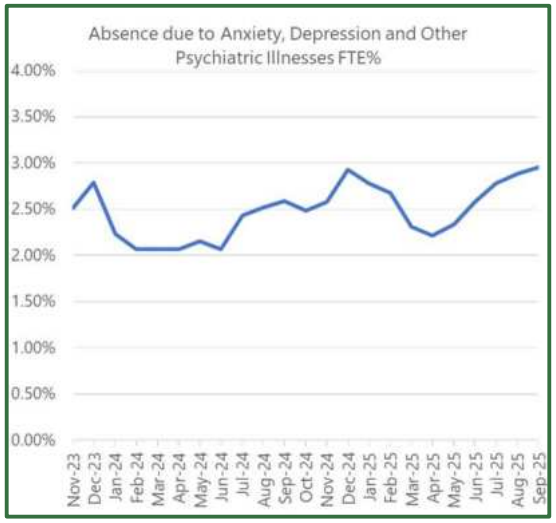
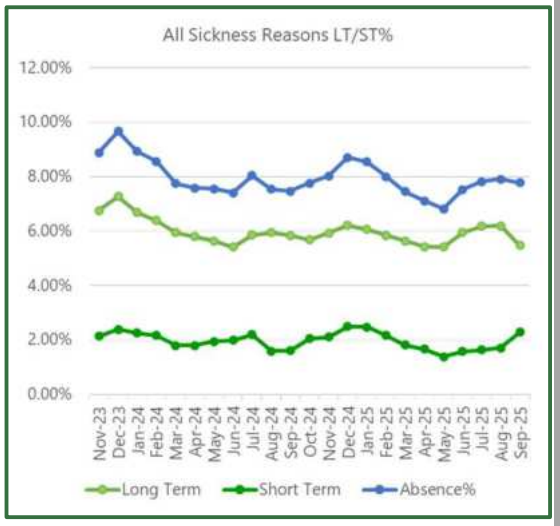




Sep-25	
Average working days lost per FTE (Annual)	
17.76 days	
Single month Absence %	
7.77%	
Long Term	**Short Term**
5.48%	2.28%
Mental Health	**Other MSK**
(S10 Stress/Anxiety)	(excluding Back)
2.96%	0.80%

September 2025



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

Analysis

There was a slight decrease in overall sickness absence rates between August 2025 and September 2025, reducing from 7.91% to 7.77%. Long term absence decreased from 6.20% in August 2025 to 5.48 % in September 2025, however short-term absence increased slightly to 2.28% (August 2025 - 1.71%).

The highest reasons for absence in September 2025 were Anxiety/ Stress/ Depression, other musculoskeletal problems, gastrointestinal problems and injury fracture. Absence due to Mental Health increased slightly from 2.89% in August 2025 to 2.96% in September 2025.

WAST Occupational Health continue to meet national KPIs set by the All-Wales Occupational Health standards and scope of practice, which states the 1st offered appointment date will be within 29 calendar days of the date referral received. The waiting time for a management referral in September was 10.4 days. We continue to use our external provider, Insight Health services, to help maintain KPIs and provide timely support to employees.

The team continue to triage all referrals and enquiries to ensure prioritisation of anything that requires urgent attention.

This year's flu campaign has begun and there are scheduled clinics for WAST and Public Health Wales staff.

Remedial Plans and Actions

- The Health and Wellbeing Plan for 2025-29 has been developed and implemented. The focus of the plan is on deliverables to improve workplace relationships, increase the trauma-awareness of the organisation and address health and wellbeing challenges.
- Team members from OH/Wellbeing/TRiM continue to promote our services via Siren, outstation visits and drop-in clinics. We regularly give presentations to newly recruited staff to highlight and promote the Occupational Health & Wellbeing service.
- The team continue to collect feedback and review services provided by our external partner organisations to help improve those services.

Expected Performance Trajectory

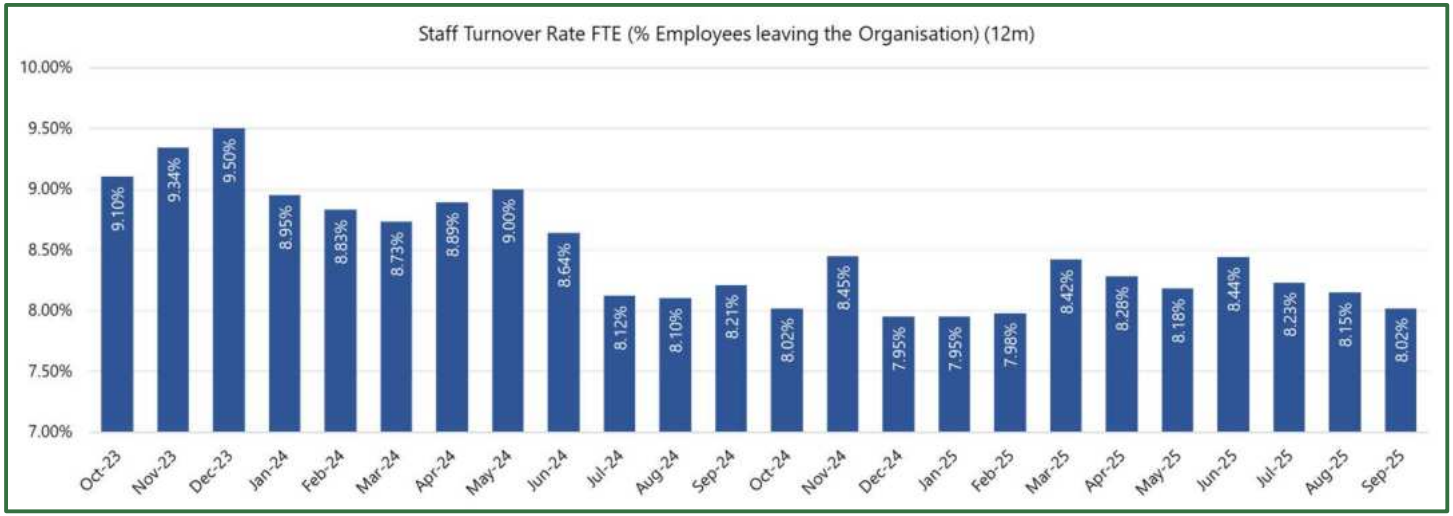
The Trust has indicated through its IMTP that sickness levels will fall in this financial year, but the Trust is unlikely to achieve the 6% target for the year.

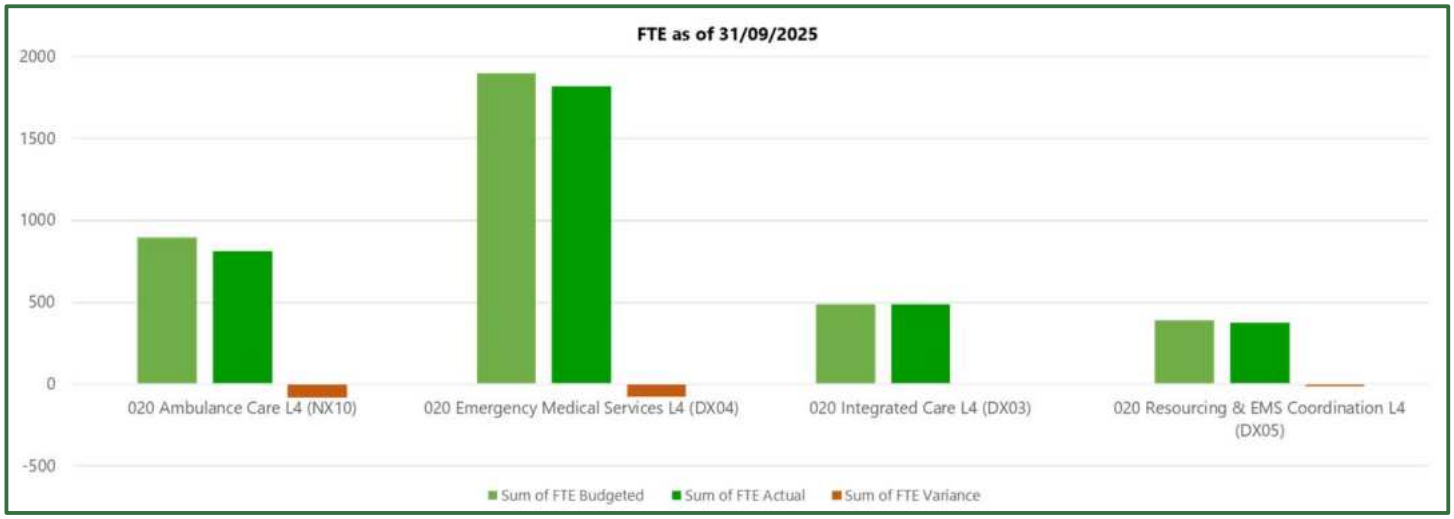
Our People
Capacity – Staff Turnover

(Responsible Officer: Carl Kneeshaw)

G

PCC





Analysis

The staff turnover rate in September 2025 was 8.02%, minimally decreasing from 8.15% in August 2025. September saw 32 leavers (26.54 FTE). Of those leaving, the greatest number were Operational and included;

- Ambulance Care Assistants/Patient Transport Drivers (8 people)
- Call Operators (5 people)
- Paramedics (4 people)
- Emergency Call Handlers (3 people)
- Technician (3 people)

Current trends are being monitored via the leaver's questionnaires; however, these are not mandatory.

In September, this was compensated by 85 joiners (83.70 FTE). A headcount of 79 people into Operational roles and 6 people into Corporate roles, the top including:

- Paramedic (28 people)
- Call Operators (22 people)
- Technicians (9 people)
- Emergency Call Handler (6 people)
- Non-Emergency Call Handler (4 people)

Remedial Plans and Actions

- Discussions around the future skill mix of our EMS workforce are ongoing, this could have considerable impact on the EMS workforce going forward. However, sufficient training capacity has been planned during 2025-26 to enable the trust to recruit any staff into the organisation, regardless of what grade that may be.

Expected Performance Trajectory

Turnover and FTE trends and themes are being monitored with plans adjusted accordingly.

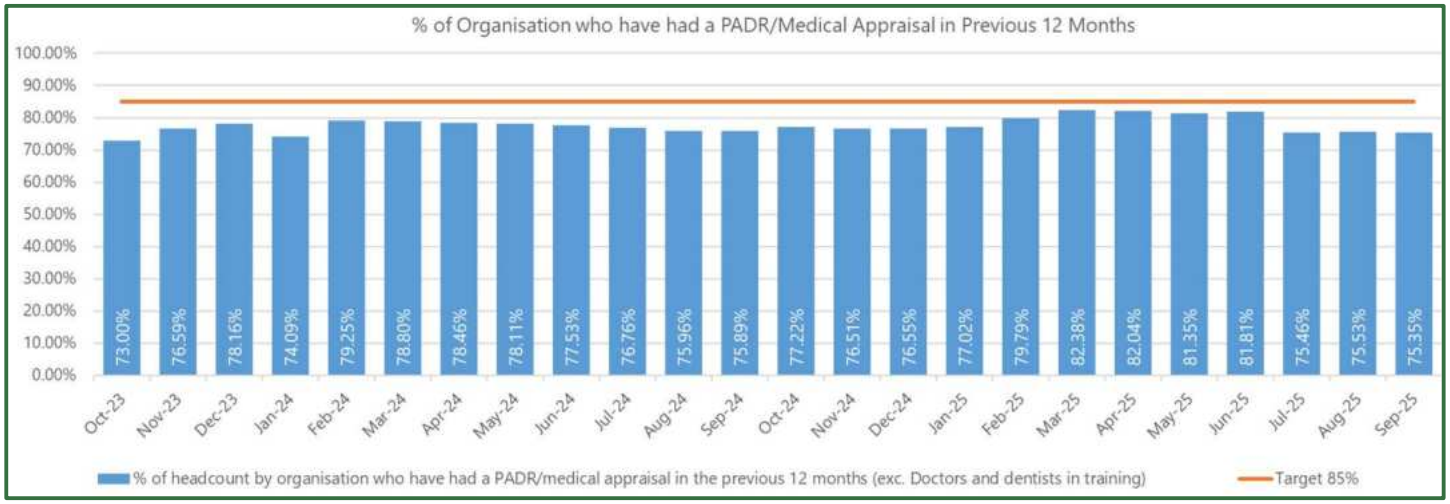
Our People
Capability - PADR and Training Rates Indicators

(Responsible Officer: Angela Lewis)

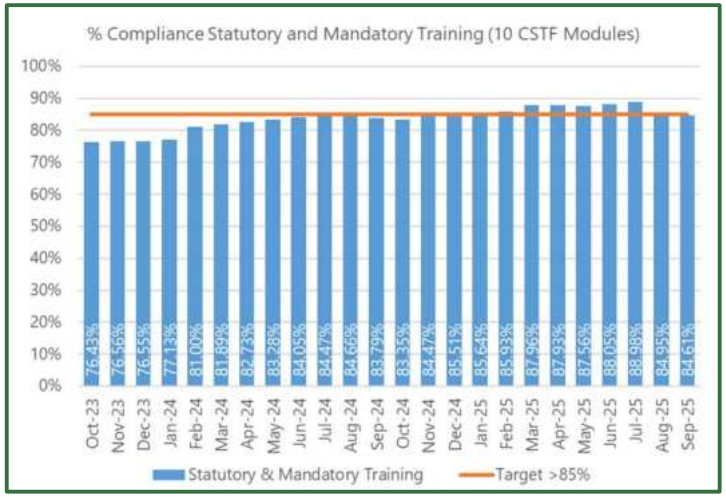
PADR: R | Stat & Mand: A | CI | PCC

Health & Care Standard: Health – Staff & Resources

Self-Assessment: Strength of Internal Control: Strong



ESR Data correct at time of export. PADR data does not include pay progression.



Analysis

PADR rates (excluding pay progression meetings) minimally decreased from 75.53% in August 2025 to 75.35% in September 2025 and remain below the 85% target. Over the reporting period this target has only been achieved once, in December 2022.

In September 2025 Statutory & Mandatory Training rates reported a combined compliance of 84.61% falling below the 85% target for the second consecutive month.

There are currently 20 Statutory and Mandatory courses that NHS employees must complete in their employment. These are listed in the table:

Remedial Plans and Actions

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

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

Expected Performance Trajectory

Performance is improving as compliance has risen.

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

Data source: ESR

Our People
Health and Well-being – Shift Overruns

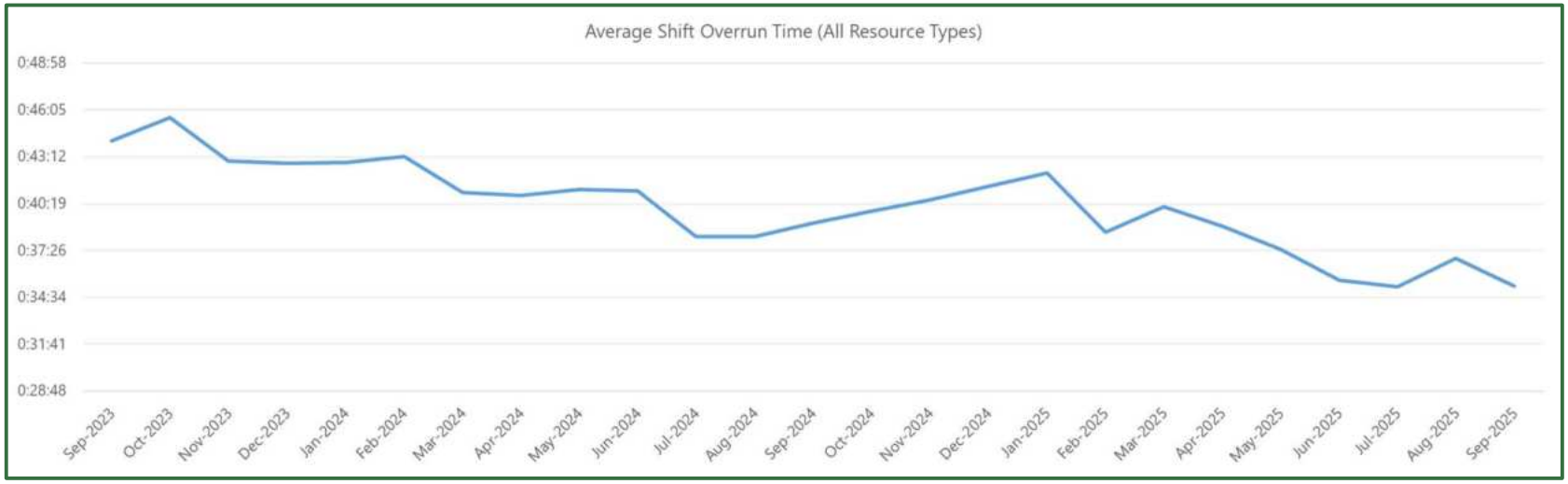
(Responsible Officer: Angela Lewis)

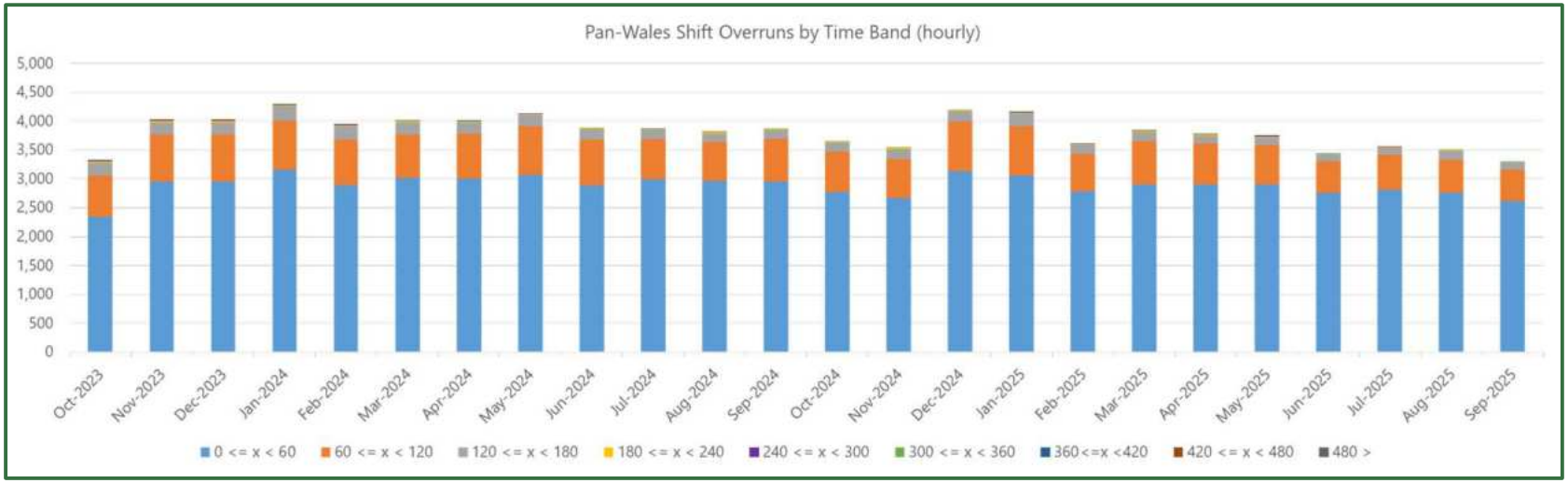
Overruns G

CI

PCC

FPC





Analysis

There were 3,292 shift overruns during September 2025.

The average overrun figure for September 2025 was 35 minutes and 16 seconds, a slight decrease from August 2025 (36 minutes 58 seconds). The trend continues to be downward over the past two years.

The highest volume of shift overruns occur within the 0 to 60-minute category, accounting for 76% of the total. 18.1% fall within the 61 to 120-minute category, 4.1% in the 121 to 180-minute category, 0.3% in the 181 to 240-minute category and 0.1% in the 241 minutes and over category.

Remedial Plans and Actions

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

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

Modelling on another option has just been completed and will be shared with TU partners.

Expected Performance Trajectory

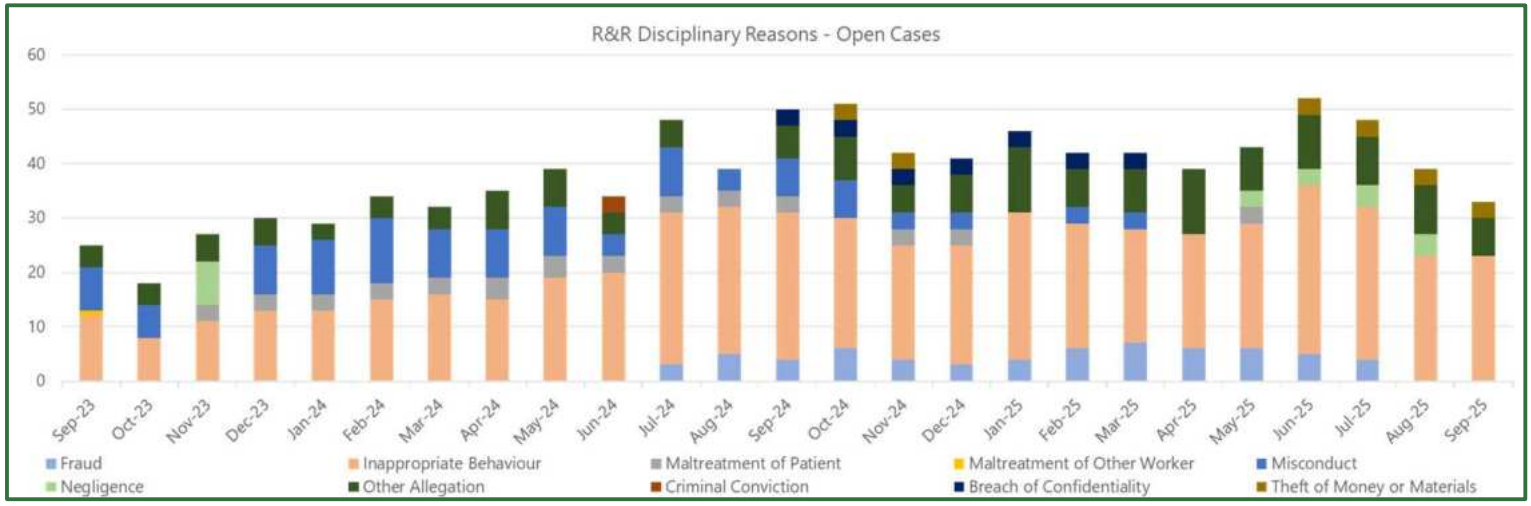
Overruns correlate with handover lost hours and may begin to decrease as handover times continue to reduce.

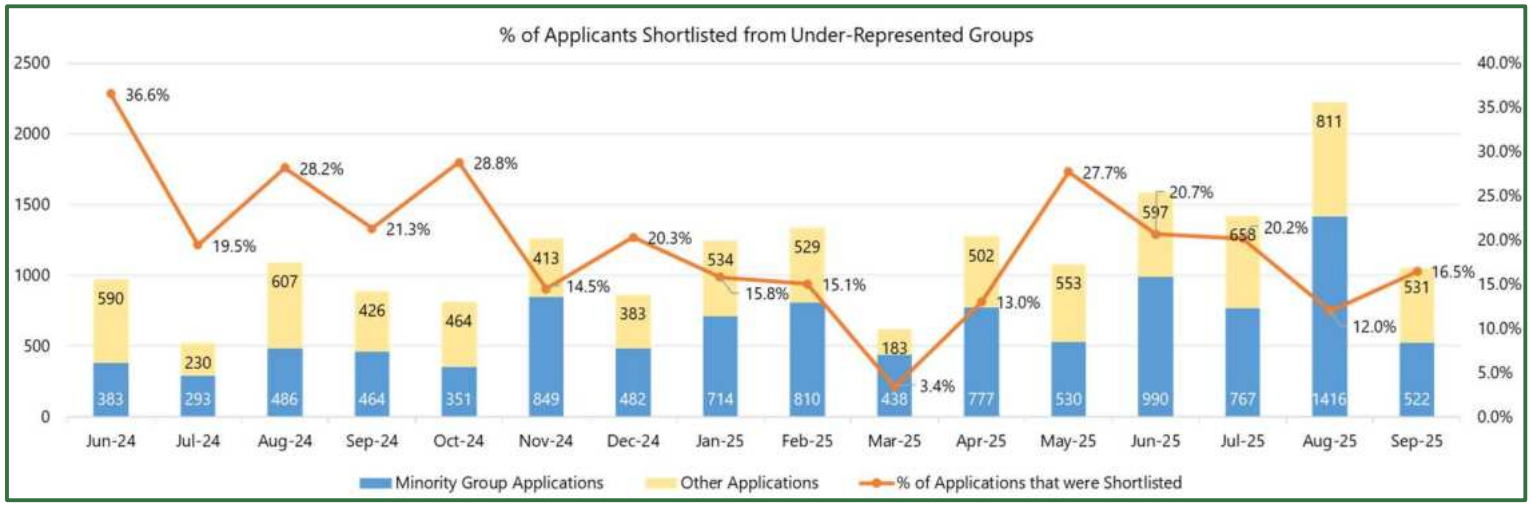
Our People
Culture – Number of R&R Disciplinary Hearings and Number of Applicants Shortlisted from Under-Represented Groups

(Responsible Officer: Angela Lewis)

Self-Assessment: Strength of Internal Control: Moderate

PCC





Analysis

There were 41 open formal disciplinary cases recorded at the end of September 2025, compared to 42 in August 2025. Of these Disciplinary cases, 56% are due to allegations of inappropriate behaviour.

There were 12 open formal Respect and Resolution cases in September 2025, a slight decrease from 13 reported in August 2025. (Previous increase due to R&Rs in relation to Roster Reviews).

The bottom graph shows that in September 2025, 1,053 job applications were processed, and 204 interviews planned.

Of the 1,053 applications, a total of 522 were from under-represented groups with 322 in the category of Ethnicity, 115 within Disability and 85 identifying within Sexual Orientation.

In September 2025, 16.5% (n=86) of all applications from under-represented groups made it through shortlisting and were invited for interview. This was an increase from the 12% in August 2025.

Remedial Plans and Actions

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

Applications: Work continues with the digital directorate, and the ED&I team to host recruitment workshops for Black, Asian and Ethnically diverse applicants and unconscious bias training for those sitting on interviews panels. Mini multiple interviews are being undertaken more widely across the Trust following positive feedback from candidates and more consistent scoring from panels making the process fairer and less bias for all involved.

Expected Performance Trajectory

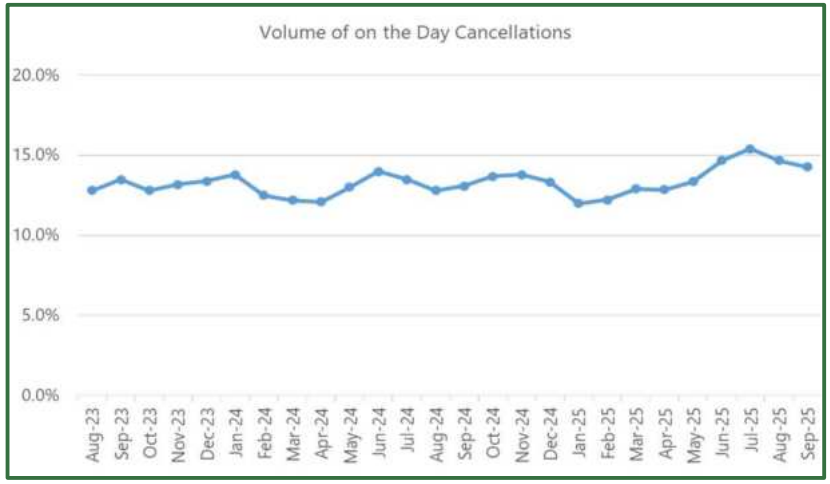
Continue to monitor levels, no trajectory for this measure.

Finance, Resources and Value
Value: Ambulance Care Indicators

(Responsible Officer: Lee Brooks)

Cancellations
G

FPC



Analysis

Inbound cancellations of 5 minutes or less of the crew arrival time saw an increase in September 2025 to 335, compared to 242 in August 2025. The total number of cancellations within 30 minutes also increased from 423 in August 2025 to 599 in September 2025.

Same day cancellations decreased slightly in September 2025 to 14.3% compared to August 2025 (14.7%).

Capacity Management Plan (CMP) cancellations decreased from 2,734 in August 2025 to 2,407 in September 2025.

Remedial Plans and Actions

The work with Hywel Dda to connect patient management systems went live in August and is now in a BAU position. Although still in its infancy, a continued stream of avoided late notice cancellations has been observed.

The biggest challenge and risk to the service lies in the level of capacity management cancellations. Focused work has commenced in Aneurin Bevan and a significant decrease in cancellations has been observed. Similar work will commence in other areas through September.

Expected Performance Trajectory

It is anticipated that CMP cancellations will continue to reduce in September.

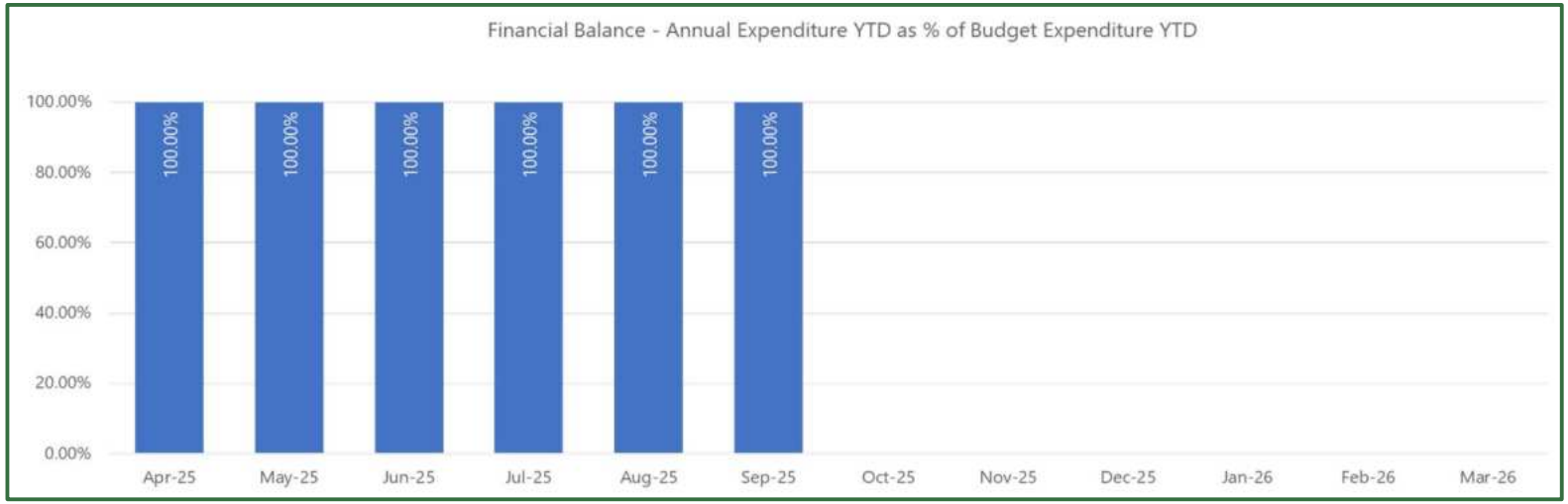
Please note that that figures may be lower than overall totals due to some records having no cancellation date.

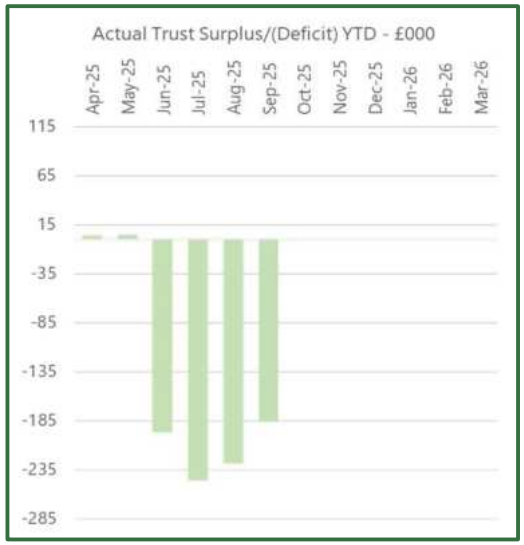
Finance, Resources and Value
Value - Finance Indicators

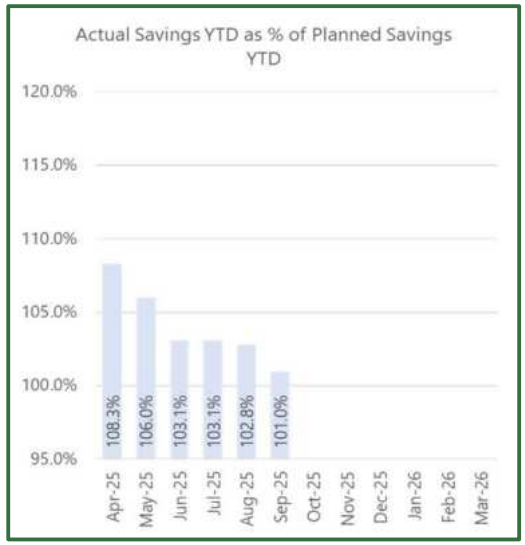
(Responsible Interim Officer: Ed Ringrose)

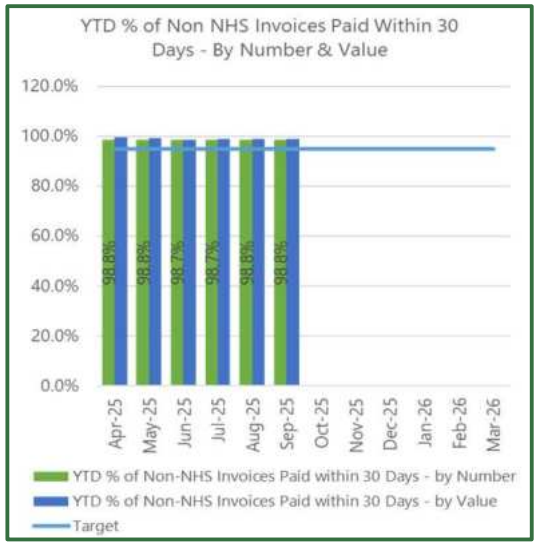
G

FPC









Analysis

The reported outturn performance at Month 6 is a deficit of £0.186m, with a forecast to the yearend of breakeven.

For Month 6 the Trust is reporting planned savings of £4.216m and actual savings of £4.260m (an achievement rate of 101.0%).

The Trust's cumulative performance against PSPP as at Month 6 is 98.8% against a target of 95%.

At Month 6 the Trust is forecasting achievement of both its External Financing Limit and its Capital Resource Limit.

Remedial Plans and Actions

There is no remedial plan required given the Trust is forecasting to breakeven; however, as the Trust moves into 2025/26 key areas
of focus include:-

- Undertaking a review of commercial opportunities for income generation (once Head of Commercial Development is in post) .
- A continued focus on the Trust's financial sustainability programme.
- Improved governance for Value Based Health Care, with a
particular focus on benchmarking; and
- An improved approach to benefits realisation

Expected Performance Trajectory

The expectation is that the Trust will continue to meet its statutory financial duties, as outlined in its IMTP for the 2025/26 financial year; however, it is expected that the Trust will continue to operate in a challenging financial environment and will need to deliver a planned level of savings in the 2025/26 financial year of c£8.5m.

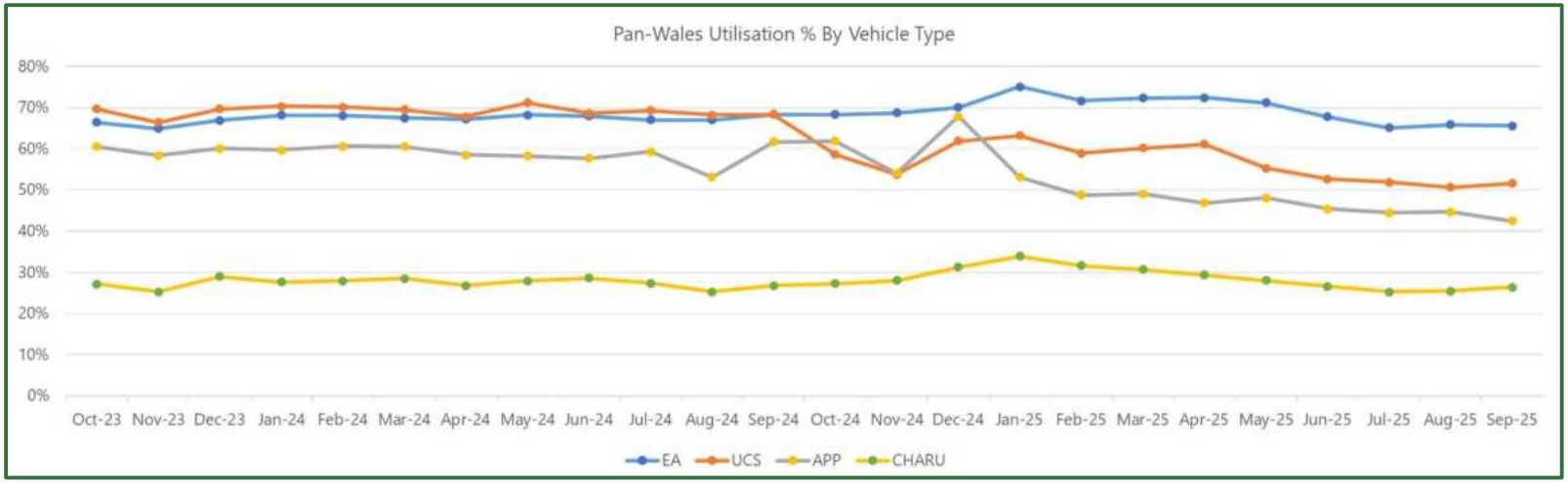
Finance, Resources and Value
EMS Utilisation

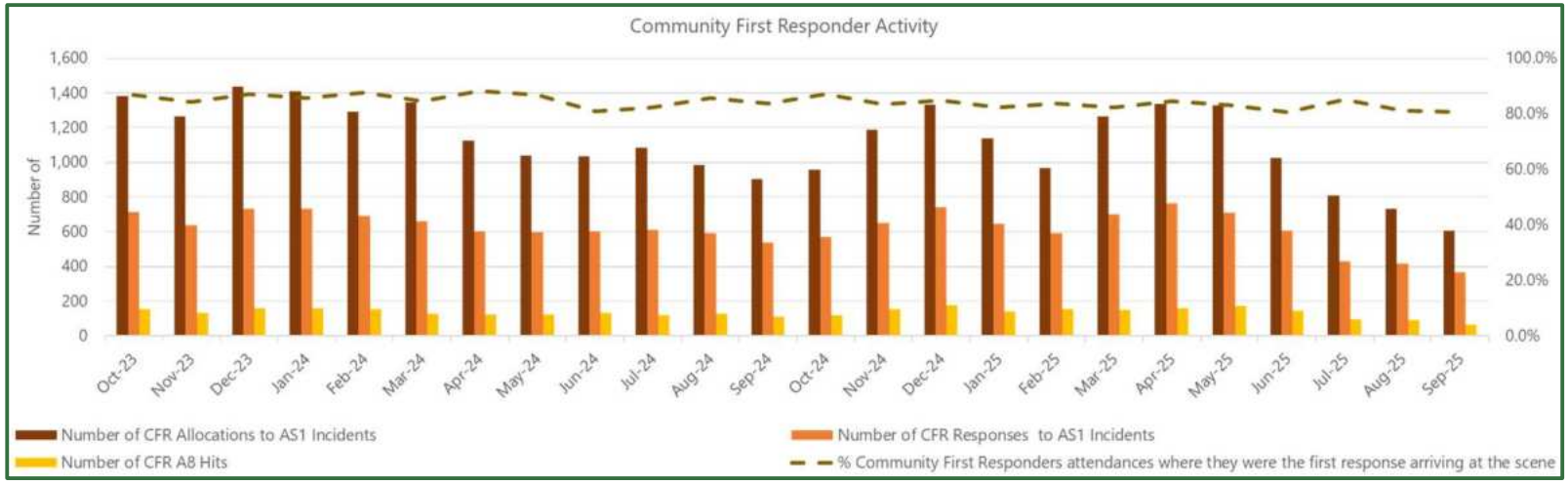
(Responsible Officer: Lee Brooks)

CHARU Utilisation G

FPC

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





Analysis

Pan Wales Utilisation metrics in September 2025 were 51.3% for all vehicles types, a minimal decrease from 51.7% in August 2025. EA saw the highest rate during the month at 65.6%, a minimal decrease but returning to an upward trend for the beginning of the year. The optimal utilisation rate for EAs needs to be lower so that they are free to respond to incoming calls.

CFR data collation is under review due to the new Assemble system going live in June 2025. At present hours for which a CFR volunteers are entered manually by the individual, however, there is work ongoing to connect this to the current CAD system from which they are dispatched to appropriate call codes. From the data available, in September we can see that CFRs were allocated to 607 EMS incidents and responded to 369. In September 2025 80.5% Community First Responders attendances where they were the first response arriving at the scene.

Remedial Plans and Actions

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

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

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

Work ongoing to connect Assemble and CAD for all CFR and Community Welfare Responders (CWR) hours.

Expected Performance Trajectory

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

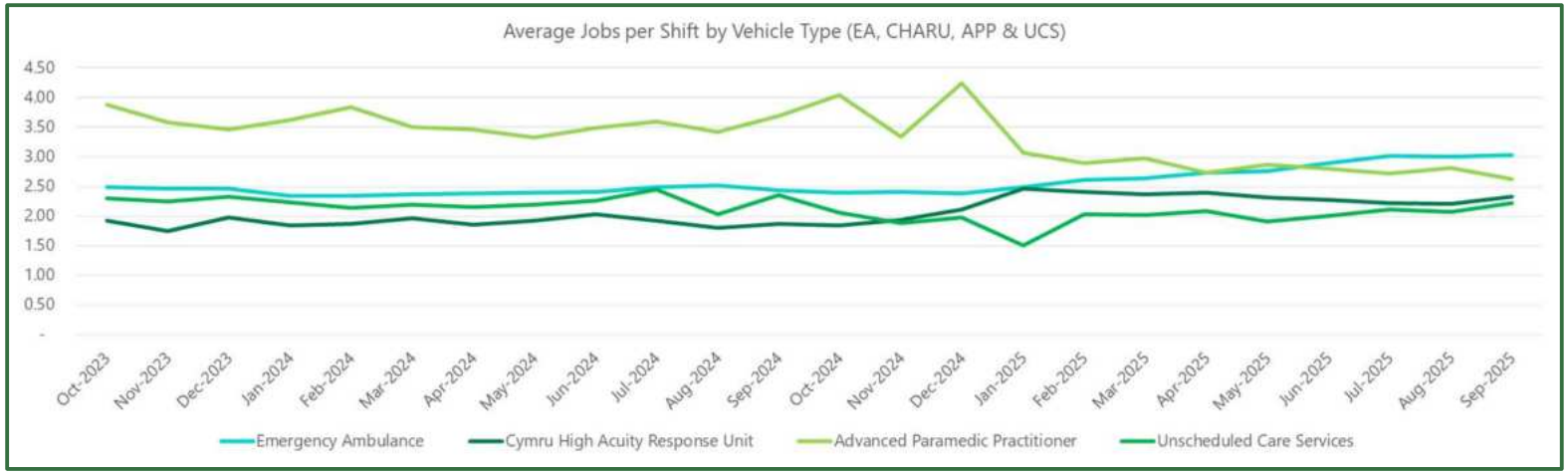
Finance, Resources and Value
Average Job/Shift Times

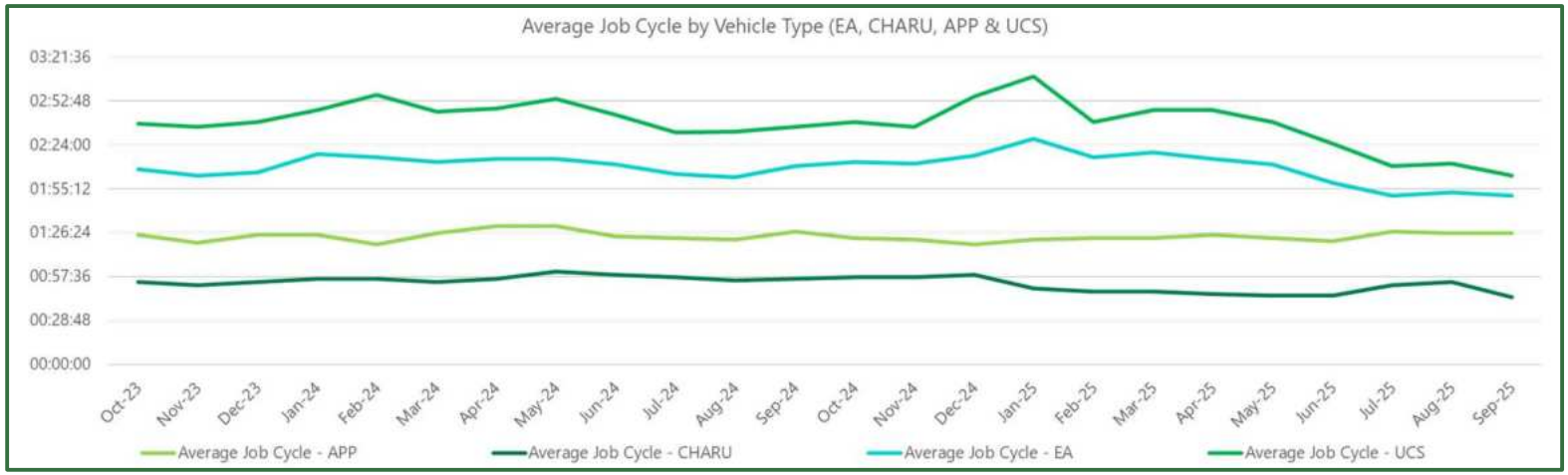
(Responsible Officer: Lee Brooks)

Jobs Per Shift
R

FPC

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





Analysis

Overall average jobs per shift was 2.39 in September 2025, a slight increase from August 2025 (2.36). EAs averaged 3.03 jobs per shift and UCS crews 2.21. Discussions with ORH indicate that 3.03 jobs per shift for EAs is higher than might be expected with the current levels of handover, with a definite upward trend as handover lost hours have come down.

APPs attended on average 2.63 jobs per shift and CHARU's 2.32. However, both sets of data need to be reviewed. The current priority is phase 2 of the Ambulance Performance Framework, with further capacity being recruited into to support the Insight & Data Services function.

As demonstrated in the bottom graph, the average job cycle decreased slightly in September 2025 for EAs (1 hours 51 minutes) and UCS (2 hours 4 minutes) and CHARU (44 minutes).
APPs (1 hour 26 minutes) remaining the same as the previous month.

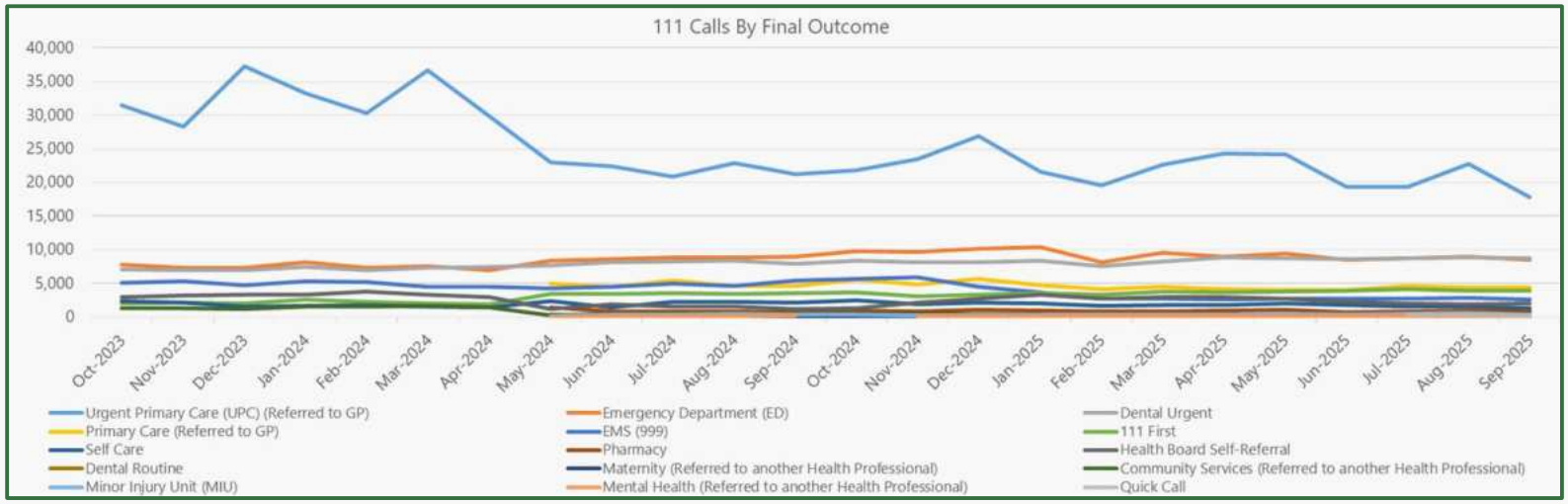
Partnerships / System Contribution
NHS111 Hand Off Metrics and NHS111 Consult & Close Indicators
Influencing Factors – Demand and Clinical Hours Produced

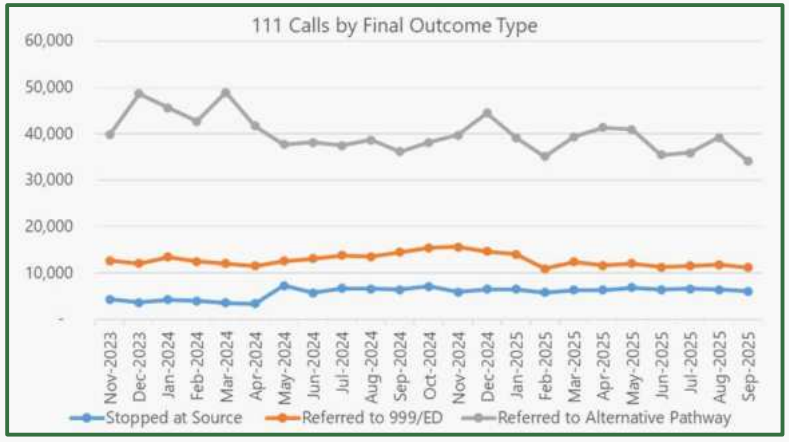
Dental: A

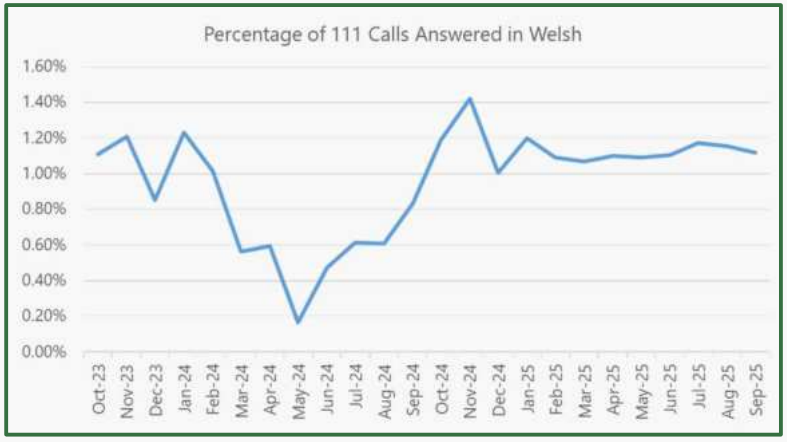
C&C Volumes: A

FPC

(Responsible Officer: Lee Brooks)







Analysis

During September 2025, 55,411 calls were allocated into the 14 categories displayed in the graph opposite; a decrease compared to the 57,446 seen during August 2025. However, data quality issues within 111 reporting have been addressed.

Calls Referred to a General Practitioner (handover of care) continued to be the top outcome for NHS111 accounting for 32.24% of all calls during September 2025, but there has been a material drop since the implementation of the new 111CAS system.

As the bottom left graph highlights, in September 2025, 6,029 calls were 'Stopped at Source', with no onward referral, a slight decrease from 6,427 in August 2025. 11,170 calls were referred to 999/ED in September 2025.

The percentage of 111 calls answered in Welsh decreased slightly from 1.15% in August 2025 to 1.12% in September 2025. This equated to 69.6% of all 111 calls being offered in Welsh being answered.

Remedial Plans and Actions

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

Expected Performance Trajectory

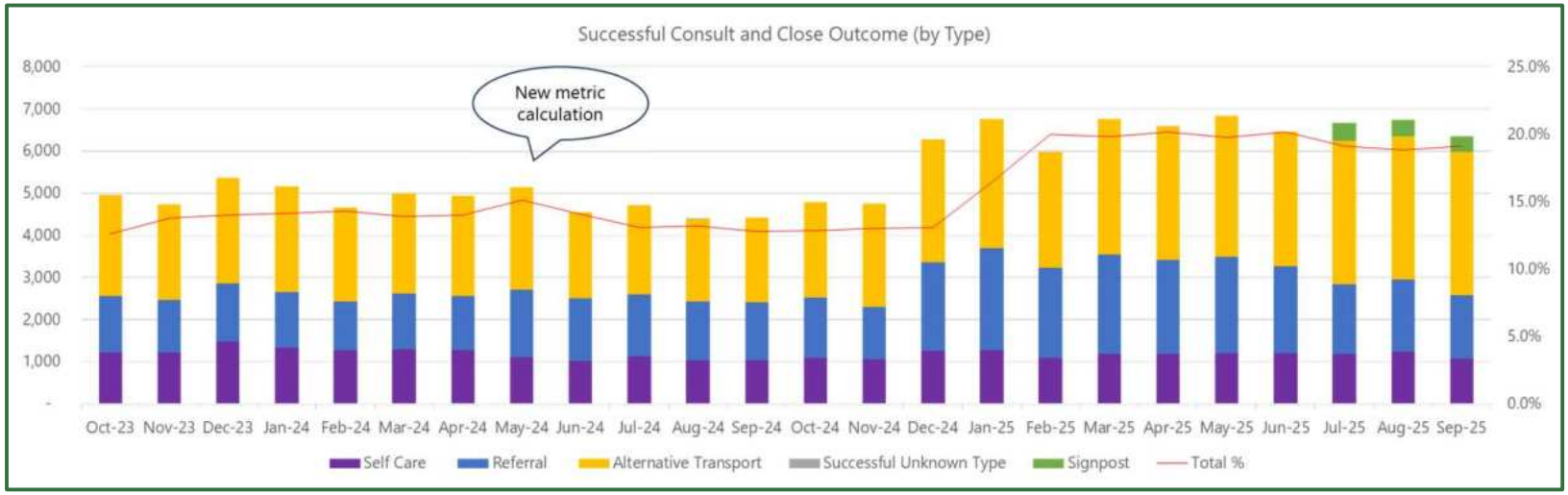
No performance trajectory is set at this time, as the Trust develops its measures and systems around these metrics. Once developed there will be an opportunity to develop benchmarks. The focus remains to shift left, where it is clinically safe and appropriate to do so.

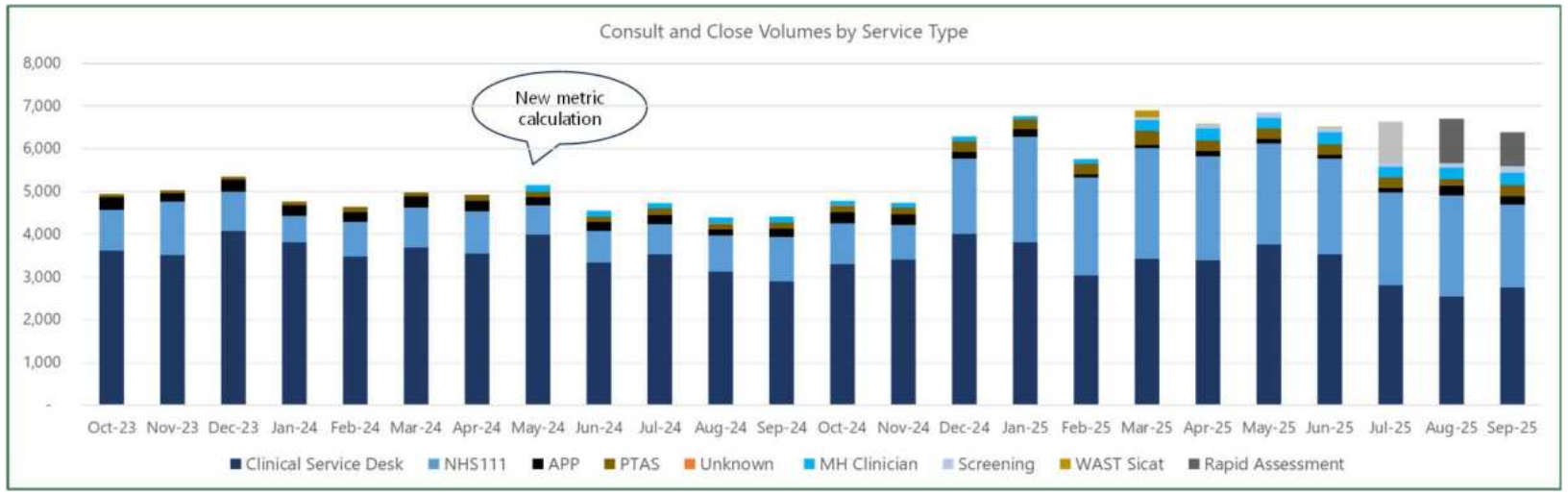
Partnerships / System Contribution
Consult & Close Indicators

(Responsible Officer: Lee Brooks)

C&C Outcomes
G

FPC





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.

Contributions from Clinical Service Desk (CSD) (8.10%), NHS111 (5.70%), WAST APP (0.60%), Health Boards using Physician Triage and Streaming Service (PTAS) (0.80%), Mental Health Clinician (0.80%), Screening (0.30%) and Rapid Assessment (2.40%) achieved 18.7% in September 2025, a minimal decrease compared to August 2025 (19.1%), but still achieving the 17% IMTP ambition for the eighth consecutive month. In September 2025, the number of 999 calls resulting in a Consult and Close outcome was 6,352, up from 4,412 in September 2024.

Of the calls successfully closed in September 2025, 62 patients received an outcome of self-care; 716 patients were referred to other services (including to Minor Injury Units and SDEC), 845 were advised to seek alternative transport services to acquire treatment and 317 were signposted.

Remedial Plans and Actions

- Work underway reviewing processes, has yielded efficiencies in remote clinical support.
- Implementation of 15 recommendations from commissioner review.
- Ambulance Performance Phase 2 go live.

Expected Performance Trajectory

Further improvement is expected linked to CSD staff attendance (reduced abstractions and less vacancies) and the CMT model. The ambition remains 17%.

Partnerships / System Contribution
Conveyance to ED Indicators

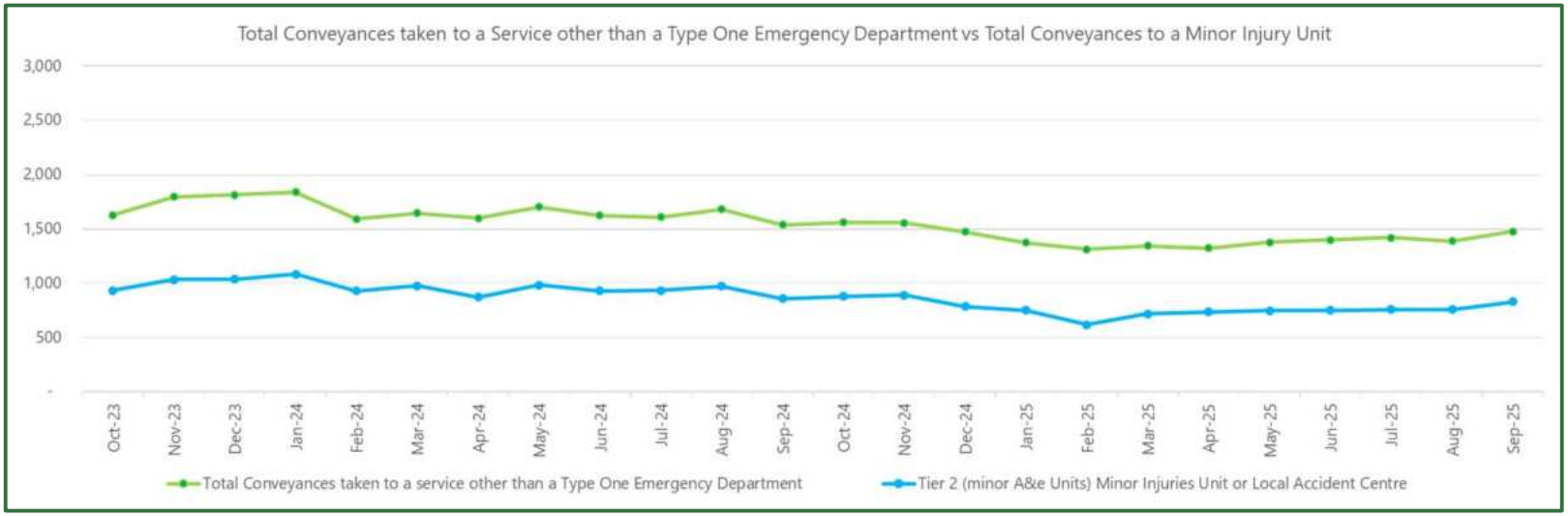
(Responsible Officer: Andy Swinburn)

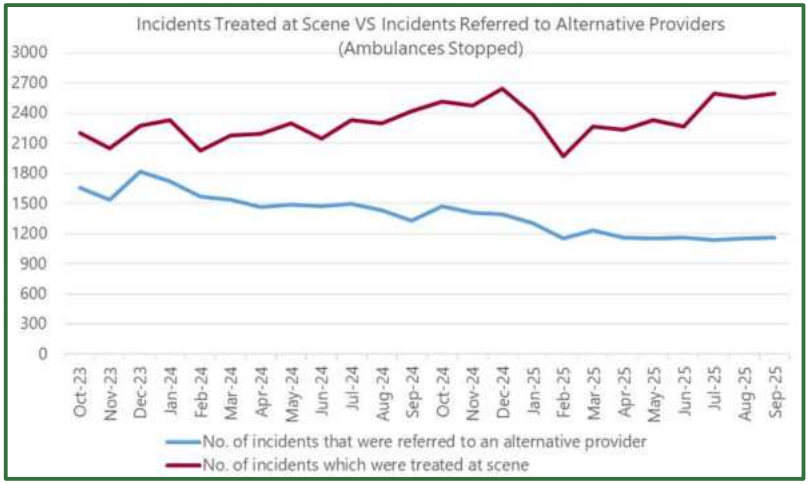
Conveyances
A

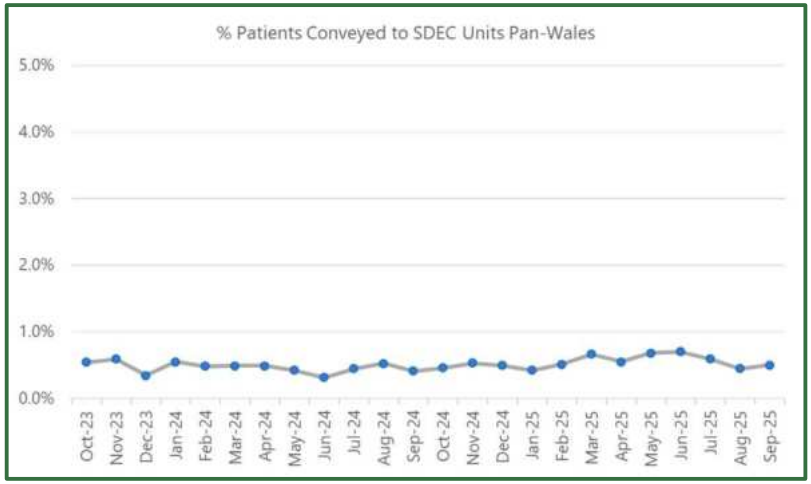
FPC

Ministerial Measure

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







Analysis

In September 2025 10.24% of patients (1,476) were conveyed to a service other than a Type One ED. 5.7% (829) were conveyed to a Tier two Minor Injuries Unit or Local Accident Centre while 38.15% of patients were conveyed to a major ED, as a percentage of verified incidents.

The combined number of incidents treated at scene or referred to alternate providers slightly increased, from 3,703 in August 2025 to 3,757 in September 2025.

Percentage of patients conveyed to SDEC units minimally increased in September 2025 to 0.5% from 0.44% the previous month.

Taxi conveyance has remained consistent for the past 12 months, averaging 842 per month to hospitals.

Remedial Plans and Actions

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

Expected Performance Trajectory

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

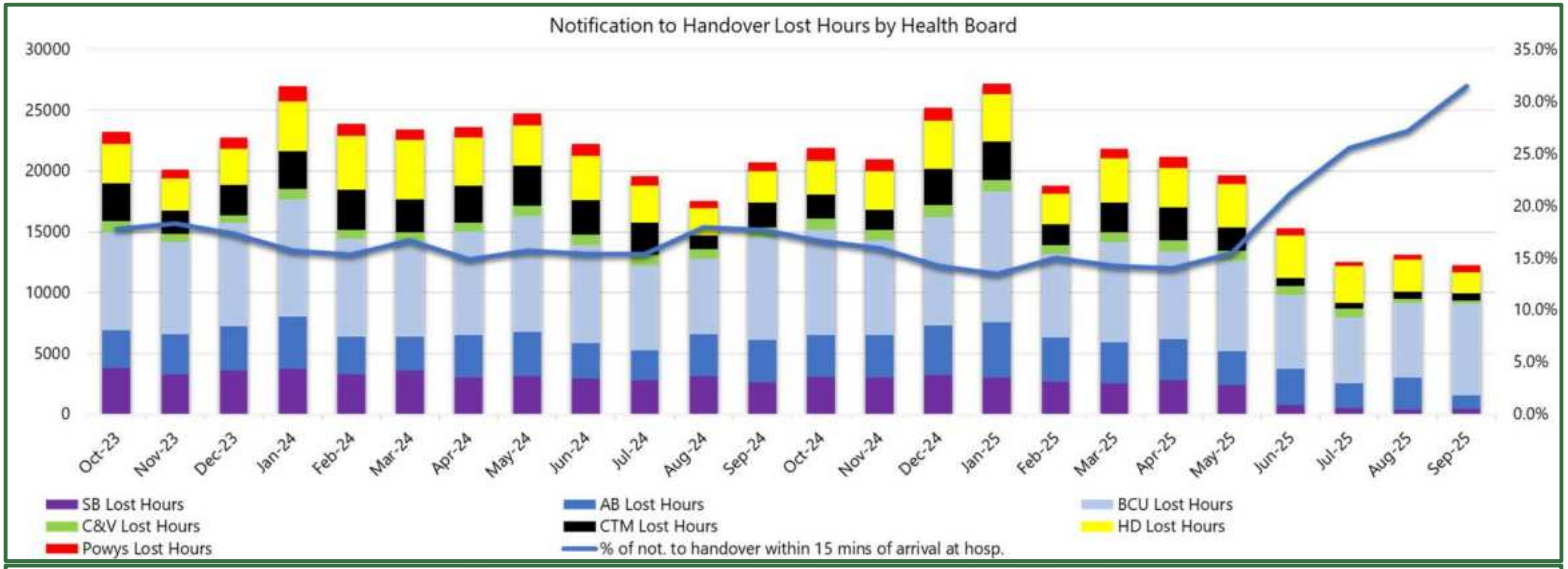
Partnerships / System Contribution
Handover Indicators

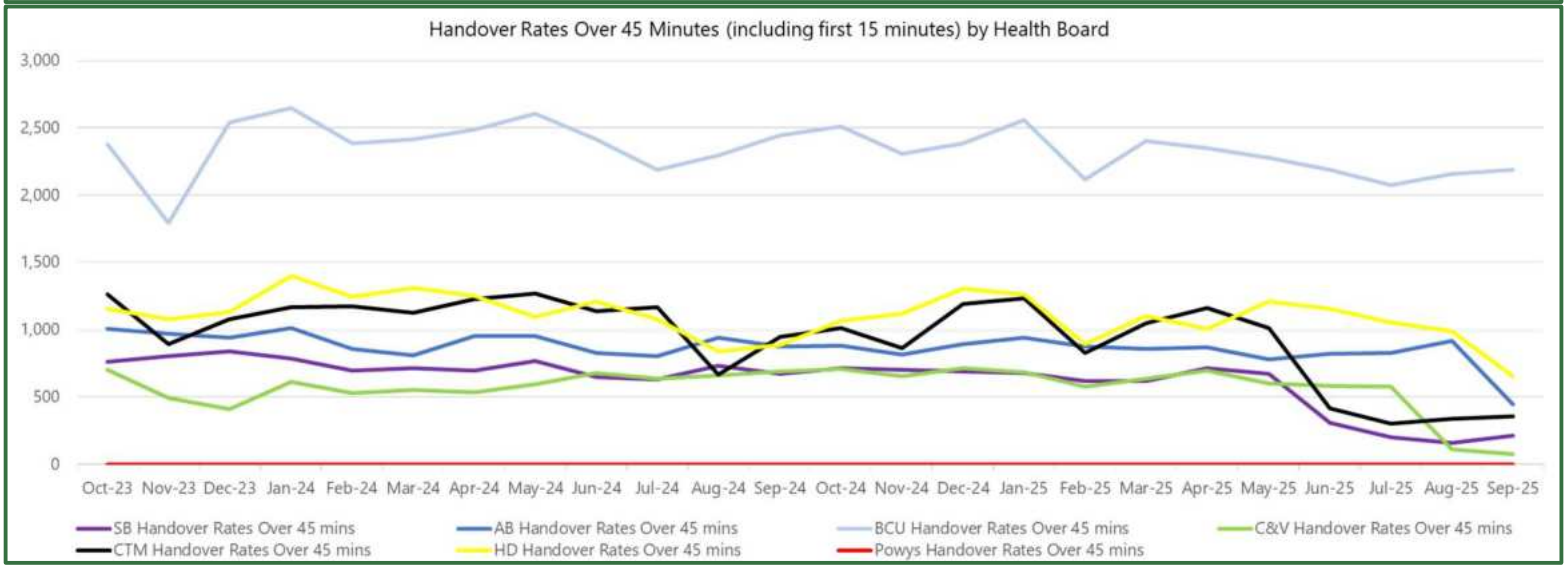
(Responsible Officer: Health Boards)

Lost Hours R

CI

QUEST





Analysis

230,091 hours were lost to Notification to Handover, i.e. hospital handover delays, over the last 12 months (Oct-24 to Sep-25), compared to 268,832 hours over the same timeframe the previous year. There were 12,284 hours lost in September 2025, which is 40.6% lower than the 20,693 hours lost during September 2024 and is the lowest monthly figure since July 2021. Three health boards have seen further reductions, compared to last month, particularly Aneurin Bevan (59.25%), Hywel Dda (35.28%) and Cardiff & Vale (16.46%).

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

- Ysbyty Gwynedd Hospital (BCUHB) at 2,961 lost hours
- Ysbyty Maelor Hospital (BCUHB) at 2,514 lost hours
- Ysbyty Glan Clwyd (BCUHB) at 1,946 lost hours
- Grange University Hospital (ABUHB) at 1,056 lost hours
- Withybush Hospital (HDUHB) at 776 lost hours

Notification to handover lost hours averaged 409 hours per day during September 2025 (30 days) compared to 424 hours per day (31 days) in August 2025.

In September 2025, the Trust could have responded to approximately 3,875 more patients if handovers were reduced, which highlights the impact these numbers are still having on the service.

Remedial Plans and Actions

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

Expected Performance Trajectory

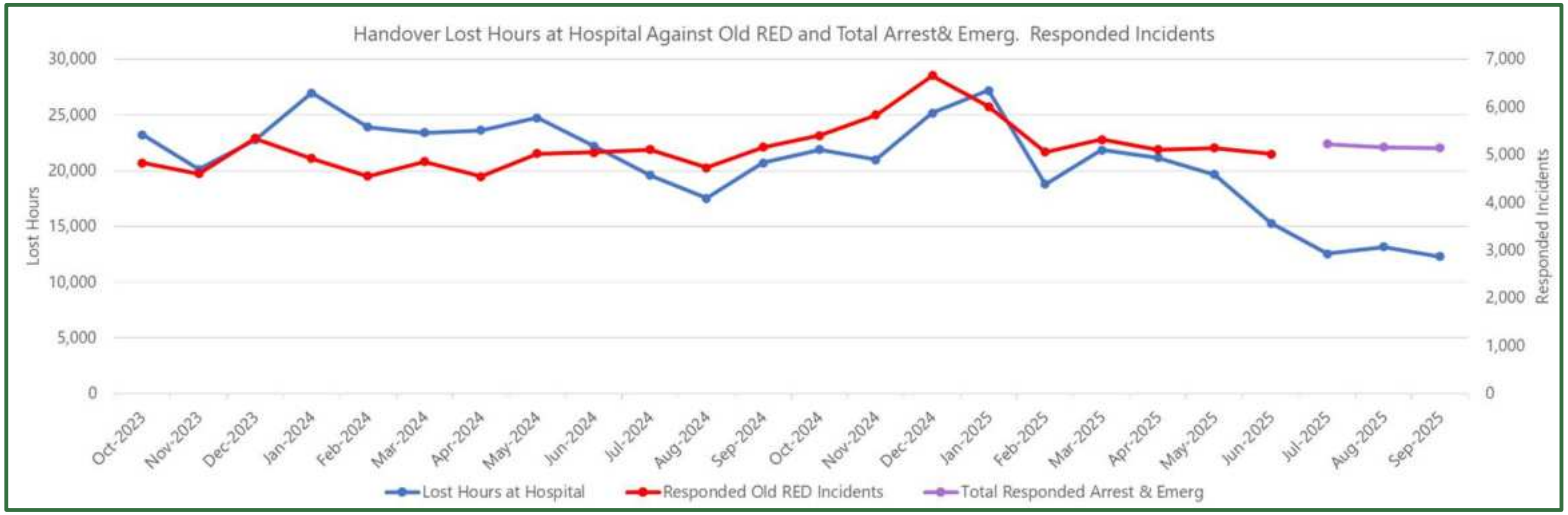
The likely expected ambition from Welsh Government is no waits over 45 minutes. W45 workshops have been facilitated with each health board by NHSWales Performance & Improvement (previously the NHS Executive).

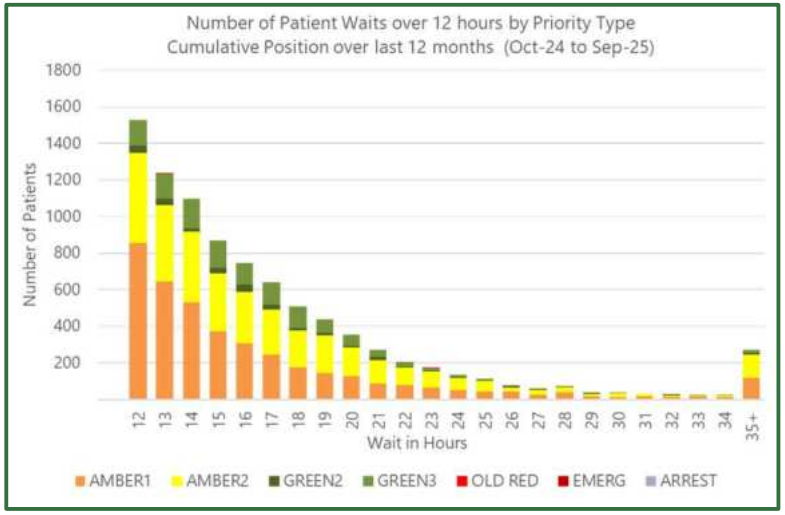
Partnerships / System Contribution

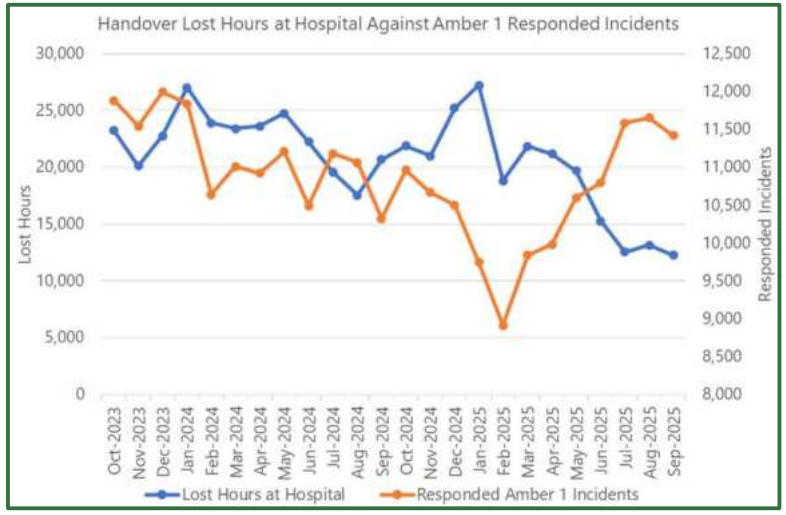
Handover Lost Hours Against Red & Amber 1 Responded Incidents

(Responsible Officer: Health Boards)

CI QUEST







Analysis

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

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

In September 2025, 323 patients waited over 12 hours for an ambulance response.

Remedial Plans and Actions

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

Expected Performance Trajectory

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

**NB: Data correct at time of abstraction*

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

Definition of Indicators

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

Agenda Item No. 9

REPORT TITLE

Digital Reporting

MEETING

Name of meeting	Finance & Performance Committee
Date of meeting	18th November 2025
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, Aasha Cowey & Kimberly Abraham

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 Innovation & Transformation, and the Clinical Digital Unit functions, as well as progress against the Digital Plan (see the **Appendix** 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. The Directorate regularly receive requests to support new projects, or information about changes to scope or direction of existing commitments and have to decide on how to resource the request and priority. Until the Digital Transformation & Innovation Programme (DTIP) group is established (see paragraph 7) the Digital Leadership Group (DLG), who meet weekly, will have a standing item on their agenda to ensure these new requests are appropriately considered against the existing workload, and not lost in the backlog.

3. **Recruitment Challenges:** Digital, and other teams around WAST, are facing significant challenges with recruitment due to high volumes of applications, a large proportion of which appear to be generated or supported by AI, leading to a risk of inconsistent levels of quality and difficulty in fairly assessing at shortlisting stage. A risk is in development, and options are being explored with the support of the People Directorate and wider NHS Wales colleagues.

Highlights

4. **Recruitment:** There is currently a total of 26 roles that Digital are actively recruiting into in 25/26 - made up of core baseline vacancies, posts from 24/25 investment, and new posts from 25/26 investment.
    - Recruitment within the **Digital Innovation and Transformation Team** has progressed well. We are expecting the Head of Digital Business Change and Benefits to join us early December and the Digital Innovation Lead (an internal appointment) to join the team mid-December. Offers have also been made to two Business Analysts, and these are now being processed. The additional capacity in this area will allow us to better manage, prioritise and monitor the digital transformation portfolio
    - Recruitment activity continues to across the **ICT team** into existing vacancies plus several other roles with job descriptions under development.
    - Within **Insight and Data Services** (IDS) 3 new Power BI Analysts are expected to join the Trust by the end of Q3 (offers have been made and accepted); however, Job Descriptions now need to be sourced / developed for the following vacant roles: Data Science Lead; Data Engagement Lead; Data Engineering Lead and an IG specialist. Additionally, 2 temporary contractors are working with the team to support with high-priority deliverables.

5. **Clinical Model Transformation (CMT):** we continue to support the CMT with a significant contribution already made in 2025/26. Highlights from the current reporting period include:
    - **Emergency Response Service (ERS):** Continuation of system changes to support the Ambulance Performance Framework Phase 2 delivery for 2nd December (including 111

and 999 CADs) and ongoing work following implementation of Phase 1 earlier this year.

- **ERS:** Metrics development for Ambulance Performance Framework Phase 2 is currently in development and scenario testing, working with suppliers to assure the data flows and reporting ahead of 2nd December go-live.
- **ERS:** First publication of Phase 1 Clinical Indicators to Commissioners as part of the regular Ambulance Service Indicator (ASIs) reporting in October.
- **Digital Front End (DFE):** The Director of Digital attended the recent Symbiosis AI Conference, where there was excellent international feedback on the Welsh Ambulance Service's work with agentic AI, particularly the progress of Albot within NHS 111 Wales, showcasing how responsible, human-centred AI can transform access to urgent and emergency care.
- **DFE:** Work progresses on the development of the online symptom checkers, phase two of the virtual assistant and development of a specification for an updated content management system. This work collectively enhances our provision of a digital front door option for the population of Wales.
- **RICS:** Digital attended the RICs workshop in October 2025 which surfaced the emerging asks for 26/27 and what digital support is required.

6. **National DOS:** WAST are engaging in a national project to unify the multiple Directories of Service (DOS) managed around NHS Wales. As WAST's DOS database is robust and well managed, and the interfaces well utilised, the team are heavily involved in the discovery and scoping phases of this national project being led by Welsh Government. Currently requirements are being scoped, and users of the DOS's are being engaged through various user research sessions.

7. **DTIP:** With the new Head of Digital Business Change & Benefits due to commence in post early December, the final arrangements are in preparation for DTIP. This includes the development of the triage and prioritisation process, KPIs and governance (including the TOR, standing agenda items and membership). Directorates will be written to early January 2025 to field membership alongside comms to support the launch. The aim is for the first DTIP to be held in February 2025. This will be chaired by the Assistant Director Digital, Innovation and Transformation. The purpose and strategic value of DTIP will be to:
    - Ensure digital efforts are prioritised, visible and aligned to the Trust's broader objectives.
    - Position Digital as a driver of transformation, not just a support service.
    - Enable the Trust to say "no" or "not yet" to non-priority work, with transparency and justification.

8. **ePCR Refresh:** the Clinical Digital Unit met with the supplier in September to review the wireframe of the new application version. Activities now focus on the Functional Design Specification (FDS) which will be shared with WAST in the coming weeks ahead of

development. As part of another ePCR project, a tool is being created on the ePCR platform that will help capture and manage cardiac arrests. Initially this will be focused on adults, whereby the tool will capture all elements of the cardiac arrest and then allow those to be transposed into ePCR when the incident is complete. This tool will significantly improve the management and ensure optimal resuscitation care is provided to our patients.

9. **Digital Clinical Updates: 1)** A 'tenant structure' is now complete, representing the people structures for both clinical and operations directorates and will support the the ePCR platform. Work is now progressing to create the front end that will allow Senior Paramedics and Duty Operation Managers to easily move team members between teams, ensuring reporting, information accesses, and insights are accurate and timely. **2)** A portal is being created to allow doctors who provide written orders for the administration of 'Just in Case' medications to be entered directly into ePCR via a 'tunnel'; this development will significantly safeguard our colleagues and ensure that patients are provided medication when approaching end of life.

10. **Copilot:** The education package is in development which will include an "AI fluency course" recognising AI as a future essential skill for our workforce. Negotiations continue at a national level regarding all-Wales NHS Microsoft 365 licensing. WAST are also reviewing an update of internal signposting and maximising the use of the Copilot chat functionality.

11. **AI Developments:** In addition to the progress with the Copilot pilot, a new AI Steering Group was launched in October, which brings an essential governance mechanism around decision making, advice, and policy with regards to the approach of Responsible AI.

12. **Innovation Labs & Digital Engagement:** After reviewing the 2025/26 IMTP plan, the Digital Directorate agreed the development of the digital innovation lab will be scoped Q4 with the commencement of the Digital Innovation Lead. This individual will build the early offer and continue initial projects already identified. These include enhancing patient liaison feedback on site, and another the development of curated applications to support patients with dementia. Digital Engagement has progressed by the securing of two vehicles which will provide a mechanism for digital staff to visit more operational sites across Wales, an implementation plan will be developed to support this.

Lowlights

13. **CAD Replacement:** this project is to consider the requirements & procurement / renewal for the replacement of the 111, 999 and NEPTS contracts. Engagement meetings with relevant operational teams and leaders are required in Q4 due to the lengthy procurement and implementation processes.

14. **ESN Phase 2:** On the Digital Plan (see Appendix), the goal for 2025/26 was to submit the Outline Business Case to Welsh Government – an activity which was completed in the summer. The original plan was then to submit one Full Business Case (FBC) to encompass all ESN projects, but this plan has recently been changed. Instead, Welsh Government have requested the FBC for handheld and Fixed Vehicle devices be submitted in September 2026 with the Air-to-Ground element being separated and submitted as soon as possible. A verbal update will provide as a standalone agenda item at the November meeting of the F&P Committee, with a full paper planned for January's Committee meeting.

15. **Cloud GRS & eTimesheets:** A specification is in development which will see these two projects come together, and the migration of GRS to a cloud platform in Q1 2026/27. Digital representatives are part of the technical group for eTimesheets, but have so far been unable to provide much support as most of the current activities surround the operations and staff's terms and conditions. There are also no known direct Digital Directorate requirements for system changes, however, will continue to provide expert advice on the migration project and how eTimesheets functionality will be captured in the new platform. For the broader GRS Cloud project, there have been some delays resulting in the go-live pushed back from January to May 2026. Technical elements are still on track, with a view of completing by January, so WAST may be able to go live earlier should a gap appear in the supplier's delivery timelines with other customers. Current work focuses on the App Registration with the National 365 Tenant (with DHCW) which is a pre-requisite for following steps. Cloud UAT (due to commence 27/10/25) has been delayed given issues with the App Registration; however, a recent update to the on-premise GRS solution will mitigate some risk of the delays before the Cloud version.

16. **Data Skills Enablement:** as a project, this work is on-hold, unable to progress due to competing priorities within the IDS team and dependent on the development of a JD and recruitment of a "Data Translator" or "Enablement Lead" who will be able to bridge technical and non-technical stakeholders to drive adoption of data products, and be responsible for the improvement of workforce data skills and confidence.

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: 1. Appendix: Digital Reporting November 2025 – Metrics (pdf)

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: • 671 – Inappropriate use of AI Technologies • 623 – Failure to comply with Data Protection 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 and Research	☐ Whole Systems Approach

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

IMPACT ASSESSMENTS FOR CONSIDERATION

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

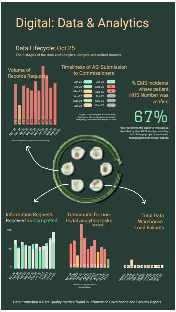
Does this paper require an impact assessment	☒ No ☐ Yes
If yes, what impact assessment is attached	

APPROVAL/SCRUTINY ROUTE

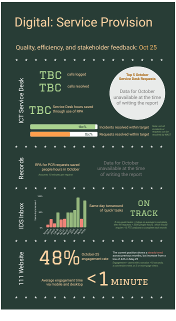
Date	Person/Group/Committee
28/10/2025	Wider Digital Leadership Group (review)
05/11/2025	Digital Leadership Group (sign-off)


Digital Contribution 25/26
Everyday Essentials
Simplified Sign-on
MS Hello solution in testing
iPad Replacement
on track for Q3
Automation / RPA
BAs appointed; processes scoping
Cloud GRS
test environment established
eTimesheets
to recommence in 26/27
EMS CAD Servers
Replace 999 & Paramount
Windows 11
50% by Q3 target already met
Cyber, Safety & Security
AI Safety / Policy
in draft; due Nov - delayed to Dec
Smart Stations
costings received; move to 26/27
Cyber Improvement
actions as per corporate risk
IG Improvement
actions for risk & toolkit
Video Compliance
Trust-wide consultation on Policy
Digital Pioneers
Enhanced IVR (111)
dep on supplier; move to 26/27
Patient Messaging
NEPTS SMS phase 2 scale-up
AI Development
Gen-AI pilot evaluation by Q2
Innovation Lab
dependent on recruitment; move to Q4
Transformation
CMT
see narrative
CAD Replacements
EMS, NEPTS & 111 contracts
ESN Phase 2
OBC business case submitted
Drones
signed-off; pre-flight checks
Digital Engagement
Digital Vehicles supported; due Q4
ePCR Phase 2
development in progress
Data, Information & Insight
Individual Insights
airway log report; tenant structure
NDR Programme
Q2 deliverables partially complete
Skills Enablement
e.g. data literacy + Datix self-serve
IDS Improvements
Data Quality training launched
Collaborations
e.g. with PHW & Research
See IMTP & STB trackers for action & milestone based progress.
RAG and progress based on Directorate Plan
Last updated 28/10/2025


CMT Digital Contribution 25/26
Remote Integrated Care Service
RICS Integrated CAD
Remote Monitoring
Low code Alignment
CPSS in 999s (pilot)
Video Triage
Welsh Clinical Portal Integration
Digital Front End
Virtual Assistant
Content Management System*
Symptom Checkers
Service Development*
*Subject to funding agreements and processes
Urgent Community Response
ePCR Access (e.g. falls responders)
Scheduling (APPs/pallative)
Emergency Response Service
Red Review Infrastructure
Call Category Changes
CPR in Community (Scoping)
Rapid Clinical Screening
Health Transport
Scoping for the art of the possible
Digital Overarching Support (all workstreams)
26/27 IMTP + CMT
Unclear requirements, and new in-year requests being received without impact assessments or prioritisation
Metrics & reporting
Testing & validation of supplier work ongoing ahead of Phase 2 go-live
IG & Data Protection
Late engagement in projects, and competing priorities


Digital: Data & Analytics
Data Lifecycle: Oct 25
The 6 stages of the data and analytics lifecycle and related metrics.
Volume of Records Requests
Nov-24
Dec-24
Jan-25
Feb-25
Mar-25
Apr-25
May-25
Jun-25
Jul-25
Aug-25
Sep-25
Oct-25
Timeliness of ASI Submission to Commissioners
Jan-25
Feb-25
Mar-25
Apr-25
May-25
Jun-25
Jul-25
Aug-25
Sep-25
Oct-25
Nov-25
Dec-25
% EMS incidents where patient NHS Number was verified
67%
this represents the patients who can be identified by their NHS Number enabling data linkage projects and easier triangulation with Health Boards
Information Requests Received vs Completed
100
50
0
Turnaround for non-trivial analytics tasks
(avg days)
Total Data Warehouse Load Failures
Data Protection & Data Quality metrics found in Information Governance and Security Report


Digital: ICT Systems
Data for September & October 2025 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%
EMSC
CAD C3
Aug-25: CRS experienced temporary failure (not CAD so not captured here)
999
EMS
Telephony
10/03/25: LifeX loss of connectivity
07/05/24: LifeX outage all Wales
NEPTS
CAD Cleric
CSD
ECNS
Lowcode
ePCR
Terrapace
111
CAS
07/06/25: UK-wide 111 telephony outage
111
Telephony


Digital: Service Provision
Quality, efficiency, and stakeholder feedback: Oct 25
ICT Service Desk
TBC calls logged
TBC calls resolved
TBC Service Desk hours saved through use of RPA
Top 5 October Service Desk Requests
Data for October unavailable at the time of writing the report
tbc% Incidents resolved within target
tbc% Requests resolved within target
Note: not all incidents or requests can be resolved by WAST
Records
RPA for PCR requests saved people hours in October
Assumes 10 minutes per request
Data for October unavailable at the time of writing the report
IDS Inbox
100%
50%
0%
Same day turnaround of 'quick' tasks
ON TRACK
If non-quick tasks > 3 days on average to complete, then 90 requests = 2000 people hours, which would require >13 FTE analysts to complete each month.
111 Website
48%
October-25 engagement rate
The current position shows a steady trend across previous months, but increase from a low of 44% in May-25
Engagement = users with a session >10 seconds, a conversion event, or 2 or more page views.
Average engagement time via mobile and desktop
<1 MINUTE

Agenda Item No. 10

REPORT TITLE

Information Governance Progress Report

MEETING

Name of meeting	Finance & Performance Committee
Date of meeting	18th November 2025
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

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) 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 intelligence from the period of **1st August to 30th September 2025**, and the topics were discussed at the September and October meetings of IGSG.

Highlights

3. **Meeting Minute Guidance:** meeting and minutes guidance was presented to the group for advice and support on the use, storage, retention and deletion of meeting recording and transcripts, especially noting the more frequent use of AI tools such as Microsoft Copliot for generating minutes or AAA reports. IGSG supported the development of a standard message to be used at the point of recording for meetings, clarifying the purpose, retention policy and restrictions on use.

4. **Dormant Accounts:** there has been excellent progress on this, with the number of "enabled" dormant accounts (i.e. those posing a risk) decreasing from 736 to 564 in recent weeks (from an initial level of more than 3000). The IGSG reporting now distinguishes true dormant accounts from system or meeting room accounts, aligning with DHCW definitions and improving clarity of reporting. This work is important in tightening WAST's digital security posture and demonstrates the impact of sustained focus and action. Ongoing tracking has also been incorporated to the KPI report (see Appendix).

5. **IG Copilot Assistant:** a Copilot AI-agent has been developed and is being trialled to support the IG team with data protection query related demand. The tool allows users to ask questions and provides tailored guidance, including direct links to internal and the Information Commissioner's Office (ICO) resources. For example, it successfully advised a user on completing a DPIA for SMS test projects by referencing ICO guidance. Early feedback is positive, with the tool helping reduce demand and wait times for responses from the IG team. It should be noted completed DPIAs will still need to be reviewed by the IG team.

6. **FOI Position:** an update on Freedom of Information requests and improvements was received and supported by IGSG, focusing on three main items: 1) the proposed plan regarding the implementation of new case management tooling (to be deferred until Q2 2026/27); 3) the sharing of category information with Directors (to maintain the motive-blind principle, but to give more information to better enable risk management, proactive comms, and prioritisation related to FOIs); 3) guidance on use of spreadsheets (to reduce the risk of sensitive or identifiable being released as part of the FOI responses).

7. **IG Toolkit:** the IG Toolkit for 2025/26 is 90% complete, with most outstanding actions related to the CCTV or surveillance related risks and compliance. Remaining tasks included updating of records of processing, confirming the Cyber Assessment Framework assessment dates, a risk assessment for unsupported IT systems or software, and addressing the Bring

Your Own Device (BYOD) policy documentation. The priority for the IG team currently is the CCTV retention and compliance issues, with a risk assessment in development. However, all actions are on track to be completed by the March 2026 deadline, including the mandatory IG training compliance completion rate, which stands at 91% (above the 85% target).

8. **IGSG KPI report:** revisions to the KPI report have been made (see Appendix), with positive feedback from the IGSG members. The latest version of the KPI report sees the addition of new Data Quality metrics related to the timeliness of reporting to Commissioners and Welsh Government, as well as monitoring of the new Data Quality awareness training which was released Trust-wide early October.

Lowlights

9. **Data Breaches:** there have been several recent social media related data breaches, and so further social media communications / notices have been developed, incorporating feedback from previous breach investigations and discussions. Additionally, a proposal was made to run a deepfake simulation campaign to test staff awareness of cyber threats that may come through various media and communication channels. Scenarios may include video impersonation or spear phishing, inspired by real-world examples to help understand the scale of data breach risk, and support education and awareness efforts. This is currently being designed into a future cyber campaign and details cannot be shared in advance.

10. **IGSG attendance:** the October meeting of IGSG saw no representation from Operations, Clinical or Trade Union partners, despite the discussion of high-priority items including cyber risk, data breaches and policy changes. By way of escalation to ELT, the group requested support to reinforce the expectation of cross-functional attendance at future meetings.

11. **Late IG Engagement:** there is a recurring issue where there are delays in notifying the IG team team about information-related incidents, leading to late reporting to the regulator – the Information Commissioner's Office (ICO). One recent breach was known about internally for weeks before reported.

12. **Records Requests demand:** The Trust's Records Team is under extreme pressure, with a 34% increase in records requests in September 2025 compared to September 2024 (this is a common trend). Following the recent retirement of a team member, one Records Officer post remains unfilled, with the job description still pending review and banding confirmation at panel. Via the AAA to ELT, support has been requested to expedite the job review process to allow backfill and recruitment to progress.

Alerts

13. **Expired Mandatory Training:** in August, 290 members of staff were identified as having overdue mandatory IG training and therefore were non-compliant. After reminder letters were sent, the number reduced to 194; however, some of these staff members have not completed their mandatory IG training for several years, so further communication and escalation was deemed necessary. Those who have a professional registration will be further investigated in Q3 and Q4, with letters planned to be sent to line managers for awareness throughout November. The ELT endorsed escalation measures for long-term non-compliance, including formal notification and potentially regulatory follow-up.

14. **WhatsApp Usage:** there have been several recent data breaches involving the use of WhatsApp, raising concerns about its widespread use for sharing of sensitive information between colleagues. Other NHS Wales organisations are already actively considering or have implemented bans on WhatsApp on corporate devices. The Digital Advisory Group will provide a recommendation on an all-Wales approach with IGMAG expected to guide the final decision. In preparation for any block or further action, WAST cyber team are conducting a usage audit of WhatsApp on Trust devices.

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

The Finance & Performance Committee is requested to receive the following:

1. Appendix – Information Governance KPI 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
BAF Risks: • 623 – Failure to comply with data protection legislation • 260 - Significant and sustained cyber attack resulting in denial of service and loss of critical system

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
05/11/2025	Digital Leadership Group
23/10/2025	Content taken from September & October IGSG Highlight Reports and AAAs

INFORMATION SECURITY & GOVERNANCE KPI REPORTING

Oct 25 Report
Reporting period:
Apr-23 to Sep-25

IG TOOLKIT & IMPROVEMENT

2025-26 Completion against the Toolkit categories and WAST improvement plan

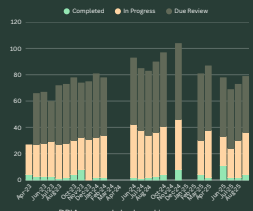
88%

2024-25 IG Toolkit submitted Mar-25

STATUS: "standards not met"

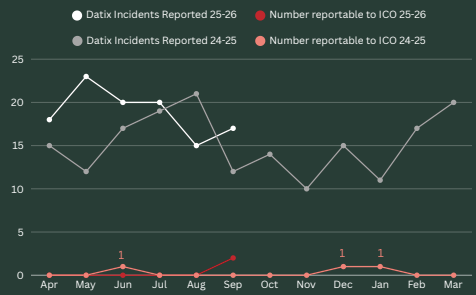
- Leadership & Oversight
- Policies & Procedures
- Training & Awareness
- Individual Rights
- Transparency
- Records of Processing Activity
- Contracts & Info Sharing
- DPIAs & Risks
- Breach & Monitoring
- FOI & EIR
- Information Security
- Business Continuity

The **DPIA log** continues to be reviewed and updated weekly, including cloud security assessments.



DPIAs completed and in progress

DATA PROTECTION BREACHES



IG related incidents reported on Datix

INFO SECURITY

0 cyber incident reported to CRU under NIS regulations in 2025-26 to date

Last incident reported was in December 2024

enabled dormant accounts

<< Target for disabled accounts is 90%

RECORDS MANAGEMENT

Subject Access Requests

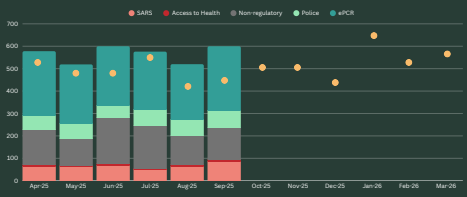
Must be responded to within 30 calendar days from receipt in line with GDPR.

Access to Health

Requests for personal information which fall under the Access to Health Records Act 1990 require response within 40 calendar days.

Other Requests

Requests which do not fall under either of the 2 other regulations must have a legal basis. These include requests from Police, Coroner etc.



Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
98%	100%	100%	96%	100%	99%	-	-	-	-	-	-
1			2		1						

<< Compliance (%)
<< Breaches (#)

DATA QUALITY

Timeliness of ASI submission to commissioner

Apr		Oct	
May		Nov	
Jun		Dec	
Jul		Jan	
Aug		Feb	
Sep		Mar	

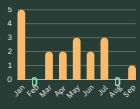
April and June submissions were 2-3 days overdue. August was delayed buf with agreed extension; Sept also delayed due to manual corrections

Patient NHS Number Completion Rate

71%

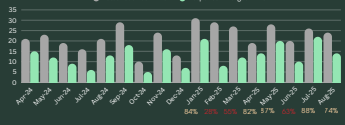
% EMS incidents where NHS Number was verified

Data Load Failures



FREEDOM OF INFORMATION

FOI Requests & Responses



Freedom of Information

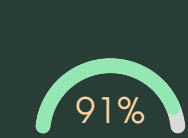
The FOI Act gives the public the right to access information held by public authorities. ICO target is for organisations to respond to **90%** within 20 working days.

<< FOI compliance

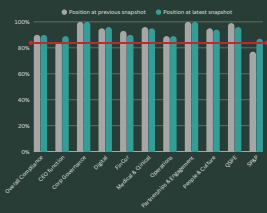
<< Total number of questions received in all FOI requests per month

Rolling average questions per request >> 11

AWARENESS & TRAINING



Mandatory ESR **Data Protection & IG training compliance** has achieved the 85% target



Improvement here is for Aug 25 compared to Mar 25

Completion rate of WAST **AI Awareness** course, launched April 2024

NEW

Number of people completed WAST **Data Quality Awareness** course, launched October 2025

NEW

Correct answer rate for **Accuracy Question** of DQ Awareness course

NEW

Correct answer rate for **Validity Question** of DQ Awareness course

NEW

Correct answer rate for **Consistency Question** of DQ Awareness course

NEW

Correct answer rate for **Uniqueness Question** of DQ Awareness course

Phishing campaign Mar 25

4970 users targeted by simulator Mar-25

55% (2756) opened / read the email

13% (668) reported the email

Oct-24 campaign saw **10%** Dec-24 **11%**

22% (1103) clicked the link

12% (617) supplied credentials / opened attachments

32% of the 1103 (who clicked and/or gave details) completed training

Feb-24 campaign saw **>21%** click the link, Oct-24 **17%**

Agenda Item No. 11

REPORT TITLE

IMTP Development Process Internal Audit Report 25/26

MEETING

Name of meeting	Finance & Performance Committee
Date of meeting	18th November 2025
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Rachel Marsh (Executive Director of Strategy, Planning & Performance)
Author(s) of report	Helen Britton (Head of Planning)

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 paper is to provide the Finance & Performance Committee (F&PC) with an assurance update regarding the findings from the Integrated Medium Term Plan (IMTP) Development Process Internal Audit Report 25/26, and to formally note the Trust's management response to the findings.

2. Between July – August 2025, Audit and Assurance Services - NHS Wales Shared Services Partnership undertook an audit of the organisation's IMTP development process for 2025-2028. The audit aimed to assess how priorities were identified, stakeholder engagement was managed, and alignment with national planning criteria was achieved.

3. The audit concluded **substantial assurance**, recognising a structured project management approach to IMTP development, supported by document guidance and timely submission to the Trust Board and Welsh Government.

4. However, several areas for improvement were identified:

- **Key Finding 1:** Strengthen planning capacity and prioritisation to manage emerging deliverables and ensure clear rationale for IMTP inclusion amid ongoing transformation.
- **Key Finding 2:** Improve consistency in applying the Project Path Framework (PPF) Business Case process to support robust and transparent revenue funding decisions.
- **Key Finding 3:** Clarify roles and timelines within the IMTP development process to avoid delays and consider extending circulation of project highlight reports to the new Steering Group to enhance oversight.

5. A series of key management actions have been agreed to address each of the areas for improvement and are outlined in the main body of this report. The target implementation date for the management is **31st December 2025**.

6. A copy of the internal audit report is provided with this paper for information.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

7. **NOTE** the Internal Audit Report on the IMTP development process, which provides **substantial assurance** and acknowledges the Trust's structured approach to planning, stakeholder engagement, and timely submission.

8. **NOTE** the management response, which accepts the findings and outlines actions to strengthen planning capacity, prioritisation, governance, and the consistent application of business case/investment submission process.

ADDITIONAL PAPER(S)

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

1. Appendix 1 – IMTP Development Process Final Internal Audit Report 2025/2026

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
3rd November 2025	Strategic Transformation Board
18th November 2025	Finance & Performance Committee
2nd December 2025	Audit Committee

SITUATION

9. The purpose of this paper is to provide the Finance and Performance Committee with an assurance update regarding the findings from the IMPT Development Process Internal Audit Report 25/26, and to formally note the Trust's management response to the findings.

BACKGROUND

10. Between July – August 2025, Audit and Assurance Services - NHS Wales Shared Services Partnership undertook an audit of the organisation's Integrated Medium- Term Plan (IMTP) development process for 2025-2028. The audit aimed to assess how priorities were identified, stakeholder engagement was managed, and alignment with national planning criteria was achieved.

11. The IMTP is a statutory requirement under the NHS (Wales) Act 2006, with additional obligations under the Wellbeing of Future Generations (Wales) Act 2015. WAST's IMTP was approved by the Board in March 2025 and formally signed off by Welsh Government on 30 June 2025.

12. It should be noted that the audit was conducted during a period of significant organisational transition, including interim leadership arrangements and staffing changes within the Strategy, Planning and Performance Directorate.

ASSESSMENT

13. The audit concluded **substantial assurance**, recognising a structured project management approach to IMTP development, supported by document guidance and timely submission to the Trust Board and Welsh Government.

Table 1: Scope and Assurance Summary

Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	The Trust has an appropriate planning approach to ensure key priorities are identified for the IMTP that have clear measurable targets and actions towards delivery of the ministerial priorities.	1, 2, 3	Reasonable
2	Key priorities are aligned to other health boards' plans and the criteria set out in the NHS Wales Planning Framework.	-	Substantial
3	The Trust has a process for identifying key stakeholders when undertaking IMTP planning and ensures they are actively engaged.	-	Substantial
4	Appropriate governance arrangements are in place, which provide effective oversight of the planning process, ensuring the IMTP is subject to scrutiny and review prior to submission to Welsh Government.	3	Reasonable

14. However, three key areas for improvement were identified:

Key Finding 1: Strengthen planning capacity and prioritisation to manage emerging deliverables and ensure clear rationale for IMTP inclusion amid ongoing transformation.

Key Finding 2: Improve consistency in applying the Project Path Framework (PPF) Business Case process to support robust and transparent revenue funding decisions.

Key Finding 3: Clarify roles and timelines within the IMTP development process to avoid delays and consider extending circulation of project highlight reports to the new steering group to enhance oversight.

Theme	Management Action	Owner	Completion Date	Status
1. Lack of consolidated tracking	Centralised digital tracker including prioritisation decisions	Planning	Dec-25	**On track** – work has commenced to develop the IMTP tracker
	Change control processes introduced	Planning	Dec-25	**On track** – IMTP change control process developed and to be implemented
	IMTP referencing system	Planning	Dec-25	**On track** – included in current tracker and will be built into the 26/27 IMTP process
2. Application of a Business / Investment Case process	Review and implement business case process for 26/27 IMTP process and update planning guidance	Planning / Finance	Dec-25	**On track** – discussions to review investment options approach underway.
3. Project Management approach and timeframes	Review IMTP project delivery arrangements	Planning	Dec-25	**On-track** – IMTP project arrangements have been reviewed and updated
	Single IMTP project plan with clear timelines, reporting arrangements, risk management and early escalation	Planning	Dec-25	**On –track** – IMTP project plan being refreshed with new reporting arrangements alongside strengthening risk management and escalation

15. The target implementation date for the management actions outlined above is **31st December 2025**. A full detailed response can be found in Appendix 1.

RECOMMENDATION

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

NEXT STEPS

17. The next steps are as follows:

- **Progress Implementation of Agreed Actions**
  Management will deliver the three key improvement actions by **31 December 2025**, focusing on:

    - A centralised digital tracker for IMTP deliverables
    - Strengthened application of the Project Path Framework (PPF)
    - Enhanced project planning and governance arrangements

- **Embed Improvements into the 2026–29 IMTP Cycle**
  Lessons learned from the 2025–28 cycle will inform updated planning guidance, clearer timelines, and more consistent engagement across directorates.

- **Maintain Oversight Through Existing Governance Structures**
  Progress will be monitored via the Integrated Strategic Planning and Development Group (ISPD), the newly established IMTP Development Group and regular reporting through the key governance routes.

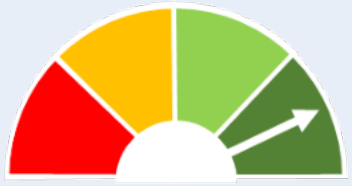
- **Ensure Visibility and Assurance**
  Highlight reports and risk escalations will be shared with relevant groups to ensure transparency, accountability, and timely intervention where needed.

IMTP Development Process

Final Internal Audit Report

2025/26

Welsh Ambulance Services University NHS Trust



Substantial Assurance

Contents

Review Reference	WAS-2526-07
Fieldwork	July - August 2025
Executive Sign Off	9 October 2025
Audit Committee	2 December 2025
Executive Lead	Executive Director of Strategy, Planning & Performance
Audit Team	Osian Lloyd, Head of Internal Audit; Felicity Quance, Deputy Head of Internal Audit

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

Review of the process undertaken for the development of the Integrated Medium-Term Plan (IMTP), including the mechanisms to identify priorities, engagement with stakeholders and alignment to national criteria.

Overview

The NHS (Wales) Act 2006 sets out the requirements for NHS Planning in Wales. Under the legislative framework, local health boards and NHS trusts have a statutory duty to prepare a three-year IMTP that sets out how they will comply with their financial break-even duties while improving the health of the people for whom they are responsible.

The Wellbeing of Future Generations (Wales) Act 2015 sets in law the need to consider the long-term strategic approach to deliver a better future. This is underpinned by 'A Healthier Wales', which remains the vision and long-term plan for health and social care in Wales. We acknowledge that the Welsh Ambulance Services University NHS Trust (the Trust) was required to comply with this Act for the first time from 30 June 2024 and has set its wellbeing objectives for 2025/26.

The Trust's IMTP (2025-2028) was approved by the Board on the 27 March 2025 prior to submitting for approval by Welsh Government in accordance with the timelines set. Formal approval of the IMTP was received from Welsh Government on 30 June 2025.

Welsh Government has approved changes to the Ambulance Performance Framework that introduces new prioritisation categories and amending existing ones, with greater focus on clinical outcomes and quality of care. These changes will need to be considered as part of planning for the IMTP (2026-29). Additionally, arrangements with the NHS Wales Joint Commissioning Committee (NWJCC) are still developing, which may impact the Trust further.

While our focus was on the last IMTP planning process (that occurred during 2024/25), business continuity was discussed due to key staffing changes within the Strategy, Planning and Performance Directorate. The Director has taken up the position of interim CEO from July 2025 until 1 October 2025, with the Director of Partnerships and Engagement providing cover during this period. An Interim Deputy Director of Planning and Performance is also in place. Two key employees, including the Assistant Director of Planning and Transformation, are leaving the Trust, and a member of staff is on a period of long-term absence. Discussions identified that a transition plan has been developed that includes identifying a member of staff with the required skills and experience to oversee the next IMTP planning cycle.

Some financial aspects have been considered during this audit, however, a detailed review of financial planning will be included as part of our budget-setting audit, included within the 2025/26 Internal Audit plan.

We have concluded substantial assurance on this area. The Trust adopts a structured project management approach to IMTP development, supported by documented guidance. This ensures that key elements of the planning process are undertaken, such as stakeholder engagement and the capturing lessons learnt, and has enabled the IMTP to be submitted to the Trust Board and Welsh Government within the set deadline. The matters requiring management attention include:

- Given the pace and scale of transformational activity within the Trust, enhancements are needed within the planning process to ensure there is sufficient resource capacity to support effective delivery of the IMTP when new deliverables emerge during the year; actions are appropriately prioritised; and there is clear rationale for inclusion on the IMTP.
- Improvements are required in the application of the Project Path Framework (PPF) to ensure consistency and appropriate oversight of revenue funding decisions.
- Clarification of responsibilities and timescales to prevent delays with the IMTP development. Full details of matters arising are detailed within the Findings & Agreed Action Plan. During the course of fieldwork, we also noted that it would be beneficial for the circulation of the IMTP project highlight reports to be extended to the newly established steering group to support oversight. We have highlighted this for management information and does not impact the overall opinion.

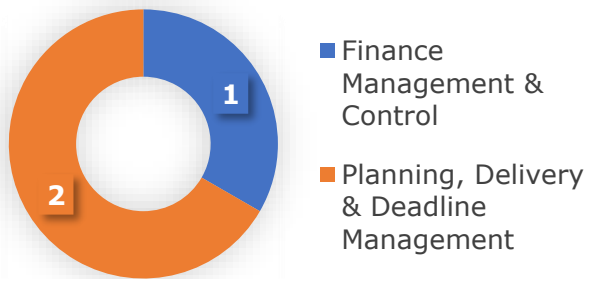
Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	The Trust has an appropriate planning approach to ensure key priorities are identified for the IMTP that have clear measurable targets and actions towards delivery of the ministerial priorities.	1, 2, 3	**Reasonable**
2	Key priorities are aligned to other health boards' plans and the criteria set out in the NHS Wales Planning Framework.	-	**Substantial**
3	The Trust has a process for identifying key stakeholders when undertaking IMTP planning and ensures they are actively engaged.	-	**Substantial**
4	Appropriate governance arrangements are in place, which provide effective oversight of the planning process, ensuring the IMTP is subject to scrutiny and review prior to submission to Welsh Government.	3	**Reasonable**

Management Actions

0	3
High Priority	Medium Priority

Themes



Risk Types

Public Perception & Reputational Risk

Financial Loss

Findings & Agreed Action Plan

Objective 1: IMTP priorities are defined, with clear measures, targets and actions or delivery	**Reasonable**

Planning

IMTP development is undertaken by a dedicated team using a formal project management approach (running from July to March). Key elements include the *State of the Nation* report (establishing a baseline of the Trust's current position at September 2024 following the Board's previous IMTP approval in March 2024), collaborative planning (identifying key risks, emerging priorities and the financial context), prioritisation, engagement, and governance.

The IMTP planning process is supported by annually updated guidance, which is currently under review and will soon be hosted on a new Integrated Strategic Planning and Development (ISPD) SharePoint site. We note that the Planning Framework (June 2023) is being updated but current practices remain extant with the document accessible to all staff on Siren.

The Quality and Performance Management Framework details that planning should be undertaken at a directorate level to support IMTP delivery. Directorates maintain three-year plans, which are reviewed annually, but submissions have been inconsistently applied. A redesigned, digitised template, developed from user feedback, is available on the new SharePoint site for the next IMTP planning cycle (to be carried out during 2025/26).

IMTP Delivery Programmes were replaced by the Clinical Model Transformation (CMT) Board, who collect IMTP-related data from its workstreams using a dedicated template. While this approach is still embedding, there is recognition that there needs to be clearer delineation between CMT and directorate plans so there will be improvements to directorate reporting to prevent duplication in future planning cycles.

Prioritisation

The Trust has adopted the MoSCoW (Must have, Should have, Could have, Will not have right now) technique for prioritising resources to IMTP deliverables. Two prioritisation workshops were held in January and February 2025 involving members of the Executive Leadership Team (ELT), directorate leads, and trade union representatives focussing on forthcoming priorities and associated costs and resources. From review of the relevant supporting documentation, it was difficult to track the prioritisation status of submissions, particularly those carried forward from previous years (see **Key Finding 1**). Given that there will be new staff within the Planning team and the continued scale of transformational change across the Trust impacting staff capacity, the rationale for including carried-forward actions needs to be clearly articulated to maintain strategic alignment and the effectiveness of the planning process (see **Key Finding 1**).

Funding

The Project Path Framework (PPF), aligned with the UK Government's 'Five Case Model,' provides a structured approach for developing project specifications and revenue business cases for investments exceeding £50,000. However, its effectiveness is currently limited due to insufficient documentation and a lack of awareness, which may lead to inconsistent application (see **Key Finding 2**).

Timeframe

While the IMTP Planning Guidance included a high-level timeline, the project plan lacked sufficient detail in clarifying responsibilities and timescales, which contributed to delays in the development of the 2025-28 IMTP (see **Key Finding 3**).

In its Structured Assessment of the Trust (November 2024), Audit Wales highlighted that although the Finance and Performance Committee (FPC) and the Board were kept informed of the IMTP's progress, neither had the opportunity to review a full draft until March 2024, when it was

formally approved for submission to Welsh Government. In response, and in line with the agreed management action, Non-Executive Directors (NEDs) were emailed a copy of the IMTP in March 2025, ahead of the submission deadline. While this represented an improvement, the planned timescale for circulating the draft IMTP was missed, and NEDs were not formally notified of the delay (see **Key Finding 3**).

Minimum Data Set (MDS)

Welsh Government provides a MDS template to capture numerical information of operational activity and outcomes, workforce plans, and financial plans. Discussions with the officers involved in the process confirmed that independent data validation checks are undertaken to ensure alignment across the required data sets and the IMTP narrative. Following Welsh Government's review, no significant changes were required to the Trust's MDS submission.

Lessons Learnt

The planning approach for the 2025-28 IMTP was revised to incorporate key lessons learned from the previous cycle. Areas for improvement from the current IMTP exercise have been shared with ELT (30 July 2025), with particular emphasis on improving communication, e.g. requests for input were sometimes unclear or inconsistent, and deadlines were not always communicated effectively or early enough.

Key Findings		Risk & Impact	Agreed Management Action
1	**Lack of Consolidated Tracking** The Trust is experiencing an increasing volume of transformational change both internally and externally (such as with the NHS Wales Joint Commissioning Committee (NWJCC) and the Ambulance Performance Framework) that impacts resource capacity. As new deliverables emerge throughout the year, there is a need to strengthen how these are recorded and prioritised. The absence of a consolidated tracker means there is currently no robust mechanism to clearly determine the: • **Number of Submissions** – no document was provided during the audit that clearly records all IMTP submissions received and their prioritisation. • **IMTP Actions Carried Forward –** there is limited recording and visibility of the number of IMTP actions carried forward and how they are prioritised alongside new deliverables. For example, at the January 2025 prioritisation workshop, it was reported that 48 actions were rolling forward into 25/26 - *14 prioritised as must do's, 32 as should do's, 1 could do, 1 not categorised. Many confirming as deliverable in Q1*. While fluctuations in carried forward actions are expected as the IMTP plan is being drafted, there was a lack of clarity and reconciliation with those highlighted at the workshop compared to Finance & Performance Committee (FPC) reporting (20 May 2025) of IMTP actions carried forward, e.g. 17 directorate-led actions have been carried forward to the IMTP (2025-28), but the number of CMT-specific IMTP priorities were unclear. • **Rationale** – the Integrated Strategic Planning & Development Group (ISPD) highlight report to the Strategic Transformation Board (STB) on 20 December 2024 detailed that approximately 25% of current IMTP actions were being carried forward into 2025/26, contributing to an already overburdened work plan with 152 new actions. The reason for including actions within the IMTP, particularly where priorities have shifted or are being carried forward has not always been clearly defined, e.g. continual development and implementation.	Insufficient capacity to deliver the IMTP may lead to ineffective performance reporting, delayed delivery of priorities and reduced assurance for decision makers. **Medium Priority**	**Agreed Action:** • Design and implement a centralised digital tracker to record and monitor all IMTP deliverables. The tracker will include a clear process for capturing prioritisation decisions, (e.g. deliverables to be carried forward/closed/amended) along with clear lines of accountability and reporting across committees and directorates. • Establish and communicate a clear and structured process for responding to organisational changes or new emerging priorities that may impact delivery of existing IMTP deliverables to support consistent decision-making and resource allocation. • All IMTP deliverables to be assigned with a robust referencing number to align the IMTP document and digital tracker. **Expected Evidence of Implementation:** • Centralised Digital Tracker • Change Control Process **Officer:** James Houston (Assistant Director of Planning & Transformation)

Key Findings		Risk & Impact	Agreed Management Action
	Theme: Planning, Delivery & Deadline Management	Control Design	**Target Implementation Date:** 31 December 2025
2	**Project Path Framework (PPF) Application** Although the PPF business case process was formally approved by ISPD on 22 March 2024, it was not applied during the 2024/25 IMTP planning cycle. Funding decisions were appropriately escalated for approval, e.g. ELT, however, the Framework's use was limited due to a lack of communication, supporting templates, and a mechanism to record submissions, limiting consistency and oversight.	Inconsistent processes and limited awareness may result in reduced accountability and oversight, resulting in variable application of the PPF, inconsistent revenue investment decisions, and missed opportunities to apply a structured, evidence-based approach.	**Agreed Action:** • Review and implement the business/investment case submission process as part of the wider review of the IMTP Delivery approach for 2026-29. • Update IMTP Planning Guidance for 2026-29 to reflect revised approach and build into project plan.
			Expected Evidence of Implementation: • IMTP Planning Guidance • IMTP Project Plan
		Medium Priority	**Officer:** James Houston (Assistant Director of Planning & Transformation)
	Theme: Finance Management & Control	Control Design	**Target Implementation Date:** 31 December 2025

Key Findings		Risk & Impact	Agreed Management Action
3	**Timeframes and Delays to IMTP Development** While a project management approach was adopted, project planning lacked clarity around key responsibilities and timescales contributing to delays in the development of the 2025-28 IMTP (see Appendix A): • **IMTP Project Team:** Attendance at project team meetings was generally good, but varied across directorates, with some (People & Culture and Quality, Safety and Patient Experience) showing a notable trend of lower engagement. • **Project Plan:** An email to the team (9 December 2024) requested initial IMTP narrative sections to be drafted by 13 December 2024. However, the Project Plan detailed some of these tasks with deadlines at the end of January 2025 impacting the first IMTP draft, which was due 31 January 2025. The Plan has not been updated to record when the IMTP narrative sections were completed. Other key milestones, such as directorate plan submissions, CMT workshops, and draft IMTP reporting dates are also not recorded. • **Operational Delays:** There was a delay in directorate plans being submitted and CMT workshops were scheduled late January 2025 despite the first IMTP draft being due 31 January 2025. IMTP project reporting to ELT (12 February 2025) noted that IMTP narrative requests had a 'Red' RAG status as there were few deliverables identified for years 2 and 3, and year 1 lacked SMART objectives. • **Reporting Delays:** Reporting to Non-Executive Directors (NEDs) was delayed. Initially scheduled for the week commencing 17 February 2025, the draft was not shared until 3 March 2025. There was no formal communication issued to notify them of the delay.	Unclear timeframes and responsibilities may hinder timely input and review, leading to delays in the IMTP's development and potential impact on the submission to Welsh Government.	**Agreed Action:** • Review the IMTP project delivery arrangements and membership to ensure appropriate attendance and engagement across the organisation. • Detailed IMTP project plan to be developed with key leads identified, setting out clear responsibilities and milestone dates. • Embed a regular and robust monitoring and progress reporting process as part of the IMTP development project arrangements. Risks to be reported and escalated through the IMTP governance structures including cause, impact and proposed mitigation strategies.
			Expected Evidence of Implementation: • IMTP Development Group (Terms of Reference) • IMTP Project Plan • IMTP AAA reporting
		Medium Priority	**Officer:** James Houston (Assistant Director of Planning & Transformation)
	Theme: Planning, Delivery & Deadline Management	Control Operation	**Target Implementation Date:** 31 December 2025

Objective 2: Priorities align with other health boards and national planning criteria.	**Substantial**

The NHS Wales Planning Framework for 2025–2028 outlines the Cabinet Secretary's five strategic priorities (Timely Access to Care, Population Health and Prevention, Building Community Capacity, Mental Health Access, Women's Health). The Trust submitted the required ministerial templates for four of the five priorities, and assurance against the delivery of these were reported to FPC (21 July 2025). The Women's Health template was not completed as the delivery expectations focused on Women's Health Hubs which are not applicable to the Trust. Nonetheless, regular progress updates are provided to Welsh Government, including plans for maternity and neonatal support, and a lead midwife was permanently appointed this year, which had previously been a key IMTP action.

The Planning Framework details enabling actions to support delivery in areas such as digital innovation, workforce development, and financial sustainability. The Trust has identified relevant enabling actions and incorporated them into IMTP deliverables. For example, the implementation of a community-based falls response forms part of the Six Goals Programme and is reported under CMT delivery. A verbal update on progress will be provided to FPC on 16 September 2025, with written updates on the delivery of enabling actions planned for future meetings.

Welsh Government has approved the IMTP, although formal feedback on the submission has not been provided. The Trust received its accountability conditions on the 28 July 2025 and reporting to FPC on 16 September 2025 will outline how these are being addressed.

To support alignment of the Trust's IMTP with other NHS organisations, quarterly meetings are held with Digital Health and Care Wales to forward plan their Joint National Plan. Health boards also attend the NWJCC's Interim Ambulance Care and 111 Commissioning Group meetings. IMTPs are shared within a dedicated channel for Assistant Directors of Planning (ADOPs), where all NHS Wales organisations are represented. Health board IMTP priorities focus on urgent and emergency care, supported by a dedicated programme board which the Trust attends.

Reporting to Trust Board on 30 January 2025 highlighted a risk that the Integrated Commissioning and Planning (ICAP) meetings with health boards (that previously formed part of the Emergency Ambulance Services Commissioner (EASC) structure) had been stood down due to a change in the commissioning arrangements. No alternative arrangements have yet been established within the NHS Wales Joint Commissioning Committee (NWJCC), which is still developing its governance framework. While this is outside of the Trust's control, oversight of the risk has been maintained through ISPD highlight reporting to STB and ELT monitoring through its risk register.

Following a review of the previous IMTP cycle, Welsh Government noted significant variation with NWJCC commitments and risks not being clearly identified or addressed in health board plans and highlighted the need for greater clarity in service commissioning. Examples of good practice were identified for each organisation, with the Trust's plan commended for having a clear and comprehensive approach to delivering the falls framework.

Objective 3: Stakeholders are identified and actively involved in planning.	**Substantial**

The Trust has embedded stakeholder engagement at an early stage of the IMTP development process through a range of mechanisms. Phase 1 of the engagement plan (up to the end of September 2024) included staff and patient feedback captured through the *State of the Nation* report and a collaborative planning event held on 2 October 2024. Staff feedback was gathered through 'WAST Live' (that provides an opportunity for staff to ask ELT questions), surveys and other methods. Key themes emerging from the engagement included training and career progression, staff welfare and working conditions, and patient care and service delivery. These themes are incorporated in several IMTP deliverables under Strategic Objective 2: Enabling our people to be the best they can be.

Patient and public engagement was facilitated through the Patient Experience and Community Involvement (PECI) team. Feedback highlighted the Trust's kind and caring staff and the quality of clinical care provided. However, several priority areas were identified including in relation to reducing ambulance delays in emergency response, improving transparency in communication, promoting inclusivity (which are being progressed through IMTP delivery within the CMT programme), addressing capacity challenges within the 111 service, and raising awareness of injury prevention, such as falls, aligning with the Trust's Population Health Plan.

Trade union engagement has been provided through opportunities to attend the collaborative planning event, prioritisation workshops, and IMTP project team meetings. Regular updates were also provided to the Corporate Partnership Forum and the Welsh Ambulance Services Partnership Team (WASPT) in January and March 2025.

Despite interim arrangements (see Objective 2) and the NWJCC being in its infancy, there has been sufficient consultation and information sharing throughout the IMTP's development. The IMTP Planning Guidance details the commissioning timeframes, including a development session in October 2024, where key Trust risks were considered. The Trust has provided several updates (evidence provided for October 2024, February and March 2025) to the NWJCC Interim Ambulance and 111 Commissioning Group, whose members attended the collaborative planning event. Further, the IMTP submission to Welsh Government includes Appendix 6, a letter of support from NWJCC, which acknowledges the Trust's intention to break even during the 2025-26 financial year, contingent on the successful delivery of a significant cost reduction programme.

Objective 4: Governance ensures effective oversight and timely review of the IMTP.	**Reasonable**

A dedicated IMTP project team met at least fortnightly through the planning cycle, although attendance varied across directorates (see **Key Finding 3**). For the first time during the 2024/25 planning cycle, bi-weekly IMTP project highlight reports were introduced and shared with key individuals involved in IMTP planning. Extracts from these reports were also shared with ISPD and presented at ELT on 12 February 2025, noting an overall project RAG status of 'Green'. However, as highlighted in **Key Finding 3**, some directorates had yet to submit their narratives, and several deliverables required further refinement to ensure they were fully populated and SMART.

The ISPD meets every six weeks and reports to STB using the 'Alert, Advise, Assure' (AAA) framework. Oversight of IMTP development was appropriate, with updates provided on prioritisation, actions carried forward, and key risks - particularly relating to delays in directorate planning and CMT workshops.

The original intention was to present an early version of the IMTP to NEDs by the end of January 2025. The deadline was later revised to mid-February 2025, but in practice, reporting occurred in early March 2025 (see Appendix A and **Key Finding 3**), following a decision taken not to share an incomplete draft. NEDs were not formally notified of the delay. Despite this, Trust Board and FPC were kept informed throughout the process via Board development days (November and December 2024) and regular updates on the progress with the development of the 2025-28 IMTP. We note that the IMTP project team is amending the timeline for the next IMTP cycle to assist with earlier reporting.

The final draft of the IMTP was submitted in line with the project timeline, with reporting to ELT (5 March 2025); FPC (18 March 2025); and Trust Board (27 March 2025), where the IMTP was formally approved for submission to Welsh Government. The Financial Plan for 2025/26 was also endorsed, acknowledging its ambitious nature and the potential impact on service delivery and patient safety, as there are efficiency targets of £8.5 million, with associated risks linked to potential additional savings requested by the NWJCC.

Reporting to FPC on 21 July 2025 confirmed that the Trust's IMTP was submitted to Welsh Government by the agreed deadline of 31 March 2025, with formal approval received on 30 June 2025.

For the upcoming planning cycle (to be carried out during 2025/26), governance arrangements are being strengthened through the introduction of a steering group with director representation, reporting into ISPD. This will provide a formal escalation route for issues such as delays in key project tasks or inconsistent attendance at project team meetings. It would be beneficial for the circulation of the IMTP project highlight reports to be extended to this group to support oversight.

Appendix A: IMTP Reporting Timeframe

	Dates	Detail
Reporting to Integrated Strategic Planning & Development (ISPD)	8 November 2024	The IMTP Planning Guidance details that directorate planning will be undertaken between August and September 2024. ISPD highlight reporting to the Strategic Transformation Board (STB) notes that the deadline for directorate priorities was extended to the end of October 2024 though not all submissions had been received. The report also highlights a risk that CMT workshops were scheduled for late January 2025, after the first prioritisation workshop (08/01/25), and close to the deadline for completing the first draft of the IMTP.
Reporting to Executive Leadership Team (ELT)	18 September 2024	Key areas of IMTP focus.
	4 December 2024	Planning and engagement session
	12 February 2025	The first draft of the IMTP was presented to ELT as per the IMTP project timeline but notes that some narratives are still outstanding.
	5 March 2025	The final draft of the IMTP (version 0.3) was submitted to ELT as per the IMTP project timeline.
Reporting to Non-Executive Directors (NEDS)	November & December 2024	November/December 2024 - Board development sessions on IMTP.
	16 January 2025	Finance & Performance Committee (FPC) - update on progress in developing the plan and includes draft IMTP contents page. Meeting minutes note that the draft IMTP was being prepared for presentation to ELT on 12 February 2025 after which it will be circulated to the Board and Committee members by mid-February
	30 January 2025	Trust Board - update on progress and presentation as per FPC (16/01/25) including draft IMTP contents page.
	3 March 2025	ELT reporting (12/02/25) that it was planned to circulate a first draft of the IMTP to Non-Executive Directors (NEDs) week commencing 17/02/25. Email to NEDs (03/03/25) with early draft of IMTP (version 0.2). FPC reporting (18/03/25) noted that this was later than planned and that no comments have been received to date.
	18 March 2025	The IMTP project timeline proposed the final draft of the IMTP to be presented to FPC (18/03/25). We confirmed that version 0.4 of the IMTP was presented along with its appendices (Challenges and Opportunities, Equality Impact Assessment, and Financial Plan) and the endorsement for approval at Trust Board.
	27 March 2025	The IMTP project timeline proposed the final draft of the IMTP to be taken to Trust Board (27/03/25). We confirmed that version 0.5 of the IMTP was presented along with its appendices (Challenges and Opportunities, Equality Impact Assessment, Financial Plan, ministerial templates for timely access, prevention, community capacity, and mental health) and the approval for the IMTP to be submitted to Welsh Government by 31 March 2025.

Appendix B: Assurance Opinion and 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

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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

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]

Agenda Item No. 12

REPORT TITLE

Integrated Medium Term Plan (IMTP) 25/26 Quarter 2 Assurance Report

MEETING

Name of meeting	Finance & Performance Committee
Date of meeting	18th November 2025
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Rachel Marsh (Executive Director of Strategy, Planning & Performance)
Author(s) of report	James Houston (Assistant Director of Planning & Transformation)

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 paper is to provide the committee with a progress update and assurance on the IMTP 25/26 quarter 2 deliverables position, supported by the 'what good looks like' outcome measures.

2. This paper also provides the committee with a more detailed overview of the 'go live' assurance process in readiness to implement the phase 2 Ambulance Performance Framework changes on the 2nd December.

3. Strong progress continues to be made across the organisation in delivering the commitments set out in the 25/26 IMTP at the quarter 2 position. The Clinical Model Transformation Programme has made good progress across the key work streams, with a particular focus on further embedding key foundational programme documents and processes. Phase 2 of the Ambulance Performance Framework changes is progressing well and is on track for implementation in early December. Whilst the CMT programme continues to move ahead at pace, there has also been positive progress across the directorate level IMTP deliverables. It is to be noted, however, that organisational capacity is a continued constraining factor.

4. The 'what good looks like' outcome metrics are also included as part of the commitment for a six-monthly reporting cycle into committee. These metrics continue to be developed and help to ensure that in addition to the MIQPR, there is a clear and tangible link between the IMTP and performance reporting.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

Committee is asked to:

1. **NOTE** progress for the quarter 2 IMTP deliverables (CMT & Directorate level reported deliverables)
2. **NOTE** the Go Live approach for implementing Phase 2 of the Ambulance Performance Framework
3. **NOTE** the 'What good looks like' outcome measures

ADDITIONAL PAPER(S)

Set out here any annexes. See writing and presentation guidance here regarding materiality and use of the Reading Room
1. Appendix 1: CMT Programme Highlight report 2. Appendix 2: IMTP Directorate Deliverables Q2 report 3. Appendix 3: 'What good looks like' outcome metrics

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
22nd September 2025	Strategic Transformation Board
18th November 2025	Finance & Performance Committee

SITUATION

1. The purpose of this paper is to provide the committee with a progress update and assurance on the IMTP 25/26 quarter 2 deliverables position, supported by the 'what good looks like' outcome measures. This paper also provides the committee with a more detailed overview of the 'go live' assurance process in readiness to implement the Phase 2 Ambulance Performance Framework changes on the 2nd December.

BACKGROUND

2. The 2025/26 IMTP deliverables are monitored through two internal delivery mechanisms reporting into the Strategic Transformation Board (STB). Implementation of the Trust's Integrated Clinical Services Model is reported via the Clinical Model Transformation (CMT) Board and the wider organisational deliverables are monitored via the Integrated Strategic Planning & Development Group (ISPDG).

ASSESSMENT

3. In line with our commitment to digitise our reporting and monitoring functionality, both the CMT Programme deliverables and wider IMTP deliverables (captured on directorate level plans) have a digital solution in place.

4. The CMT programme has transitioned from Microsoft Excel to MS Project / Planner, and following several cycles of monitoring, this process is well embedded and continues to mature as an effective digital solution.

5. The transition to a digital solution for directorate level plans was undertaken in Q1 with directorate level plans being transitioned to Microsoft Lists which are stored on a central SharePoint site.

6. Completion of the Q2 reporting process provided a helpful opportunity to test the newly digitised process and progress reporting functionality. The team encountered some technical challenges in the progress reporting processes and the alignment of how IMTP deliverables had been captured within the directorate plans. These aspects have been identified as key areas for improvement in the recent IMTP Development Internal Audit. A temporary workaround was put into place to capture the Q2 progress updates with discussions taking place with ISPD members in October to understand the challenges and agree the improvement actions required. Work will take place with directorate leads and Business Managers during Q3 to collaboratively agree the improvements which will be overseen and enacted by planning leads to minimise any disruption or additional workload on directorate teams.

7. The current IMTP reporting process only includes progress updates for IMTP deliverables that are due for completion within the specified quarterly reporting period. However, to support the development of the 2026/27 IMTP, all Q1 – Q4 2025/26 IMTP deliverables (not just those due for completion in Q2) were reviewed. This was a sizeable piece of work undertaken during a period of instability in the planning team following the recent appointment of two key posts into the JCC and wider capacity shortfalls during this period. It is important to put on record our thanks to wider team members for stepping in to support this work and to directorate leads for providing timely updates.

Clinical Model Transformation (CMT) Progress (Quarter 2)

8. The Clinical Model Transformation (CMT) Programme continues to progress in line with its strategic ambition to transition to an integrated, clinically-led Clinical Services Model. Key programme management activities are advancing across several core areas to ensure robust oversight, clear benefits realisation, and sustained stakeholder engagement.

9. Foundational documents underpinning the programme have been refreshed and have now received formal approval. The **Programme Definition Document (PDD) and the CMT Board's Terms of Reference (ToR)** were endorsed by the CMT Board and approved by the Strategic Transformation Board (STB), reinforcing the programme mandate and governance framework.

10. **Quality Impact Assessments (QIAs) have now been formally approved for all CMT workstreams.** Additionally, the QIA and EQIA for Phase 2 call flow changes aligned with the new Ambulance Performance Framework have now

been formally approved through the appropriate governance mechanisms, including through QuEST and Trust Board to provide robust assurance to implement Phase 2 call flow changes.

11. Significant progress has been made in **embedding a structured benefits realisation framework**. Four of the five workstream scorecards have been approved, with the final workstream, and overall programme-level scorecard under review. These outputs, along with logic benefits maps, will feed into a comprehensive Benefits Realisation Plan (in development), ensuring that outcomes are measurable, attributable, and aligned with programme objectives.

12. **Patient personas** are being redeveloped to align with the Ambulance Performance Framework (APF) changes, with board-level approval expected in Dec- 25.

13. In preparation for the 2026/27 planning cycle, **CMT programme deliverables have been reviewed and refreshed** to support strategic discussions at the Executive Leadership Team (ELT) and Senior Leadership Community (SLC) session in Nov-25.

14. In terms of **workstream-level progress**, the CMT Programme Highlight Report has been included as Appendix 1, and **summarised in the table below, noting any areas that are currently reporting as 'off track'**.

Table 1: Overview of the CMT Q3 Highlight report

Workstream/Enabling Group		RAG	Notes
Digital Front-End		**Green**	On Track
Remote Integrated Care		**Amber**	Off Track; alignment of CSD and 111 to formally establish RICS has been deferred to Spring 2026 in order to prioritise MIS-led CAD changes aligned with Phase 2 Call Flow changes.
Urgent Community Response		**Yellow**	On Track (cautionary status)
Emergency Response	*Call Flow and Prioritisation*	**Green**	On Track
	Out of Hospital Cardiac Arrest	**Green**	On Track
Health Transport		**Yellow**	On Track (cautionary status)
CMT Metrics		**Yellow**	On Track (cautionary status)
Change Management		**Yellow**	On Track (cautionary status)
Partnerships & Engagement		**Green**	On Track

Ambulance Framework (Phase 2 implementation)

15. All key milestones remain on track for early Dec-25 implementation of revised call categories in support of the implementation of the Phase 2 Ambulance Performance Framework changes (Orange Now, Yellow Soon, and Green Planned).

16. All critical activities – operational, communications, governance, and metrics – are progressing as planned, with strong assurance processes in place and no significant risks currently identified. The CMT Board has formally confirmed its support for a 2 December 2025 go-live date along with endorsement from the Trust Board in an extraordinary meeting in Oct. The Call Flow and Categorisation group maintains delegated operational oversight to ensure readiness for implementation and ongoing monitoring.

17. To enable seamless implementation, a robust process will be in place for approval of go-live, to be agreed by the Call Categorisation Group following delegation of authority from CMT Board on the 20th October. This process was developed for the Phase One implementation on the 1st July 2025 and is in the process of being updated ahead of the Phase Two Go Live. This process includes:

    a. Approval of a Go Live Checklist
    b. Development of an Operational Order
    c. Arrangement of several Go Live Touchpoints on the day
    d. Maintaining a Live Issues Log on the day

18. The Go Live Checklist will outline key areas of attention ahead of the 2nd of December and includes (but not limited to) reviewing key SOPs, planning staffing levels, technical sign-off of the CAD Developments, ensuring on-the-day developer support, and ensuring communications and engagement material is ready for release on the day of Go Live.

19. The Operational Order will outline the strategic command structure, implementation team structure, and tactical approaches to escalating CSP or REAP levels on the day, within which the use of Go Live Touchpoints and Live Incident Logging (issues, decisions, risk) are a key feature. Table 2 provides an example of the arrangement for the Phase One Go Live in July.

Table 2: Go live command meeting schedule

APPENDIX 3 – COMMAND MEETING SCHEDULE

Time	Action
08:00hrs	Initiate the Implementation
08:30 - 09:00	**Touch point 1**
09:30	Review and monitor
12:00 – 12:30	**Touch point 2**
13:00	Review and Monitor
15:30 – 16:00	**Touch point 3**
16:30	As required by Implementation Lead
19:00	**Touch point 4**

20. CMT Board has delegated authority for Go Live to the Call Categorisation Group (having itself been delegated authority from Trust Board on the 23rd October). As such the Strategic Command Structure on the 2nd December will comprise of the Strategic Commander for Operations, the National Delivery Manager as Tactical Commander and the Call Categorisation SRO, as Implementation Lead.

Directorate led IMTP Deliverables

21. The quarter 2 position of the directorate led IMTP deliverables was reviewed by STB in September (see appendix 2 for the full IMTP quarter 2 report). The review focussed on the deliverables by exception with those reporting as either Amber or Red.

Table 3: Overview of all 25/26 directorate level deliverables (Q2 RAG status)

Directorate/Objective	Green	Yellow	Amber	Red	Not Started	Complete
Operations	8		3		5	1
Finance & Corporate Resources	5	2				
People & Culture	11	2	2		2	1
Partnerships & Engagement	3			4		1
Digital	9	1	4			
Quality, Safety & Patient Experience	2	1	9			1
Corporate Governance	4					1
SO6: Delivering exceptional value (SP&P and non-aligned deliverables)	1		2		4	

22. The four reported 'Red' deliverables were cautiously flagged as 'off track' relating to the work in support of our Wellbeing Objectives. These deliverables were paused during Q2 as a result of capacity constraints and competing priorities. Assurance was provided that the work will be completed during Q3/Q4 in line with the statutory requirement to finalise this work by the end of the financial year.

23. Whilst many of the Amber reported deliverables are not due for completion in Q2, they have been cautionary flagged with an amber status due to potential issues completing the work within the projected delivery timescales. The

underlying cause is linked back to organisational capacity where work to deliver the Clinical Model Transformation programme and preparatory work for the new Ambulance Performance Framework have taken organisational priority. This has been particularly prevalent for colleagues that have required critical involvement to enable this work including our Information and Digital Services (IDS) teams, where there is a known capacity constraint.

24. There has been positive progress during Q2 across the wider deliverables as outlined in the assurance report (see appendix 2). Some areas of progress to note include the deployment of the **Virtual Assistant** functionality onto the NHS 111 Wales website with positive uptake from patients. Key new posts have been recruited into including the **Learning Disability Clinical Lead** and **Head of Commercial Development**. The **re-location of operational teams from Bryn Tirion to Ty Elwy** was successfully completed, alongside the completion and approval of **key business cases** to support estates development for the **Bangor Fleet Workshop** and **Dolgellau Ambulance Station**.

'What Good Looks Like' Outcomes Measures

25. Included in the IMTP are a range of 'What Good Looks Like' in 2027 statements for key areas of the organisation. An updated report is included with this paper (see appendix 3) providing a quarter 2 update for each of the statements. The previous update was provided in quarter 2 for the 2024/25 IMTP and improvements made compared to the same period last year are highlighted for reference.

RECOMMENDATION

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

NEXT STEPS

27. The next steps are as follows:

- **Directorate reporting**: Complete the improvement work to enhance the digital reporting of the Directorate level plans and ensure there is clear alignment between the deliverables as outlined in the IMTP document and directorate plans in readiness for the Q3 reporting period.

- **CMT Internal Audit:** a CMT Programme audit has commenced in Q3, targeting four critical lines of enquiry: definition of success and milestones, roles and responsibilities, progress reporting, and stakeholder engagement.

- **Ambulance Framework Phase 2 implementation:** Continue preparatory work in readiness to implement the changes in early Dec.

Welsh Ambulance Services University NHS Trust

Clinical Model Transformation (CMT) Programme Highlight Report

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

Clinical Model Transformation (CMT) Programme Highlight Report
Released: 27th October 2025

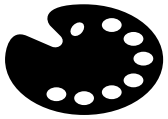
Transformation Support Office

Content

Use hyperlinked headers to navigate to each section

Programme Management Update

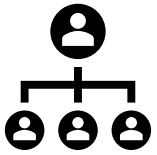
Programme Management Highlights



Developing our programme vision:

- **CMT Manager's Information Pack finalised and approved** and deployment ready.
- **Evolving our Transformation Delivery Network (TDN)**; Planning underway for the first trial session to take place at the end of November.

- ❑ **Patient personas to be finalised and approved**; work continuing to align patient personas with the Ambulance Performance Framework. Aim to bring to Dec-25 CMT Board for approval.



Establishing the CMT Programme Delivery & Assurance Arrangements:

Benefits realisation: **Four of five workstream-level scorecards approved**, following Health Transport (v3) approval at CMT Board (Oct-25). Further revisions required to RICS scorecard. **Programme-level scorecard in development**. Draft presented to CMT Board Oct-25, with revised version to be presented to Board in Dec-25.

FY26/29 IMTP Deliverables: Proposed CMT programme deliverables developed in readiness for ELT/SLC IMTP planning session on the 11th November.

- ❑ **Benefits realisation:** Benefits Realisation Plan to be developed; aim to submit to December CMT Board for approval.
- ❑ **Digitising our approach:** Power BI dashboards launched for risk and issue management and operationalised across project and workstream groups.
- ❑ Work to be initiated to **dependency map milestones across CMT workstreams aligned with wider IMTP planning.**

Developing formal programme documentation and audit readiness:

- **All Workstream QIAs now approved following RICS approval at CQGG (21/10).**
- **Audit:** CMT programme audit brief agreed, and process formally initiated.
- **Coronial Statement Review:** Work to refresh the Trust's Coronial Statement aligned with our Evolving Clinical Services Model underway, including development of a CMT Chronology of Events.

- ❑ **Coronial Statement Review: Minor revisions to the** CMT Chronology of Events and finalisation of the refreshed Coronial Statement. Aim to bring to Dec-25 CMT Board for approval.

QIA Update

APPROVED

Clinical Quality Governance Group
Approval Group

APPROVED (14/04)

APPROVED (12/05)

Call Flow **Phase 1**

APPROVED (24/07)

APPROVED (29/09)

Call Flow **Phase 2**

APPROVED (21/10)

Status	Description	Characteristics
Green	Project is on track and progressing well, meeting or exceeding expectations in terms of schedule, budget, quality, and objectives. **Action Required:** No immediate action is necessary, but ongoing monitoring and regular reporting are still required to ensure the project maintains its positive trajectory.	• Project milestones and deliverables are being achieved as planned. • Risks and issues are under control or adequately mitigated. • The project is progressing within the defined timeline and budget. • Key performance indicators are being met or surpassed.
Yellow	Provides an early warning that challenges or barriers are anticipated, but are not yet impacting on progress. **Action Required:** Close monitoring of factors anticipated to impact on progress, contingency planning, and reprioritisation if appropriate.	• Workload reprioritisation has been required to keep the project on track i.e. the impact has been transferred. • The project remains on track overall, however there are notable issues or risks or amber/red statuses recorded against key enablers, or interdependent projects that may impact over time. • The project remains on track overall but there may be moderate slippage against some tasks or actions.
Amber	An amber status signifies a cautionary state, indicating that the project is encountering challenges or potential risks that need attention to prevent further escalation. **Action Required:** Close monitoring of the project, proactive measures to mitigate risks, and corrective actions to address identified issues should be taken promptly to prevent further deterioration.	• Some project objectives are not being met as planned. • Certain milestones are at risk of being missed. • There are notable issues or risks that could impact project success if not addressed promptly. • Project performance or progress is below expectations but can be recovered with timely actions.
Red	A red status indicates a critical situation where the activity is significantly behind schedule, over budget, or facing major issues that jeopardize its success. **Action Required:** Immediate attention and intervention are necessary to address the issues and bring the project back on track.	• Major project objectives are not being met. • Critical milestones are consistently missed. • Key deliverables are incomplete or of poor quality. • Significant risks or issues are unresolved, and their impact on the project is severe.

RAG Status Definitions

CMT Programme Update

Report Date:	Programme RAG	Previous RAG	For Noting:	Senior Responsible Owner:	Rachel Marsh
Oct-25	Yellow	Yellow	**Call Flow Phase Two:** Reported as Monday 1st December Go-Live within previous STB Report. **CMT Board Notes:** The Go-Live date has since been pushed back to Tuesday 2nd December for operational and patient safety reasons, with authority delegated to the Call Categorisation Group.	Programme Manager:	Heather Holden

CORE CMT WORKSTREAM UPDATE

Workstream	RAG Status	RAG Trend	Summary Position
Digital Front-End	Green	↔	**Virtual Assistant Implementation**: Contracts for Phase 2 have been finalised, covering enhancements including WhatsApp integration, multilingual capability, and chat-based agent functionality. A new "AIBot" logo has been designed and approved, with deployment to the website planned once development work progresses. Internal and external kick-off meetings are scheduled for mid-October to commence the discovery, design, and development stages. **Symptom Checker Implementation**: Virtual design workshops are being held throughout October to agree the system architecture, review security requirements, and develop an initial user interface mock-up. Engagement with NWSSP has been scheduled to support translation of content using the Welsh Translation Tool. Impact assessments and cloud security reviews will be undertaken alongside the supplier as the solution develops. **Content Management System (CMS):** Work is underway to identify the most suitable CMS product and implementation partner. Briefing materials have been issued to potential suppliers, with fact-finding sessions planned to inform selection and migration of existing website content to the new platform.
Remote Integrated Care	Amber	↔	**Care Planning Function:** Continued development on a sustainable pre-winter model, and advancing procurement for remote monitoring, including the *Falls Desk* implementation which remains on track for implementation by early November. Queue management processes went live on 7 October following successful refresher training. **New Call Flows and Categories:** Alignment ongoing with the *Ambulance Performance Framework – Phase 2*, with close collaboration between Emergency Response and Integrated Care workstreams. **CPSS Strengthening and Evaluation:** This has been temporarily paused due to winter resource pressures, with a review planned for Q4 2025/26. Expansion remains dependent on the single CAD implementation. **Alignment of CSD and 111** to establish *Remote Integrated Care Services* has been deferred to Spring 2026. A Task & Finish group is progressing CAD-related milestones, and organisational change processes and SOP updates are expected to complete by November, with finalisation of terms and conditions pending SLT approval. **Enabling Deliverables (by exception):** Development of the CAD remains at amber, due to the dependency on MIS completing the Ambulance Performance Framework changes.

CMT Programme Update

Workstream		RAG Status	RAG Trend	Summary Position
Urgent Community Response		**Yellow**	↔	**UCR Scheduling:** Interim winter scheduling solution approved by the CMT Board (Sep-25), with a draft SOP scheduled for review at the next APP Scheduling meeting. On-track for December Go-Live as planned. Work continues to align data and operational processes with the long-term APP scheduling model. **Falls & Frailty Response Model:** Funding approved for Falls Desk; Task and Finish Group established through RICs board with proposed 'go live' date of 12/11. Evaluation metrics to be confirmed through Falls & Frailty Group. **National reporting to Welsh Government delayed due to Power BI dashboard limitations; completion by December 2025 is unlikely without additional digital support.** **Tasking Optimisation:** MHRV Pilot extended to March 2026, with workshops held in October on development and definition of the wider Mental Health & Learning Disabilities Offer. Work on both the evaluation and wider service offer to continue collaboratively. Go-Live of an APP Point of Care role from late-October, and a CTAS T&F Group has been established to assess opportunities for integrated access models. **Advanced Practice Delivery Group:** TAPP1s have commenced university, though several remain without placements. An AQM auditing SOP has been finalised, and the APP Roster Review team will meet with ORH in late October to update roster keys. A "Principles of Advanced Practice" document has been completed, defining Health Board responsibilities and outlining a standardised approach to appraisal and supervision. Development of a comprehensive APP training framework is ongoing, to include clinical modules and an e-Portfolio. **Data inaccuracies continue to impact evaluation and reporting of APP workstreams**.
Emergency Response	**Call Flow and Prioritisation Steam**	**Green**	↔	**Rapid Clinical Screening:** Project Closure Report is in draft and will be submitted to the CMT Board for noting in due course. **Call Flow Implementation (Phase 2): On track for 2nd December go-live** following approval of the Statement of Works and completion of the CAD development in a Test environment. Internal testing ongoing, with live CAD updates expected by end of Oct-25. RCS0 optimisation continues, with testing CAD alerts to prevent timeout issues. Focus over the next reporting cycle will be on SOP approvals, system validations, staff preparation. QIA and EQIA have been approved via the required governance routes (CAG-CQGG-QuEST) and accompanied the Assurance Report to Trust Board (23/10). **CMT Board Notes:** Trust Board pack reviewed by CMT Board for onward submission to an exceptional Trust Board. **The Board approved the delegation of authority for go-live approval in line with the process followed for Rapid Clinical Screening and Call Flow Phase One go-lives.** **HCP Call Flows:** An options appraisal is in development with review by key governance forums to follow. The appraisal will consider options to transition from Protocol 35 to a new protocol, or alternatively a new AQM model. External engagement on process design to follow.
	Improving OHCA Outcomes Stream	**Green**	↔	**Focus on Restart A Heart Live and Shock October campaign** which reached over 3000 schools, 200 of those in Wales. Further engagement undertaken with teachers at the National Education show in Cardiff to build on the delivery of CPR in schools. A new system for reviewing and reporting individual and trust wide resuscitation metrics (Analyse) is going live in October, which will enable comprehensive performance tracking.
Health Transport		**Yellow***	↓	**Access to Planned Transport: Issues with the technical solution** (integration between MIS and Cleric) **continue to appear in the live CAD**. Discussions continue with MIS, and development of a statement of works will enable accurate quotations ahead of development. The initial table-top **Test-of-Change exercises** have been completed with the objective of assessing the feasibility of centralising taxi bookings under Ambulance Care. Initial results are positive with early results suggesting over 50% of bookings could be accommodated on existing resource. A second Test-of Change is planned**.** ***CMT Board Notes:** **RAG Status updated following the CMT Board on 20th October 2025 to reflect MIS-Cleric Interface issues.**

CMT Programme Update

ENABLING GROUP UPDATES			
Group	**RAG Status**	**RAG Trend**	**Summary Position**
Quality & Performance Metrics	**Yellow**	↔	**RAG status remains Yellow (cautionary status);** work is currently on track, IDS capacity remains limited, with high number of data requests received, particularly regarding Call Categorisation. Risk management remains in place through Call Flow and CMT Metrics groups. • **Ambulance Performance Framework:** Phase Two Monitoring and Assurance Plan approved by CQGG, with inclusion of additional clinical review on monitoring patient deterioration. Assessment of patient experience metrics will remain dependent on ICO recommendations and subsequent delivery by WAST. • **CMT Evaluation:** Board was advised that the contract with Edge Hill University is nearing completion, with initial client engagement meetings underway. The evaluation is structured as a three-year process, with Year 1 focused on data collection prior to any interim reporting. The methodology will be co-designed with Edge Hill to ensure balance across outcomes, experience, and staff perspectives, supported by workshops to achieve system-wide buy-in and avoid future disputes over approach. • **CMT Board Notes:** Governance arrangements for the independent evaluation were clarified, with the evaluation to report directly to the CMT Board, subject to any objections from LW in his role as Executive Sponsor of the independent evaluation. Interim reports will be aligned with Cabinet Secretary timelines and internal governance cycles. The Terms of Reference have been strengthened to prioritise organisational needs and relevant evaluation domains over academic outputs. The Board noted that the evaluation was initiated internally prior to Welsh Government involvement and should continue to be managed by the organisation.
Change Management	**Yellow**	↔	**RAG status remains Yellow (cautionary status);** work is currently on track, however there is no significant progress to report since the last reporting cycle. • Change Management group had not met since the last CMT Board and there were no matters arising for the Boards attention.
Partnerships & Engagement	**Green**	↔	**RAG status remains Green (On Track status);** work continues to support and maintain positive trajectory. • **Board was advised** of continued preparations for Phase 2 of Welsh Government's *Ambulance Performance Framework* changes, with comprehensive internal and external communications in development. Materials include refreshed website content, animation and social media assets, stakeholder briefings, and planned media engagement, alongside tailored internal resources and staff videos. • **CMT Board Notes:** External Engagement Briefing Pack reviewed by CMT Board for onward use, pending minor design alternations. • **Board was advised** that the refreshed *Transformation Delivery Network* is now operational and being tested across two quarterly cycles, supported by CMT Executive and SRO leads. A *CMT Information Pack* has been approved and published to enhance staff understanding of programme aims and progress. • **Board was assured** that communications activity remains on track, with no new risks or alerts identified during this reporting period.

APPENDICES

Workstream Highlight Reports (HLR2s)

Produced for the CMT Board on the
20th October 2025

Navigation


Working in collaboration with the wider health and social care system
Online Digital Advice
Remote Integrated Care
Urgent Community Response
Emergency Response
Health Transport
Non-Urgent Health Query
Urgent Health Care Need
Life-Threatening Illness Or Injury
Health Related Transport Need
Service Offer
Health Need
Health Need
Service Offer

Digital Front-End Workstream

Executive Sponsor: Jonny Sammut

Senior Responsible Owner: Ceri Griffiths

Digital Front-End Workstream Update

Report Date:	Current RAG	Previous RAG	For Noting:	Executive Sponsor:	Jonny Sammut
Oct-25	**Green**	**Green**	**Virtual Assistant:** Contract signed and discovery, design and development to be imitated **Symptom Checkers:** Virtual Workshops to be held during October to design the architecture of the Symptom Checker solution **Content Management System:** Initially working to identify a suitable CMS product	**SRO:**	Ceri Griffiths

Task / Milestone	RAG Status	RAG Trend	Current Position	Forward View
Virtual Assistant	**Green**	↔	• **Contracts have been finalised for Phase 2 for the additional elements of Virtual Assistant improvements.** • **An AIBot logo has been designed and approved for use**, this design will be shared and added to the website in due course (date TBD). • Kick-off internal and external meetings have been scheduled for mid-October for the discovery, design and development stage of the project.	• Supplier to work through development aspects of the WhatsApp integration, multilingual and chat-based Agent Integration.
Symptom Checker Implementation	**Green**	↔	• **Virtual Workshops to be held during October to design the architecture of the Symptom Checker solution**, evaluate security aspects, and finally for the supplier to provide an initial mock-up of the User Interface. • View to utilise NWSSP Welsh Translation Tool to process the translation of the website. Meeting to be held with NWSSP on 08/10 to discuss how to use and deploy the translation tool within WAST. • Impact Assessments / Cloud Security to be worked through with the support of the supplier as the project develops and the requirements are understood.	• Further design and development meetings to be held jointly between WAST and the supplier once the initial workshops have been completed.
Content Management System (CMS)	**Green**	↑	• Initially working to identify a suitable CMS product and a supplier to undertake the implementation of the new product and assist with the migration of existing website content to the new product.	• Briefing notes supplied to suitable CMS suppliers with invitations for fact finding sessions.

Remote Integrated Care Service Workstream

Executive Sponsor: Liam Williams

Senior Responsible Owner: Pete Brown

Remote Integrated Care

Report Date:	Overall Programme RAG	Previous RAG	For Noting:	Executive Sponsor:	Liam Williams
Oct-25	Amber	Amber	Implementation of the **Falls Desk** to be reported through the RICS Workstream with early mapping of process, milestones, and risks underway, working towards an implementation date of the first week November 2025.	SRO:	Pete Brown

Deliverable	Scope	RAG Status	RAG Trend	Summary Position
Care Planning Function	Focus on developing a sustainable model for pre-winter and exploration into the procurement requirements for remote monitoring **inclusive of Falls Desk implementation.**	Green	↑	• Implementation of queues, AQM, and process on track to be live **7th October** with refresher training successfully complete 16.09 and 17.09. • Remote Clinical element of the Falls Desk being implemented within the Workstream where the initial workshop held and subsequent weekly touchpoints organised are to ensure implementation of a Falls Desk by first week **November 2025.** • Milestones, tasks, risks, and dependencies mapped. • Recruitment, process mapping, and technical developments to commence imminently to ensure quick delivery. • Ongoing alignment with *Urgent Community Response.*
New Call Flows & Categories	Design and deploy call flows and categories into Integrated Care, in this instance, Ambulance Performance Framework Phase 2.	Green	↔	• Close links and working with **Emergency Response Workstream,** translating the implementation into operationalisation within Integrated Care.
Strengthening Application & Evaluation of CPSS	Exploration into the use of CPSS, expansion of use, and evaluation of the digital tool.	Yellow	↔	• Expansion phase paused due to resource and capacity pre-Winter. However, exploration into requirements following revisiting in Q4 25/26 to be undertaken to showcase impact. • Expansion of CPSS has strong links and is dependent on the implementation of a single CAD. • Winter Desk improvements continuous within operations.
Alignment of CSD and 111	Core components and tasks relating to alignment and integration of services to establish Remote Integrated Care.	Amber	↑	• Full launch of RICS deferred to Spring 2026, as noted by CMT Board. • Task & Finish group established to commence milestones to implementing CAD solution, however this is still dependent on MIS capacity and internal delivery. • Core Organisational Change Processes to be finalised by November along with the relevant SOPs updated. • Terms and Conditions set to be finalised in the next upcoming Senior Leadership Team meeting following development with Trade Union Partners.

RICS Enabling Deliverables

Report Date:	Remote Integrated Care **Enabling Deliverables**	For Noting:
Oct-25		The following key milestones and deliverables, while not directly reporting into the CMT governance structure, are critical enablers for broader transformational outcomes and are therefore important to highlight
Scope:	Phase 2 of Remote Integrated Care Service developments which **do not** fall under the Clinical Model Transformation (CMT) Programme Board however are key enablers for delivering objectives relating to Remote Integrated Care.	

Task / Milestone	RAG	Update
SCW Report	**Green**	• The SCW response document was reviewed and approved by the board, with recognition of significant progress and improvements already made based on its recommendations. • The document will be utilised as a reference for ongoing programme development. • Next steps are to share the approved response more widely across the CMT programme as both an assurance piece and a good news story, highlighting best practices.
Confident and Competent Workforce Plan	**Green**	• The proposal presented focuses on assessing staff confidence and competence through a baseline survey, with results to inform targeted CPD offerings, clinical supervision, and learning resources. • Initial steps to include defining clear metrics for success, including patient outcomes, experience, and operational/process measures, to demonstrate the value and impact of the investment. • The direction of travel and progression of the work is fully supported and will be enhanced with further development to be aligned with planning for 2026/27.
Specialist Clinical Practice Intervention: Paediatric & Respiratory	**Green**	• Rapid implementation of a training programme for clinical advice line clinicians was achieved, with 75% of the target group trained and mop-up sessions planned. • The training included pre- and post-assessment of knowledge, showing a significant increase in respiratory knowledge scores (from 4.5 to 8.5 out of 10). • Early indications suggest positive outcomes, including improved confidence and competence among staff and a reduction in demand flowing back to 999.
Clinical Consultation Before Dispatch and SPOA Update	**Yellow**	• Clinical consultation before dispatch went live in three health boards, resulting in fewer ambulances sent to residential homes and more patients managed via alternative pathways through SPOA. • The first day showed positive results despite some technical and process issues, with expectations for further improvement as staff gain confidence and systems settle. • Integrated care clinicians and APP navigators are now embedded within SPOA, enabling direct access to local solutions and new pathways, marking a step change in integrated care delivery.
CAD Update	**Amber**	• Task and finish group to commence with the internal discussions and plans, reaching out to MIS to progress further. • Noted that, although the progression of the CAD mitigates • Status at Amber due to dependency with MIS completing Phase 2 implementation before meeting for CAD developments.

Focus on...

Specialist Clinical Practice Intervention: Paediatric & Respiratory

BENEFITS

During the winter months, there is generally an **increased demand** for **paediatric** and **respiratory** care. This rise can be due to factors such as decompensation in patients with existing respiratory conditions, seasonal illnesses such as **RSV**, and environmental influences that may worsen **chronic health issues**.

To address these challenges, we aimed to equip our Integrated Care Teams, both **clinical** and **non-clinical**, with the necessary **resources**, **education**, **tools**, and **support**.

Our goal was to enable them to effectively manage the anticipated surge in respiratory and paediatric cases expected to impact the999 and 111 services.

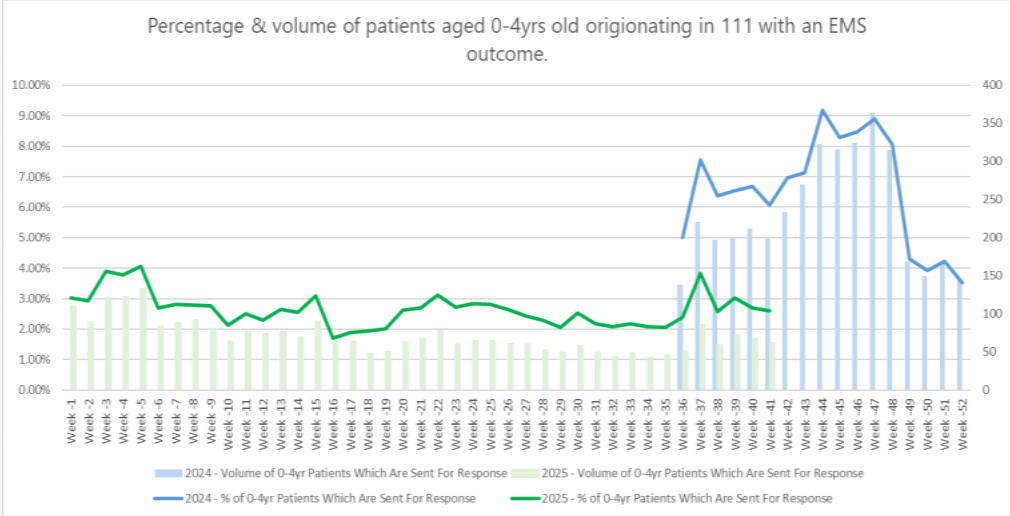
Clinical Advice Line (CAL) Specialist Training	To date, 75% of all CAL provided with specialist training (mop-up sessions scheduled)
Resource Hub Development	Range of resources published to SharePoint
CPSS Update for Call Handlers	Updated in Sept-25, enhancing management of paediatrics presenting with breathing problems
Specialist Induction Sessions	Completed for new 111 and CSD Cohorts and a regular feature.

CONFIDENT & COMPETENT

Pre- and post-assessment of knowledge, showing a significant increase in respiratory knowledge scores, from 4.5 to 8.5 out of 10.

SERVICE IMPACT

Graph below shows a high number of related calls are being managed by a call handler, supported by the Clinical Advice Line



Urgent Community Response Service Workstream

Executive Sponsor: Andy Swinburn

Senior Responsible Owner: Sonia Thompson

Urgent Community Response Workstream Update

Report Date:	Current RAG	Previous RAG	For Noting:	Executive Sponsor:	Andy Swinburn
Oct-25	Yellow	Yellow	**Falls & Frailty** – Referral process discrepancies persist and reporting issues continue to affect ability to deliver on national reporting requirements. **Tasking Optimisation** – All Health Boards now have an APPNAV model at various stages of operation. A CTAS Task & Finish Group has been established to consider how the SPOA framework aligns with the CTAS framework. **ACPDG -** APP Roster Review awaiting ORH developments to progress work. Work continuing to develop standardised support and training for both current and aspiring APPs. Data inaccuracies are affecting APP workstream evaluation and performance reporting.	SRO:	Sonia Thompson

Project/Working Group	RAG Status	RAG Trend	Summary Position
UCR Scheduling	Green	↔	• Interim winter scheduling solution approved by CMT; draft SOP under review at the next APP Scheduling meeting.
Falls & Frailty Response Model	Amber	↓	• Referral process discrepancies persist as **staff continue to use the previous referral process and safeguarding measures are no longer in place for previous process.** • Papers submitted to the UCR Workstream Board proposing optimisation of existing resources ahead of Winter. • Funding approved for Falls Desk; Task and Finish Group established through RICs board with proposed 'go live' date of 12/11. Evaluation metrics to be confirmed through Falls & Frailty Group. • **National reporting to Welsh Government delayed due to Power BI dashboard limitations; completion by December 2025 is unlikely without additional digital support.**
Tasking Optimisation	Yellow	↔	• **MHRV extended to March 2026** with agreement to evaluate further in Q4 25/26. New MHP commenced in post (Sep-25) with further recruitment planned to maximise availability. • The UCR Board noted ongoing RCDM training and APPNAV updates across regions, including the introduction of a new UCR APPNAV POC role due to start from the beginning of October. **All Health Boards now have an APPNAV model in place at various stages of operation.** We will continue to monitor progress and seek opportunities for further integration or extended operating hours. • A **CTAS Task & Finish Group has been established** and Terms of Reference approved. The group will consider how the SPoA (Single Point of Access) framework and 111 work fits within the CTAS framework.
Advanced Practice Delivery Group	Green	↔	• TAPP1s have commenced university however some remain without placements. • AQM auditing SOP has been written. • **APP Roster Review team meeting with ORH on 20/10** to discuss updating roster keys. • **Principles of Advanced Practice document completed**, outlining the value of advanced practice alongside Health Board responsibilities and the standard desired approach to appraisal and supervision. • A **standardised development framework for APPs is also in development** to support them through their training and will include the induction, wound care, respiratory, paediatrics, end of life care, prescribing and leadership managed within an e-Portfolio. • **Data inaccuracies continue to impact evaluation and reporting of APP workstreams**.

Emergency Response Workstream

Executive Sponsors: Lee Brooks (Call Flow and Prioritisation Stream) and Andy Swinburn (Improving OHCA Outcomes Stream)

Senior Responsible Owners: Ceri Griffiths (Call Flow and Prioritisation Stream) and Greg Lloyd (Improving OHCA Outcomes Stream)

Emergency Response Service
Call Flow and Prioritisation Stream

Report Date:	Current RAG	Previous RAG	For Noting:	Executive Sponsor:	Lee Brooks
Oct-25	Green	Green	**Rapid Clinical Screening** – formal project closure underway. **Call Flow Implementation (Phase 2)** – Statement of Works completed and Internal Testing to take place commencing 08/10. **HCP Call Flow –** Options appraisal in development	SRO:	Ceri Griffiths

Project/Working Group	In Scope	RAG Status	RAG Trend	Summary Position
Rapid Clinical Screening	Delivery of downstream Rapid Clinical Screening function including recruitment to B7 Clinical Navigator roles, implementation of Clinical Leadership arrangements for screening function, and all technical and operational arrangements.	Green	↔	• **Project Closure Report is in draft** and will be submitted to the CMT Board for noting in due course. The project will remain open to the CMT Board until formal completion of the closure report.
Call Flow Implementation Phase 2 (Orange Now, Yellow Soon, and Green Planned)	Delivery of new Emergency Ambulance Performance Framework as directed by Welsh Government including all technical and operational arrangements.	Green	↔	• **Go-Live has formally been scheduled for 2nd December**. • The Statement of Works has been approved alongside the ongoing CAD development work to ensure test CAD readiness by 8th October. • **Internal testing of the new categories is on track for completion by the end of October**, following which the live CAD will be updated. • The **QIA and EQIA were submitted to CAG -> CQGG -> and QuEST** alongside the Ambulance Performance Framework Explainer documents; **both have now been formally approved** and will be submitted to Trust Board on the 23rd October along with the Assurance Report. • **Testing is underway to improve the handling of Rapid Clinical Screening (RCS0) calls**, with changes to CAD alerts being trialled to reduce timeouts. The next few months will focus on finalising SOPs, validating system changes, and preparing for go-live, with staff engagement remaining central to successful delivery. • Communications and Training Plans are to be reviewed internally with imminent approvals expected by the Call Flow and Prioritisation Stream. • Toolkits and documents (such as the explainer) will support managers with change internally.
Healthcare Professional Call Flows Implementation Group	Collaboratively redesign our Health Care Professional Flows aligned to our Integrated Clinical Services Model and the new Ambulance Performance Framework.	Green	↑	• Following an initial meeting, an **options appraisal is in development** to present to the Task & Finish Group before presenting to additional groups such as Call Flow Categorisation Project Group, SOT, CAG and CQGG. • The **expectation is to move from Protocol 35 to an alternative protocol or develop an AQM**. • Invitations will be extended to external stakeholders to join the HCP Call Flow Task & Finish Group for input in due course to inform call flow process design

Emergency Response Service
Improving OHCA Outcomes Stream

Report Date:	Current RAG	Previous RAG	For Noting:	Executive Sponsor:	Andy Swinburn
Oct-25	Green	Not Applicable		SRO:	Greg Lloyd

Project/Working Group	In Scope	RAG Status	RAG Trend	Summary Position
OHCA Delivery Group	Implementation of the OHCA Action Plan, ensuring that delivery aligns with the new Ambulance Performance Framework and supports improved clinical outcomes through a system-wide approach to OHCA response and prevention.	**Green**	↔	• Focus on Restart A Heart Live which was from Edinburgh studios this year with SALC taking a leading role in the delivery of education to over 3000 schools (200 Welsh schools) • Engagement with teachers at the National Education show in Cardiff to build on the delivery of CPR in schools • A new system for reviewing and reporting individual and trust wide resuscitation metrics (Analyse) is going live in October.

Health Transport Workstream

Executive Sponsor: Lee Brooks

Senior Responsible Owner: Mark Harris

Health Transport Workstream Update

Report Date:	Current RAG	Previous RAG	For Noting:	Executive Sponsor:	Lee Brooks
Oct-25	Yellow*	Green	Interdependency mapping ongoing. MIS-Cleric development is a key external dependency. Work on hold due to call categorisation development.	SRO:	Mark Harris

Project/Working Group	In Scope	RAG Status	RAG Trend	Summary Position
Access to Planned Transport	Phase One: Develop a pathway process from RICs	Yellow*	↓	• Front-End Patient Flow meeting to be arranged to confirm required process and inform development of SOP(s). • **Specification of requirements to be developed for MIS to overcome existing MIS-Cleric issue, however development work will be on-hold due to supplier capacity**. MIS-Cleric interface resolution actively managed with escalation planned if needed. • The initial Test of Change exercise will commence on Wednesday 8th October 2025 with a tabletop review of patient flow data to identify opportunities for improved allocation between NEPTS and taxi services; findings will inform future live testing and support optimisation of transport resources.
	Phase Two: Identify additional routes of call origin	Green	↔	• Workstream Board noted additional refinement required to existing narrative. Discussions around areas of inclusion for Phase Two remain ongoing during completion of Phase One.

*RAG status updated from Green to Yellow following the CMT Board on 20th October 2025 to reflect MIS-Cleric issue.

Welsh Ambulance Services University NHS Trust

IMTP Delivery Highlight Report All Y1 Deliverables (Outside Scope of CMT)

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

IMTP Delivery Highlight Report
Released: September 2025

Strategy, Planning & Performance

Summary of Position

Deliverables:

Total (non CMT) deliverables specifically committed to delivery within the IMTP is 89

5 Complete	20 Amber
43 Green	4 Red
6 Yellow	11 Not started

Summary of Position by Directorate

Deliverables:
Total (non CMT) deliverables specifically committed to delivery within the IMTP is **89**

Directorate/Objective	Green	Yellow	Amber	Red	Not Started	Complete
Operations	8		3		5	1
Finance & Corporate Resources	5	2				
People & Culture	11	2	2		2	1
Partnerships & Engagement	3			4		1
Digital	9	1	4			
Quality, Safety & Patient Experience	2	1	9			1
Corporate Governance	4					1
SO6: Delivering exceptional value (SP&P and non-aligned deliverables)	1		2		4	

SO3: Being at the forefront of Innovation & Technology - Digital

IMTP Objective	IMTP Deliverable	RAG Status	Delivery Confidence	Progress Summary
Pillar 1 Everyday Essentials	eTimesheets delivered by Q2	**Green**	**Low**	Technical work complete, but alignment of contractual terms and conditions still required.
	Simplified sign on implemented by end Q4	**Amber**	**High**	Small trial of preferred simplified sign-on solution expected Q3
	Cloud-based GRS implemented in 2025/26			Test environment established. Implementation work ongoing
	Robotic Process Automation RPA scaled up by end Q4			Business analysts to be recruited to support automation activities. Some ad-hoc progress linked with AQ developments
Pillar 2 Digital Pioneers	Innovation lab developed by end Q2	**Amber**	**High**	Engagement across WAST to design lab and align with DTIP and WIIN. Two proof of concept projects identified. Lab establishment to continue into Q3.
	Drones will be tested with the aim to deploy by Q2	**Green**	**High**	HART Drone Demo completed Aug-25. Deployment expected in Q3.

SO3: Being at the forefront of innovation & technology – Digital

IMTP Objective	IMTP Deliverable	RAG Status	Delivery Confidence	Progress Summary
Pillar 2 Digital Pioneers	**SMS functionality** implemented in NEPTs by end of Q4	**Green**	**High**	Feasibility scoping in progress but note dependency on small specialist teams already committed to CMT projects.
	Visual interactive voice response IVR in NHS 111 Wales available in contact centres Q4	**Amber**	**Low**	Deprioritised due to development work on CMT by WAST & suppliers
	AI development in line with national direction throughout 2025-28	**Green**	**High**	Copilot pilot and evaluation in progress. Virtual Assistant deployed on 111 Wales Website in Q2. Board Development session scheduled for Q4. Recruitment into Digital Innovation & Transformation team by Q3 will support.
Pillar 5 Data, Information & Insight	**Individual insights** to support individual performance monitoring and development developed and rolled out during 2025/26	**Yellow**	**Moderate**	Airway Log delivered Sept-25. Other clinician level insights projects are currently lower priority than CMT deliverables.
	NDR programme will commence and take place throughout 2025-27	**Green**	**High**	Delivery as per NDR plan reported to DHCW quarterly. Completed deliverables include signature of national Joint Controller Agreement, GitHub familiarisation and config, and cloud feasibility study.

Delivery Confidence 2025/2026 – Digital

Objective	IMTP Deliverable	RAG Status	Delivery Confidence	Progress Summary
SO3: Being at the forefront of innovation & technology				
Pillar 3 Digital Transformation	**EMS & NEPTS CAD** replacements - business case(s) written Q2-Q3	**Green**	**Moderate**	Project kicked-off in Q2, but significant cross-organisational work to develop the business cases.
	Emergency Services Network (ESN) phase 2 Full Business Case developed by end Q3		**High**	Business Case submitted Q2.
Pillar 1 Everyday Essentials	**iPad replacement** phases 1 & 2 completed by Q3	**Green**	**Moderate**	>100 new iPads issued to date. Full rollout paused due to financial complexity. Continue to replace devices on individual need basis.
Pillar 4 Security, Safety & Cyber	**AI safety / Policy guidance** developed by end of Q3	**Green**	**High**	AI Steering Group to be established Oct-25. AI Policy due Q3 as planned.
Pillar 4 Security, Safety & Cyber	**Smart station** initiative will be rolled out by Q4	**Amber**	**Moderate**	June 2025, discovery phase is near completion. 'Show and tell" session held in June with participation from digital, estates, and workforce teams. Finance: Indicative costings are awaited to inform next steps and plan delivery of any next phases for smart station initiatives.
Pillar 1 Everyday Essentials	**Simplified sign on** will be developed and implemented by the end of Q4 giving users a better **digital experience**	**Green**	**High**	Small trial of preferred simplified sign-on solution expected in Q3.

SO5: Being Quality driven and Clinically led – QSPE

IMTP Objective	IMTP Deliverable	RAG Status	Delivery Confidence	Progress Summary
Defining our focus and delivering on population health and health inequalities	Delivery plan for the **Population Health Plan** developed by end Q2	**Amber**	**Moderate**	Draft Population Health Plan and health inequalities matrix have received assurance. While delivery is delayed due to resource constraints, the plan supports strategic objectives and compliance with 2023 standards. A refresh is planned for IMTP 2026–2029 to embed population health as routine practice.
Excellent clinical leadership	**Learning Disability role** in remote clinical team by end of Q2	**Complete**	**Complete**	Learning Disability Clinical lead recruitment achieved and completed.
	Violence & Aggression risk mitigation actions to be taken forward in Q2	**Amber**	**Moderate**	Case Manager role, including training via NASEG. Business case submitted to EDON not progressed due to lack of funding. Delays to delivery due to resource constraints, with revised delivery now targeted for Q4 2025-2026.
High quality Health & Safety systems	**Initial evaluation of the fume** mitigation work completed end Q2	**Amber**	**Moderate**	Diesel Fume project delays into Q1 25/26 GS lead Resource / Capacity impact. Team inspections held locally.
Meaningful engagement and co-production communities	**Implementation of audit recommendations** on community involvement by the end of Q2			Patient Engagement Planning is linked to the OCP process, which may affect delivery due to structural, financial, and governance changes. The work aligns with Our WAST Way and includes actions from the NWSSP audit.
Systems that meet the requirements of the Duty of Quality and Duty of Candour	**Thematic analysis learning from harm** via medical examiner reporting undertaken during Q2	**Amber**	**Low**	Team capacity has been strengthened, but data access limitations via IDS are affecting productivity. Efforts to create a local semantic environment are underway, focusing on Medical Examiner data and Incident Management alignment.

SO5: Being Quality driven and Clinically led – QSPE Delivery Confidence

IMTP Objective	IMTP Deliverable	RAG Status	Delivery Confidence	Progress Summary
Defining our focus and delivering on population health and health inequalities	Updated health inequalities maturity matrix for reducing completed by end Q1	**Amber**	**Moderate**	Resource dependency. Work continues alongside prioritised new work with updates made to the current HI maturity matrix.
	Draft Population Health Plan approved in Q1	**Amber**	**Low**	In June 2025, QuESt received assurance on the draft Population Health Plan and health inequalities maturity matrix, confirming alignment with the Trust's strategic goals and 2023 standards. A refresh is planned for IMTP 2026–2029 to embed population health as standard practice across the organisation.
High quality Health & Safety systems	A Health & Safety plan for WAST incorporating further improvements to legislative compliance, & manual handling developed in Q1	**Amber**	**Moderate**	Known capacity constraints, for delivery to shift to end of FY, with the strategy being driven via NARSF in September. Manual Handling Deep Dive completed, recommendations incorporated into the Health & Safety Strategy, in draft. The strategy will also embed a culture change process and ensure legislative compliance through process reviews. Completion and approval are targeted for end of 2025-2026.
Systems that meet the requirements of the Duty of Quality and Duty of Candour	Develop data engineering and modelling around harm developed in Q1	**Amber**	**Low**	The requirement will be refreshed for IMTP 2026–2027, with progress dependent on WAST's digital data strategy. Current work is ongoing with IDS, but data access and capacity constraints are likely to delay delivery until the next cycle.
	A Health & Safety culture change framework will be developed in Q3	**Amber**	**Moderate**	A sector-wide UK group approach is being explored, with buy-in still to be confirmed. The work links to Our WAST Way and is estimated for Q4 delivery, though progress is impacted by capacity constraints.
High quality Health & Safety systems	Initial evaluation of the fume mitigation work completed end Q2	**Green**	**High**	Diesel Fume project delays due to impact form a lack of Capacity Team inspections held locally
	'Always On' and Duty of Quality Reporting will be delivered by end of Q4	**Yellow**	**Moderate**	'Always On' reporting has been achieved as part of MIQPR and shared via the Trust Board to support public transparency. While internal delivery continues, progress is impacted by IDS capacity and shifting priorities. External reporting options are being explored, and dashboard translation is under discussion at the QPM Steering Group.
Systems that meet the requirements of the Duty of Quality/Candour	A formal patient & public reference group will be in place by the end of Q4	**Green**	**Moderate**	Where the OCP will provide Patient Experience and P&E reference groups separately, the focus of work from each area will be determined to carry out during 2026-27 and continued, to include Patient Experience metrics/ measurements.

People & Culture - Delivery Confidence 2025/2026

Objective	IMTP Deliverable	RAG Status	Delivery Confidence	Progress Summary
SO2: Enabling our people to be the best they can be				
Ensuring the right Capacity needed to achieve our purpose	A post implementation review of the of the All-Wales Flexible Working Policy processes in WAST undertaken during 2025/26	**Green**	High	Policy development and training/awareness sessions complete. Planned to move to BAU shortly following completion of assurance.
	Actions within the Strategic Workforce Plan delivered throughout 2025/26	**Amber**	Moderate	Work continues on the Power BI Workforce Dashboard, though automation challenges between ESR and the Data Warehouse are causing delays. Directorate-level workforce plans are progressing slowly due to limited engagement. Plans are in place to accelerate discussions.
	ESR National Optimisation, NHS Project & interface with GRS developed in Q1 to be delivered throughout 2025-27	**Green / Yellow**	High *(will rollover to next year)*	Progress continues across several key digital and data quality initiatives, including e-Timesheets, ESR programmes, RPA processes and data warehouse interface. Capacity challenges are causing minor delays.
	Improving Attendance plan delivered throughout 2025/26	**Complete**		Now moved to BAU and figures are reported monthly to ELT, SLT and PCC.
	Nurse retention plan will be delivered throughout 2025/26	**Green**	High *(potential to rollover to next year)*	Content development of onboarding and induction platform remains on track for completion and pilot is planned. Drafts of Health and Wellbeing Passport and Managers Guide are complete and are undergoing internal review.
	Recruitment strategy developed by the end of Q4	**Not Started**	*Rollover to next year*	New Head of Service has been appointed and will start in October, who will have this deliverable as part of their portfolio.
	Undertake preparations for Future NHS Workforce Solution Transformation Programme during 2025/26	**Green**	Moderate *(will rollover to next year)*	A business case is in development to secure funding for dedicated project management support. Implementation plans continue to progress with external parties.

People & Culture - Delivery Confidence 2025/2026

Objective	IMTP Deliverable	RAG Status	Delivery Confidence	Progress Summary
SO2: Enabling our people to be the best they can be				
Ensuring the skills and Capability needed to achieve our purpose	Excellence and consistency for education and development will be delivered across WAST in line with University Trust Status priorities (section 8)	**Green**	High *(will rollover to next year)*	Good progress continues in quality assurance across key areas (e.g. HART, EPRR and QI). Next phase will focus on CHARU and RCDM for APPs. Revised education offer for Entry Level Trainers (call Handling/QI) is nearing completion with enrolment due to begin in late August.
	Our WAST Way leadership behaviours framework and an aligned development framework, developed and launched in 2025/26	**Green**	High	Launch is complete. Essential Conversations training continues to be delivered to Band 7 and below managers. Feedback and insights will be gathered through multiple channels.
	People & Culture Plan evaluated and refreshed in 2025/6	**Not Started**	N/A	Deferred to align with organisation-wide Long Term Strategy refresh.
	The capability of managers to lead / manage change developed, supported by a Change Management Toolkit throughout 2025-28	**Green**	High *(will rollover to next year)*	Recruitment complete to Change Manager position. Arrangements underway to offer all SROs and Exec Sponsors accredited change management training. Progress continues with the cascade approach, maturity matrix and the change management toolkit.
	WAST People Development Plan (PDP) signed off by end Q4	**Green**	High	Policy and plan in development, with the aim to submit the final version to the Policy Group in Q3. Learning materials continue to expand and recruitment for the Essential Skills team is ongoing.

People & Culture - Delivery Confidence 2025/2026

Objective	IMTP Deliverable	RAG Status	Delivery Confidence	Progress Summary
SO2: Enabling our people to be the best they can be				
Establishing our Culture as the way we achieve our purpose	Anti-Racist Wales, LGBTQ+, Disability, Sensory Loss Standards, Armed Forces, Covenant Duty, Carers Leave Bill plans implemented throughout 2025/26	**Yellow**	High	Significant progress has been made in completing legislative and statutory requirements. Improvements have been seen in the gender pay gap and in workforce diversity in terms of representation of ethnic minority groups, LGBTQ+ community, and individuals with disabilities.
	Our compassionate practices approach expanded and embedded throughout 2025/26	**Green**	High	Disciplinary Policy documentation reviewed and updated to reflect more compassionate approach, with guidance to managers and employees due for completion in Q4. Welfare Officer role profile in development.
	Sexual Safety Plan delivered throughout 2025-28	**Green**	High *(will rollover into next year)*	Discussions underway to delivery Sexual Safety sessions as part of 111 corporate induction. Connect Futures sessions have been delivered with a third scheduled in September.
	Strategic Equality Plan 24-28 (4 Year plan) implemented throughout 2025-28	**Green**	High *(will rollover to next year)*	Significant progress made in legislative requirements with the final draft of the Strategic Equality Plan Annual Report shared with PCC in August. Latest WRES report has been received, showing improvement year on year.
	Health and Wellbeing Plan implemented throughout 2025-29	**Amber**	High *(will rollover to next year)*	TRiM app is in development and training launch is scheduled in September. Discussions are ongoing to resolve Health Diagnostic Clinic issues; interim arrangements are in place. A lead has been identified to progress SEQOHS accreditation work in Q3.
	Develop and implement new process and practices to enhance our approach to amplifying colleague voices throughout 2025/26	**Green**	High *(will rollover to next year)*	Organisational level results from June Pulse survey has been shared with directorates with second pulse survey live in Aug-Sept. Preparations are underway for 2025 Staff Survey.

Partnerships & Engagement - Delivery Confidence 2025/2026

Objective	IMTP Deliverable	RAG Status	Delivery Confidence	Progress Summary
SO4: Developing services in collaboration				
Meet the requirements of being a named body under the Wellbeing of Future Generations Act	A process for evidencing application of Wellbeing Objectives through our established governance frameworks developed during Q2	Red	High	Work has been paused because of competing priorities. To be addressed from Q3 onwards for completion at end of Q4 as we have statutory obligations to finalise.
	A programme of internal and external communication of our Wellbeing Objectives enacted in Q1	Red	High	
	Action plan to address gaps in five ways of working developed by the end of Q4	Red	High	
	Undertake maturity assessment against the five ways of working by the end of Q2	Red	High	
University Trust Status (UTS) in collaboration with WG, embracing a 'democratised culture' of learning, research and innovation (R&I)	Our research priorities will be delivered throughout 2025-28	Green	High	Research annual report completed and received. Co-production and implementation of RD&I initiatives ongoing with Welsh Government and Research Innovation networks.
	Oversee the development of any appropriate additional plans to deliver UTS priorities for 2025-28 (NB priorities will be delivered in other areas of IMTP)	Complete		No longer required as no additional plans have been needed.
Well placed to influence system thinking / strategy development	Quantitative and/or qualitative measures will be developed in Q1 to evidence the proposed approach to strategic engagement	Green	High	Survey currently live to seek feedback on ambulance performance framework communications.
	Strategic engagement will take place in support the development of our new CMT model throughout 2025-28	Green	High	Focus has been on communication on the changes to the Ambulance Performance Framework. Preparations for go-live of Phase 2 are ongoing.

Operations: EMS - Delivery Confidence 2025/2026

Objective	IMTP Deliverable	RAG Status	Delivery Confidence	Progress Summary
SO1: Providing the right care or advice, in the right place, every time				
Efficient and effective dispatch of the right resource	Review of the skill mix of emergency response crews throughout 2025/26	**Green**	Unknown	
Rapid call answering, initial triage & onward referral	New CCC in Ty Elwy fully operational in Q1	**Complete**	Unknown	Jun 25 - The move of all Operations from Bryn Tirion to Ty Elwy completed on 8th May 2025 with EMSC being the final phase.
Fulfil our statutory requirements for civil contingencies, ensuring our preparedness through testing, learning & training	Continue to plan and prepare for major incidents as per the responsibilities of the Civil Contingencies Act and collaborate with the JCC on further developments the preparedness and response to major incidents e.g. Manchester Arena Inquiry and Grenfell Inquiry throughout 2025-28	**Not started**	Unknown	
SO2: Enabling our people to be the best they can be				
Ensuring the right Capacity needed to achieve our purpose	Outputs of the work of the Shift Overrun task and finish group delivered by Q2	**Amber**	Unknown	

Operations: Integrated Care - Delivery Confidence 2025/2026

Objective	IMTP Deliverable	Q3 RAG Status	Delivery Confidence	Progress Summary
SO1: Providing the right care or advice, in the right place, every time				
Rapid call answering, initial triage & onward referral	Review and evaluation of the demand & capacity in 111 with a roster review completed by the end of Q4	**Green**	Unknown	

Operations: Ambulance Care - Delivery Confidence 2025/2026

Objective	IMTP Deliverable	RAG Status	Delivery Confidence	Progress Summary
SO1: Providing the right care or advice, in the right place, every time				
A clear vision for Ambulance Care services that supports wider health & care transformation	An internal vision for Ambulance Care services agreed by the end Q1	**Green**	Unknown	August25 - Expected completion end of October 2025
	Plans to respond to the requirements of the national vision for non-emergency transport and the internal vision for Ambulance Care developed and implemented throughout 2025-27	**Green**	Unknown	August25 - Draft paper for consideration, that are also for EV vehicles to be included in the next replacement schedule.
	The future shape of the Ambulance Care fleet will be agreed and a delivery plan developed by the end of Q4	**Green**	Unknown	August25 - Draft paper for consideration, that are also for EV vehicles to be included in the next replacement schedule.
A flexible, user-centred Non-Emergency Patient Transport Service with the right capacity in place to meet demand	Current plurality model reviewed and updated by end Q4	**Green**	Unknown	July 25 - Cleric agreement in place. SLT approved on 365 until March. James Hayley joined the team temporary. Weekly meetings planned. Engagement started early. Update in three weeks.
	Data and insights to improve co-ordination and decision making with health boards throughout 2025/26	**Not Started**	Unknown	
	Digital solutions to enhance patient experience adopted in NEPTS by end of Q4	**Not Started**	Unknown	
	NEPTS roster review completed by end of Q2	**Amber**	Unknown	Sept 25 - End of Sept/Oct for recommendations
	Review of NEPTS and UCS alignment completed with a delivery plan by end Q4	**Green**	Unknown	July 25 - On agenda for informal SOT. 6/7 engagement sessions planned in September like a mini–CEO Roadshow to receive feedback.

Operations: Ambulance Care - Delivery Confidence 2025/2026

Objective	IMTP Deliverable	Q3 RAG Status	Delivery Confidence	Progress Summary
SO1: Providing the right care or advice, in the right place, every time				
A transfer & discharge service supporting HBs with their transformation agendas	Engagement will take place with health boards throughout 2025/26	**Not started**	Unknown	
	Internal vision for Transfer & Discharge (T&D) services reviewed by end Q1	**Amber**	Unknown	July 25 - Action in IMTP next year. Keen to pursue.
	Opportunity to develop a 24/7 major trauma desk assessed by the end of Q4	**Green**	Unknown	July 25 - Funding to support expansion to other areas. 12months, band 7 on track
	Proposed T&D model will be agreed internally by end Q4	**Not Started**	Unknown	

Corporate Governance - Delivery Confidence 2025/2026

Objective	IMTP Deliverable	RAG Status	Delivery Confidence	Progress Summary
SO2: Enabling our people to be the best they can be				
Strengthen Welsh Language compliance through strong leadership, enabling Welsh language to flourish	Engage with priority service areas that deal with patients & public on the Welsh language skills by end Q3	**Green**	High	Once gap analysis of ESR WL skills levels data is completed (by end Sept 25), engagement with priority service areas will commence to agree actions on how to strengthen their bilingual service provision. Some preliminary conversations have started.
	Engage with staff to ensure that their ESR Welsh language competencies are up to date by end Q1	**Complete**		As of June 2025, 96% of staff have recorded their Welsh language skills, with monthly reminders to those yet to include this information being sent.
	Five-year Welsh language clinical consultation plan by end Q2	**Green**	Moderate	Discussions amongst execs are ongoing with WLAG to drive and monitor progress. Changes to service model through CMT are being reviewed for impact. Focus remains on 111 (999 and NEPTS are out of scope).
	Review current recruitment processes for the Trust consider the need for Welsh language skills when looking to advertise new posts by end Q4	**Green**	High	Preliminary work undertaken, but outcome of WG review still awaited - expect guidance to be available by end of 2025 enabling completion of the deliverable by end of March 2026 as planned.
	Undertake a gap analysis via ESR Welsh language competency data by end Q2	**Green**	High	Gap analysis underway and on track for completion by end of Sept 25.

Finance & Corporate Resources- Delivery Confidence 2025/2026

Objective	IMTP Deliverable	RAG Status	Delivery Confidence	Progress Summary
SO3: Being at the forefront of innovation & technology				
The right buildings in the right place, enabling our staff to provide the best and safest care across Wales	Bangor Fleet Workshop completed in 2025/26	**Green**	**High**	Business case approved in July 2025. Work has commenced on site and will be completed by the end of the financial year.
	BJC for 2026/7 vehicle procurement will be written and submitted in line with WG timescales	**Green**	**High**	Engagement complete, with final verification of outcomes at Format SOT scheduled for 23rd Sept. BJC in drafting stage currently for submission through governance routes. Continued discussion with WG officials and timescales for submission confirmed.
	Dolgellau Ambulance Station completed in 2025/26	**Green**	**High**	Business case approved in June 2025. Work will commence on site in mid October and will be completed by the end of the financial year.
	Estates SOP will be reviewed in context of AWC funding by end Q3 (includes consideration of AWC schemes e.g. Swansea)	**Amber**	**Moderate**	Completion of this action is dependent on completion of the 6 facet survey which will be provided later this year. In the meantime, specific schemes will be progressed as opportunity arises, with the first of these being a solution for Swansea in 26/7 funding.
	Monmouth Ambulance Station completed in 2025/26	**Green**	**High**	Business case to be presented to Trust Board in September 2025 for approval. This will enable the contract to be awarded and work to start in the autumn. At this point, the programme indicates that the work can be completed by the end of the financial year.
	Resource and support to further enhance the approach to decarbonising our fleet to be explored during 2025/26	**Amber**	**Moderate**	Discussions are still ongoing within FinCoR. This action is wider than resources to decarbonise the fleet and will need to be considered in the context of resources to support all actions within the DAP and the new Strategic Delivery Plan when confirmed (and subsequent WAST response).
	The 2025/26 vehicle procurement programme will be delivered by end Q4	**Green**	**High**	This is on track for delivery in 2025/26. All orders have been placed, and commissioning contracts are in place with confirmed build slots.

SO6 Delivering Exceptional Value - Delivery Confidence 2025/2026

Objective	IMTP Deliverable	RAG Status	Delivery Confidence	Progress Summary
SO6: Delivering exceptional value				
Generate income alongside our core commissioned functions (SP&P)	A commercial strategy based on outcome of market analysis exercise approved by end of Q4	**Not Started**	Moderate	Objective will transition to the newly appointed Head of Commercial once in post.
Developing and implementing our plans for Environmental Sustainability and Adaptation	Adaptation Plans risk assessment undertaken by end Q2 (SP&P)	**Amber**	Moderate	Work has commenced. Transitional arrangements being put into place following AD Planning & Transformation leaving.
	Adaptation Plan drafted for approval by end Q4	**Not Started**	Moderate	Work has commenced. Transitional arrangements being put into place following AD Planning & Transformation leaving.
	Refresh of the DAP in response to the revised WG Decarbonisation Strategic Delivery Plan in line with WG timelines	**Green**	Moderate	Strategic Delivery Plan being reviewed following Welsh Government draft proposal. WAST submitting feedback to support finalisation of document. This will inform the review of the Decarbonisation Plan
A Value Based approach across the organisation which is embedded in culture	A refreshed approach to Value Based Healthcare will be developed throughout 2025/26	**Not Started**	Moderate	To be followed up with key colleagues.
	Work with the JCC and partners to develop a costing and benefit methodology for emergency ambulance services, NHS111 and non-emergency patient transport services during 2025/26	**Not Started**	Moderate	To be followed up with key colleagues.
Sustainable savings & efficiencies	Savings plans will be reviewed and refreshed by end Q4	**Green**	High	Savings plans are being developed.

Status	Description	Characteristics
Green	Project is on track and progressing well, meeting or exceeding expectations in terms of schedule, budget, quality, and objectives. **Action Required:** No immediate action is necessary, but ongoing monitoring and regular reporting are still required to ensure the project maintains its positive trajectory.	• Project milestones and deliverables are being achieved as planned. • Risks and issues are under control or adequately mitigated. • The project is progressing within the defined timeline and budget. • Key performance indicators are being met or surpassed.
Yellow	Provides an early warning that challenges or barriers are anticipated, but are not yet impacting on progress. **Action Required:** Close monitoring of factors anticipated to impact on progress, contingency planning, and reprioritisation if appropriate.	• Workload reprioritisation has been required to keep the project on track i.e. the impact has been transferred. • The project remains on track overall, however there are notable issues or risks or amber/red statuses recorded against key enablers, or interdependent projects that may impact over time. • The project remains on track overall but there may be moderate slippage against some tasks or actions.
Amber	An amber status signifies a cautionary state, indicating that the project is encountering challenges or potential risks that need attention to prevent further escalation. **Action Required:** Close monitoring of the project, proactive measures to mitigate risks, and corrective actions to address identified issues should be taken promptly to prevent further deterioration.	• Some project objectives are not being met as planned. • Certain milestones are at risk of being missed. • There are notable issues or risks that could impact project success if not addressed promptly. • Project performance or progress is below expectations but can be recovered with timely actions.
Red	A red status indicates a critical situation where the activity is significantly behind schedule, over budget, or facing major issues that jeopardize its success. **Action Required:** Immediate attention and intervention are necessary to address the issues and bring the project back on track.	• Major project objectives are not being met. • Critical milestones are consistently missed. • Key deliverables are incomplete or of poor quality. • Significant risks or issues are unresolved, and their impact on the project is severe.

RAG Status Definitions

This paper is aimed at providing both performance and strategic updates around the 7 key thematic areas within the IMTP. These updates focus on quarter 2 2025/26 and highlight the progress WAST is making against the 2027 'What Good Looks Like' roadmap.

The last update was provided in quarter 2 2024/25 and improvements made against the same period last year are highlighted within this update and the more detailed 'State of the Nation' performance update.

3.1 NHS 111 Wales

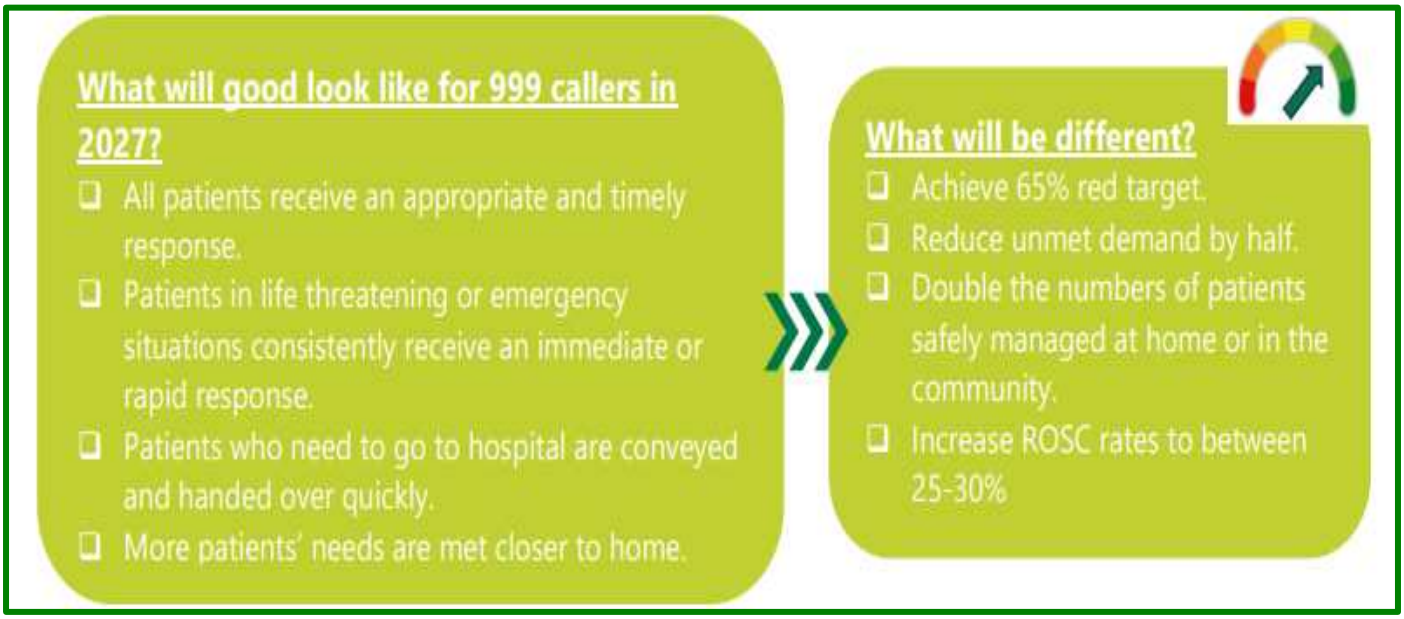
- The **111 call abandonment rate** for quarter 2 2025/26 was 10.3%, remaining above the 5% target. This target has not been achieved since January 2024, with figures over the past year being negatively affected by the transition onto the new 111 CAD system and an independent review has identified a demand and capacity gap within the current funded establishment.

- During August 2025, **111 patient survey data**, showed that 63% of people 'found the 111 service helpful', 75% said 'they followed the advice provided' and 57% said 'they would consider using the service again'. However, this data was based on just 13 responses during the month, with proactive work ongoing to increase the number of people who take part in completing the survey.

- The number of **111 calls 'stopped at source'** in quarter 2 2025/26 was 19,080, or 9.4% of the total calls for that period. This was an improvement on the 16,292 closed with no further follow up in quarter 1 2024/25, which equated to 10.7% of the total calls into the service over that time period.

- Urgent Primary Care **direct booking system** is now available to clinicians for a range of symptoms, which enables them to seamlessly book appointments during in-hour periods; however, the access is very limited, not pan-Wales and the activity levels very low.

3.2 Emergency Medical Services (EMS) – 999



- On 1 July 2025, our new ambulance response model was implemented, and two new response categories replaced the previous (old) Red category. The new categories are Arrest (Purple), for cardiac and respiratory arrests, and Emergency (Red), for major trauma and other incidents where patients are at significant risk of cardiac or respiratory arrest if they do not receive a rapid response. The median response time for Arrest incidents in September was 7 minutes 15 seconds, within the 6-8 minute time bracket, while for Emergency incidents it was 8 minutes 36 seconds.

- Reducing Unmet EMS demand is defined by the Trust as **patient cancellations and clinical safety plan 'can't sends'** declining to the levels seen in the 2019 EMS Demand & Capacity Review. The Can't Send element of this figure was switched off in early 2025 while the number of ambulances being cancelled by patients has significantly reduced during 2025. Quarter 2 2025/26 saw 20,405 ambulances cancelled by the patient, which was a 28.7% reduction on the 28,061 cancelled during the same quarter in 2024/25.

- During quarter 2 2025/26 18.9% of patients were managed via **Consult and Close** with a further 17% of patients responded to being managed via **See and Treat**, with no further requirement for a conveyance of any kind. Over the same period 45.8% of patients required a conveyance of some type. This compares to 12.9% for Consult and Close and 17.6% See and Treat during quarter 2 2024/25. During that quarter, 44.9% of patients were conveyed. This highlights a marked improvement in the Trust's Consult and Close rate and a similar level of performance when comparing the other metrics year on year.

- **ROSC rates** for quarter 2 2025/26 were 24.2%, which was an improvement on the 22% achieved during quarter 2 2024/25. However, they remain slightly below the ROSC rate ambition of 25-30%. The main factors that directly influence this metric are response times, bystander resuscitation and response type/numbers, but improvements in these metrics have been seen since the implementation of the new response model on 1st July 2025.

3.3 Ambulance Care

- **Targets on timeliness** continue to perform well within Ambulance Care, with Oncology journeys for quarter 2 2025/26 seeing 71.5% of journeys arrive on time and Renal journeys 72.5%, both achieving the 70% target. However, Discharge and transfer journeys booked in advance, at 81% for the quarter, did not achieve the 95% target.

- The **volume of on the day cancellations** has increased slightly over the past year, recording a figure of 14.8% in quarter 2 2025/26, compared to 13.2% over the same period last year. This trend will need to reverse over the next year to realise the planned efficiency improvements.

- The **Medical Transfer Protocol Suite (MTPS)** was introduced, consisting of three Medical Priority Dispatch System protocols. The three additional protocols provide more granularity to the assessment and coding of transfers for step up of care, routine inter facility transfers and mental health transfers and improve understanding on the nature and urgency of transfer demand and the resources required to complete them in a timely manner.

- In terms of **patient satisfaction rates,** in August 2025, 94% of patients were 'happy with the transport they received'. Also, 87% of patients were happy when asked 'how long did you wait for your transport to take you home after your appointment', which was an improvement on the 66% recorded for the same period last year. These figures were based on 221 responses over the course of the month which was also an improvement on last year.

3.4 Our People

- **Sickness absence**, across all directorates, was 7.77% for September 2025, which failed to achieve the 6% target. This figure was also slightly above the 7.46% recorded in September 2024.

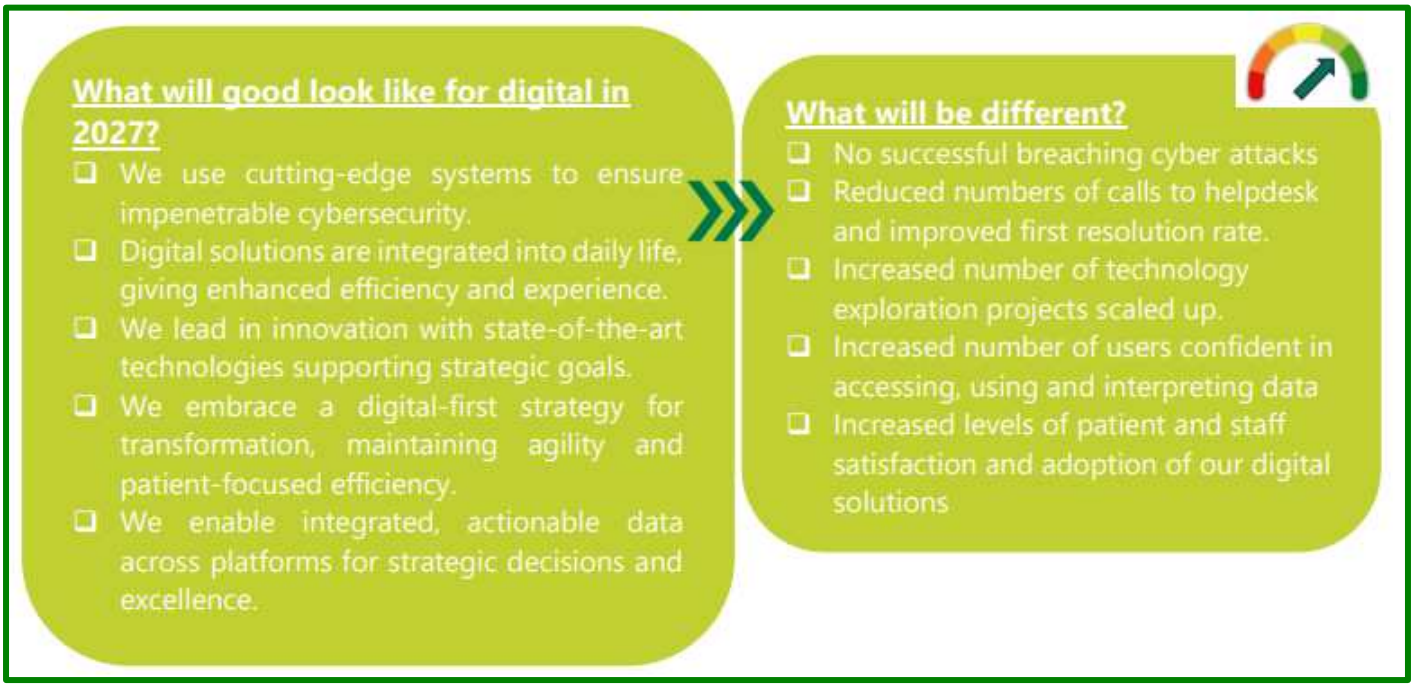
- **Staff turnover rates** have seen a downward trend since 2023 and the 8.02% in September 2025 was the fourth lowest figure recorded in the past 3-years and below the 8.21% seen in September 2024.

- The **NHS Staff Survey completion rate** for 2024 was 35.2% (1,520 completed). This ranked 5th out of 14 NHS Wales organisations. For 2025 our main focus in on increasing participation rates, enabled by a robust communications and engagement plan.

- **PADR rates** for September 2025 were at 75.4%, which continued to be below the 85% target, and slightly below the 75.9% figure recorded for September 2024. This did follow a slight increase in rates during the early part of 2025 which saw the figure peak at 82.4% during March 2025. All directorates are being actively encouraged to ensure that PADR compliance and staff engagement is viewed as a priority.

- Women's Health Network – 96 members; Black Asian and Ethnically Diverse Network – 6 members; WAST Voices – 83 members; Nothing Without Us (Staff Disability Network) – 17 members; Working Carers Network – 15 members and Culture Champions – 120.

3.5 Our Digital Roadmap



- Closed report goes to every F&P. **No successful breaching cyber-attacks** so far this year.

- Monthly KPI report produced from calls logged with the service desk. First time resolution has increased to 54.1% in July 2025, an increase of 13.4% on the same period last year.

- The Digital Directorate has published its **Digital Plan for 2024-2029**. The Directorate's new Digital Innovation and Transformation arm is currently under development and is likely to launch in quarter 4 2025/26. The Directorate is already working with other areas on developments such as the new 111 website virtual assistant, named Albot, with activity for August and September the equivalent of 7% of 111 call demand, and the introduction of drone technology.

- There is a drive to increase the number of users confident in accessing, using and interpreting data and the Directorate will be **recruiting into a Data Enablement role** during quarter 4 to help achieve this going forward.

- The service desk run a monthly **customer satisfaction survey** across our user base. Since April 2025 customer satisfaction has remained strong, with 93.8% of respondents rating the service as Good or Average. All dissatisfied respondents are proactively contacted to provide support, better understand their experience and capture any improvement actions.

3.6 Partnerships and the Wider System

- A **reputation audit** was conducted to capture feedback from across the Trust's key stakeholder groups (including Senior Health Board leaders, managers and wider system partners). The findings were then thematically organised and presented at a Board Development session.

- The **transformation programme** continues to engage with highly influential stakeholders to secure support for our evolving clinical model.

- We will continue to develop and deliver **world class research and innovation** that has far reaching impact. Our partnerships continue to grow with R&I collaborators such as Warwick University. Our capacity continues to grow through such partnerships in areas like linked data provision, such as SAIL and UK Out of Hospital Cardiac Arrest Outcomes Registry. WAST has contributed to innovative policy changes and groups such as the NHS R&D framework and toolkit. There is on-going work to measure the Trust against the NHS R&D Framework.

- **A tracker** is in development through the Integrated Strategic Planning and Development group (ISPD) to try and track external additional funding that is not brought via core JCC funding. The Trust also needs to establish a baseline for additional income through commercial streams and this will be aided by the recent recruitment (now in post) of a new Head of Commercial Development post.

3.7 Quality Driven and Clinically Led

- All Duty of Candour requirement have been met and learning acted upon. The Trust has a Quality Strategy and a Quality Plan. Both are in response to the statutory Duty of Quality. The Trust has a new Putting Things Right Assistant Director in place following an Organisational Change Policy The **Trust now regularly reports on a Duty of Candour metric**, specifically whether the 'in person' notification has been sent. The Duty of Candour was triggered on 10 occasions during quarter 2 2025/26, down from 25 in quarter 1.

- The Trust publicly reports on seven key clinical indicators within the MIQPR. The **ROSC rate** is not yet consistently achieving the 25-30% target range but did record a rate of 27.4% in August 2025. Call to Door times for both Stroke and STEMI are now reported regularly within the MIQPR, but with both being over 2 hours in quarter 2 2025/26, it is recognised that these remain too long. A key area for development is data linking (via NHS numbers) to enable the Trust to track patient outcomes once they have been handed over into hospital care.

- A **People's Experience Framework** has been launched which will be used to frame and deliver all experience work across the Trust. The framework is a maturity matrix aimed at empowering us to evaluate the Trust's current position and develop ambitious improvement plans for people's experience through a value lens.

- The **Strategic Workforce Plan** was agreed in late 2024, which sets out the Trust's road map through to 2030 for key workforce actions. These include, expanding the apprenticeship programme, increased CPD opportunities, developing new clinical leadership structures around the clinical model transformation, a coaching and mentoring framework and increased clarity on career pathways in the Trust.

Agenda Item No. 12.2

REPORT TITLE

Developing the 2026/27 Integrated Medium Term Plan (IMTP) (refreshed approach)

MEETING

Name of meeting	Finance & Performance Committee
Date of meeting	18th November 2025
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

Executive sponsor	Rachel Marsh (Executive Director of Strategy, Planning & Performance)
Author(s) of report	James Houston (Assistant Director of Planning & Transformation)

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 paper is to provide the Finance and Performance Committee with an update and overview of the urgent work undertaken to refresh the organisational approach to develop the 2026/27 Integrated Medium Term Plan (IMTP).

2. The paper describes the internal decision making to support an urgent review of the IMTP planning guidance and project delivery arrangements. Included with the paper is a copy of the refreshed IMTP planning guidance document. The planning guidance document sets out a clear eight pillar framework for delivery which organises all of the core processes and activities that support the approach to develop the plan. Included within the guidance document are the high level governance dates alongside the key project milestones.

3. It is to be noted that the planning guidance has been developed at pace and is included in draft form for information, following an initial review by the Strategic Transformation Board (STB) on the 3rd Nov. A final review is required with key groups in readiness for final sign off and approval at the next STB meeting.

4. Whilst undertaking the refresh of the planning guidance, work has continued at pace to take forward the key activities and processes to commence development of the plan. The current project remains on track with no risks to report on the development process to date.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

Committee is asked to:
NOTE the update provided in this report.
NOTE the IMTP development approach described in the draft IMTP Planning Guidance (subject to further refinement and approval).

ADDITIONAL PAPER(S)

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

1. Appendix 1: CEO roadshow staff feedback summary

2. Appendix 2 – Refreshed IMTP Planning Guidance 2026/27 – 2028/29.

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
3rd November 2025	Strategic Transformation Board

18th November 2025	Finance & Performance Committee

SITUATION

1. The purpose of this paper is to provide the Finance and Performance Committee (F&PC) with an update and overview of the urgent work undertaken to refresh the organisational approach to develop the 2026/27 Integrated Medium Term Plan (IMTP).

BACKGROUND

2. The Trust's 2025/26 IMTP was approved by Welsh Government, receiving positive feedback on the plan and the key areas of focus across the three year planning horizon.

3. Feedback from Welsh Government, findings from an internal audit undertaken in Q1 and insights from an internal 'lessons learned' exercise, have all been considered to shape and inform the approach to developing the 26/27 IMTP.

4. The Trust received 'substantial assurance' from an internal audit review of the 25/26 IMTP Development process. This was a positive achievement, and the details of the internal audit findings, recommendations and management responses are outlined in a separate paper also reporting into the Nov F&PC.

5. The planning cycle has formally commenced across the trust to develop next years plan in readiness for submission to Welsh Government on the 31st March 2026.

ASSESSMENT

6. The IMTP planning guidance used for the 25/26 IMTP was initially refreshed and submitted to the executive team and key governance groups (including STB in Sept) setting out the approach in mid-September.

7. As part of the planning approach, an early conversation was held with the Executive Leadership team (ELT) during an 'away day' in September to consider the strategic landscape and organisational positioning for next year. It was recognised that potential political implications arising from the outcome of the May-26 Senedd elections and changes across the NHS Wales executive team may impact the mandate and priorities of NHS Wales. Any changes to the

mandate and priorities could have a bearing on the trusts plans and ambitions, potentially necessitating 'in year' alterations.

8. In addition, there is an acknowledgement that the financial position for the year ahead will be challenging. Whilst the financial settlement for 2026/27 has yet to be confirmed, early financial analysis indicates that the minimum unfunded cost pressures are projected to be circa £8-9 million (excluding a decision regarding the availability of recurrent funding for Employers NI), with a potential requirement to deliver further additional savings on top. This could mean that the organisation will be required to deliver significant costs savings in year, impacting the ability for the organisation to fund any additional projects requiring additional investment. Discussions have commenced regarding the financial position and process to consider investment bids as part of the IMTP development process.

9. There was a strong consensus across ELT members that the organisation has been running 'hot' for the last 18 months. The organisation has and continues to experience an unprecedented volume of change as a result of the positive progress to deliver the Clinical Transformation Programme and introduction of the new Ambulance Performance Framework. Therefore, it was recognised that the organisation should consider re-framing its ambitions away from 'more' transformational change and focus on a period of 'benefits realisation' with a consolidated list of key priorities. This view was supported by the NHS 'Staff Survey' and staff feedback captured during the CEO roadshows where colleagues noted 'change fatigue' and 'capacity constraints' which have impacted progress in delivering wider organisational objectives. (See appendix 1 for an overview of the CEO roadshow feedback). The proposed re-framing of the plan was also supported following a Board Development session at the end of October.

10. In parallel to these discussions the planning team has experienced a period of instability following the recent appointment of three key planning posts into the JCC along with wider capacity shortfalls in the team.

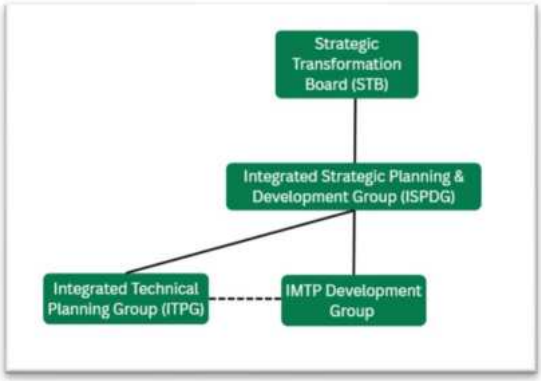
11. Following a discussion with STB in Sept, it was agreed that an urgent refresh and streamlining of the IMTP planning approach and underpinning project delivery arrangements were required to simplify the process and release additional capacity back into the organisation.

IMTP Project Delivery arrangements

12. The proposed project delivery arrangements have been reviewed, and following a collaborative discussion with key directorate leads involved in the production of the IMTP, it was agreed that a single development group is established (known as the IMTP Development Group). This group consolidates the previous IMTP Steering Group and IMTP Project Group into a single function and includes key leads from across all directorates to ensure a collaborative and cross-working approach is applied. The new group met in October, and work is continuing at pace to finalise the terms of reference and project delivery arrangements. The group will be responsible for providing a high level steer on the IMTP development whilst also delivering and monitoring the IMTP development project plan and key actions.

13. The governance arrangements remain unchanged with the group reporting into the Integrated Strategic Planning Development Group (ISPDG) which reports and escalates issues into the Strategic Transformation Board (STB).

    Graphic 1: Overview of governance and reporting arrangements



IMTP Planning Process (Refreshed approach)

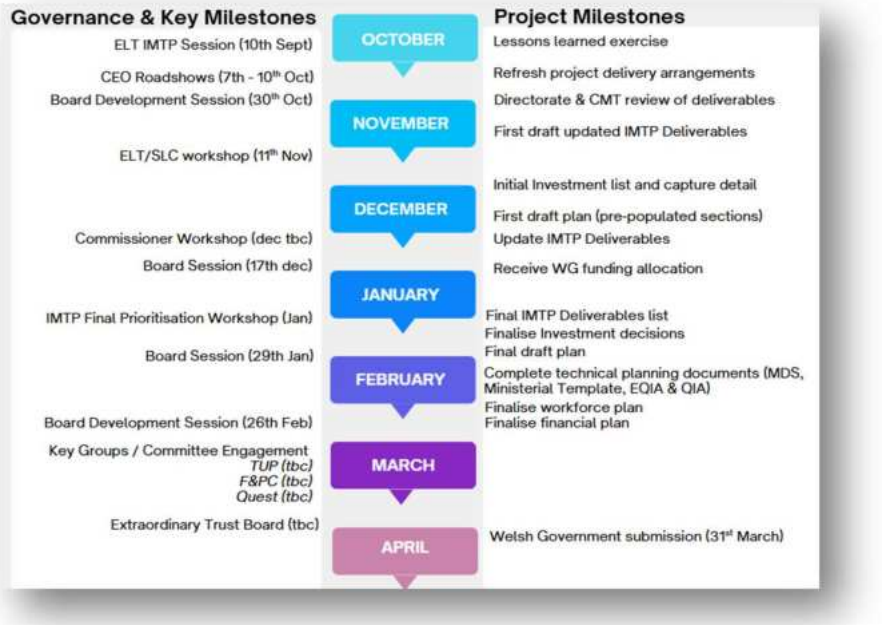
14. The planning approach has been urgently refreshed to directly respond to the feedback and requirement to streamline the process and provide greater clarity on the key processes to develop the IMTP.

15. The refreshed planning guidance (see appendix 2) has been developed with the IMTP Development Group and is currently receiving a final review and edits. It is therefore shared as a working draft for information and consideration, noting that it may be subject to final changes.

16. In line with the feedback from ELT, some of the large scale engagement workshops have been stood down (including the 'IMTP Kick Off event' and 'Dragons Den' workshop). These have been replaced by re-purposing organisational meetings already in the diary and making use of already established groups that are well placed to support this activity.

17. An overview of the 'draft' high level governance milestones and key project dates is outlined in the graphic below. Taking on board feedback, there are more touchpoints with the Board built into the engagement approach for this cycle. This included a session with the Board at the end of Oct alongside sessions in the Dec and Jan Board meetings in addition to the annual Board Development session to be planned for mid-February. This will ensure that the Board is closer to the development and decision making regarding the prioritisation of the plan.

18. Overview of key governance and project milestones



19. The guidance document is framed around eight key 'pillars' setting out the high level steps in the IMTP development process, with more detailed activities contained and described within each pillar. These activities will be distilled into a clear action plan and delivered with a robust project planning methodology.

20. Following a discussion with STB, it was agreed that the IMTP document would continue to be framed around the organisations Strategic Objectives set out in the Long Term Strategy 'Delivering Excellence'. A comprehensive cross-

referencing exercise will also be undertaken to map all of the deliverables against the wider 'key' drivers that shape the plan including the 'Wellbeing Objectives and Duty of Quality.

21. Whilst the planning process has been urgently refreshed, the work required to develop the plan has continued at pace. Key progress is outlined below:

- ***Staff Engagement***: exercise undertaken at the CEO roadshows to gain feedback on 'what matters most' to our people in relation to next years plan.
- ***Project delivery arrangements:*** project arrangements refreshed.
- ***Initial review of IMTP deliverables:*** all directorates and the CMT programme have undertaken an initial review of the current IMTP deliverables to identify which are due for completion, roll over or stopping whilst also identifying any new deliverables for inclusion.
- ***Board engagement:*** an IMTP development session was held during the Oct Board Development session to consider the framing and focus of the 2026/27 plan.
- ***ELT/SLC prioritisation workshop:*** workshop undertaken in early November to review the first draft IMTP deliverables, consider any interdependencies and identify any pieces of work requiring additional investment**.**

22. Whilst urgent changes have been made to the IMTP delivery arrangements and development approach, the project remains on track to meet the WG submission deadline of the 31st March.

RECOMMENDATION

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

NEXT STEPS

24. The next steps are as follows:

- Formalise and embed the project delivery arrangements and overarching project arrangements (including detailed project plan).
- Continue to deliver the IMTP development activities and processes as outlined in the IMTP guidance document via the IMTP Development Group.

Welsh Ambulance Services University NHS Trust

Refreshed IMTP Planning Guidance 2026/27 – 2028/29

(Working Draft for review and feedback)

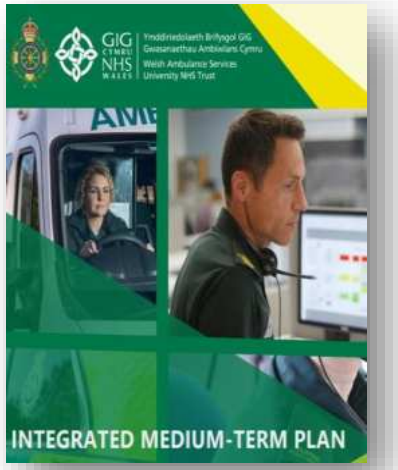
Version 0.3 DRAFT October 2025

GIG CYMRU NHS WALES

Ymddiriedolaeth Brifysgol GIG
Gwasanaethau Ambiwlans Cymru

Welsh Ambulance Services
University NHS Trust

Our approach to Organisational Planning



Purpose of this document

The purpose of this guidance document is to specifically set out our organisational approach to develop our Integrated Medium-Term Plan (IMTP) for 2026/27 – 2028/29.

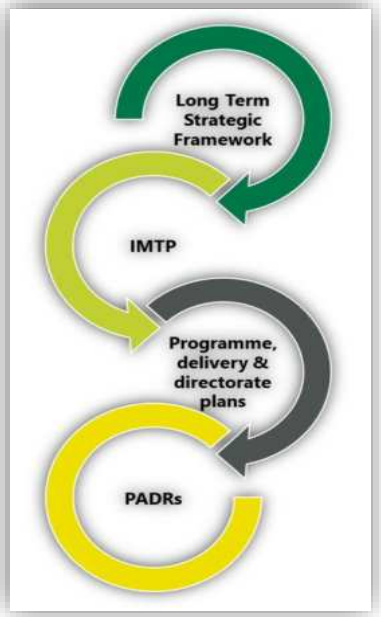
The IMTP is a core feature of our organisational planning approach, and this guidance document is underpinned by the broader WAST Planning Framework which sets out 'how we approach planning' across the breadth of the organisation.

WAST Planning Framework

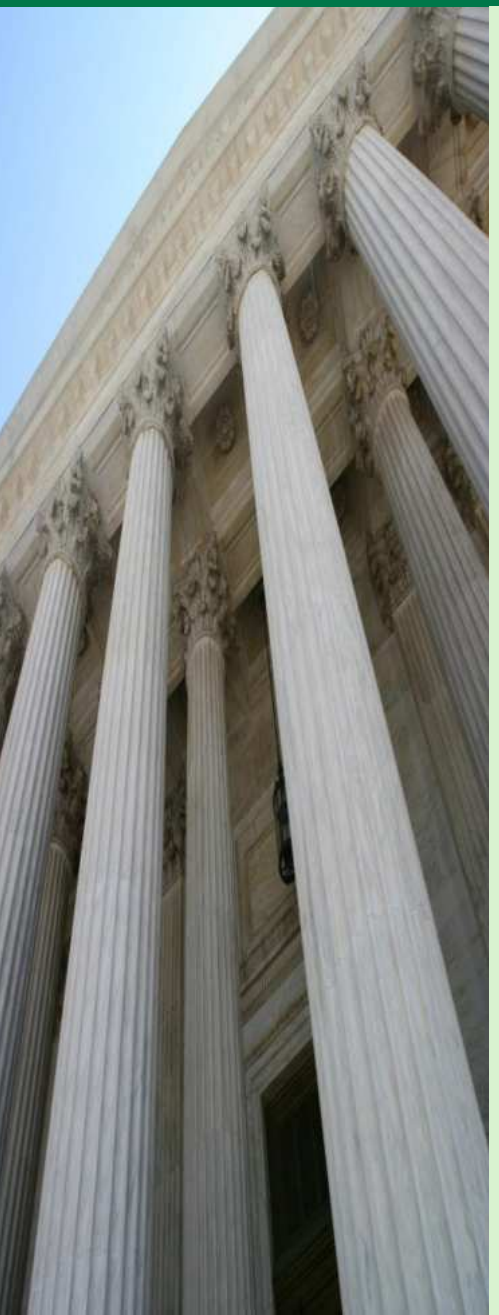
The WAST planning framework is built on the foundations of adopting an 'integrated' and 'collaborative' approach towards organisational planning.

It sets out how we 'connect' the organisation through planning to ensure there is a 'golden thread' between the organisational vision and long-term strategy, directorate level plans and individual PADRs.

The IMTP forms a key delivery mechanism to help deliver our organisational priorities.



Building the IMTP



There are many stages that are critical to the successful development of an approvable IMTP.

We have organised the work into eight key pillars to help build the plan. Each pillar represents a key overarching area of work with a range of processes and actions captured within each one.

The pillars do not represent a linear approach to IMTP development. Key activities will be progressed simultaneously through a joined up and integrated planning approach.

Eight Key Pillars for Success

- Planning & Preparation
- Gathering Intelligence
- Listening & Engagement
- Agreeing the Priorities
- Technical Planning
- Writing the Plan
- Governance & Approvals
- Communicating the Plan

High Level Milestones

The adjacent graphic outlines the high-level milestones from the project plan.

The left column maps out the key governance and engagement meetings.

The right column maps out the key project milestones that underpin the main processes to support development of the plan.

Confirmed dates are being finalised for each milestone as part of the wider review of the IMTP project plan.

Pillar 1: Planning & Preparation

Planning & Preparation

Early planning and preparation is key to put in place the right arrangements to underpin the IMTP development process. This ensures that there is a proportional approach to take forward the work and that key timescales are mapped out early to meet the required governance deadlines, notably the deadline for submission to Welsh Government on the 31st March 2026.

1a. Delivery Mechanisms

Following a review of the initial project delivery arrangements it was agreed that a 'single' project group is established to collaboratively lead the development of the IMTP (***IMTP Development Group***).

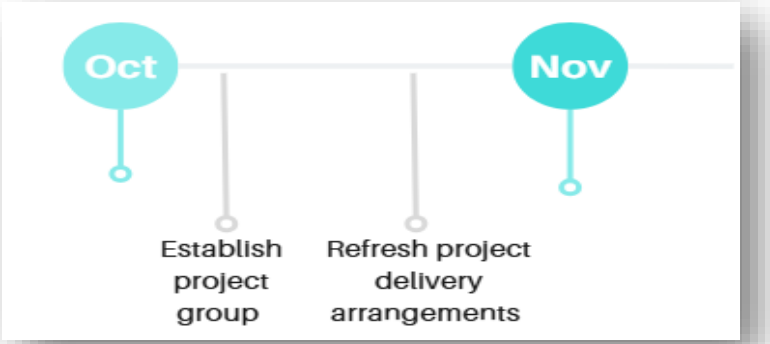
The reporting and governance arrangements remain unchanged and are outlined on the next slide alongside the function of the group.

1b. Project Approach

Development of the IMTP will adopt a proportional project management approach including the development of a high level & detailed project plan setting out clear actions, timelines and action owners.

A full Risk, Action, Issues and Decisions (RAID) log will be maintained. A regular AAA report will be completed following each IMTP Development group meeting.

Key Milestones



Key Outputs

- Project Group
- Project Plan
- RAID Log
- AAA reporting

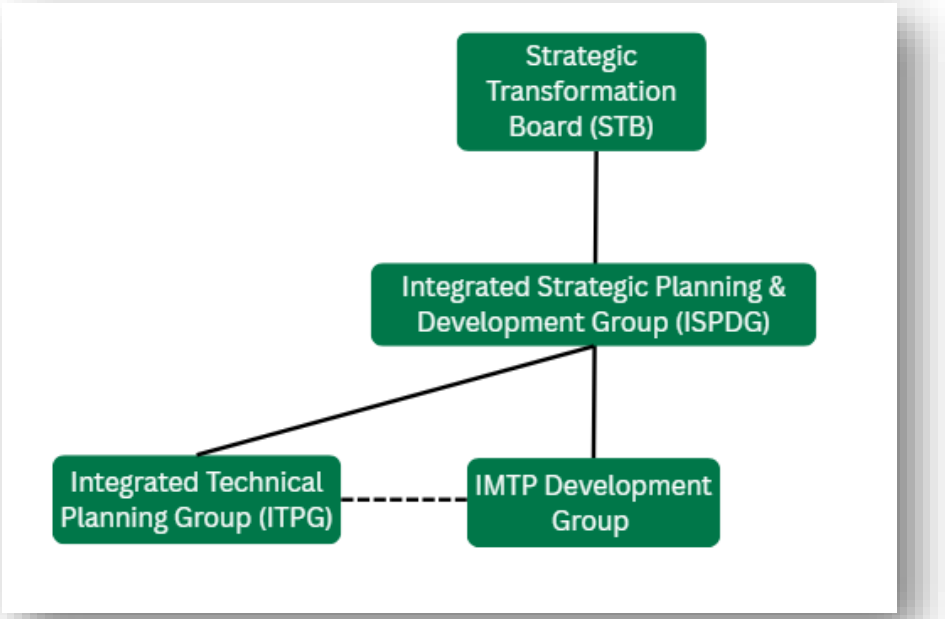
Pillar 1: Planning & Preparation

IMTP Development Group

The IMTP Development Group is a cross-directorate group that includes nominated leads from across all directorates, including senior directorate leads and business partners to reflect the dual role of the group. The purpose of the group is to:

(1) Provide **expertise and oversight** of the IMTP development approach, and

(2) **Lead and monitor the transactional project delivery** and implementation of the project plan.



Role & function

STB: Executive steer and decision making

ISPDG: Oversight and monitoring

IMTP Development Group: Lead the development of the plan and project delivery arrangements, escalating to ISPD and STB as required.

ITPG: Bring together planning, workforce, finance and capital leads to oversee and support key technical process and documentation (e.g., Interdependencies and Minimum Data Set).

Pillar 2: Gathering Intelligence

Gathering Intelligence

Intelligence gathering is a key process to ensure our plan considers and effectively responds to the different internal and external 'drivers' to shape our organisational direction and priorities.

2a. Lessons Learned

A detailed internal lessons learned exercise will be undertaken of last years IMTP process, coupled with Welsh Government's feedback and the Internal Audit findings to deliver a revised, improved approach.

2b. Internal Drivers

A full assessment of internal data and intelligence will be used to inform the plan. This will include a review of our Corporate Risks, Performance and Activity data outlined in the state of the nation report.

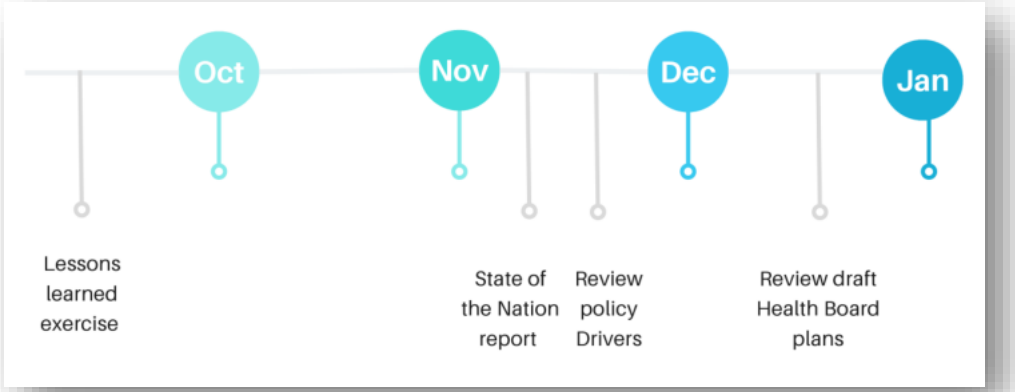
2c. Policy Drivers

A full assessment of the key external drivers will be undertaken to understand the operating landscape, including the NHS Wales Planning Guidance, Welsh Government priorities, Commissioning Intentions and other key policies (E.g., Duty of Quality).

2d. Health Board Plans

We will request early sight of draft Health Board plans to understand their direction, focus and priorities. This intelligence will be used to understand any interdependencies which may shape / influence our plan.

Key Milestones



Key Outputs

- Lessons learned summary
- IMTP checklist
- State of the Nation report outlining key data and information to support the planning approach.

Pillar 3: Listening & Engagement

Listening & Engagement

Listening and engagement is a key process to ensure our plan takes into consideration and effectively responds to the different internal and external 'drivers' that will shape our organisational direction and priorities.

3a. Patient Feedback

Review the key feedback collected from PECI team following patient engagement events to understand the priorities of our service users.

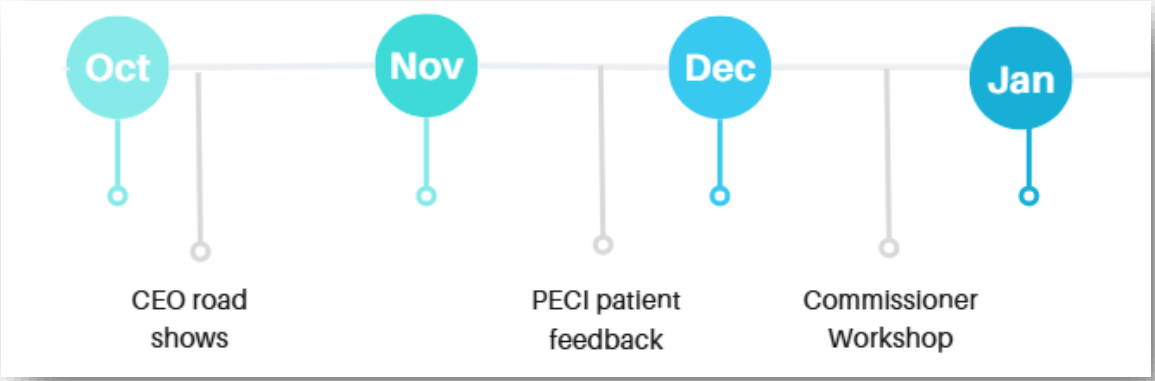
3b. Staff Feedback

The CEO roadshows form a key mechanism to capture feedback from staff about 'what maters to you'. Continued engagement will take place with Trade Union Partners via the Corporate Partnership Forum.

3c. Commissioner Feedback

A Collaborative workshop will be held with the Joint Commissioning Committee (JCC) to discuss emerging WAST priorities and response to the updated commissioning intentions

Key Milestones



Key Outputs

- Patient and feedback themes
- Board & Executive positioning
- Commissioner feedback
- Agreed Commissioning Intentions

Pillar 4: Agreeing Priorities

Agreeing the Priorities

A critical aspect of the IMTP planning process is to review and agree the key organisational priorities to include in the plan. It is important that the priorities reflect the internal and external drivers presented to the organisation, whilst also ensuring that the priorities are achievable within the context of financial and organisational capacity. A collaborative approach is required to understand the organisational inter-dependencies and enabling work required from other directorates / teams.

4a. 25/26 Deliverable Review

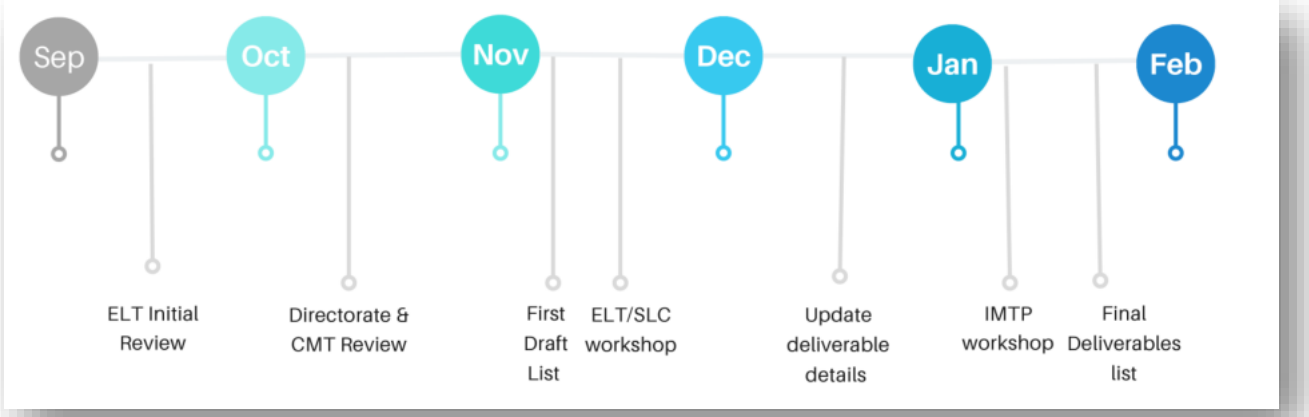
An initial review will be undertaken with ELT, directorates and the CMT programme to review the position of the current IMTP deliverables (complete, roll over, stop, new) to collate a first draft list and to capture any key interdependencies. As part of this, consideration will be given to any FSP actions for inclusion.

4b. Prioritisation Workshops

An initial prioritisation workshop will be held with ELT/SLC in Nov to review the first draft list, interdependencies and investment options.

The ITPG will consider the outputs of this workshop to refine the prioritisation list and work through interdependencies and financial planning. Further work will be undertaken with directorates to firm up the details for each deliverable in readiness for submission to a final prioritisation workshop in January.

Key Milestones



Key Outputs

- Agreed priorities and list of IMTP deliverables

Pillar 5: Technical Planning

Technical Planning

Underpinning the IMTP document are a range of technical planning documents. This includes the Minimum Data Set (MDS), Workforce Plans and Ministerial Templates.

5a. Minimum Data Set

The ITPG will lead on the completion of the Minimum Data Set (MDS) with support from Informatics leads where required.

5b. Ministerial Templates

The four ministerial templates will be drafted by the planning team in collaboration with key service leads and reviewed by the project group.

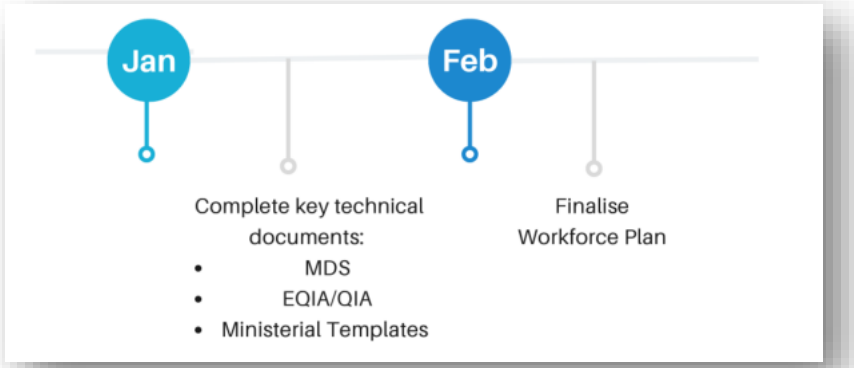
5c. EQIA /QIA

Key leads from the project group with support from quality colleagues will lead the completion of the EQIA and QIA process.

5d. Workforce Plan

Workforce colleagues in collaboration with the ITPG will lead on the completion of the workforce plan.

Key Milestones



Key Outputs

- Minimum Data set (MDS)
- Ministerial Templates
- EQIA/QIA
- Workforce Plan

Pillar 5: Technical Planning – Financial Planning

Technical Planning

In support of the financial plan, the organisation will need to consider its position and decide on the inclusion of any priorities that require additional capital or revenue funding and its overall affordability within the financial envelope for 2026/27.

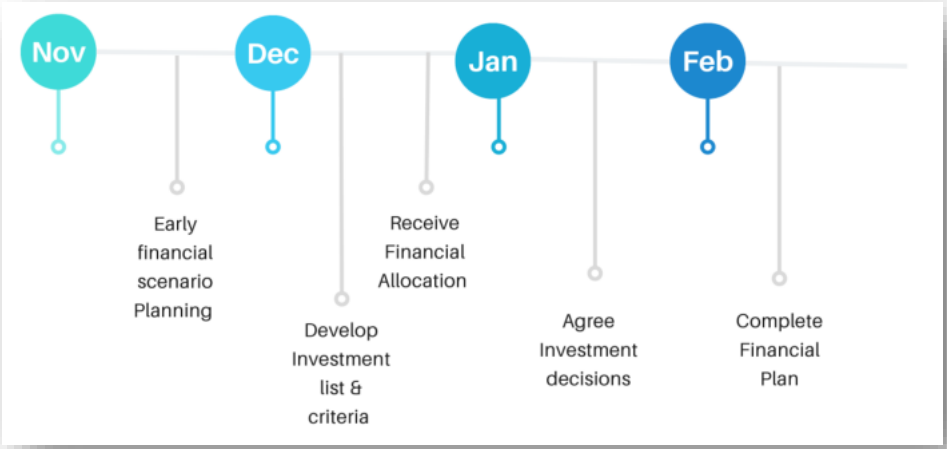
5e. Investment

Deliverables that may require additional investment will be highlighted through the initial review of the IMTP deliverables. A prioritisation workshop with ELT and the wider Senior Leadership community will take place in Nov to identify a definitive list of investment ideas. Key leads will be required to complete a short investment form (capturing key information) which will be assessed using an investment criteria. A panel will then agree the funding position for wider review and endorsement by ELT/STB. As part of the process charity funding can be considered.

5f. Financial Plan

Initial work will be undertaken to draft the financial plan considering various potential funding scenarios prior to receiving confirmation of the financial allocation in Dec. Further work will be undertaken on the financial plan following confirmation of the investment decisions in January.

Key Milestones



Key Outputs

- Investment Priorities
- Financial Plan

Pillar 6: Writing the Plan

Writing the Plan

The culmination of the steps within the IMTP process is the drafting, review and approval of the IMTP document. The document is shaped by the NHS Planning Guidance which sets out the high-level requirement for narrative-based description and tangible actions the organisation is committing to deliver over the three-year planning horizon from 2026/27 to 2028/29.

6a. Document Structure

The framing and structure of the IMTP is critical to ensure the plan describes a coherent story. The plan could be framed around a range of different drivers (e.g., Strategic Objectives, Well being objectives or Quality drivers). Early decision with executive leads regarding the approach is required.

6b. Drafting the Plan

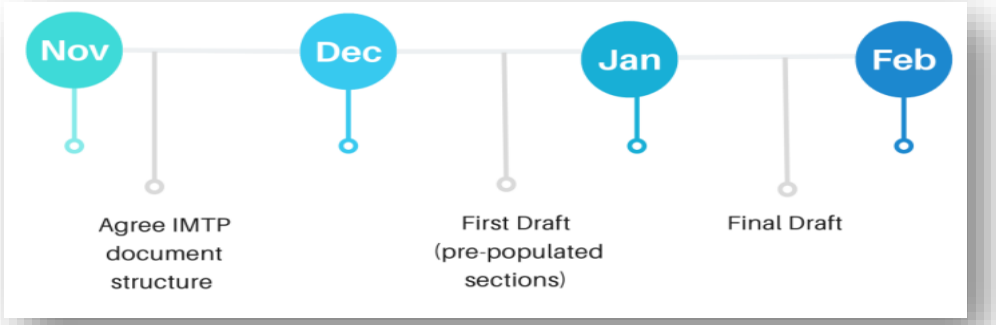
Drafting the plan will be undertaken in a phased approach to minimise the impact of undertaking this work later in the process. An initial draft to update the sections that can be pre-populated will be undertaken in Nov, with the second full draft completed in Jan. The IMTP Development Group will lead on the drafting of the plan and versions shared with key groups for review (e.g., ISPD/ELT).

6c. Design & Translation

The final version of the plan will be professionally designed to bring the plan to life with key visuals and infographics.

All key materials will be translated into Welsh for sharing with the public and wider stakeholders.

Key Milestones



Key Outputs

- Cover letter
- Final IMTP Document

Pillar 7: Governance & Approvals

Governance & Approvals

A well planned and robust approach is required to ensure a timely review and approvals process to meet the Welsh Government submission deadline of the 31st March 2026. This process will require:

7a. Project & Executive Review

Early drafts of the plan will be shared with key groups (including project group, ISPD, ELT and STB) for review and feedback to ensure the plan is fit for purpose and meets the Planning Guidance.

7b. Commissioner Review

The plan will be shared with the Joint Commissioning Committee for review and endorsement prior to submission to Trust Board for final approval.

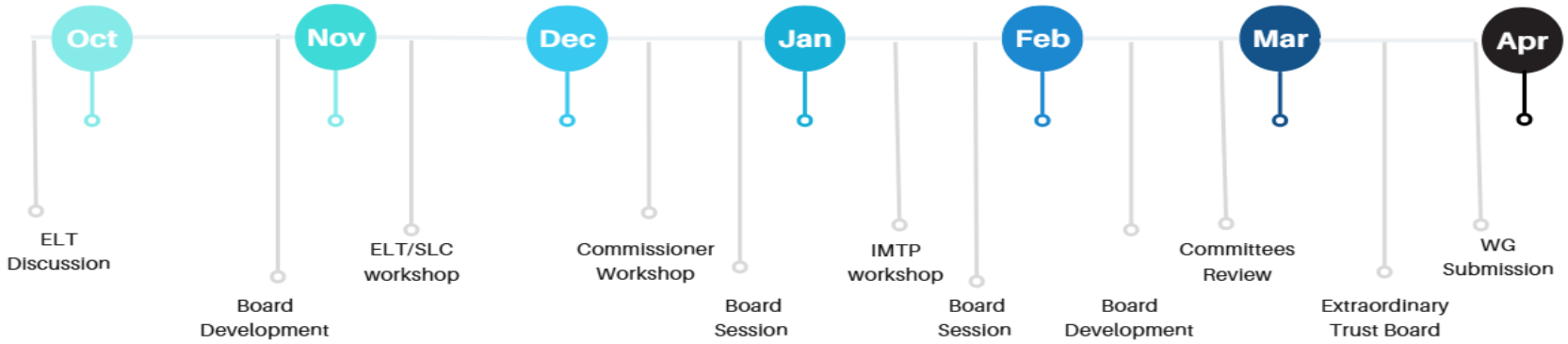
7c. Committee / Board level Review

Drafts of the plan will be shared with key committees (e.g., Quest, F&P) for review alongside Board Development sessions. An extraordinary Trust Board will be held in March for final approval.

7d. WG Submission

The Trust Board approved IMTP and technical appendices will be submitted to Welsh Government on the 31st March

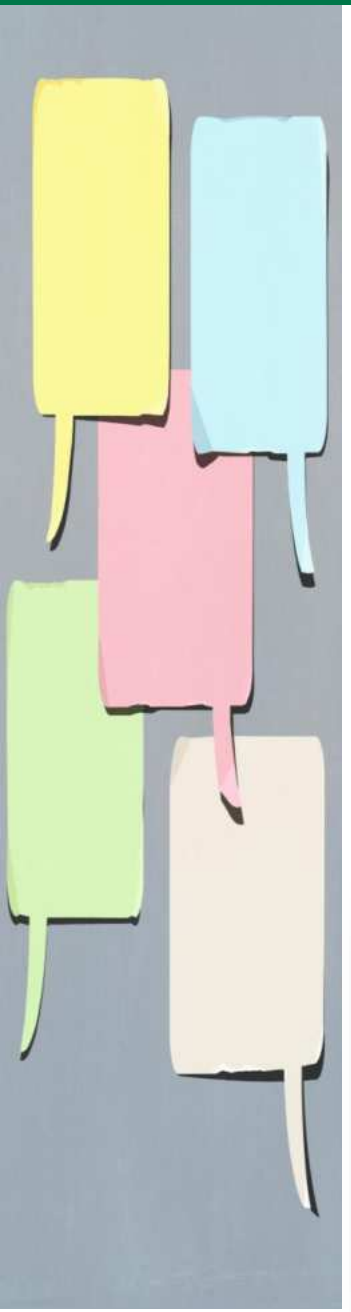
Key Milestones



Key Outputs

- Approved IMTP plan and technical appendices

Pillar 8: Communicating the Plan



Communicating the Plan

Effective communication is important to ensure that our internal and external stakeholders are well informed and can easily access information about our plan.

The approach this year builds on the previous communications approach and seeks to strengthen and tailor the communication materials to each stakeholder group.

8a. Project Communications

Enhanced project level communication materials will be developed to keep internal stakeholders better informed of progress and next steps throughout the planning cycle. This will include regular 'key messages' being shared.

8b. Communicating the Plan (Internal)

A hybrid approach will be adopted to communicate the plan with our staff and volunteers available across different communication channels. Initial approach considers the following:

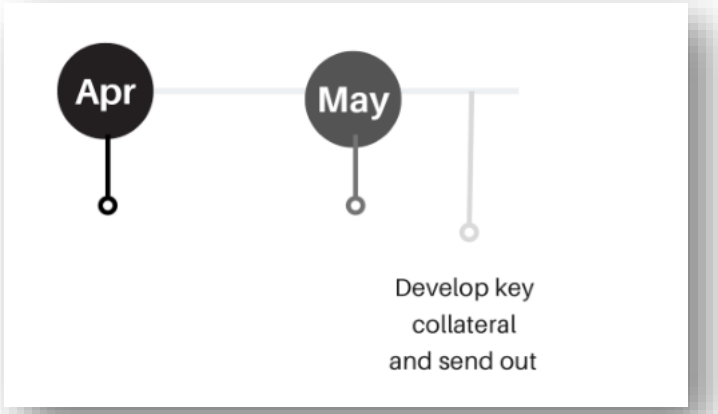
- Full IMTP uploaded onto Intranet
- IMTP Posters, Animation video & Podcast
- Staff focussed IMTP Easy Read

8c. Communicating the Plan (External)

A hybrid approach will also be adopted for external stakeholders with Welsh translation.

- IMTP Easy Read
- IMTP Animation Video
- IMTP Posters (English & Welsh)
- Social media materials

Key Milestones



Key Outputs

- Key outputs are outlined in the sections above for each element of the communications approach.

Next Steps: Developing Directorate Level Plans

A key element of the internal planning approach is the development of directorate level plans. The core purpose of the directorate level plans is two-fold:

(1) Capture and monitor delivery of the IMTP deliverables that sit within a directorate for delivery (i.e. predominantly this will include deliverables that sit outside of key formal programmes for example CMT). and

(2) Capture and monitor delivery of key actions that sit at a directorate level to progress and are not outlined in the IMTP. This could include director objectives or key areas of improvement.

Typically, business as usual functions would not be included in a directorate level plan.

More detailed Directorate level planning guidance will be issued in Q4.

Developing Directorate Plans

Development of directorate level plans will commence in Q4 following confirmation and approval of the final IMTP Deliverables list. Directorates will then be required to undertake internal directorate level planning to review and refresh their plans for submission in Q1 (date tbc).

Planning leads will work closely with directorate leads to support this work and to ensure a consistent approach is adopted to develop and upload the plans via the digital solution.

Key Outputs

- Each directorate will have a detailed directorate level plan.

Thank you for reading the IMTP Planning Guidance document.

The document is currently being reviewed with key leads before being finalised and approved.

If you have any questions, please contact:

- James Houston (Assistant Director of Planning & Transformation)
- Helen Britton (Head of Planning)

Welsh Ambulance Services University NHS Trust

CEO Roadshows: Analysis and Summary of Staff Feedback

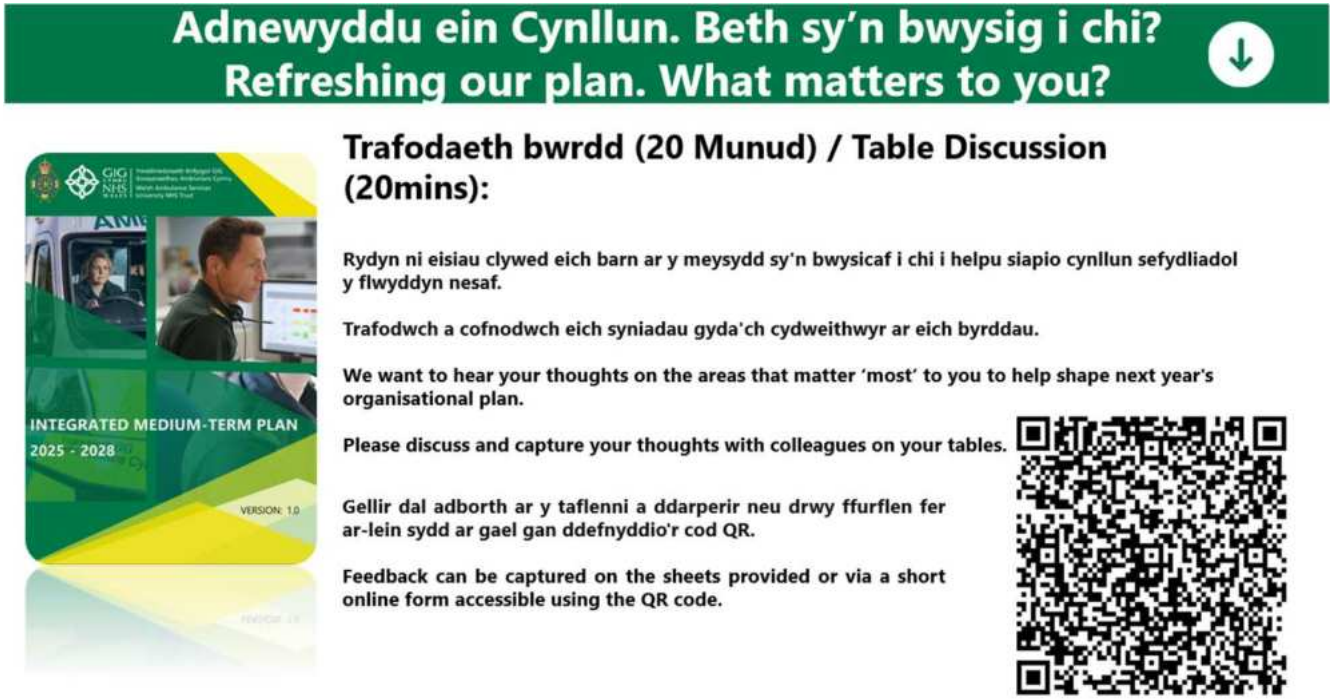
Planning Team
Oct 2025
Version 0.1 DRAFT

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

CEO Roadshow Analysis

Staff Feedback to ‘What matters to you?’

The purpose of this pack is to provide a high-level thematic analysis and summary of the feedback captured from attendees during the Oct-25 CEO. Colleagues were asked to think about and share ‘what matters to you’ to help shape next years plan.



CEO Roadshow Analysis

High level themes

The feedback can be broadly summarised into 10 overarching themes as outlined below.
A summary of the more detailed feedback for each of the themes is included in the appendix.

Workforce Wellbeing & Support

Culture, Leadership & Communication

Career Pathways & Talent Development

Digital Transformation & Data Use

Estates, Fleet & Infrastructure

Change Management & Consolidation

Partnership & System Integration

Equity, Inclusion and Staff Experience

Patient Safety, Experience and Outcomes

Organisational Learning & Improvement

CEO Roadshow Analysis

Detailed Feedback

Workforce Wellbeing & Support

Desire to feel heard and supported – especially during times of change. Requests for visible leadership, flexible working, mental health support.

- Better check-in conversations and visible leadership
- Standardised wellbeing offers and 24/7 mental health support
- Time for reflection, CPD, and training embedded in rostered hrs
- Flexible working (shorter shifts, variation across directorates)
- Reduced uncertainty and clearer communication during change

Culture, Leadership & Communication

Need for authentic, compassionate leadership and inclusive culture.

'Make uncomfortable conversations comfortable' / 'People remember how we made them feel'

- Desire for more dialogue, not just surveys
- Visibility and accessibility of leaders
- Clear ownership and strategic direction

Equity, Inclusion and Staff Experience

Uneven experiences across sites, roles, and access to opportunities. Feeling unheard or unseen

- Variation in estate quality and flexible working access
- Greater representation and support for volunteers
- Amplifying EDI agenda internally and externally

CEO Roadshow Analysis

Detailed Feedback Continued

Change Management & Consolidation

Overwhelm from pace: staff want fewer priorities but done well.

'We need time to embed change before the next one arrives'

- Slower pace, time to embed and evaluate
- Realistic timelines and expectations
- Clear prioritisation in IMTP
- Feedback on initiatives like CMT and single allocator model

Career Pathways & Talent Development

Calls for flexible pathways, transparent career progression, succession planning, and recognition of diverse skills

- Succession planning and talent mapping
- Volunteer-to-career pathways
- Apprenticeships and localised recruitment
- Lattice (not ladder) career models
- Mentorship and development under "Our WAST Way"

Organisational Learning & Improvement

Desire to build capacity for shared learning, innovation and improvement

- Lessons learned platforms
- Real engagement and case study sharing
- Research and innovation beyond clinical teams
- Benchmarking and benefits realisation

CEO Roadshow Analysis

Detailed Feedback Continued

Patient Safety, Experience and Outcomes

Commitment to patient safety, outcomes, and listening to lived experience

- Lived experience and PROMs/PREMs
- Closing treatment loops and improving outcomes
- Sharing data for patient benefit
- Expanding awareness of pathways and alternatives to ED

Digital Transformation & Data Use

Enthusiasm for digital innovation, but need for training, literacy, and safe use

- Digital literacy and CPD for all staff
- AI use—benefits and risks
- Cybersecurity and DSE compliance
- Better internal comms platforms
- Data-informed decision-making and feedback loops

Partnership & System Integration

Strong appetite for collaboration across Health Boards and Local Authorities

- Better alignment with urgent care, NEPTS, and integrated care
- Shared priorities and timing across directorates
- Clearer operational models for estate/fleet/people
- Amplifying WAST's role in population health

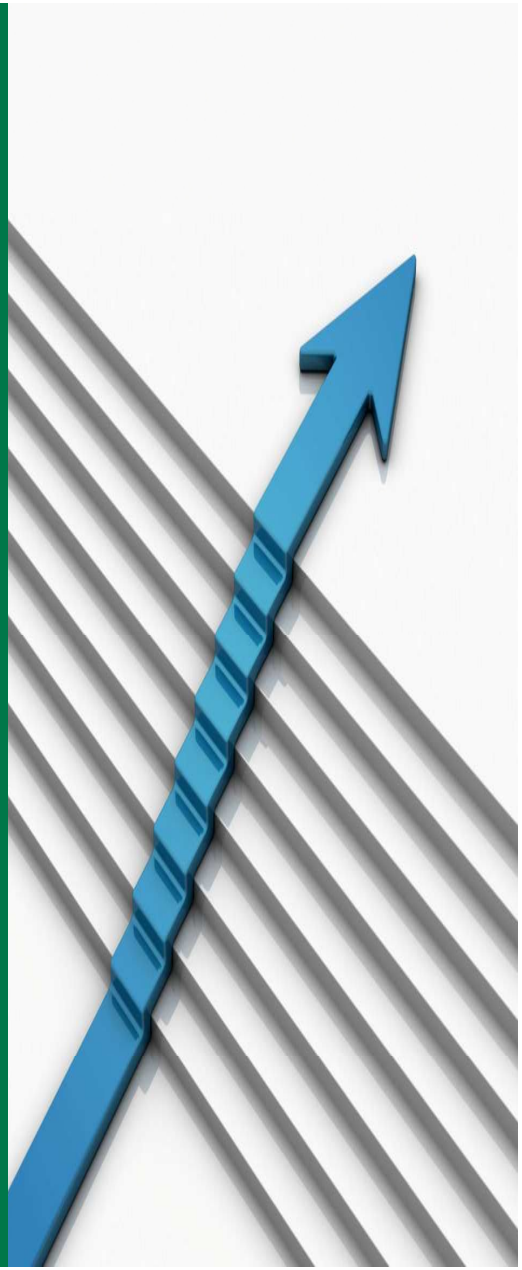
Detailed Feedback Continued

Estates, Fleet & Infrastructure

Concerns about equity, vehicle cleanliness, adequate fleet size and future-proofing infrastructure

- Fit-for-purpose, future-proofed estates
- Clean, safe vehicles with adequate fleet size
- Equity in workplace experience across sites
- Continued funding assurance

CEO Roadshow Analysis



Strategic Implications for WAST

What this means for us

- Consolidate and embed change before introducing new initiatives
- Prioritise workforce wellbeing to sustain patient care
- Invest in leadership visibility, communication and career development
- Align IMTP with staff priorities; clarity, realism and impact
- Strengthen partnerships and equity across the system

Next steps

- Use insights to refresh the IMPT approach and guide strategic planning
- Share findings with teams to foster transparency and trust
- Continue listening – this is just the beginning

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

Agenda Item No. 13

REPORT TITLE

2025/26 Quality Governance Reviews

MEETING

Name of meeting	Finance and Performance Committee
Date of meeting	18 November 2025
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

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

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 approach to the 2025 quality and governance reviews, previously referred to as effectiveness reviews, has been revised. The Audit, Risk and Assurance Committee (ARAC) has

initiated a programme of work to explore opportunities for further efficiencies within the Board's governance framework. To support this, a sub-group of ARAC has been established to oversee the review. The focus of the review is on reassessing the distribution of delegated responsibilities across the Board's committees, with the aim of improving efficiency and effectiveness. This work responds directly to findings from the 2024/25 reviews, particularly those relating to Non-Executive Director (NED) availability, quorum challenges, the volume of meetings, and the transitional status of the Academic Partnerships Committee (APC).

2. The review is driven by key project objectives:

   - Aligning committee remits more closely to the six strategic objectives
   - Improving efficiency and effectiveness in governance
   - Reducing meeting frequency and alleviating quorum/NED availability pressures
   - Ensuring strong scrutiny, challenge, and support through increased NED attendance on key committees
   - Balancing workloads and minimising disruption during a period of executive transition

3. A number of options were considered, with the preferred option to be further considered by the full ARAC at their meeting on 2 December. This option reduces the number of committees from seven to six, with each committee having four NEDs and a quorum of three. It recommends that the Academic Partnership Committee (APC) is disbanded, redistributing its functions (research, innovation, partnerships) to the Finance and Performance Committee (FPC) and the People and Culture Committee (PCC). Remit adjustments will be made to ARAC (resilience, cyber, information governance). This option meets the project's objectives, including improved NED attendance, reduced meeting frequency, and better alignment to strategic objectives.

4. However, it is proposed that full implementation of Option 1 – particularly the major changes affecting FPC and ARAC – is deferred. The Board will be starting a development and effectiveness programme with an external provider in Q4, running into Q1 2026/27 and part of their scope will be a review of committee responsibilities and structures, therefore making major changes before that work is completed would be premature.

5. Notwithstanding the broader work on committee structures, this committee is required to undertake a review of its effectiveness annually. Members will recall that the 2024/25 review was extensive therefore this year ARAC has agreed a light-touch review consisting of a qualitative survey seeking views on the terms of reference, membership and any changes to operating arrangements.

6. The survey results are included in this report, and draft changes have been made to the terms of reference in line with these results and the broader work undertaken by the ARAC sub-group. Most responders to the survey did not wish to see major changes to the committee's membership or terms of reference, indicating general satisfaction with the current structure and

remit. The improvements in quality and volume of reports is recognised, noting there is more to be done. The presence and contribution of Non-Executive Directors (NEDs) are consistently valued, with positive feedback on their breadth of experience, scrutiny, and support, which strengthens the committee's operations. Members are keen to ensure that duplication with the board and other committees is avoided.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The Committee is requested to:

1. Note the wider board committee framework changes proposed and provide feedback on the recommendations.
2. Note the responses to the survey, inviting members who did not have an opportunity to complete the survey to provide further feedback.
3. Approve changes to the terms of reference.

ADDITIONAL PAPER(S)

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

Annex 1 – Marked up changes to the committee's terms of reference

Annex 2 – Progress on changes agreed to operating arrangements following the 2024/25 reviews

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 noted in the SBARN

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
16 July and 24 September	ELT discussions on 2025-26 reviews
25 July and 30 September	ARAC Sub-Group discussions on 2025-26 reviews
2 September 2025	ARAC update on quality and governance review
7 October 2025	APC meeting re quality and governance review
30 October 2025	NED discussion on quality and governance review

SITUATION

2. This paper seeks the committee's endorsement for changes to its terms of reference for 2026/27, effective from 1 April 2026 as part of the annual round of quality and governance reviews (formerly known as effectiveness reviews). It also brings members up to date with wider changes proposed for the board's committee framework.

BACKGROUND

3. Following the 2024/25 committee quality and governance reviews, the Audit, Risk and Assurance Committee (ARAC) identified opportunities to further streamline the Trust's governance structure. A project plan was initiated with the aim of ascertaining if the endorsed spread of board responsibilities could be redistributed in a way that is more efficient and effective. A sub-group of ARAC was formed to support this work.

4. The project takes account of the key concerns raised during the 2024/25 reviews which included Non-Executive Director (NED) availability and consequent quorum pressures, the transitional status of the Academic Partnerships Committee (APC) post-university Trust status, and the high volume of meetings (52 ordinary meetings a year).

5. The review aimed to align committees wherever possible to our six strategic objectives, so they are best placed to drive progress, monitor outcomes and performance, and to respond to emerging priorities.

6. ARAC will formally consider the outputs of the sub-group at its meeting on 2 December and the effect on the board's committee structure, along with the views of this committee on the proposed changes. They will also be asked to endorse the changes to this committee's terms of reference at that meeting. The board will then be asked to endorse the recommendations of ARAC and approve the terms of reference at their January 2026 meeting.

ASSESSMENT

The Board's Committee Framework

7. From July to September the Executive Leadership Team (ELT) and the ARAC sub-group considered a number of issues and options, some of which fully met the

objectives of the project and others that only partially met the scope. Those included:

- Option 1 reduces the number of committees from seven to six. Each committee would have four NEDs and a quorum of three. The Academic Partnership Committee (APC) would be disbanded. Its functions relating to research, innovation, and commercial partnerships would move to the Finance and Performance Committee (FPC), while its responsibilities for education partnerships and collaboration would move to the People and Culture Committee (PCC). To balance the extra responsibilities transferred to FPC, the areas of resilience, cyber security, and information governance (mainly internal controls) would transfer from FPC to ARAC.

- Options 2-4 included variations on committee frequency, further remit reallocation, and consideration of a new research/innovation committee. Each has specific advantages or drawbacks, with some not fully aligning with all project objectives or raising particular concerns.

1. Option 1 was favoured by the ELT and the ARAC sub-group as it meets the project's objectives, including increased NED attendance, reduced meeting frequency, and better alignment to strategic objectives.

2. However, it is proposed that full implementation of Option 1 – particularly the major changes affecting FPC and ARAC – is deferred. The Board will be starting a development and effectiveness programme with an external provider in Q4, running into Q1 2026/27. The programme will review whether the current number and scope of committees are right for an organisation of WAST's size and complexity. It will also look at whether the Board's focus, timing, and balance between strategy, performance, risk management, and culture are appropriate. The findings from this review (expected in Q1) are likely to influence both the remit and meeting frequency of some committees, especially FPC, where there is currently significant overlap with work going to the Board. This may lead to further changes to terms of reference mid-year.

3. In light of this, it will be recommended to ARAC that the following changes to the Board's committee framework take effect from 1 April 2026, with any material changes deferred until the external provider has reported back to the Board on committee structures:

- APC will continue to meet twice annually in 2026/27, with a focus on the research and development portfolio. This was agreed at the APC meeting on 7 October.
- APC delegated responsibilities relating to education partnerships and collaboration will transfer to PCC and those related to commercialisation will transfer to FPC.
- Four NEDs will be asked to attend each of the following committees: FPC, QUEST, PCC and ARAC. This will ensure a quorum of three per meeting. The board skills mix has been updated, and the Trust Chair and NEDs will hold discussions in October on their committee commitments.
- Minor changes are proposed for the Quality, Patient Safety and Experience Committee (QUEST) with the transfer of value based healthcare from FPC.
- No changes are proposed for the Charity or Remuneration Committees.

8. Any changes to terms of reference proposed by this committee from today's meeting will also be reflected in updated terms of reference.

9. Committee members are invited to provide any feedback on the above which will be communicated to ARAC.

The Finance and Performance Committee

10. In parallel with the work on the wider committee structures, each committee is required to complete an annual effectiveness review. Members will recall that the 2024/25 quality and governance reviews for this committee were comprehensive, involving a detailed examination of the terms of reference and the assurance reporting arrangements for each delegated responsibility. These reviews led to several changes to the terms of reference.

11. A number of improvements were agreed as a result of the 2024/25 reviews, and they are being monitored by ARAC. The most recent monitoring report on these is at Annex 2.

12. Given the extensive review undertaken in 2024/25, ARAC agreed that this year's approach would be qualitative. A survey of members was carried out to gather feedback on the proposed changes to the terms of reference (including membership) and to identify what is working well and where improvements could be made. Four responses were received with replies in red where appropriate:

Survey Topic	Responses
Are there any changes you wish to see to the terms of reference	No - I believe these are fit for purpose. Inclusion in the TOR of the responsibilities from the Academic Partnerships Committee related to collaborations with commercial partners. This would sit best where the commercial and financial sustainability work is reported, which is currently FPC. Terms of reference amended to provide for this. No thank you but to note that under recent proposals, commercialisation will move from APC to FPC with effect from 1 April 2026. Please confirm that this will need to be added to the TORs and therefore the committees remit. FPC already has the remit for commercialisation. Terms of reference have been broadened to include commercial partnerships which was transferred from APC.
Are there any changes you would like to see to the committee's membership	I believe that the membership of the Committee is effective - the NEDs who are Members have a breadth of backgrounds, which aptly supports the wide remit of this Committee; i.e. financial and non-financial/performance related matters. To have four NEDs in the membership, and three for quorum. This has been proposed on the amended terms of reference. No. We have 3 NEDs on the committee (inc. one as chair) which is sufficient and meets standard governance requirements. Quoracy has to date not been an issue. The ARAC sub-group recommendations are to have four NEDs in committees to ensure a quoracy of three. FPC remit is multifaceted and meets more regularly than other committees - 6 instead of 4 meetings per annum. There is currently some duplication with the scrutiny required on key aspects of the remit by Trust Board. A focus on appropriate differentiation between FPC and Trust Board could contribute to clarity on optimal levels of scrutiny while reflecting the inevitable interdependencies across committee remits. This is specifically part of the scope for the external board effectiveness and development review taking place in Q4 2025/26 and Q1 2026/27.
What works well in this committee	Good quality reports

Survey Topic	Responses
	Agendas are structured well and are manageable for each meeting. The meetings are well prepared and chaired. The Chair allows everyone an opportunity to contribute. A good balance of scrutiny and support. They have a predictability about them, supported by the cycle of business, which is welcomed. FPC members are well versed in the work of the committee which is wide and varied. The clear commitment of the NEDs to review the large volume and length of papers. They provide excellent scrutiny in a constructive way balancing our different strengths. I as Chair am extremely grateful for their professional input. I have trust and confidence in the ELT who operate in an open and transparent way and who support successful delivery of the committees remit. The corporate governance team provide first rate administration resulting in the smooth operation of the committee which meets bi-monthly rather than the usual quarterly arrangements.
What improvements would you recommend	Potentially some bespoke development on areas of the terms of reference where committee members and the board generally have less exposure and experience such as the infrastructure elements of fleet, estate, and environmental. Members are requested to discuss if bespoke development would be welcomed and on which areas. Some reports are quite complicated. Members are invited to seek advice from the report writer, or the Corporate Governance Team should further information or knowledge in the specific areas be needed. As above, it may be desired to have specific bespoke training opportunities. The writing guidance developed recently should assist in helping writers with succinct report summaries, distilling complex areas.

Survey Topic	Responses
	Work that is ongoing with the MIQPR and the role of FPC and other committees in its monitoring. A consistency of the way in which we report metrics across FPC and other committees. A meeting has been arranged for this on 24 November. Nothing obvious comes out mind, as the Committee runs effectively. Improvements in reducing the volume and increasing the quality of the papers that reflects the deeper dive done on this topic in 2024/25 - ongoing, measured and incremental improvements would be welcome. Further discussions on expectations and the requirement for succinct papers could help to balance the inevitable tension between operational and strategic delivery. The writing guidance will be reviewed regularly. Members are encouraged to suggest improvements and provide feedback on reports after each meeting. Clarification on any potential overlap across committees and any conflicts of interests should be reviewed regularly. Annual quality and governance reviews are key in ensuring there is limited duplication; the work of the ARAC sub-group seeks to ensure those responsibilities delegated to committees is appropriately and equitably split; committee AAA reports are distributed to the board in a timely way where potential duplications can be detected; the Director of Corporate Governance/Board Secretary attends each of the committees as a further internal control and brings the issues of duplication to members regularly.

13. Based on the recommendations from the ARAC sub-group, responses to the qualitative survey, and discussions between NEDs and the Trust Chair on membership, a marked up version of the proposed changes to the terms of reference is at Annex 1 for endorsement by the committee. This includes the transfer of value based healthcare to the Quality, Patient Experience and Safety Committee, which was agreed by them on 4 November. All changes will take effect on 1 April 2026.

RECOMMENDATION

14. The recommendation is as set out in the front cover above.

NEXT STEPS

15. Submission to ARAC and for onward approval of the board of:

    1. The preferred option and implementation plan for the broader committee structures along with the views of this committee.

    2. Changes to terms of reference of this committee including membership changes if any.

16. At the next meeting of this committee the cycle of business will be updated for approval.

17. The annual report of this committee will be presented for endorsement in Q1 of 2026/27 before being presented to ARAC and the board.

FINANCE AND PERFORMANCE COMMITTEE

TERMS OF REFERENCE AND OPERATING ARRANGEMENTS ~~2025/26~~2026/27

1. INTRODUCTION

1.1. The Trust's Standing Orders provide that "*The board may and, where directed by the Welsh Government must, appoint committees of the Trust either to undertake specific functions on the board's behalf or to provide advice and assurance to the board in the exercise of its functions. The board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees*".

1.2. In line with Standing Orders the board shall nominate annually a committee to be known as the **Finance and Performance Committee** (the 'committee'). The detailed terms of reference and operating arrangements set by the board in respect of this committee are set out below.

1.3. committees play an important role in supporting the board in fulfilling its responsibilities by:

- providing advice on strategic development and performance within the terms of reference;
- undertaking scrutiny and gaining assurance on key aspects of organisational performance, and supporting achievement of the Trust's strategic goals;
- carrying out specific responsibilities on the board's behalf; and
- providing a forum where ideas can be explored in greater detail than board meetings are able to allow, providing time and space to consider issues in greater depth.

Regular and timely reporting and escalations to the board on the issues within the committee's remit allow for more focused discussions by the board.

2. PURPOSE

The purpose of the Finance and Performance committee is to enable scrutiny and review of the Trust's arrangements in respect of the:

2.1 overall financial position (both capital and revenue) of the Trust and its compliance with statutory financial duties;

2.2 ability of the Trust to deliver on its core objectives as set out in the Integrated Medium Term Plan (IMTP);

2.3 monitoring of the IMTP and ensuring achievement of key milestones;

2.4 robustness of any cost improvement measures and delivery of key strategies and plans;

2.5 ensure development of the long term strategy and delivery of the Trust's strategic aims in relation to value and efficiency, including an increased focus on benchmarking;

2.6 scrutinise business cases for capital and other investment;

2.7 oversight of the development and implementation of the digital, estates, fleet, and environmental strategies; information governance and information security; and business continuity including emergency preparedness, resilience and response, cyber security, and cyber resilience.

2.8 The committee shall, in carrying out its functions and responsibilities, consider how their decisions secure an improvement in the quality of health services (the duty of quality) as outlined in The Health and Social Care (Quality and Engagement) (Wales) Act 2020. This includes but is not limited to ensuring the provision of high-quality, safe, and effective healthcare services that meet the needs of patients, service users, and their families.

2.9 The committee shall demonstrate the duty of quality through its own operating arrangements, ensuring that its processes, procedures, and decision-making mechanisms uphold the highest standards of transparency, accountability, and governance. It shall regularly review and refine its operating procedures to align with best practices and legal requirements, fostering an environment of continuous improvement. Furthermore, the

committee shall monitor, assess, and report on the implementation of Health and Care Quality Standards, outcomes, and performance indicators where relevant within their remit.

2.10 In alignment with the Wellbeing of Future Generations (Wales) Act 2015, this committee will adopting a long-term perspective in its deliberations and decisions. The committee will consider the broader implications of its actions, particularly in relation to the three wellbeing objectives established by the trust in order to contribute positively to the wellbeing of future generations. These objectives are: 1) being a socially responsible and inclusive employer, 2) fostering an innovative and sustainable organization, and 3) ensuring we are a proactive, accessible, and equitable care provider

3. DELEGATED RESPONSIBILITY

With regard to its role in providing advice and assurance to the board, the committee will specifically:

Strategic Development and Delivery

Long Term Strategy

3.1 Oversee and contribute to the development of the Trust's long term strategic direction and make recommendations to the board for its approval, including any adjustments to the Trust's current long term strategy, Delivering Excellence: Our Vision for 2030.

3.2 Oversee and contribute to the development of the Trust's Integrated Medium Term Plan (IMTP) and ensure alignment of that plan to deliver the long-term strategy.

3.3 Monitor and review progress against the IMTP.

Long Term Plans

3.4 Oversee and contribute to the development of the long term plans associated with Delivering Excellence: Our Vision for 2030, including but not limited to:

- Estates plan
- Fleet plan

- Digital plan
- Environmental plan
- Commercial development plan
- Wellbeing objectives

3.5 Hold a central overview of all long term plans that align to the long term strategy. These plans will be reviewed for alignment by the relevant committee first and their implementation will be guided by the IMTP or relevant local directorate plans.

Finance

3.6 Oversee and contribute to the financial strategy, in relation to both revenue and capital.

3.7 Monitor the Trust's in-year and forecast revenue financial position against budget and review and make appropriate recommendations for corrective action where required.

3.8 Monitor progress against the Trust's capital programmes including for estates, fleet and digital

3.9 Receive, review and ensure mitigation of financial risks of delivery of plans;

3.10 Review progress against the Trust's annual operating framework and make recommendations to the board in relation to development of the annual financial plan and budget setting and financial strategy, financial sustainability programmes, efficiency review implementation and required savings targets.

3.11 Review performance against the relevant Welsh Government financial requirements.

3.12 In accordance with the Scheme of Reservation and Delegation:
- Review all business cases and contract awards for approval by the board and
- Consider whether post implementation evaluations of the above will return for key learning points.

Commercial

3.13 Receive assurance on the development of commercial partnerships and the Trust's commercial framework when developed.

~~**Value Based Healthcare**~~

~~3.14 Receive assurance on delivery of core aims in relation to delivering value and development of value based health care in an out of hospital setting.~~

Performance

~~3.15~~3.14 Review performance against targets and standards set by Commissioners and/or Welsh Government for the Trust and, where appropriate, against national ambulance quality indicators.

~~3.16~~3.15 Review the effectiveness of the Trust's Quality and Performance Management Framework and receive assurance on the value of outcomes produced by the framework.

~~3.17~~3.16 Endorse (and recommend to the board) and monitor progress and ensure the development of robust intelligent targets against:

- Board level key performance indicators (KPIs) in the Monthly Integrated Quality and Performance Report (MIQPR).
- KPIs reporting outside of the MIQPR including digital systems and information governance and information security

~~3.18~~3.17 Monitor and review plans to recover areas of underperformance, reviewing where appropriate associated KPIs as part of any deep dives, and providing assurance to the board and escalating to the board or a relevant committee as required.

Planning

~~3.19~~3.18 Monitor the effectiveness of commissioning arrangements.

~~3.20~~3.19 Review and consider matters relating to demand and capacity including proposals for reviews in this area and recommendations arising from such reviews.

Infrastructure

3.213.20 Review proposals for acquisition, disposal, and change of use of land/buildings.

3.223.21 Receive assurance on compliance with environmental regulations and national targets in relation to the environment and sustainability.

3.233.22 Receive assurance on compliance with fire safety and waste regulations.

Business Continuity and Cyber

3.243.23 Oversight and scrutiny of the Major Incident Plan and Business Continuity Plan and receive assurance that such plans are effective.

3.253.24 Oversight and scrutiny of cyber resilience including assurance on awareness and training of WAST staff and volunteers; maintenance of upgrades/updates of systems, and replacement of legacy/high-risk systems.

3.263.25 Oversight and scrutiny of cyber security including assurance of regular monitoring of risks and threats, business continuity planning and engagement with national cyber centres and stakeholders.

Information Governance and Information Security

3.273.26 Receive assurance the information governance and information security arrangements are appropriately designed and operating effectively to ensure the reliability, integrity, safety, and security of information to support the delivery of high quality, safe healthcare across the organisation.

3.283.27 Review progress of measures to improve information security and adherence to Caldicott principles against the Information Governance Toolkit, Network and Information Systems (NIS) Directive (2018), Data Protection Act (2018), and receive assurance on compliance with relevant standards, legislation and regulations.

3.293.28 Receive assurance on, and review effectiveness of the Trust's information security protocols.

3.303.29 Review performance of the Trust in relation to statutory and mandatory information requests and reporting requirements including but not limited to freedom of information requests, data breaches, police requests and subject access requests.

Policies

~~3.31~~3.30 Approval of policies within the remit of the committee

Risk and Audit

~~3.32~~3.31 Oversee the effective management of strategic and principal risks, as set out within the Board Assurance Framework (BAF), as appropriate to the purpose of the committee.

~~3.33~~3.32 Receive and gain assurance from internal and external audits in their remit. The committee will receive assurance that management actions to address recommendations are in place via the audit tracker and receive appropriate reporting as agreed by the Audit, Risk and Assurance committee. This committee will, where appropriate, scrutinise the impact of actions in response to audit recommendations.

4. AUTHORITY

4.1 The committee is authorised by the Trust Board to investigate, or have investigated, any activity within its terms of reference. In doing so, it will have the right to seek any information it requires from any employee or inspect any books, records, or documents relevant to its remit, ensuring patient/client and staff confidentiality as appropriate. All employees are directed to cooperate with any reasonable request made by the committee.

4.2 The committee is authorised by the board to obtain outside legal advice or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Trust's procurement, budgetary and other requirements.

4.3 The committee is authorised to approve Trust wide policies other than those policies reserved to the Board~~in accordance with the policy for the Review, Development and Approval of Policies~~.

Chair's Action

4.4 There may, occasionally, be circumstances where decisions which would normally be made by the committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the committee. This is most likely, but not exclusively, to arise with respect to approval of policies particularly given the current backlog.

4.5 In these circumstances, the Chair, and the Lead Executive, supported by the Director of Corporate Governance/Board Secretary as appropriate, may deal with the matter on behalf of the committee after first consulting with at least two other Members (Non-Executive Directors).

4.6 The Director of Corporate Governance/Board Secretary must ensure that any such action is formally recorded and reported to the next meeting of the committee for consideration and ratification.

4.7 **Sub-committees**
The committee may establish sub-committees or task and finish groups to carry out on its behalf specific aspects of committee business. Formal sub-committees may only be established with the agreement of the board.

5. MEMBERSHIP AND QUORUM

5.1 The Trust's Standing Orders at 3.3.5 and 3.3.6 provide the rules around committee membership. That includes that the designation of Chair, definition of member roles and powers and terms and conditions of appointment are determined by the board, based on the recommendation of the Trust Chair. Executive Directors and other Trust officers cannot be appointed as committee Chairs, nor should they be appointed to serve as 'members' on any Committee set up to review the exercise of functions delegated to them. They may however be 'in attendance' as appropriate.

5.2 The application of these provisions means that the designation of 'members' in NHS Wales committees is applied to Non-Executive Directors. This ensures there is independent scrutiny, support and challenge, and is a relevant for quorum (see below) and – where it is required – for voting

5.3 Notwithstanding the above, the 'members' and 'prescribed attendees' listed below are often referred to collectively as members or membership.

Committee Membership

5.4 The will comprise ~~three~~ four Non-Executive Directors, one of whom will be designated as Chair, and the following prescribed attendees :

- Executive Director of Finance and Corporate Resources (Joint committee Lead)
- Executive Director of Strategy, Planning and Performance (Joint committee Lead)
- Executive Director of Operations
- Executive Director of Quality and Nursing
- Director of People
- Director of Digital
- Trade Union Partners (x 2)
- Director of Corporate Governance/Board Secretary
- Head of Commercial (when appointed)
- Chairs of Sub-committees (if any)

5.5 In the absence of the committee Chair, one of those in attendance must be designated as Chair of the meeting.

5.6 Members may send deputies in their absence who will act with their full authority. To instigate a substitution arrangement, the member of the Committee must notify the Director of Corporate Governance/Board Secretary before the day of the meeting that he/she is unable to attend and the name of the member who will attend as the substitute.

5.7 The Chair of the Trust Board and the Chief Executive have a standing invitation to attend meetings. In addition, the Committee Chair may invite others (either Trust staff or persons outside the Trust) attend all or part of the meeting to assist with its discussions on any particular matter. The Committee

may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge, and expertise

Quorum

5.8 The quorum for meetings of the committee shall be ~~two~~ four Non-Executive Directors.

5.9 ~~While only two Non-Executive Directors are required for quorum, it is strongly recommended that all three Non-Executive Director members be present at each meeting to ensure robust discussion and effective oversight. The presence of all Non-Executive Directors is crucial for fostering diverse perspectives and maintaining rigorous challenge and scrutiny. Therefore,~~ ~~o~~Other Non-Executive Directors of the board may be co-opted to meetings where it is not possible ~~for all three Non-Executive Directors to attend~~to reach a quorum.

Member Appointments

5.10 The membership of the committee shall be determined by the board, based on the recommendation of the Trust Chair, taking account of the balance of skills and expertise necessary to deliver the committee's remit, and, subject to any specific requirements or directions made by the Welsh Government.

5.11 Non-Executive Members shall be appointed to hold office for a period of one year at a time, (Membership being reviewed by the Chairman of the board on an annual basis) up to a maximum of their term of office. During this time a member may resign or be removed by the board.

5.12 Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the board, based upon the recommendation of the Trust Chair

and, where appropriate, on the basis of advice from the Trust's Remuneration committee.

6. COMMITTEE MEETINGS

Secretariat and Support to committee Members

6.1 The Director of Corporate Governance/Board Secretary, on behalf of the committee Chair, shall:

(a) arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and

(b) ensure the provision of a programme of organisational development for committee members, as part of the Trust's overall board development programme developed by the Director of People and Culture.

Frequency of Meetings

6.2 Meetings shall be held bi-monthly or otherwise as the Chair of the committee deems necessary, consistent with the Trust's annual plan of board business. Meeting agendas, papers and minutes shall be circulated no less than seven days prior to each meeting.

Withdrawal of individuals in attendance

6.3 The committee may ask any member or individual who is normally in attendance but who is not a member to withdraw to facilitate open and frank discussion of any particular matter.

7. RELATIONSHIP AND ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

7.1 The committee is directly accountable to the board for its performance in exercising the functions set out in these terms of reference.

7.2 The committee, through its Chair and members, shall work closely with the board's other committees and groups to provide advice and assurance to the board through the:

- joint planning and co-ordination of board and committee business; and
- sharing of appropriate information;

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the board's overall assurance framework.

7.3 The committee will consider the assurance provided through the work of the board's other committees and sub-groups to meet its responsibilities for advising the board on the adequacy of the Trust's overall framework of assurance.

7.4 The committee shall embed the Trust's corporate standards, priorities, and requirements, e.g. equality and human rights through the conduct of its business.

8. REPORTING AND ASSURANCE ARRANGEMENTS

8.1 The committee Chair shall:

(a) report formally, regularly and on a timely basis to the board and the Chief Executive (Accountable Officer) on the committee's activities. This includes verbal updates on activity, the submission of committee minutes and written reports where appropriate throughout the year;

(b) bring to the board and the Chief Executive (Accountable Officer's) specific attention any significant matter under consideration by the committee; and

(c) ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Trust.

8.2 The Director of Corporate Governance/Board Secretary, on behalf of the board, shall oversee a process of regular and rigorous self-assessment and evaluation of the committee's performance and operation including that of any sub committees established.

9. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

9.1 The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the committee, except in the following areas:

- Quorum (as set out in section 5)

10. REVIEW

10.1 These terms of reference and operating arrangements shall be reviewed at least annually but more frequently if required.

Item 10.2 Annex 1

Group	Changes to operating arrangements	Progress Update	Intended Completion Date	Completion Status
Section 1: Board and all committees	1.1 Further consideration to holding board meetings at venues other than Cardiff in 2025/26.	Work has begun on this consideration, and it is intended that it will be brought to the ARAC in December 2025.	01 January 2026	
	1.2 Introduce progress reports on 'what good looks like' for the strategic objective within committee remits will support the call for more of a strategic focus.	This is an action that sits outside of CorGov and is being advanced by the Strategy, Planning and Performance Directorate.	30 October 2025 – *check in date*	
	1.3 Revised approach to minutes for the Trust Board and its committees.	Draft developed and being consulted on. Q2 deliverable	30 September 2025	
	1.4 Updated board skills matrix for board members, which is aligned to the board committees.	The updated skills mix questionnaire will be shared with the board by the end of August 2025.	30 September 2025	
	1.5 Where possible in 2025/26 the introduction of more hybrid meetings.	This is happening for all committees where it is considered appropriate / welcomed by the respective Chair.	n/a	

Item 10.2 Annex 1

Group	Changes to operating arrangements	Progress Update	Intended Completion Date	Completion Status
	1.6 A reduction in the reporting against the audit tracker will be considered by ARAC in an attempt to reduce volume for committees and increase assurance.	This is a Q4 deliverable on our CorGov Directorate Plan and is in progress.	Q4 2025/26	
	1.7 New report front covers and SBAR templates. This includes a short form report which includes a requirement to set out purpose of report and alignment to strategic objectives, wellbeing objectives and health and care quality standards. This will support the desire to use more presentations over SBAR where appropriate.	The new templates and report writing guidance was published w/c 12 August 2025	n/a	
	1.8 Writing guidance will set out the purpose of the executive summaries in an attempt to ensure they are reflective of the comments received by members of the board and the committees of the board.	The new templates and report writing guidance was published w/c 12 August 2025	n/a	

Item 10.2 Annex 1

Group	Changes to operating arrangements	Progress Update	Intended Completion Date	Completion Status
	1.9 Presentation guidance and support will be provided to colleagues in the Trust.	The new templates and report writing guidance was published w/c 12 August 2025	n/a	
	1.10 Feedback following meetings on reports – both positive and where there are areas of improvement – are encouraged from committee members. This will ensure that we are working towards a continuous improvement in paper length and assurance.	No formal action required. Feedback is being given in meetings regarding report quality and the assurances that this affords.	n/a	
	1.11 A 'reading room' will be established in iBabs for documents that members may wish to review for further information, but which are not vital for scrutiny and oversight.	Completed; in use for all board committees and the board via iBabs.	n/a	
	1.12 Members encouraged to pose questions to report writers before meetings and allowing more time for questioning during sessions were suggested to enhance engagement.	No formal action required.	n/a	

Group	Changes to operating arrangements	Progress Update	Intended Completion Date	Completion Status
	1.13 Continue with agenda setting meetings and encourage themes for meetings to aid in the flow and triangulation. Members are encouraged to review the agenda both when it is commissioned and closer to the meeting and alert the secretariat if insufficient time has been allocated. Likewise, presenters should ensure they are cognisant of the time allocated which includes time to present and for discussion.	No formal action required as the agenda setting meetings are continuing throughout 2025/26.	n/a	
Section 2: Academic Partnership Committee	2.1 Consideration for greater use of presentations within meetings to reduce the number of papers received. This was specifically in reference to Academic Partnership Committee but will be considered for all committees.	No formal action required. Noted that where presentations are in use, cover papers are requested to make it clear to the audience what it has been received for, to aid discussion.	n/a	
Section 3: Audit, Risk and Assurance Committee	3.1 The Corporate Governance Team will ensure that ARAC is aware of the discussion on internal audit reports from	This is business as usual.	n/a	

Group	Changes to operating arrangements	Progress Update	Intended Completion Date	Completion Status
	committees if they review them ahead of ARAC, and vice versa when they come to ARAC first.			
	3.2 Trending on risk scores will be added to the risk management report.	This is business as usual from Q2 2025/26.	n/a	
	3.3 A paper setting out a more focused understanding of where the three lines of defence sit within the organisation and their importance will be cycled into the work programme.	This will be brought to ARAC in quarter three in December 2025 with the Governance and Accountability handbook. The outline of the handbook is before ARAC at this meeting.	30 October 2025	
	3.4 The committee induction programme for ARAC and other committees with be rolled out as new members join.	The committee induction for each committee is being delivered as required / when new members join respective committees.	n/a	
Section 4: Charity Committee	4.1 A further development session to be considered for the Corporate Trustee in 2025/26 on trustee responsibilities.	This has been programmed for the board development day in February 2026.	28 February 2026	

Group	Changes to operating arrangements	Progress Update	Intended Completion Date	Completion Status
	4.2 Lived experience to demonstrate on new proforma the charitable impacts beyond staff benefits.	This is business as usual.	n/a	
	4.3 Committee to maintain a strong focus on equality, diversity and inclusion in its strategic direction.	No formal action required. Equality, diversity and inclusion matters considered within the charity's operations as business as usual.	n/a	
Section 5: Finance and Performance Committee	5.1 A board development session on the use of the MIQPR will be held on 24 April 2025, and the annual review of all MIQPR metrics will come through committees in May.	Complete	Complete	
	5.2 A new finance dashboard is in development and will be considered by the committee in 2025/26.	WAST (and other NHS Wales orgs) are dependent on a national dashboard being developed as part of the NHS Wales finance system refresh (Oracle Financials). If no national solution is produced by end of Dec 25, then WAST will tailor an internal bespoke solution commencing in	March 2026 – *Check in for December 2025*	

Group	Changes to operating arrangements	Progress Update	Intended Completion Date	Completion Status
		Quarter 4 of the 2025/26 Financial year in readiness for rollout from Quarter 1 of the 2026/27 financial year.		
Section 6: WASPT	6.1 Continue with agenda setting meetings with the co-chairs and encourage themes for meetings to aid in the flow and triangulation as well as timing of individual items. Members are encouraged to review the agenda both when it is commissioned and closer to the meeting and alert the secretariat if insufficient time has been allocated. This will ensure there is sufficient time for solution focused discussions and airing of issues.	No formal action required. This is business as usual.	n/a	
	6.2 The terms of reference provide that papers are available seven days before the meeting, however this does not always align with the Trade Union	This is business as usual, and the Corporate Governance Team work closely with Trade Union Partners (TUPs) to align publication of papers with TUP	n/a	

Group	Changes to operating arrangements	Progress Update	Intended Completion Date	Completion Status
	Partners pre-meeting timetable. Best endeavours are made to ensure papers are available for that pre-meet and likewise Trade Union Partners will endeavour to timetable that meeting within the seven days to allow for a full pack to be available.	pre-meets to allow TUP time to review the papers and raise any issues ahead of the meeting.		
	6.3 Partnership working will continue in 2025/26 to ensure that there is continuous effort to maintain trust and openness, the details of which will be discussed in the group.	No formal action required.	n/a	
	6.4 The sessions on how to run effective meetings and on financial reporting will be carried over into 2025/26.	*Financial reporting:* Finance colleagues will deliver this session, and it is intended for Q3 2025/26. Arrangements will be progressed from September.	20 December 2025	

Item 10.2 Annex 1

Group	Changes to operating arrangements	Progress Update	Intended Completion Date	Completion Status
	6.5 The sessions on how to run effective meetings and on financial reporting will be carried over into 2025/26.	*Effective meetings:* The delivery of this action is aligned to the meeting practice and participation guidance coming out in Q2 2025/26.	30 September 2025	
	6.6 There are opportunities to learn more about legislative changes, as well as policy issues through workshops post WASPT meetings, as well as taking advantage of employment-related sessions with the People Services Team which will be explored in 2025.	No formal action required.	n/a	

Item 10.2 Annex 1

Colour	Meaning	Typical Action
Blue	Completed	No further action needed
Green	On track	Continue as planned
Amber	Minor issues	Monitor closely, possibly mitigate
Red	Major issues	Escalate and intervene urgently

Agenda Item No. 14

REPORT TITLE

Risk Management and Board Assurance Framework

MEETING

Name of meeting	Finance & Performance Committee
Date of meeting	18 November 2025
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 Committee's remit.

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

3. The more detailed description contained within the BAF (Annex 4) provides the Committee with an opportunity to review the controls in place against each principal risk and the

assurance provided against those controls where applicable. This will assist Members in evaluating current risk ratings supported by the scoring matrix (Annex 2).

4. Members can take assurance that each of the principal risks have been reviewed during this reporting period in line with the agreed schedule detailed at Annex 3 with continual and dynamic focus on the highest rated risks scoring 15-25. Attention has been given to the risk ratings of each risk and the mitigating actions identified and taken to ensure that risks achieve their target score. This is in addition to the standard and regular review of all controls, assurances, and any gaps.

5. The Executive Leadership Team (ELT) approved the principal risk activity on 29 October 2025 having considered the review of each risk undertaken throughout the period by Risk Owners. There have been no material changes to the principal risks during this period.

6. **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.

7. **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.

8. **Risks 542** *Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan* at a score of 16 (4x4). Work remains ongoing to reframe the risk and present it using the new approach to separate controls, assurances and gaps into internal and external themes and categories; those that the Trust manages and those that it monitors. Each of the assurances against the controls will be described over three lines of assurance.

9. The detail of the Trust newest **Risk 671** *Unauthorised or Inappropriate use of AI technologies* has been included in full on the BAF having been approved for inclusion on the Corporate Risk Register in the last round at a score of 16 (4x4) with a target of 8 (2x4).

10. **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).

11. **Risk 623** *Failure to comply with Data Protection Legislation* remains unchanged at a score of 15 (3x5) and continues to be reviewed.

12. **Risk 100** *Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience* remains static at a score of 12 (3x4) during this period; however, this risk will be considered more closely to determine whether it can be factored into the new relationships with stakeholders reputation risk which is before the Trust Board at its next meeting on 27 November 2025.

13. **Risk 139** *Failure to Deliver our Statutory Financial Duties in accordance with legislation* remains unchanged at a score of 12 (3x4) during this period; however, this risk will be considered in close detail in the next round in line with the financial position for 2026/27.

14. 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 - Summary table
2. Annex 2 – Scoring Matrix
3. Annex 3 – Frequency of Risk review
4. Annex 4 - Board Assurance Framework

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

RISK(S) THIS REPORT MITIGATES

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

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

29 October 2025	Executive Leadership Team

Annex 1 – Corporate Risk Register Summary

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
641 FPC	The Trust's inability to implement the learning from all relevant Manchester Arena Inquiry (MAI) recommendations impacting its response to a major incident/mass casualty incident	**IF** the Trust has not fully implemented the MAI recommendations AND a major incident or mass casualty incident is declared **THEN** there is a RISK that the Trust's Incident Response will be suboptimal **RESULTING IN** avoidable patient harm and/or death, detriment to staff wellbeing, reputational damage and potentially expose the Trust to legal liability	Executive Director of Operations	**20 (4x4)** →
542 FPC	Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan	**IF** there is a lack of resources and available technology and infrastructure **THEN** there will be a failure to deliver the commitments outlined in the action plan and within the Welsh Government timelines **RESULTING IN** negative environmental and social impacts causing and reputational damage	Executive Director of Finance & Corporate Resources	**16 (4x4)** →
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		**16 (4x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		RESULTING IN potential breach of confidentiality and data protection law, data, damage to Trust, and non-compliance with other legislation, regulation and standards.		
594 FPC	The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death.	**IF** a major incident or mass casualty incident is declared **THEN** there is a risk that the Trust cannot provide its pre-determined attendance as set out in the Incident Response Plan and provide an effective, timely or safe response to patients **RESULTING IN** catastrophic harm (death) and a breach of the Trust's legal obligation as a Category 1 responder under the Civil Contingency Act 2004.	Executive Director of Operations	**15 (3x5)** →
623 FPC	Failure to comply with Data Protection Legislation	**IF** the Trust fails to comply with and demonstrate it is meeting the accountability requirements under the Data Protection Act, the UK General Data Protection Regulation (GDPR) and the Common Law Duty of Confidentiality **THEN** the Trust will breach its legal obligations and potentially cause the personal or sensitive data to be compromised, lost, or inappropriately used **RESULTING IN** unauthorised data breaches/loss, financial or compensatory penalties, an increased regulatory scrutiny or enforcement as well as stakeholder mistrust and reputational damage.	Director of Digital Services	**15 (3x5)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
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	**8 (2x4)** →

Annex 2 - Risk Scoring Matrix

Consequence:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Safety & Well-being - Patients/ Staff/Public	Minimal injury requiring no/minimal intervention or treatment. No time off work. Physical injury to self/others that requires no treatment or first aid. Minimum psychological impact requiring no support. Low vulnerability to abuse or exploitation - needs no intervention. Category 1 pressure ulcer.	Minor injury or illness, requiring minor intervention. Requires time off work for >3 days Increased hospital stay 1-3 days. Slight physical injury to self/others that may require first aid. Emotional distress requiring minimal intervention. Increased vulnerability to abuse or exploitation, low level intervention. Category 2 pressure ulcer.	Moderate injury/professional intervention. Requires time off work 4-14 days. Increased hospital stay 4-15 days. RIDDOR/Agency reportable incident. Impacts on a small number of patients. Physical injury to self/others requiring medical treatment. Psychological distress requiring formal intervention by MH professionals. Vulnerability to abuse or exploitation requiring increased intervention. Category 3 pressure ulcer.	Major injury leading to long-term disability. Requires time off work >14 days. Increased hospital stay >15 days. RIDDOR Reportable. Regulation 4 Specified Injuries to Workers. Patient mismanagement, long-term effects. Significant physical harm to self or others. Significant psychological distress needing specialist intervention. Vulnerability to abuse or exploitation requiring high levels of intervention. Category 4 pressure ulcer.	Incident leading to death. RIDDOR Reportable. Multiple permanent injuries or irreversible health effects. An event which impacts on a large number of patients.
Quality/ Complaints/ Assurance/ Patient Outcomes	Peripheral element of treatment or service suboptimal. Informal complaint/inquiry.	Overall treatment/service suboptimal. Formal complaint (Stage 1). Local resolution. Single failure of internal standards. Minor implications for patient safety. Reduced performance.	Treatment/service has significantly reduced effectiveness. Formal complaint (Stage 2). Escalation. Local resolution (poss. independent review). Repeated failure of internal standards. Major patient safety implications.	Non-compliance with national standards with significant risk to patients. Multiple complaints/independent review. Low achievement of performance/delivery requirements. Critical report.	Totally unacceptable level or quality of treatment/service. Gross failure of patient safety. Inquest/ombudsman/inquiry. Gross failure to meet national standards/requirements.
Workforce/ Organisational Development/ Staffing/ Competence	Short-term low staffing level that temporarily reduces service quality (< 1 day).	Low staffing level that reduces the service quality.	Late delivery of key objective/service due to lack of staff. Unsafe staffing level (>1 day)/competence. Low staff morale. Poor staff attendance for mandatory/key professional training.	Uncertain delivery of key objective/ service due to lack/loss of staff. Unsafe staffing level (>5 days)/competence. Very low staff morale. Significant numbers of staff not attending mandatory/key professional training.	Non-delivery of key objective/service due to loss of several key staff. Ongoing unsafe staffing levels or competence/skill mix. No staff attending mandatory/professional training.
Statutory Duty, Regulation, Mandatory Requirements	No or minimal impact or breach of guidance/statutory duty.	Breach of statutory legislation. Reduced performance levels if unresolved.	Single breach in statutory duty. Challenging external recommendations/improvement notice.	Enforcement action. Multiple breaches in statutory duty. Improvement notices. Low achievement of performance/ delivery requirements. Critical report.	Multiple breaches in statutory duty. Zero performance rating. Prosecution. Severely critical report. Total system change needed.
Adverse Publicity or Reputation	Rumours. Low level negative social media. Potential for public concern.	ocal media coverage - short-term reduction in public confidence/trust. Short-term negative social media. Public expectations not met.	Local media coverage - long-term reduction in public confidence & trust. Prolonged negative social media. Reported in local media.	National media coverage <3 days, service well below reasonable public expectation. Prolonged negative social media, reported in national media, long-term reduction in public confidence & trust. Increased scrutiny: inspectorates, regulatory bodies and WG.	National/social media coverage >3 days, service well below reasonable public expectation. Extensive, prolonged social media. MP/MS questions in House/Senedd. Total loss of public confidence/trust. Escalation of scrutiny status by WG.
Business Objectives or Projects	Insignificant cost increase/ schedule slippage.	<5 per cent over project budget. Schedule slippage.	5–10 per cent over project budget. Schedule slippage.	Non-compliance with national targets.10-25 per cent over project budget. Schedule slippage. Key objectives not met.	>25 per cent over project budget. Schedule slippage. Key objectives not met.
Financial Stability & Impact of Litigation	Small loss. Risk of claim remote.	Loss of 0.1–0.25% of budget Claim less than £10,000.	Loss of 0.25–0.5% of budget. Claim(s) between £10,000 and £100,000.	Uncertain delivery of key objective. Loss of 0.5-1.0% of budget. Claim(s) between £100,000 and £1 million. Purchasers failing to pay on time.	Non-delivery of key objective. Loss of >1 per cent of budget. Failure to meet specification. Claim(s) >£1 million. Loss of contract/payment by results.
Service/ Business Interruption	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours. Some disruption manageable by altered operational routine.	Loss/interruption of >1 day. Disruption to a number of operational areas in a location, possible flow to other locations.	Loss/interruption of >1 week. All operational areas of a location compromised, other locations may be affected.	Permanent loss of service or facility. Total shutdown of operations.
Environment/Estate/ Infrastructure	Minimal or no impact on environment/service/property.	Minor impact on environment/ service/property.	Moderate impact on environment/ service/property.	Major impact on environment/ service/property.	Catastrophic impact on environment/service/property.
Health Inequalities/ Equity	Minimal or no impact on attempts to reduce health inequalities/improve health equity.	Minor impact on attempts to reduce health inequalities or lack of clarity on the impact on health equity.	Lack of sufficient information to demonstrate reducing equity gap, no positive impact on health improvement or health equity.	Validated data suggests no improvement in the health of the most disadvantaged, whilst supporting the least disadvantaged, no impact on health improvement and/or equity.	Validated data demonstrates a disproportionate widening of health inequalities, or negative impact on health improvement and/or equity.

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	Frequency:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
1 Highly Unlikely: Will probably never happen/recur	Not for years	1	2	3	4	5
2 Unlikely: Do not expect it to happen/recur but it is possible	At least annually	2	4	6	8	10
3 Likely: It might happen/recur occasionally	At least monthly	3	6	9	12	15
4 Highly Likely: Will probably happen/recur, but not a persisting issue	At least weekly	4	8	12	16	20
5 Almost Certain: Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

Annex 3 - Frequency of Risk Review

Risk Score	Review Frequency	Risk Rating
15 – 25 Red	Review monthly	High
8 – 12 Amber	Review quarterly	Medium
1 – 6 Green	Review every 6 months	Low

Annex 4 – Board Assurance Framework – **CONFIDENTIAL**

Risk ID 641	The Trust's inability to implement the learning from all relevant Manchester Arena Inquiry (MAI) recommendations impacting its response to a major incident/mass casualty incident	Date of Review:	01/10/2025	TREND	20 (4x5)
		Date of Next Review:	01/11/2025	➡	

IF the Trust has not fully implemented the MAI recommendations AND a major incident or mass casualty incident is declared	**THEN** there is a RISK that the Trust's Incident Response will be suboptimal	**RESULTING IN** avoidable patient harm and/or death, detriment to staff wellbeing, reputational damage and potentially expose the Trust to legal liability.

	Likelihood	Consequence	Score
Inherent	5	5	25
Current	4	5	20
Target	2	3	6

IMTP Deliverable Numbers:

Strategic Objective:

EXECUTIVE OWNER	Executive Director of Operations	ASSURANCE COMMITTEE	Finance & Performance Committee

Risk Commentary

Following the Manchester Arena Incident in May 2017, whereby twenty-two (22) innocent people were sadly killed, and the subsequent Public Inquiry (MAI), ambulance services across the UK have reviewed their ability to respond to a Major Incident. WAST has undertaken its own review and has identified sixty-eight (68) of the MAI recommendations as being pertinent to the ambulance service and/or multi-agency preparedness and response. Once these recommendations have been implemented then the risk will be mitigated to target; however, additional financial resources are required to do this.

As part of the Trust's ongoing commitment to deliver the necessary change against the MAI recommendations, a dedicated team was established in June 2023 to investigate and assure the Board that all necessary organisational processes were in place should an incident occur in Wales. Since the beginning of this project, significant progress has been made in addressing the recommendations (as identified in the 'Controls' section below) and the Trust is better prepared because of the work undertaken to date.

As part of the ongoing work, the Trust has completed a series of investigations and developed a series of 'Capability Reports' to demonstrate and explain where remaining challenges to an anticipated Major Incident could occur. The capability gaps identified are detailed in the below reports, which were shared with the Board, and are supported by a significant base of evidence produced as part of the 'R105' self-review process. The reports are:

- **R106 Capability Report**
- **Capability to Prepare**
- **Capability to Respond**
- **Capability of Specialist Assets**

The reports identify that a significant proportion of the MAI recommendations remain outstanding, and the Trust is unable to progress these further or fully implement the identified learning without financial support. The reports highlighted what is needed to complete or significantly progress twenty (20) MAI recommendations and forms the basis of the 'Gaps in Controls' and 'Actions' sections. Transitioning these gaps and actions across into the 'Controls' section when achieved will act as a longitudinal method of tracking progress of completion against the MAI recommendations, and the associated risk reduction as this occurs. If the Trust is unable to implement the MAI recommendations fully, there remains a risk to the public, the organisation, and commissioners in the event of a mass casualty incident.

This Board Assurance Framework (BAF) extract is supported by a more detailed appendix of itemised actions required to permit greater scrutiny of remaining gaps and actions, as well as a detailed repository of control measures that have been successfully implemented.

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. **Forty-six (46)** of the pertinent MAI Recommendations have been implemented into WAST practice through the work undertaken to date.	1. MAI recommendations that have been marked as implemented by the EPRR MAI Project are authorised and ratified by Operations Senior Leadership Team and cascaded via the approved governance route (AAA) to ELT and Trust Board. This forms a documented governance route for rationale for completion and details of this are recorded in the EPRR share drive alongside evidence of compliance. Additional details of assurance are provided in the annex to this Corporate Risk. Ongoing monitoring and assurance of lessons learned is captured through BAU processes and the established debriefing/lessons learned process such as the Organisational Learning Spreadsheet.
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Two (2) outstanding MAI Recommendations, identified as pertinent to WAST by the self-assessment, require action against to implement the associated learning **(REF: MAI recommendations 26 & 88).** These are not included in the R106 funding request.	1. Work is progressing against these recommendations as part of the ongoing MAI project. It is anticipated that these recommendations can be implemented without additional financial support. Regular updates on these four recommendations are provided through the regular 'touch point' meetings with EPRR HoS, ADO for National Operations & ED of Ops, with periodic updates to SLT that are then cascaded via the approved governance route.

Risk ID 641	The Trust's inability to implement the learning from all relevant Manchester Arena Inquiry (MAI) recommendations impacting its response to a major incident/mass casualty incident	Date of Review:	01/10/2025	TREND	20 (4x5)
		Date of Next Review:	01/11/2025	➡	

2. Eighteen (18) outstanding MAI Recommendations that have been submitted to Trust commissioners via the 'R106' process as requiring financial support to implement the learning **(REF: MAI recommendations 16, 17, 20, 23, 24, 25, 50, 53, 71, 84, 85, 86, 87, 92, 108, 109, 117, 124).**	2. The outstanding recommendations are not able to be implemented independently by WAST and may remain unresolved until such time that additional financial resources and practical arrangements are in place to support this work. Trust commissioners have been notified of this via the formal R106 submission completed in August 2024.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Implement the learning relating to forty-eight (48) recommendations identified in the MAI report as pertinent for WAST **(REF: Outstanding MAI recommendations (26 & 88).**	Assistant Director of Operations, National Operations & Support	CLOSED	This programme of work is underway, with nearly all recommendations completed. **2** recommendations remain outstanding, with a plan in place to implement all these recommendations. May 25 – Progress report has been submitted to SLT and outstanding actions are now monitored through the risk register (Ref: 641). Submission to commissioners and further scrutiny sessions completed and awaiting commissioner outcome expected in August 2025.
2. Submit evidence to Commissioners demonstrating that additional funding is required to implement a further twenty (20) recommendations identified in the MAI report **(REF: MAI recommendation R106).**	Assistant Director of Operations, National Operations & Support	CLOSED	March 25- During March and April the Trust has engaged with commissioners on a series of scrutiny sessions to review content of submission for the MAI; following these scrutiny sessions it will be for the commissioners to formally respond to the Trust, determining next steps and any subsequent course of action. A formal submission of requirements has been submitted to commissioners for consideration and approval. Commissioners have been engaged with since early 2024 to raise awareness and facilitate early discussion. The Trust is awaiting a formal response to the submission. May 25 – Progress report has been submitted to SLT and outstanding actions are now monitored through the risk register (Ref: 641). Submission to commissioners completed and awaiting commissioner outcome expected August 2025. **Oct25 – A series of scrutiny sessions with Commissioners has been undertaken, the most recent being in September 2025. The Commissioner has provided a timescale to respond to the submission as being November 2025.**
3. Implement the necessary amendments to Trust infrastructure, resourcing level and equipment required to address the remaining recommendations once funding has been made available. (**REF: MAI recommendations 16, 17, 20, 23, 24, 25, 50, 53, 71, 84, 85, 86, 87, 92, 108, 109, 117, 124).**	Assistant Director of Operations, National Operations & Support	March 2029	An assortment of 20 proposals rests with commissioners at present. As these proposals are funded, capabilities gaps will be addressed and an associated reduction in the risk score can be expected. Some of these proposals may take several years to implement (e.g. a North Wales HART Unit) which is reflected in the target date. Other proposals could be accomplished in a much shorter timeframe if funded. Once the implementation of infrastructure, resourcing and equipment has occurred, WAST will either be compliant with the MAI recommendations, or, in some circumstances, may need to undertake further work to integrate the MAI learning into practice (e.g. once the EPRR Training & Exercising Team have established, they will then need to provide sufficient levels of exercising to comply with the exercising-related MAI recs).

Risk ID 542	Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan	Date of Review:	08/10/2025	TREND	16 (4x4)
		Date of Next Review:	08/11/2025	➡	

IF there is a lack of resources and available technology and infrastructure	**THEN** there will be a failure to deliver the commitments outlined in the action plan and within the Welsh Government timelines	**RESULTING IN** negative environmental and social impacts causing reputational damage

	Likelihood	Consequence	Score
Inherent	5	4	20
Current	4	4	16
Target	2	4	8

IMTP Deliverable Numbers: 17, 18, 33

Strategic Objective:

EXECUTIVE OWNER	Executive Director of Finance and Corporate Resources	ASSURANCE COMMITTEE	Finance and Performance Committee

Risk Commentary

Challenges continue around resources and technology, and currently there is not an ability to reduce this score. Decarbonisation Programme Board continue to meet. Noting some progress on positive movement to actions within the DAP. Recent progress is focussing on implementation of PHEV and BEV SRVs. WG is refreshing the Strategic Delivery Plan – final version of the document not yet received

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. Oversight of implementation and delivery of Decarbonisation project and monitoring of action plan at Decarbonisation Programme Board and Capital Management Board	1. Regular meetings of the Decarbonisation Programme Board quarterly. Requirements of the Decarbonisation project have been presented to the Trust Board & Finance and Performance Committee. Challenges of the project have also been highlighted. Report goes regularly to FPC and then onto Trust Board. Next update will be **January** FPC meeting
2. Capital and Estates directorate lead support – Director of Finance (DOF)	2. Regular briefings to DOF
3. Partnership working via Communications/Stakeholder liaison group with NHS Wales, Welsh Government and other bodies to gain support and knowledge- with the anticipation of working in collaboration.	3. Sharing of knowledge via partnership working through various forums is documented in minutes of meetings held. Requirements also form part of the action plan
4. Approach changed for heating/lighting/energy systems to become more energy efficient- replacing old inefficient plant with more sustainable technology such as natural gas boilers for air source heat pumps	4. (i) Estate Survey undertaken every 5 years. This is a 6-facet survey to understand where the back log is and the requirements for energy systems. Next survey round to take place in 2025/26 which will inform the update of the Estates SOP. (ii) Approved Estates SOP (iii) Estate Retrofit Guide and framework used to prepare schemes
5. Changing procurement practices for fleet, Estates, equipment, supplies, and ICT to reduce emissions	5. Fleet SOP shows move to ULEV vehicles. BJC 2025/26 details intention for move to EV for smaller and support vehicles**. Ambitions for further decarbonisation of fleet to be included in 2026/27 Business Justification Case (currently in development)**
6. Board Development sessions with respect to Decarbonisation to raise awareness of decarbonisation requirements, additional sessions will be required.	6. Board Development session occurred on 8th November 2021 – presentation slides are available.
7. Finance & Performance Committee has oversight of decarbonisation project, decarbonisation to become a standard agenda item.	7. (i) Routine updates at every other FPC meeting (3 times a year) (ii) Annual report (which includes a Sustainability section) is approved by the Finance & Performance Committee
8. KPIs with respect to energy transmissions are communicated to Estates team annually by sustainability manager	8. KPIs to Estates team includes energy use at all WAST managed buildings
9. ISO14001 accreditation in place	9. ISO14001 – Annual audits are undertaken against the accreditation. Environmental Coordinators act as champions in the organisation.
10. Environment Strategy in place	10. Environment strategy has been approved by the Trust Board. This covers the next 5 years
11. Programme Board Risk Register	11. Programme Risk Register reviewed at every Decarbonisation Programme Board meeting
12. Reporting to WG via DCR reporting, qualitative, and quantitative reports and emissions reporting	12. Submissions to WG – quarterly DCR reporting. Annual qualitative and quantitative reporting
13. Membership of National Programme Board (WG), Transport Task and Finish Group and BELP Project Board	13. Minutes and papers of meeting
14. Full engagement in Strategic Development Plan (SDP) refresh process undertaken by Welsh Government	15. WAST specific comments provided. Full engagement in support of influencing future SDP (and therefore DAP) actions.
	External - Independent Assurance: • Sustainability section in Annual Report audited by Internal Audit. Annual audits by BSI on accreditation

Risk ID 542	Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan	Date of Review:	08/10/2025	TREND	16 (4x4)
		Date of Next Review:	08/11/2025	➡	

GAPS IN CONTROLS	GAPS IN ASSURANCE
1. Establishment of further workstreams to address a Programme Plan to support strategy requirements	
2. Ability to deliver on EV infrastructure plan including electrical capacity issues for the purposes of electronic charging points for vehicles	
3. Procurement of an electronic fleet of vehicles – this is not currently possible for anything other than a car/van (limited)	
4. Resources to be able to deliver extent of DAP – work ongoing to establish actions required and potential cost impacts. Note detailed schemes are challenging to work up without appropriate resource which in turn allow for realistic financial estimates to be made about cost.	

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Establishment of potential further workstreams to address a Programme Plan to support strategy requirements: Consider further workstreams required in support of delivering DAP actions, including grouping of similar actions	Capital Development and Estates Team	Not needed. Action closed. **Do these need to be removed?**	Workstreams were set up to manage delivery of the EFAB projects and the transport element (Transport Project Board). Links are also made into ongoing work to develop the IMTP and develop longer term strategies e.g. Fleet Vehicle Procurement Strategy 2025 – 30.
2. Ability to deliver on EV infrastructure plan including electrical capacity issues for the purposes of electronic charging points for vehicles: develop an investment strategy/prioritised list of sites where further EV charging is required. Will need further investment.	Decarbonisation Programme Board	Ongoing programme of investment. Next phase to be complete by March 2026	Actions taken in line with investment provided to implement rapid charging by end of March 2025 at a small number of sites. Confirmed adequate charging provision for the replacement of 20 x PHEV and 10 x BEV in March/April 2025. This action is ongoing. Further consideration of the increasing resource requirements will be highlighted at the Transport Project Board, Decarbonisation Programme Board and through the Capital Management Board. Specific action in relation to development of investment plan was closed on the Audit Tracker in March 2025, given that this has been absorbed within other strategic investment plans.
3. Procurement of an electronic fleet of vehicles – this is not currently possible for anything other than a car/van (limited): development of specifications for vehicles considering achievable and safe ULEV options where possible. NOTE: will be dependent on confirmation of 2024/25 BJC funding	Fleet Team	Ongoing programme of investment. Next phase to be completed by March 2026	Position remains that only vans can currently be purchased. This will be delivered by March/April 2025. Further PHEV SRVs and full BEV small NEPTS vehicles to be procured in 2025/26 for implementation by end March 2026.
4. NED support ended April 2022: A new NED will need to be nominated to champion this risk/project at Trust Board level	Director of Corporate Governance / Board Secretary	Not being progressed **Do these need to be removed?**	To be further discussed with relevant Directors. It is unlikely that a NED Champion role will be allocated in the near future.
5. Resources to be able to deliver extent of DAP – work ongoing to establish actions required and potential cost impacts. Note detailed schemes are challenging to work up without appropriate resource which in turn allow for realistic financial estimates to be made about cost: Development of an investment requirements schedule (also aligned to IA recommendations). Contribute resources to support the Decarbonisation Strategy action plan	Director of Finance & Corporate Resources	31.03.25 March 2026	Discussions ongoing regarding enhanced resource requirements to implement low carbon emission vehicles. Targeted Estate Fund (TEF) bids were submitted, and it has been confirmed that 3 of the 6 submitted projects have been supported. Work is well underway on delivery of the 2025/26 schemes.

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

Risk ID 671	Unauthorised or Inappropriate use of AI technologies	Date of Review:	07/10/2025	TREND	16 (4x4)
		Date of Next Review:	07/11/2025	➡	

IF	**THEN**	**RESULTING IN**
staff use Gen-AI tools (e.g. ChatGPT, Copilot, Gemini) or other AI-enabled platforms (including standalone apps, algorithms or built-in functionality) outside of approved organisational channels or without appropriate governance	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	potential breach of confidentiality and data protection law, data leakage (staff, public and business sensitive information), damage to Trust reputation through such a breach or through FOI responses, and non-compliance with other EU, UK or Welsh legislation, regulation and standards

	Likelihood	Consequence	Score
Inherent	5	4	20
Current	4	4	16
Target	2	4	8

IMTP Deliverable Numbers:

Strategic Objective: Being at the forefront of innovation and technology

EXECUTIVE OWNER	Director of Digital	ASSURANCE COMMITTEE	Finance & Performance Committee

Risk Commentary

The current risk is high due to the appetite of WAST to adopt new AI technologies, and the ease of access by individuals to a breadth of (freely) available Generative-AI tools offered by tech start-ups and companies globally, and the limited guidance and regulation offered in this sector for health & care providers.

Given the evolving nature of AI technologies, it will not be possible to fully mitigate this risk. The consequences will remain, but with greater awareness, confidence and support for staff, the chance of breach, bias, or reputation damage from AI output can be reduced.

CONTROLS	ASSURANCES
1. Guidance & Awareness a) Gen-AI guidance (issued to all WAST January 2025) b) Copilot guidance (issued to Copilot pilot cohort only) c) Engagement sessions (small audience)	1. Guidance & Awareness a) Copilot Pilot feedback form
2. Strategic Alignment a) IMTP reference to use cases	2. Strategic Alignment a) AI safety and adoption updates reported via Digital Report to Finance & Performance Committe bi-monthly b) IGSG maintain responsibility for data protection and information security, including in respect to AI. IGSG report via AAA to ELT monthly and an IG report passes to Finance & Performance Committee bi-monthly.
3. Technical Controls a) Digital issued and managed Copilot licences (and pilot) b) Deactivation of licences not regularly used	3. Technical Controls a) Monitoring of Copilot users via MS Purview b) Copilot pilot evaluation feedback allows scrutiny of use cases and applications at regular intervals
4. Processes a) Cyber Assurance of suppliers during procurement processes through existing mechanisms e.g. cyber essentials b) Data Protection related to AI projects / tools covered by existing DPIA c) Alignment with NHS Wales guidance and position including e.g. procurement routes	4. Processes a) Cyber risks and Data Protection logs reported to IGSG. b) Monitoring of Datix incidents related to data breaches and security
5. Expertise a) Ability to draw on Digital expertise for advice (including data science, algorithmic, cyber, data protection, data quality and other relevant domains) b) Leverage support from existing suppliers with technical expertise (e.g. Microsoft)	5. Expertise a) AI risks and issues informally reported via IGSG to date in lieu of dedicated forum
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Guidance & Awareness a) Copilot rollout and chat requires guidance for all WAST staff b) General awareness sessions / e-learning for all WAST staff	1. Guidance & Awareness a) eLearning compliance
2. Strategic Alignment	2. Strategic Alignment

Risk ID 671	Unauthorised or Inappropriate use of AI technologies	Date of Review:	07/10/2025	TREND	16 (4x4)
		Date of Next Review:	07/11/2025	➡	

a) AI Mission Statement / strategy b) Clear set of 'approved' use cases c) Steering Group to maintain alignment of use cases and horizon scan (for opportunity and risk)	a) Regular reporting and clear governance route from AI Steering Group to Board
3. Technical Controls a) MS 365 Copilot chat offer for all staff (without need for upgraded licence) - needs monitoring for appropriate use b) Sanctioned / unsanctioned apps list to be maintained c) Monitoring and auditing of users d) Sensitivity tagging project for all digital documents to support access management e) Metadata / data quality project to support accurate AI use	3. Technical Controls a) Escalation route established for inappropriate use of Copilot chat and other available tooling b) SharePoint access and controls to be tested and confirmed
4. Processes a) Procurement to consider AI specific requirements b) IG x AI Programme to be developed c) WAST AI Policy to consider UK and Welsh position across several domains (data protection, cyber security, WBFGA, Equality Act, Welsh Language etc)	4. Processes a) Processes to be identified, developed and maintained by AI steering group
5. Expertise a) AI lead to be determined and position filled b) AI Steering Group to advise and guide on AI-related decisions and progress c) Connection in with NHS Wales and public sector specialist groups.	5. Expertise a) DTIP forum in development to support governance routes and in decisions related to capacity, planning and prioritisation of Digital expertise to WAST projects b) AI Steering group AAAs reported through correct governance routes

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Publication of WAST AI Policy	Leanne Smith	November 2025	AI Policy in development with support from TU Partner
2. Agreement on sanctioned and unsanctioned apps, and block of certain apps / sites	James Rowland	Q4 25/26	WAST to align with national steer on sanctioned / unsanctioned apps
3. AI Steering group (AISG) to be established	Leanne Smith	October 2025	To report to IGSG
4. Awareness campaign (including ethics, DP, shadow IT risks)	Leanne Smith	Q1 26/27	To be managed by AISG
5. Board Development Day and AI Mission Statement development with Trust Board	Leanne Smith	February 2026	
6. Copilot rollout to avoid ChatGPT risk – requires usage monitoring mechanism	Aasha Cowey	June 2026 (current pilot licences run until this time	Dependent on funding
7. Alignment with WG and NHS Wales AI policy positions	Leanne Smith	Q4 25/26	Proactively engage with WG AI Commission
8. eLearning for all staff	Kara Walsh	Q4 25/26	Supported by AISG
9. IG x AI programme (confirming DPIA and checklists are appropriate)	Kelly Holding	Q4 25/26	Will be a requirement of the 26/27 IG Toolkit
10. WG AI Commission membership / alignment	Leanne Smith	Q3 25/26	Proactively engage with WG and NHSW AI groups
11. Document sensitivity / confidentiality tagging project (linked to SharePoint migration project)	Leanne Smith / Aled Williams	Q4 26/27	Large scale project across digital
12. AI Lead to be identified and agreed	Leanne Smith	Q3 25/26	AISG to have oversight
13. Monitor usage	Kara Walsh	Ongoing from Q3 25/26	AISG to have oversight

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Welsh Ambulance Services University NHS Trust

RISK ID 594	The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death	Date of Review:	01/10/2025	TREND	15 (3x5)
		Date of Next Review:	01/11/2025	➡	

				Likelihood	Consequence	Score
IF a major incident or mass casualty incident is declared	**THEN** there is a risk that the Trust cannot provide its pre-determined attendance as set out in the Incident Response Plan and provide an effective, timely or safe response to patients due to vehicles not being released from hospital sites	**RESULTING IN** catastrophic harm (death) and a breach of the Trust's legal obligation as a Category 1 responder under the Civil Contingency Act 2004	**Inherent**	4	5	20
			Current	3	5	15
			Target	2	5	10

IMTP Deliverable Numbers: 1, 5, 6, 7,14, 15, 24

Strategic Objective:

EXECUTIVE OWNER	Director of Operations	ASSURANCE COMMITTEE	Finance & Performance Committee

Risk Commentary Q1 2024/2025

The challenges across the unscheduled care system**.** Handover lost hours in **August** were **13,135** and **September** were **12,189.** There is a direct correlation with ambulance availability and high levels of resources unavailable due to protracted waits at hospital E.Ds. Several incidents declared have failed to provide sufficient on the ground assurance that vehicles would be released. Health Boards have declined to incorporate testing of vehicle release into a recent mass casualty exercise. Further, a recent workshop undertaken by the EPRR team as part of the Manchester Arena Inquiry assurance process which has tested our ability to fulfil the PDA in North and South Wales, both in and out of hours, has confirmed that we would only meet the PDA in one of these four mass casualty scenarios.

After a thorough review and assessment of Risk 594 within the Corporate Risk Register at SLT on 02/10/2024, we propose reducing the risk score from 20 to 15 (likelihood from 4 to 3) due to the following reasons:

· Mitigation/Controls have been Implemented: We have several controls measures that directly address the identified risk and are content we have exhausted all opportunities for additional controls. These controls are embedded within the corporate risk register.

· Immediate Release Protocol: The revised version of the IR protocol v1.3 has been agreed and shared at COO group and published which has included the release schedule for ambulances at the declaration of an incident as set out below:

·50% of vehicles released within 10 minutes

· 75% of vehicles released within 20 minutes

· 100% of vehicles released within 30 minutes

· Monitoring and Review: We will continue to monitor the risk within the normal governance channels (SOT/SLT/ADLT etc) to ensure that mitigations are still in place and any emerging risks are promptly identified and addressed.

22/01/25 - In light of the critical incident declared earlier this month, a review of the risk scoring is scheduled for this at SLT on 11th February in the first instance and this will be updated following conversations.

March 25 – following review at SLT, it has been agreed to maintain the score as it stands currently.

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. Immediate release protocol	1. The Immediate Release Protocol is a Nationally agreed NHS Wales protocol. Refusals by Health Boards are Datixed by WAST and compliance report provided weekly to the DG for Health & Social Services. V1.3 has been reviewed, updated and released (August 2024).
2. Resource Escalation Action Plan (REAP)	2. The Senior Leadership Team convenes every Tuesday as the Weekly Performance Meeting to review performance and demand data, and review/assign REAP Levels as appropriate. Dynamic escalation via Strategic Command structure. REAP has undergone an annual review with v5.1 released in January 2025
3. Regional Escalation Protocol	3. Daily conference calls to agree RES levels in conjunction with Health Boards
4. Incident Response Plan	4. The Incident Response Plan has been ratified via EMT
5. Mutual Aid arrangement with NARU	5. AACE National Policy on mutual aid in place
6. Clinical Safety Plan	6. CSP adopted by EMT and operational; reviewed annually by SLT in December 2023, Version 2.21 of the Clinical Safety Plan was released. The reduction in the demand is the assurance which is dynamically monitored via ODU. New version 3.3 released in December 2024.
7. Operational Delivery Unit 24/7 cover	7. Shift reports from ODU & ODU Dashboard received by Exec, SOT, and On-Call Team at start/end of shift and cover review at weekly performance meeting
8. In hours and Out of hours command cover	8. Civil Contingency requirement as set out in the Command Policy and Incident Response Plan. Cover review at weekly performance meetings
9. Notification and Escalation Procedure	9. Published procedure in operation, reviewed 3 yearly by SLT
10. Continued escalation of risk to partners and stakeholders	10. Referenced by the Executive Director of Operations in correspondence sent to health board Chief Operating Officers dated 30 March 2023. It was further emphasised at the face-to-face COO Peer Group meeting on 14 April 2023.

RISK ID 594	The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death	Date of Review:	01/10/2025	TREND	15 (3x5)
		Date of Next Review:	01/11/2025	➡	

	External Independent Assurance N/A
11. CEO letter to Health Boards dated 3 Jan 2023, and DOO letter to Chief Operating Officers dated 30 March 2023 to seek assurance on plans.	11. Acknowledgement and acceptance of risk by HBs and balancing the risk across the whole system. Improvement in handovers in C&VHB and ABUHB. This has been sustained form some months across C&V in a phased programme of improvement with no delays more than 2 hours. Programme of improvement underway in ABUHB commencing at 4-hour tolerance with a plan to reduce over time. In other HBs there remains little or no controls with variation in both handovers and risk levels across HBs.
12. Health boards are asked to provide assurance of existing and tested plans to immediately reduce emergency ambulances on incident declaration.	12. All Health Boards responded with assurance of plans except BCU.
13. Multi Agency Exercise to be arranged.	13. This exercise has taken place although Health Boards declined to incorporate vehicle release plans
14. Meeting with Welsh Government to outline this risk; WG agreed to write to HBs seeking assurance from EPRR leads in HBs on the ability to clear EDs and release vehicles. WG agreed to incorporate testing into the forthcoming mass casualty exercise, and a timeframe for vehicle release was proposed by WAST with 30% of vehicles released within 10 minutes of an incident declaration, 50% within 20 minutes and 100% within 40 minutes.	14. WG have confirmed that they have written to HB EPRR leads. Health Board COOs approved the proposals for vehicle release as outlined.
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
Despite the controls listed, the single most limiting factor in providing a pre-determined response in line with the Incident Response Plan is the lost capacity due to hospital handover delays. In this area, WAST has no control. – link to CRR 223 on CRR.	The Trust is not assured that Hospital sites have plans in place that are trained and tested to release ambulances effectively and immediately in the event of an incident declaration.
	Following two incidents (Pembroke Dock Ferry fire on 11th February 2023 and the Swansea gas explosion on 13 March 2023), The Trust is not assured by the effectiveness of assurances given by Health Boards (responses provided following correspondence from WAST CEO – formal returns received from LHBs except BCU). Despite these two incidents being lower-level incident declarations where the pre-determined attendance was met, the experience does not add confidence to the ability to release all resources from hospitals which would support assurance. Further testing of the pre-determined attendance levels has been undertaken as part of the Manchester Arena Inquiry recommendations; This tested the Trust's ability to fulfil the PDA in North Wales and South Wales in the event of a mass casualty scenario both in hours and out of hours. This simulation concluded that in three of these four scenarios, the Trust would be unable to fulfil the PDA. A further declared major incident at Treforest Industrial Estate in December 2023 following an explosion, failed to release resources from Morriston Hospital, Wales's dedicated burns unit (formal debrief still to be conducted).

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Review of Manchester Arena Inquiry	Assistant Director of Operations	**CLOSED**	This programme of work is underway, and a workshop has confirmed that the PDA would be unable to be met in three out of four simulated mass casualty scenarios. The financial case associated with MAI is planned to be familiarised with ELT and JCC during Jan and Feb 2024, with the final outline case to ELT in March 2024. A revised timeline for the governance process for the final MAI reports has been agreed, commencing in May 2024 and finalising at Trust Board the end of July 2024. 01/10/2024 - Progress against the 68 recommendations, directly or through partnership working, that relate to the Trust continues. The Trust has undertaken a detailed review of its provision as part of its obligation under recommendations 105 and 106 and has recently produced an evidence-based series of reports aimed at addressing the identified gaps. This has been supported further by the development of three Quality Impact Assessments that have been approved by the Clinical Quality Governance Group. The work identified 20 recommendations for which there is a financial dependency. The submission to commissioners of the Trust's reports relating to these recommendations has now occurred and the Trust awaits their considered response. The remaining recommendations continue to be progressed, and it is anticipated these will conclude within the next six months. To ensure the continued visibility of these report findings within the Trust, a corporate risk is being developed for inclusion in the Trust's risk register. This will enable the alignment of outstanding MAI

RISK ID 594	The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death	Date of Review:	01/10/2025	TREND	15 (3x5)
		Date of Next Review:	01/11/2025	➡	

			recommendations with a clearly defined business-as-usual framework, ensuring proper governance of capability gaps while awaiting financial decisions from commissioners and the implementation of necessary changes. Jan 2025 - Progress against the 68 recommendations, directly or through partnership working, that relate to the Trust, continues. We expect to complete all recommendations that do not rely on financial investment by the end of this financial year. To ensure the continued progression and completion of the recommendations with financial dependency (18 recommendations), a corporate risk has been developed for inclusion in the Trust's Corporate Risk Register and Board Assurance Framework. As the risk progresses through the internal governance route, culminating in final approval at Trust Board in January 2025, there is an alignment of the outstanding MAI recommendations with a clearly defined business-as-usual framework, which will support the governance of capability gaps whilst awaiting financial decisions from commissioners and the implementation of necessary changes. Mar25 – Progress of MAI will now be reviewed within CRR 641. During March and April the Trust has engaged with commissioners on a series of scrutiny sessions to review content of submission for the MAI, following these scrutiny sessions it will be the commissioners to determine next steps and any subsequent course of action. May 25 – Actions complete subject to closure report to SLT with outstanding actions monitored through the risk register (Ref: 641). Submission to commissioners completed and awaiting commissioner outcome expected August 2025.
2. Further correspondence to Welsh Government to seek assurance of testing plans following recent mass casualty exercise where Health Boards declined to incorporate vehicle release plans	Assistant Director of Operations	**CLOSED**	Immediate Release Protocol Developed and Released August 2024. Correspondence with Welsh Government remains ongoing. 22/02/2024 - Risk 594 has also been referenced in the context of MAI presentation to Welsh Government (6th Feb 2024). Further follow up will be provided as MAI progresses. Welsh Government has been and will continue to be kept up to date on the developing case, as have the JCC. May25 – Further correspondence submitted to the NHS Executive dated 28 April 2025, highlights that plans remain untested in the context of a continued deterioration on handover delays.
3. Request from COO network to share Action cards related to risk	Executive Director of Operations	**Q1 CLOSED**	May24 – LB will follow up with COO network on the sharing of their action cards to WAST. March 24 – This risk was discussed at both JCC management and in the COO meeting. May25 – The Trust has now exhausted its influence on this risk, and with further correspondence to NHS Executive in April 2025 highlighting the outstanding risk and untested plans, the Trust considers all actions closed.

Risk ID 623	Failure to comply with Data Protection Legislation	Date of Review:	26/09/2025	TREND	15 (3x5)
		Date of Next Review:	25/10/2025	➡	

				Likelihood	Consequence	Score
IF the Trust fails to comply with and demonstrate it is meeting the accountability requirements under the Data Protection Act, the UK General Data Protection Regulation (GDPR) and the Common Law Duty of Confidentiality	**THEN** the Trust will breach its legal obligations and potentially cause the personal or sensitive data to be compromised, lost, or inappropriately used.	**RESULTING IN** unauthorised data breaches/loss, financial or compensatory penalties, an increased regulatory scrutiny or enforcement as well as stakeholder mistrust and reputational damage	**Inherent**	4	5	20
			Current	3	5	15
			Target	2	5	10

IMTP Deliverable Numbers: 1, 13, 14, 18, 19

Strategic Objective:

EXECUTIVE OWNER	Director of Digital Services	ASSURANCE COMMITTEE	Finance & Performance Committee

Risk Commentary

The consequences of this risk depend on the worst-case scenario which crosses a number of Domains on the Risk Scoring Matrix e.g. Loss of, or access to mass clinical data, the reputational damage this would cause, subsequent high-level involvement of ICO, Regulatory Body and Government involvement the subsequent fall out, fines and reduction in the level of clinical care. The likelihood would be small NB Just like pandemics. However, there are lower consequences of failure of statutory compliance which would warrant a higher level of likelihood even daily but in this case like near misses they indicate the need for change/improvement to demonstrate managing the risks. Therefore, the consequences will always be 5 but improvements are needed to lower the risk; if we demonstrate Statutory Requirements are met, even if a serious incident/event/failure arises, evidence provided would **help** reduce / mitigate against the consequences **(e.g. penalty)**.

In March 2025 the Trust submitted a self-assessment under the Welsh IG Toolkit, and met or exceeded expectations in all areas, except for the Training & Awareness category (for which minimum expectations were not met.) **Last m**easured on the **23/09**/25, WAST had achieved **90.73**% compliance against an 85% target for statutory IG training. The Confidentiality Advisory Group (CAG), an independent body advising the UK's Health Research Authority on the use of confidential patient information in research projects, and the Secretary of State for Health for non-research uses, require organisations across NHS Wales to demonstrate compliance with legislation via the IG Toolkit, or risk requests for using sensitive patient information being rejected – this compliance achievement helps protects WAST's academic partnerships and reputation, strategic research endeavours, and patient data linkage initiatives should CAG support be pursued, but must now be maintained until the Toolkit is submitted in March 2026**. This is in addition to now meeting a new category of compliance covering video surveillance.**

If the Trust fails to meet the Minimum Expectations of the IG Toolkit, this highlights that the organisation may not be meeting its obligations under the accountability principle. The accountability principle places a responsibility on organisations to not only comply with the UK GDPR, but that they must also to be able to demonstrate compliance. If an organisation cannot show good data protection practices, it may leave them open to administrative fines (irrespective of a data breach), reputational damage and affect patients' trust in the organisation handling their data.

Recently, several projects have seen delays due to outstanding IG queries, late engagement with the IG team, and project scope change impacting data protection. These have been escalated and are being managed but demonstrate some risk still in the understanding and awareness of IG and data protection requirements and responsibilities of staff, despite the increase in training compliance. Several **data breaches** remain under investigation, and there has been an increase in inappropriate use of social media **and non-corporate communication channels (e.g. Whatsapp).**

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. Expertise: Data Protection Expertise: 2 x FTE Data Protection and Compliance Managers (DPCM); 1 FTE Information Governance Officer, 4 x FTE in the Cyber Security team	1. Two new permanent Data Protection and Compliance Managers have been in post since November 2024, bringing capacity of this skillset up to 3 x FTE.
2. Expertise: Permanent Data Protection Officer	2. Temporary Data Protection Officer responsibilities held by Head of ICT up to December 2024. A full-time, permanent DPO has been recruited, and the position has been filled since December 2024.
3. Documentation: Data Protection and Information Governance Policies and Procedures (Incl. DPIAs and Cloud Assessments)	3. Procedure for auditing Welsh Clinical Portal usage (by WAST staff) updated (Jun24). Monthly Information Governance Steering Group which includes progress updates on: - DPC, DSA and DPIA reviews (I) IG Training IG Toolkit (System for providing a level of assurance of compliance (I)

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	Incident Reporting Accountability to ELT Development of reporting (dashboard) which supports IGSG, ELT and Finance & Performance Board Committee for scrutiny.
4. Documentation: Contracts and agreements: Data processing, Data Sharing and Employment & Consultancy	4. Add: Template Model Data Processor Agreements and Data Sharing Agreements which are able to be produced when IG are engaged.
5. Ownership: Register of information assets and data flows (outdated)	5. **New Information Asset Management Group in process of being established with TOR developed.**
6. Awareness: Staff training on updated training module (Apr 2023)	6. Training compliance monitored monthly via IGSG (captured on ESR and LMS365)
7. Monitoring: Incident Reporting and management (DATIX)	7. Summary statistics reported monthly via IGSG and MIQPR
8. Monitoring: NIIAS (national intelligent integrated audit solution) for auditing access to personal information on national systems such as WCP and WDS.	8.
9. Awareness: Digital Notices / comms Ongoing (see Siren & recent Lock-screen notices)	9. Regular publication of IG related comms: Lock screen image issued 04/24 in relation to WhatsApp and training. Lock screen image in relation to physical security as ongoing recurring screen. Digital Notice on Whatsapp issued 04/25. AI Guidance issued 01/25. Cyber & IG procurement guidance drafted and available on SharePoint and shared to ADLT. Information Governance Factsheet produced and shared to new users of WCP, WDS, and Secure File Share Portal (and as and when needed to other groups). Presentations on Data Breaches and DPIAs are provided to groups.
10. Collaboration: Proactive engagement outbound (not inbound to team)	10a. Regular comms issued across WAST in Q3 and Q4 of 2024/25, explaining the importance and encouraging uptake of IG Training – this included targeted messages to non-compliant individuals, and their line managers, and escalations to Executive level as required. 10b. Requests made for IG representatives to sit on project boards of critical workstreams and other Directorate forums, helping improve understanding, and collaboration, reducing risk of non-compliant go-lives or deliverables. **Delivery of training and awareness on 'Information Governance & Transformation: What You Need to Know' to the Transformation Support Office.**
11. Compliance: Trust meeting mandatory IG training compliance threshold of 85%	11. The Trust has seen increasing compliance for the past several months – this must now be maintained
12. Ownership: documented risk for physical security with mitigating action plan	12. This risk was approved by IGSG in June 2025 and will now pass through usual Trust risk management cycles.
GAPS IN CONTROLS	GAPS IN ASSURANCE
1. Succession Planning and appropriate capacity within the team to manage the incoming demand from across the Trust and wider NHS Wales system (particularly in respect to national data sharing)	1. **Additional investment sought for IG team to bolster capacity, and ensure career progression through the specialist team (tbc in October 25).**
2. Documentation: Resource capacity constraints to update, implement or monitor the controls; and lack of engagement by management and staff which either bypass the requirements, policies or procedures.	2. **Expertise: Even with increased capacity without engagement by managers and staff to meet their compliance requirements there will continue to be information reported to IGSG which will demonstrate low levels of assurance i.e. Reports on DPIA log, DSA log, Training Levels, IG Toolkit, and Implementation Plan**
3. Documentation: Personal identifiable information (PII) is being processed or shared with no data processing contracts (DPC) or data sharing agreements (DSA) when legally required; or incomplete DPC or DSA due to stalled engagement.	3. **Documentation: Lack of Data Protection pre procurement controls which form part of Data Protection by Design and Default means that Departments could engage third parties and/or purchase IT systems, hire document scanning companies, external data consultants and analytical firms and bypass WAST's controls for appropriate due diligence or legislative required controls in managing these risks. Capacity constraints continue to impact ability to undertake audits of systems and access, timely completion of DPIAs, data breach management, and data flow mapping (Records of Processing Activity documentation.)**
4. Ownership: New data, or new data processes which have either bypassed the controls or there are no information asset owners identified and therefore asset doesn't get on to the asset register or the dataflow is not mapped and creates a weakness in assurance (See 3)	4. Ownership: Data Protection and Compliance Risks not fully realised. IGSG have approved the establishment of a sub-group to manage activities related to Information Asset Register and Ownership, however, due to vacancies and limited capacity in the IG team, this action will not be able to be progressed until January-25.
6. Documentation & Awareness: Lack of Data Protection pre procurement controls which form part of Data Protection by Design and Default means that Departments could purchase non-compliant IT systems.	
7. Awareness: The Confidentiality Advisory Group (CAG) notified WAST (via DHCW) in June 24 that for organisations with a 23-24 IG Toolkit outcome of "standards not met", any CAG approvals for research & non-research requests are likely to be rejected unless the	7. Awareness: The Confidentiality Advisory Group (CAG) required WAST to submit an IG Toolkit Improvement Action Plan (via DHCW) with adjusted timelines to show a path to a "minimum standards met" position by Nov 24. The Improvement Action Plan has been adjusted and shared, and internal stakeholders notified. This will be managed by ADLT and monitored via IGSG. The Improvement Plan Actions were met by

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organisations' IG Toolkit Improvement Action Plan can be met and evidenced by Nov 24 (instead of the original target date for this plan of Mar 25).

the Nov 24 deadline, satisfying the requirements of the CAG up to March 2025. However, with the IG Toolkit submission in March-25 this view will be reset, and WAST failed to meet the minimum expectations for Training and Awareness.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Ensure compliance with the appropriate IG level training across all Directorate and Departments a. Demonstrate a regular series of comms on IG and DP - complete b. Regular monitoring of training compliance through IGSG – evidence of ongoing c. Targeted training compliance reporting to line manager on individuals to ensure that 85% target is reached by March 2025. - achieved in July 2025. This must now be maintained and will be monitored for the next few months to ensure progress does not slip. d. BAU on Siren training notices and specific guidance or advice – evidence of ongoing e. IG checklist to be complete for all projects, and DPIAs ahead of project design / development, and critically all go-lives to have IG approval	Leanne Smith	~~Q4 2024/25~~ ~~Q2 2025/26~~ **Ongoing monitoring of Trust-wide compliance (will need to be demonstrated by March 2026) and current escalations for non-compliant individuals.** **Q3 2025/26**	IG training compliance required to meet 85% target. An Action Plan for training has been created, and a training needs analysis being progressed with L&D team. 3d. Procedures, such as audit of Welsh Clinical Portal usage, has been updated. Previous actions: April 2024 - Lock screen issued in relation to WhatsApp and training, refreshed 06/24. May 2024 - Siren notice drafted for ELT. Jan 2025 - AI guidance issued. Mar 2025 - Cyber & IG procurement guidance in development. Evidence that regular comms is being published, and so action complete, and assurances added to Controls. May 2025 - Ongoing comms on the importance of early engagement with IG to ensure legal required documents and risk assessment are completed will continue to be raised across forums. Jun 2024 - Paper to ADLT seeking support for increased awareness & training compliance Mar 2025 - Direct contact to individuals who have been non-compliant for a significant period of time, with escalation through their line management structures as required. Latest actions: July 2025 - Letters have been issued to individuals and training is requested to be completed by end of August 2025. Several potential data breach incidents remain under investigation, and there has been an increase in inappropriate use of social media by staff – further work is required to give confidence in Trust compliance beyond threshold met. **September 2025 – reduction from 290 to 194 staff with overdue mandatory training. IGSG continue to offer oversight and a route for escalation of non-compliance, with support given to further investigate staff with a professional registration who are out of compliance.**
2. Report on physical security to IGSG – working with fleet and estates team	Leanne Smith and Aled Williams	Q2 2024/25 Q1 2025/26 **Complete**	Reporting to IGSG and FPC. A risk has been drafted by members of IGSG, and agreed, but action plan now to be developed in collaboration with Fleet & Estates. **The draft risk was approved by IGSG in July 2025 and will now progress through risk management cycles.**
3. Assurance of "standards met" for all IG Toolkit requirements: gain support of all Directorates' leadership to complete the IG Toolkit Improvement Action Plan and ensure compliance for the **2025/26** IG Toolkit submission	Leanne Smith	Nov24 for IG Toolkit Improvement Action Plan (with evidence to CAG) - **complete** March 2025 for 24/25 submission **complete** March 2026 for 25/26 submission **– ahead of plan**	Paper to ADLT Jun24 seeking support for completion of the IG Toolkit improvement action plan. To ensure no impact to CAG approvals for WAST research, this improvement action plan must now be met and evidenced by Nov24. The improvement plan actions resulting from the "standards not met" results of the 23/24 IG Toolkit submission were met ahead of the Nov24 deadline to assure CAG, however, to meet the requirements of the 24/25 IG Toolkit submission, further improvement work was required before the Mar25 deadline. All other improvement work was complete, and the submission of the IG Toolkit in March 2025 saw standards either met or exceeded in all categories except for Training & Awareness, where standards were not met due to the IG Training compliance being below the 85% target. Progress on the 2025/26 improvement plan, to support the IG Toolkit submission in March 2026 is approximately 78 complete.

Risk ID 100	Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience	Date of Review:	19/08/2025	TREND	12 (3x4)
		Date of Next Review:	14/11/2025		

IF	THEN	RESULTING IN		Likelihood	Consequence	Score
IF WAST fails to persuade JCC/Health Boards about WAST ambitions	**THEN** there is a risk of a delay or failure to receive funding and support	**RESULTING IN** a catastrophic impact on services to patients & staff and key outcomes in the IMTP not being delivered	**Inherent**	4	4	16
			Current	3	4	12
			Target	2	4	8

IMTP Deliverable Numbers: 7, 9, 11, 12, 14, 15, 20, 24, 25, 32

Strategic Objective:

EXECUTIVE OWNER	Executive Director of Strategy, Planning & Performance	ASSURANCE COMMITTEE	Finance and Performance Committee

Risk Commentary

From the 01 April 2024 111, emergency ambulance and Ambulance Care are all commissioned by the Joint Commissioning Committee (JCC). This is viewed as a positive development by the Trust, supporting the development of an organisational ambition.

The ambition is appropriate levels of patient safety and good working conditions for our staff across the 111 pathway, emergency ambulance care pathway and Ambulance Care pathway. Clearly neither of these are currently being achieved in the emergency ambulance care pathway as evidenced by the long waits, shift overruns and volume of concerns and reportable incidents. The Trust is currently commissioned on the assumption of 6,000 hours of handover lost hours, with current levels at 12,560 (Jul-25). The extant WG policy is 15 minute handover i.e. no lost hours, with the current WG focus on W45 i.e. 45 minute handover, which equates to approximately 6,000 hours. There is evidence of some material handover lost reduction in some health boards in recent months. The Trust had almost recruited up to the modelled 153 CHARU FTEs and connected to this focus on CHARU productivity. CHARU UHP in January 2025 was 94%, which is the highest it has achieved, and it is now seeking to close the remaining gap through the recruitment of fully qualified paramedics (current levels are staff in post to establishment for CHARUs at 85%). The Trust delivered on its ambition to switch on key aspects of its clinical model transformation programme in 2024/25, in particular, rapid clinical screening, which included the recruitment of 28 FTES to EMSC (clinical navigators) and increasing the APP establishment to APPs. The 111-call abandonment rate has stabilised post 111 CAS go live, as the Trust has recovered it call handler staff in post to establishment, but the commissioned levels are not sufficient to achieve the 5% abandonment rate. Ambulance Care performance is stable, but the level of capacity management plan cancellations are running at c20,000 per annum. For 2025/26 the Trust's ambitions are set out its IMTP, with a particular focus on delivering further aspects of the clinical model transformation programme: the re-categorisation of 999 demand (purple, red and RCS0 etc), remote clinical care and further see & treat capability. The EA skills mix (no funding from JCC) and Manchester Area Inquiry (MIA) submission are also important considerations.

The JCC is now becoming more established. Current areas of focus for the JCC (in relation to WAST) include: a scrutiny exercise on the Trust's MAI submission, consideration of the Future Vision for NEPTS, the Emergency Ambulance Measures Review Task Group and Ambulance Patient Handover Improvement Implementation (APHID) Group. The Trust has received the JCC commissioning intentions 25/26 for 111, 999 and NEPTS, which are reflected in the Trust's IMTP. These are broadly supportive of the Trust's ambitions, but the financial pressures within NHS Wales means that there's limited financial support of the Trust's ambitions.

CONTROLS	ASSURANCES
	Internal & External Management (1st Line of Assurance)
1. JCC/WAST Forward Plan for EMS and NEPTS in place and monitored at JCC meetings	1. Minutes of meetings and a standard agenda item
2. JCC and its 2 sub-committees established as a forum to discuss WAST's strategy (sub-committees currently under review as part of move into JCC).	2. Minutes of meetings and a standard agenda item. Sub-committees now established, with report on commissioning arrangements to July Finance & Performance Committee.
3. Weekly catch up between Interim Director of 111 & Ambulance Commissioning /CEO	3. Meetings are diarised every week
4. Collaboration between JCC and WAST on specific projects e.g.	4. Representatives are co-opted onto meetings and frequency is between 3–6 weeks. Set agendas with NCCU reps co-opted.
~~5.~~	5. Note: this meeting has stopped and needs to be restarted, probably in a slightly different form. It is anticipated that this meeting will restart in its new form in the second half of 2025/26.
6. Patient Safety information e.g. Appendix B incidents, weekly/monthly patient safety reports produced	6. These reports supplied to Director of Quality and Nursing in Health Boards and other senior stakeholder's fortnightly
7. Commissioning intentions.	1. In year progress reported each quarter to the relevant commissioning meeting and 24/25 commissioning intentions approved for 111 Wales and expected to be approved by Mar-24 JCC (approved).
8. Governance arrangements for 111 commissioning: 111 Board, 111 Commissioning Board + 111 DAG etc.	2. Minutes of meetings and a standard agenda item

Risk ID 100	Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience	Date of Review:	19/08/2025	TREND	12 (3x4)
		Date of Next Review:	14/11/2025	➡	

	External Management (1st Line of Assurance) 1. Plans go to every bi-monthly meeting 2. Meet bi-monthly and agendas, minutes and action logs available
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. JCC remit is wider than just ambulances and will reduce the agenda time dedicated to WAST's three patient pathways.	1. A shorter provider brief will go to the JCC with more detailed discussions taking place at its sub-committees. There is no provider brief going at this time, but the Trust does produce extensive slides for the bi-monthly WG Integrated Quality, Planning & Delivery accountability meeting, with the Director of Commissioning for Ambulance & 111 Services in attendance.
2. Governance coordination between the JCC and WAST to be improved.	2. Identified need for a governance meeting between JCC and WAST to manage the overall commissioner/provider interface. Actioned, but has lapsed due to capacity and resourcing in NCCU team. This will be further reviewed as the JCC goes live in April-24 (period of transition likely to extend through Q1). This has lapsed at this time, but request to re-establish it sent to commissioners. This meeting has now been restarted and continues to function
3. WAST's ability to influence hospital handover delays (this is outside of the Trust's control and a Health Board responsibility)	3. Ministerial direction on handover reduction with significant pressure being applied to health boards through the NHS Leadership Board and NHS Executive accountability arrangements. The Welsh Government target is no waits > one hour, which equates to 7,000 lost hours. WG has now established an Ambulance Patient Handover Improvement Implementation (APHID) Group to take forward this ambition. This has led to the W45 initiative i.e. 45 minute handover, with handover lost hours in July 2025 being their lowest since July 2021. A continued focus by health boards is required to achieve the ambition and sustain it.
4. Funding does not flow in a manner to balance demand with capacity (outside of WAST's control)	4. Strategic demand and capacity review completed and reported to Finance & Performance Committee. Whilst the Director of 111 & Ambulance Commissioning is sighted on the findings, it has not yet been formally reported to the JCC, in agreement with WAST. This remains the case.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Agree and influence JCC/Health Boards that sufficient funding to be provided to WAST	CEO WAST	As part of 25/26 budget setting process in Q4 this year (18/03/25 F&P Committee). IMTP now with WG awaiting approval, timeframe dependent on WG.	26.06.24 Funding for a 32 FTE APPs secured for 2024/25 and 23.2 FTEs into Integrated Care. 06/08/24 WAST briefing on evolved CRM and 2023 EMS Demand & Capacity Review to JCC Board Development session in Aug-24. 21/01/25 ELT has considered the draft commissioning intentions and responded to the Director of Commissioning. 14/04/25 Commissioning intentions built into the Trust's 2025-28 IMTP with FTE additionality planned in the remote care and see & treat space. MAI scrutiny exercise on-going. Skills Mix Task & Finish on-going, due to report into ELT end of April 2025, no funding from JCC expected. 19/08/25 Q1 commissioning intentions reported to JCC sub-committee. EA Skills Mix paper went to ELT in June 2025 with further paper on 27/08/25.
2. Agree and influence JCC/Health Board of the need for significant reduction in hospital handover hours	CEO WAST	IQPD 12/02/25 The APHID is a WG led group, so timeframe is dependent on WG.	26/04/24 This modelling has been further supplemented by modelling the Ministerial target of no handovers of more than one hour. 26/06/24 May-24 levels at 24,000, which is higher than 2023 and concerning as an indicator of the winter the Trust may expect. Trust moving at pace to evolve clinical response model, with Welsh Government full sighted on impact of handover hours on the Trust. 21/01/25 The Trust experienced 26,000 ambulance unit hours lost to hospital handover in December 2025, in line with its prediction, but significantly above the WG target of no waits over one hour, which equates to approximately 7,500 hours. 14/04/25 WG has now established an Ambulance Patient Handover Improvement Implementation (APHID) Group to take forward this ambition. 19/08/25 This has led to the W45 initiative i.e. 45 minute handover, with handover lost hours in July 2025 being their lowest since July 2021. A continued focus by health boards is required to achieve the ambition and sustain it.

Risk ID 100	Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience	Date of Review:	19/08/2025	TREND	12 (3x4)
		Date of Next Review:	14/11/2025	➡	

3. Increased understanding of NEPTS by JCC	Executive Director of Strategy Planning and Performance	02/08/23 30/06/24 20/08/24 21/02/25 Timeframe tbc, subject to current discussion with JCC.	16/04/24 Workshop arranged for April 2024 (completed). 26/06/24 Workshop results reported to newly established Interim Ambulance Commissioning Committee. 06/08/24 The WAST briefing to the JCC Board Development session in Aug-24 includes coverage of five workstreams, one of which is Health Transport, which includes NEPTS and UCS. 21/01/25 Consideration of Future Vision for NEPTS at JCC meeting on 21/02/25. 14/04/25 On-going discussions with JCC on the Future Vision, in particular, next steps, with possible development of a service blueprint connected to the Vision. 18/08/25 The Director of Commissioning for Ambulance & 111 Services has raised a concern about the level of capacity management cancellations and asked for options for mitigating these, which the Trust is currently exploring.
4. Governance meeting between NCCU and WAST to manage the commissioner provider interface	Assistant Director Commissioning & Performance	02/08/23 Checkpoint Date Timeframe for establishing a replacement for CASC Assurance is a JCC responsibility.	30.09.22 Meeting in place and meeting regularly. 12/01/23 Meetings continue. 02.05.23 These have lapsed due to pressures and sickness absence in the NCCU. HB to reboot, subject to ability of NCCU to undertake. 28.07.23 Availability remains a challenge, but there is regular informal dialogue between WAST and NCCU. 18.01.24 This specific meeting remains lapsed, but the Trust is currently meeting every two weeks with the NCCU on the development of the IMTP. As the Trust moves into the new JCC from 01 April 2024 there will be a further opportunity to address this control. 16/04/24 The new commissioning arrangements are in transition and still quite fluid at the moment. 26/06/24 Request to commissioners to re-establish this meeting. 06/08/24 Meeting now re-established. 21/01/25 Meeting continues to operate. 14/04/25 Meeting continues, but the monthly CASC Assurance meeting has lapsed and needs to be restarted. This is anticipated by the Trust but is dependent on the Director of 111 & Ambulance Commissioning discussion with JCC colleagues. 19/08/25 As above, the WG IQPD meeting operates bi-monthly and provides an accountability mechanism, but the Trust is anticipating the resumption of a JCC mechanism in the second half of the year.
5. Develop and roll out the Stakeholder Influencing Plan	Director of Partnerships & Engagement AD Planning & Transformation	**Q2 24/25 onwards**	15/03/24 This action is captured in Risk 201 on the CRR. The reputation audit being repeated in Q1 will inform the development and roll out of this plan in Q2. 14/04/25 The CMT Programme Engagement Plan (PEP) is live. During Q4 the programme has undertaken a series of priority engagement sessions with key clinical groups and stakeholders on the Clinical Services Model proposals. The next steps are to undertake wider system engagement. 19/08/25 System wider engagement was undertaken as part of the phase one Ambulance Performance Framework go live on 01 July, with further communications planned as part of the phase 2 go live on 01 December 2025.

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation	Date of Review:	13/08/2025	TREND	8 (2x4)
		Date of Next Review:	13/11/2025	➡	

				Likelihood	Consequence	Score
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	**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	**Inherent**	3	4	12
			Current	2	4	8
			Target	2	4	8

IMTP Deliverable Numbers: 9, 12, 15, 18, 24, 25, 30, 31, 32

Strategic Objective:

EXECUTIVE OWNER	Executive Director of Finance and Corporate Resources	**ASSURANCE COMMITTEE**	Finance and Performance Committee

Risk Commentary: To end of **September** 2025 of the 2025/26 financial year. The risk has now been further reviewed in conjunction with the level of financial risk detailed in the Trust's financial monitoring returns submitted to WG year to date to Month **6** of the 2025/26 Financial Year. The score is consistent with that of Qtr. **2** 2025/26 due to presenting an opening balanced financial plan for 2025/26, full allocation of the £8.5m savings delivery target and YTD overachievement. Reported Financial position is currently in deficit (£0.**186**m) but revised year end forecast is one of balance. It must be noted though that clear monitoring of the savings target for 25/26 will be needed as this is £2m increase from the 24/25 delivered position and also the recovery of the current deficit albeit in a challenging financial climate for all public sector organisations.

CONTROLS	**ASSURANCES**
	Internal Management (1st Line of Assurance)
1. Financial governance and reporting structures in place	1. Risk is reviewed quarterly at FPC, and a report is submitted bi-monthly to Trust Board
2. Financial policies and procedures in place	
3. Budget management meetings	3. Diarised dates for budget management meetings and delegation of budgets
4. Regular financial reporting to ADLT, EFG, ELT, FPC and Trust Board in place	4. Diarised dates for ADLT, FPC and Trust Board and monthly reports with budget managers**. EFG meeting held late July and August 25**
5. Welsh government reporting	5.
6. Monthly review of savings targets	6. ADLT updated via core reporting. Reporting included in finance reports to committees and boards
7. Regular review monitoring and challenge via WAST and JCC / CASC quality and delivery meeting with commissioners.	
8. Monthly ICMB (Internal Capital Monitoring Board) meetings to monitor and review progress against capital programme and engagement with WG and capital leads.	8. Diarised dates for ICMB meetings with regular monthly report
9. PSPP monthly reporting and regular engagement with P2P colleagues and periodic Trust Wide communications	9. Regular PSPP communications (Trust wide) on Siren
10. Forecasting of revenue and capital budgets	a) Monthly monitoring returns to ADLT, ELT (EFG) and FPC (b) Reliance on available intelligence to inform future forecasting.
11. Business cases and benefits realisation (both revenue and capital)	11. Business cases – scrutiny and approval at senior management team which are submitted to ADLT, ELT, FPC prior to Trust Board for approval as appropriate according to value.
	External Assurances Management (1st Line of Assurance)
	5. Monthly Monitoring Returns to Welsh Government
	7. JCC management meetings and at bi-monthly meeting with JCC Finance teams
	8. Capital meetings with Trust and WG capital leads
	9. Regular P2P meetings diarised (bi-monthly)
	10. Monthly monitoring returns into Welsh Government
	Independent Assurances (3rd Line of Assurance)

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation	Date of Review:	13/08/2025	TREND	8 (2x4)
		Date of Next Review:	13/11/2025		

	1-10 Internal audit reviews covering
	1-10 External audit reviews

GAPS IN CONTROLS	GAPS IN ASSURANCE
1. Lack of formalised service contracts between Commissioner and WAST as a commissioned body	1. None identified.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Continuing negotiations with Commissioners	Director of Finance and Corporate Resources/ Director of Strategy Planning and Performance	31/03/25 31/03/26	Supported financial plan included in IMTP for 25/26. At least bi-monthly meetings with WAST finance and JCC in relation to contract payments.
2. Embed a transformative savings plan and ensure organisational buy in	Savings subgroup / FSP	31/03/25 31/03/26	The Financial Sustainability Program (FSP) will continue to be a key vehicle for the Trust to monitor and develop its savings program. Over delivery was achieved for the 24/25 financial year and the point of strong delivery is further highlighted with the programs ability to fully identify the 25/26 £8.5m savings plan before the start of the financial year.
3. Embed value-based healthcare working through the organisation	Executive Leadership Team and Value Based Healthcare Group	31/03/25 31/03/26	Work to identify the PROMS & PREMS evaluation criteria for Emergency based services via the Value-Based Healthcare working group continues.
4. Foundational economy, Decommissioning, and procurement to mitigate social and economic wellbeing of Wales	Estates, Capital and Fleet Groups, NHS Wales Shared Services Partnership	31/03/25 31/03/26	The organisation utilises the NWSSP Shared Services Procurement framework to ensure contracts tendered provide best value for money while ensuring criteria within the tender docs ask bidders to highlight their ability to serve the aims of FE, Decommissioning, Decarbonisation and social as well as the economic wellbeing of Wales. Ad hoc reports are received from Shared Services on WAST's progress in switching more expenditure to Welsh suppliers to keep the Welsh pound in Wales.

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Welsh Ambulance Services
University NHS Trust

Agenda Item No. 15

REPORT TITLE

Audit Tracker 25-26 Q2 Reporting (Jul-Sep25) – FPC 181125

MEETING

Name of meeting	Finance and Performance Committee
Date of meeting	18 November 2025
Public or Private	Public
If private - rationale	n/a

REPORT SPONSOR

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

PURPOSE OF REPORT

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

EXECUTIVE SUMMARY:

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

1. This paper provides the Committee with the 2025/26 Q2 position with respect to management actions for audits within the purview of this committee.

2. The Audit Handbook notes that it is the responsibility of this committee to:
   - Receive audits in their remit;
   - Monitor management actions to address recommendations; and
   - Scrutinise impact of actions in response to audit recommendations in terms of, for example, quality improvement, the provision of more efficient and effective patient care, improved governance, better use of resources etc.

3. The Audit Tracker has been updated in Quarter 2 of 202/26. In an attempt to manage volume of papers, the tracker has been added to the Ibabs reading room filtered to the actions assigned to this committee for oversight. This digital reading room hosts documents for additional information, not essential for scrutiny or decision-making. Access to the reading room is through the documents/shared folder in Ibabs' main menu. Documents in the reading room will not be posted on the Trust's website with committee papers; however, copies can be provided to those without access to Ibabs upon request.

Internal Audit

4. During 2025/26 Quarter 2, there were a total of 36 open internal audit recommendations relevant to the Committee: four from 2023/24 (one of which is reported in the committee's private session), 31 from 2024/25, and 1 from 2025/26.

5. Of the 36 open internal audit recommendations, 14 were due for closure in quarter, and 22 were not yet due.

6. By end of quarter, 11 (79%) of the 14 audit recommendations due for closure during quarter were confirmed as completed.

7. However, a further audit recommendation from 2024/25 that were not due for closure until Quarter 3 (October 2025) was also reported as completed. This additional closed action was originally due for completion in December 2024 and was on its second revised date.

8. New revised deadlines have been proposed for three open audit recommendations all relating to Vehicle Accident Management. All three were due for closure in quarter (September 2025), and are now on their first revised date (two due in December 2025 and one due in March 2026).

- **Vehicle Accident Management** ~ three actions linked to:
  - Development of guidance for managers when undertaking investigations
  - Where central listing of documentation will be held and how this will be managed
  - Development of a communication strategy and training materials

Trust Audit Ref. No.	Internal Audit	Directorate	Original Date	1st Revised Date	2nd Revised Date
24/25-053	Vehicle Accident Management	Operations	Sep-25	**Dec-25**	
24/25-054	Vehicle Accident Management	Operations	Sep-25	**Dec-25**	
24/25-057	Vehicle Accident Management	Operations	Sep-25	**Mar26**	

External Audit

9. During 2025/26 Quarter 2, there were three open external audit recommendations relevant to the Committee.

10. One of the three open external audit recommendation relates to the 2023/24 '*Review of Costing Saving Arrangements*' was due for closure in quarter and confirmed as completed by its original date (August 2025).

11. The other two open external audit recommendations are from 2024/25 and relate to the *'Audit Wales Report: Unscheduled Emergency Care (UEC Arrangements for Managing Demand – WAST (April 2025)'*, both of which are due to be completed by May 2026 and are therefore not yet due.

Commission Note: 2024/25 Data Quality Internal Audit Monitoring

12. In line with a commission note from the previous meeting, the Committee agreed to proactively monitor the actions generated from the **2024/25 Data Quality Internal Audit** over the coming year, via the future Audit Tracker report. As such these recommendations have been drawn out within this report:

12.1 Position at the start of 2025/26 Quarter 2

There were three open recommendations related to the 2024/25 Data Quality Internal Audit, two on first revised dates, and one on second revised date.

12.2 Closed in Quarter

Of these three open recommendations: two were due to be completed in quarter, and the remaining one due in Quarter 3 (October 2025). However, all three recommendations were closed during Quarter 2.

12.3 Action 003-24/25 ~ Assessing and Improving Digital Literacy

This recommendation was originally due for completion in December 2024. A review of available data quality training has been undertaken and found suitable. Instead the team were collaborating with the Education Team to develop awareness raising materials. These materials were likely to include: a process flow map highlighting areas where data plays a crucial role in WAST services. It has been confirmed that a Data Quality training module has been developed in-house, as a collaboration between the Insight and Data Services and Education teams. The module is to be made available to all WAST staff in October 2025 via LMS365, and monitoring of uptake will be conducted by the Information Governance Steering Group (IGSG) – a KPI will be added to the regular report to enable tracking. **This recommendation was closed in quarter.**

12.4 Action 004-24/25 ~ Information Asset Register

During July 2025, Information Asset Ownership (IAO) was actively progressed by the Information Governance Team, this work included: finalising the terms of reference for the IAO Group (owners identified), updating the IAO handbook, and adopting/adapting an NHS England IAO e-Learning module. To ensure that the Trust is able to maintain an accurate register long-term, an Information Asset Owners (IAO) Group has been established. Terms of reference for the group have been devised, membership confirmed, and the first meeting took place in October 2025. Whilst the action is completed, it is noted and accepted that evidence of the AAA report to IGSG will not be available until after the IGSG meeting in November 2025 due to meeting cycles.

This recommendation was closed in quarter

12.5 Action 09-24/25 ~ Development and Reporting of Data Quality KPIs

It was recommended that data quality KPIs be developed and reported. A monthly KPI report, which includes a placeholder for data quality metrics, is submitted routinely to the IGSG. Progress on this action was delayed due to extended recruitment timelines for the two Data Quality posts. Both new appointees joined the organisation in March 2025, and a revised date of July 2025 was applied in Quarter 4 to allow sufficient time for development of appropriate metrics. Data Quality metrics have been developed against the Data Quality (DQ) domains. These have been reported to the Information Governance Steering Group (IGSG) for a couple of months, and from September 2025 were also included in the Digital KPI reporting to Finance and Performance Committee, receiving positive feedback.

This recommendation was closed in quarter

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section

The Committee is requested to receive assurance on the monitoring of management actions to address recommendations in the Tracker and the rationale for the closure of actions.

The Committee is requested to raise any concerns regarding the impact on the risks raised in audits by extending the dates for completion of management actions relating to the Vehicle Accident Management audit.

The Committee is requested to note the progress reported against the remaining 2024/25 Data Quality internal audit recommendations which now concludes the actions associated with this audit.

ADDITIONAL PAPER(S)

Annex 1: Audit Tracker 2.0 – 2526 Q2 Updates - Internal Audit up to 2324 (FPC Public)
Annex 2: Audit Tracker 2.0 – 2526 Q2 Updates – Internal Audit 2425 (FPC Public)
Annex 3: Audit Tracker 2.0 – 2526 Q2 Updates – Internal Audit 2526 (FPC Public)
Annex 4: Audit Tracker 2.0 – 2526 Q2 Updates – External Audit up to 2324 (FPC Public)
Annex 5: Audit Tracker 2.0 – 2526 Q2 Updates – External Audit 2526 (FPC Public)

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

HEALTH & CARE QUALITY STANDARD(S) THIS REPORT SUPPORTS

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

WAST WELLBEING OBJECTIVE(S) THIS REPORT SUPPORTS

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

IMPACT ASSESSMENTS FOR CONSIDERATION

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

Does this paper require an impact assessment	☒ No ☐ Yes
If yes, what impact assessment	N/A [DPIA Checklist > DPIA not indicated]

APPROVAL/SCRUTINY ROUTE

Date	Person/Group/Committee
03 November 2025	Director of Corporate Governance/Board Secretary
11 November 2025	Assistant Directors Leadership Team (ADLT)
18 November 2025	Finance and Performance Committee (PCC) – Public

POLICIES RECOMMENDED FOR COMMITTEE APPROVAL AND ADOPTION

Committee	Finance and Performance Committee (FPC)	**Date of Meeting**	18th November 2025
Presenting Officer	Trish Mills, Director of Corporate Governance / Board Secretary		

Policy Name	Directorate	EqIA Completed	Date of Policy Group	Date of ADLT	Points of Note
[New] Estates, Environmental and Facilities Management Policy	Finance and Corporate Resources	Completed - No Issues Identified	22.09.2025	13.10.2025	FOR APPROVAL

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

Estates, Environmental & Facilities Management Policy

Policy Number:	112	**Version No:**	V0.19	**Supersedes:**	N/A - New Policy
Date of Approval:	TBA	**Review Date:**	3 Years from approval date	**Impact Assessments Completed:**	27/09/2024
Classification of Document:	Corporate	**Type of Document:**	Policy	**Approved by:**	Finance and Performance Committee
Brief Summary of Document:	The purpose of this policy is to outline the Trust's Estates, Environmental & Facilities Management governance, regulatory, statutory and assurance framework for the managements of the Trust Estate. This overarching Estates, Environmental & Facilities Management Policy (EEFM) refers to a series of Estates Procedural Guidance Notes (EPGN) and Estates Policies				
Scope:	This overarching policy covers the policies and procedures used by the EEFM Team in the management, operation, and use of all Trust premises only and applies to all building users.				
To be read in conjunction with:	Estates Procedural Guidance Notes (EPGN's), Estates Policies as defined in the main body of this policy and as detailed in Appendix 2 and the Information Security Policy.				
Owning Committee	Finance and Performance Committee				
Policy Lead: Trade Union Lead:	Susan Woodham Maldwyn Jones	**Job Title:**	Head of Estates & Facilities Management Trade Union Partner		
Executive Director:	Chris Turley	**Job Title:**	Executive Director of Finance & Corporate Resources		

Version Control Sheet

Version	Date	Author	Summary of Changes
V0.1	11/04/2024	Susan Woodham	Draft policy for review with Assistant Director Capital Development & Estates and Senior Estates & FM Team
V0.2	02/05/2024	Susan Woodham	Review completed by Task & Finish Group – pending updating of EPGN's to allow submission to policy group
V0.3	20/06/2024	Susan Woodham	Draft new policy submitted to policy group 21/06/2024
V0.4	17/07/2024	Susan Woodham	Submitted to policy group 17th July on new template
V0.5	19/07/2024	Lisa Trounce	Formatting changes and comments for Policy Lead to action re: corrections to contents page, information to be included.
V0.6	14/10/2024	Susan Woodham	Required changes completed Confirmed EQIA submitted 27.09.2024
V0.7	15/10/2024	Lisa Trounce	Further formatting and queries prior to presentation to Policy Group on 23/10/2024
V0.8	16/10/2024	Susan Woodham	Tracked changes accepted
V0.9	18/10/2024	Lisa Trounce	Formatting prior to submission to Policy Group
V0.10	05/02/2025	Susan Woodham	Tracked changes accepted and required actions from Policy Group Meeting in October 2024 now completed
V0.11	25/05/2025	Lisa Trounce	Quality check/edit prior to resubmission to Policy Group

Version	Date	Author	Summary of Changes
V0.12	27/06/2025	Susan Woodham	Comments and agreed amendments from Policy Group on 30/05/2025 incorporated.
V0.13	14/07/2025	Lisa Trounce	Quality check/edit prior to Trust-wide consultation
V0.14	09/09/2025	Susan Woodham / Richard Davies	Policy updated post consultation period: • 5.3 Reference added to EPGN Procedures contained in Appendix 1 • 7 Audit and Monitoring of EPGN's review period confirmed and route for auditing provided
V0.15	18/09/2025	Lisa Trounce	Review and editing of post consultation policy changes prior to consideration by Policy Group 22/09/2025
V0.16	22/09/2025	Lisa Trounce	Policy Group agreed actions/amendments for Policy Lead to resolve prior to policy approval.
V0.17	09/10/2025	Susan Woodham	Remaining actions agreed at Policy Group in September 2025 resolved: • Version control updated • '7. Audit and Monitoring' strengthened to include reporting arrangements
V0.18	09/10/2025	Lisa Trounce	Finalised policy with completed actions prepared for onward travel to the ADLT for endorsement.
V0.19	22/10/2025	Lisa Trounce	Prepare policy for presentation to FPC on 18/11/2025 for approval: Version number and version control updated.
Keywords	Estates, Environmental, Facilities, Estates		

Impact Assessment Reviews

Area	Date of Review	Name of Reviewer
EqIA / Welsh Language	25/09/2024	Maldwyn Jones.
Environment	02/05/2024	Nicci Stephens

Task and Finish Group Members

Name	Job Title
Susan Woodham	Head of Estates & Facilities Management
Richard Davies	Assistant Director Capital & Estates
Nicci Stephens	Environment & Sustainability Manager
Kataya Miura	Facilities Manager
Shaun Rose	Estates Manager
Ian McMurtrie	Facilities Officer

Policy Approval Route

Meeting Title	Meeting Date	Purpose/Outcome
Task & Finish Group	02/05/2024	Draft policy amendments completed
Trade Union	12/09/2024	Draft Policy Reviewed and approved
Policy Group	23/10/2024	Review prior to consultation
Policy Group	30/05/2025	Receive assurance that amendments agreed at Policy Group in October 2024 had been actioned prior to Trust-wide consultation.
28-day Trust-wide Consultation Period	14/07/2025 – 10/08/2025	Consultation Comments
Policy Group	22/09/2025	Review Updates Post Consultation > Recommend for Approval by Committee
Assistant Directors Leadership Team (ADLT)	13/10/2025	Recommend for onward travel to Committee for Approval
Finance and Performance Committee	18/11/2025	Approval and Adoption

Disclaimer: If the review date of this document has passed, please ensure that the version you are using is the most up-to-date either by contacting the document author or the Policy Team via Amb_Policies@wales.nhs.uk

Contents

1. INTRODUCTION AND AIM

The purpose of this policy is to outline the Estates, Environmental & Facilities Management (EEFM) governance, regulatory, statutory and assurance framework).The Policy covers the provision of all Estates and Facilities Management services, including management of freehold, leasehold, licence and Memorandum of Terms of Occupation (MOTO) agreements, all pre-planned preventative and reactive maintenance services, statutory compliance and records management, environmental and sustainability compliance/commitments, and the provision of an Estates Helpdesk Service.

This single over-arching EEFM Policy, together with a subset of Estates Procedural Guidance Notes (EPGNs) and Estates Policies, sets out the general principles used in the construction, maintenance, and operation of the Trust estate.

This policy has been prepared with the aim of:

- Setting out the general procedures that cover estates, environmental and facilities management tasks.
- To ensure compliance with all relevant statutory legislation.
- Identifying specific responsibilities.
- Providing all building users with signposting to guidance documents relating to the safe management of the Trust estate in line with health and safety obligations.
- Reducing the impact that the Trust has on the environment.

The Welsh Ambulance Services University NHS Trust (WAST / "the Trust") aims to secure high standards of management in its premises at all times.

2. SCOPE

The scope of this EEFM policy and the subset of Estates Procedural Guidance Notes (EPGN's), plus additional fire, waste, and environmental policies, is to provide clear direction, guidance and advice to the Trust's building and service-users, staff, internal and external stakeholders on the management arrangements for the Estate, Environment and Facilities functions.

In addition, the Trust will meet its statutory obligations relating to the Estate, Environment and Facilities if the practices and procedures contained within this policy and the subset of documents are followed.

This policy is applicable to all Trust building and service-users, staff, visitors including contractors and volunteers, and internal/external stakeholders, and applies to all premises or parts of premises owned or occupied by the Trust.

The objectives set out above will be achieved by the Trust by having regard for its statutory responsibilities under current legislation and by securing effective relationships with other relevant partners.

3. POLICY COMMITMENT

The Trust is committed to high standards of estate management practice to support its operations, and the Trust EEFM Department will:

- Provide all building users and operations with the estate and premises they require and to develop it so that they are enabled to perform well.
- Maintain the estate and premises to comply with at least the statutory minimum standard and in compliance with all applicable NHS Health Building Notes and Technical Memoranda and the Trust's environmental commitments.
- Provide safe, secure premises which minimise the risk of Health Care Associated Infections (HCAIs) to all building users, primarily staff and visitors and any other persons who may visit Trust premises including contractors.
- Operate and run the estate and premises at the optimum efficiency to ensure value for money for the Trust.

4. TRAINING AND IMPLEMENTATION

A training needs analysis (TNA) process has been followed, and a gap analysis developed to identify required knowledge, skills, and abilities within the Senior Estates Team. The TNA identified various training levels, via various methods, this includes:

- External Construction Related Training Providers
- Fire Safety, Legionella, Asbestos, Manual Handling and Working at Height Awareness Courses
- CDP for professional pathways
- Contractor control procedures.
- Environmental awareness including energy and waste management.
- ISO14001 implementation training, including internal auditor training

The Trust is committed to providing high quality evidence-based education to an engaged and skilled workforce operating within an organisational culture and framework that enables colleagues to work to the top of their skill set to deliver high quality care and services with competence and confidence.

The Senior Estates Team (SET) shall receive the following training as a minimum:

- IOSH Managing Safely
- Asbestos Awareness
- Legionella Awareness
- Fire safety Awareness
- Construction (Design & Management) Regulations 2015
- Working at Height
- Manual Handling
- ISO14001 Implementation
- Environmental Awareness

To support our operational colleagues and ensure are buildings are fit for purpose and fully compliant, an annual estates training matrix has been developed. The training matrix is used to record any changes/updates to legislation, potential new legislation and helps to ensure that compliance requirements are adopted and reflected in changes to the estates policies and procedures.

All staff are required to complete Fire Safety statutory mandatory training every 2 years, the training available through ESR.

Staff are encouraged to discuss any concerns or queries regarding education and training with a member of the Education and Training Team, by contacting the Learning & Development Hub via telephone on 0300 123 2319 or email amb_LDHub@wales.nhs.uk

5. IMPACT ASSESSMENTS

5.1 Equality Impact Assessments

In accordance with the Equality Act 2010, all policies are subject to an EqIA. This enables resources to be targeted effectively and can help to reduce inequalities.

The EqIA is processed to find out whether a policy will affect people differently on the basis of their 'protected characteristics': age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion, sex, or sexual orientation and if it will affect their human rights.

The EqIA completed in respect of this policy takes into consideration how all building users' access and egress from our Trust premises, and ensures operational use of our buildings and facilities for all and adheres to all health and safety legislation. If any building user requires assistance to access our premises or the facilities provided, a Display Screen Equipment (DSE) assessment will highlight the additional support

required and will need to be shared with the Estates Team to review any reasonable adjustments.

5.2 Welsh Language Impact Assessment

Under the The Welsh Language (Wales) Measure 2011 the Trust's Welsh Language Scheme will be replaced by standards. This means that the Trust, when formulating new policies or reviewing or revising existing policies, will be required to assess what effect a policy decision would have on opportunities for persons to use the Welsh language and on treating the Welsh language no less favourably than the English language. Further guidance can be obtained from the Welsh Language Officer.

In order to comply with the Welsh Language Standards and the Trust's Compliance Notice, the Trust is required to publish several policies in Welsh; particularly those that relate to:

- behaviour in the workplace;
- health and well-being at work;
- salaries or workplace benefits;
- performance management;
- absence from work;
- working conditions;
- work patterns

Whilst we acknowledge that there are no patients or carers expected to use our Trust premises, we ensure that all external and internal signage, statutory signage and building related documentation that may affect all building users will be in line with Welsh Language standards.

Where the Estates Department manage a front of house provision in our corporate buildings – for these areas, there is recognition and consideration of the positive impact front of house team's knowledge and awareness of the Welsh language can have on all building users. Training and awareness is provided to our front of house team to develop their understanding and use of Welsh language opportunities. We maintain a list of staff at our corporate buildings who can assist if required to deliver a reception service in Welsh or respond to a public enquiry at entry to our premises.

Additionally, there is a commitment to ensure that future recruitment plans encourage the appointment of staff who can deliver an estates/reception service to all building users in the medium of Welsh and English. ID access cards (which include staff job titles and the WAST logo) are bilingual.

5.3 Environmental Standards and Impact Assessment

This policy outlines the relevant requirements required to be in place (such as waste management plan, reduction of CO_2 emissions & reduction of carbon footprint – reference relevant EPGN in Appendix 1) in order to ensure that the Trust's ongoing commitment to reduce its' impact on the environment is maintained, and to become a more sustainable organisation in line with Trust policy and Environmental Governance Systems.

The membership of both the Trust's Policy Group and Employment Policy Sub-Group, include representation from the Estates Department . These representatives will ensure that the Estates Team have had an opportunity to consider all policies submitted for approval to establish whether an impact assessment, waste management plan, or CO_2 Reduction Plan is required and to action this where indicated.

5.4 Counter Fraud

Anti-Fraud and Corruption Concerns
The Welsh Ambulance Services University NHS Trust is committed to taking all necessary steps to counter fraud, bribery, and corruption within the organisation. Staff should report suspected incidents of fraud and corruption to the Trust Local Counter Fraud Specialist, who will be happy to discuss any issues or concerns. Alternatively, staff may contact the confidential NHS Counter Fraud Authority, Fraud and Corruption Reporting line on 0800 028 40 60; or the on-line reporting facility Service https://cfa.nhs.uk/report-fraud Fraud investigations may lead to disciplinary action and / or prosecution and civil recovery procedures.

5.5 Records Management

The ~~University~~ Trust recognises the importance of sound records management arrangements for both clinical and corporate records. The Trusts' records are its corporate memory, providing evidence of actions and decisions and representing a vital asset to support daily functions and operations. Records support policy formation and managerial decision-making, protect the interests of the Trust and the rights of patients, staff, and members of the public.

5.6 Information Governance

Information Governance (IG) is an overarching term used to describe all aspects of information management. The Trust and its staff shall ensure that they provide satisfactory assurance to stakeholders as to how the organisation fulfils its statutory and

organisational responsibilities in relation to the management of information. This enables management and staff to make appropriate and informed decisions, work effectively, comply with relevant legislation, and achieve the organisation's aims and objectives.

The IG framework ensures that it sets out the high-level principles for confidentiality, integrity, and availability of information to promote and build a level of consistency across the Trust.

6. ROLES AND RESPONSIBILITIES

6.1 Chief Executive

The Chief Executive, as Accountable Officer, has overall responsibility for ensuring the Trust has appropriate policies in place to ensure the organisation works to best practice and complies with all relevant legislation.

6.2 Executive Director of Finance and Corporate Resources

The Executive Director of Finance and Corporate Resources has overall authority and responsibility for the Trust's premises, agreeing the estates and facilities management strategy and future direction of the policy.

Reporting to the Finance and Performance Committee, who has oversight of compliance with statutory regulations and targets. To that end an annual update is provided to this Committee.

The Designated Person provides the essential senior management link between the organisation and professional support, which also provides independence of the audit-reporting process. The Designated Person will also provide an informed position at Board level.

This duty is delegated to the Assistant Director of Capital Development and Estates, as the senior manager with responsibility for the delivery of the estates, environmental & facilities services.

6.3 Assistant Director of Capital Development & Estates

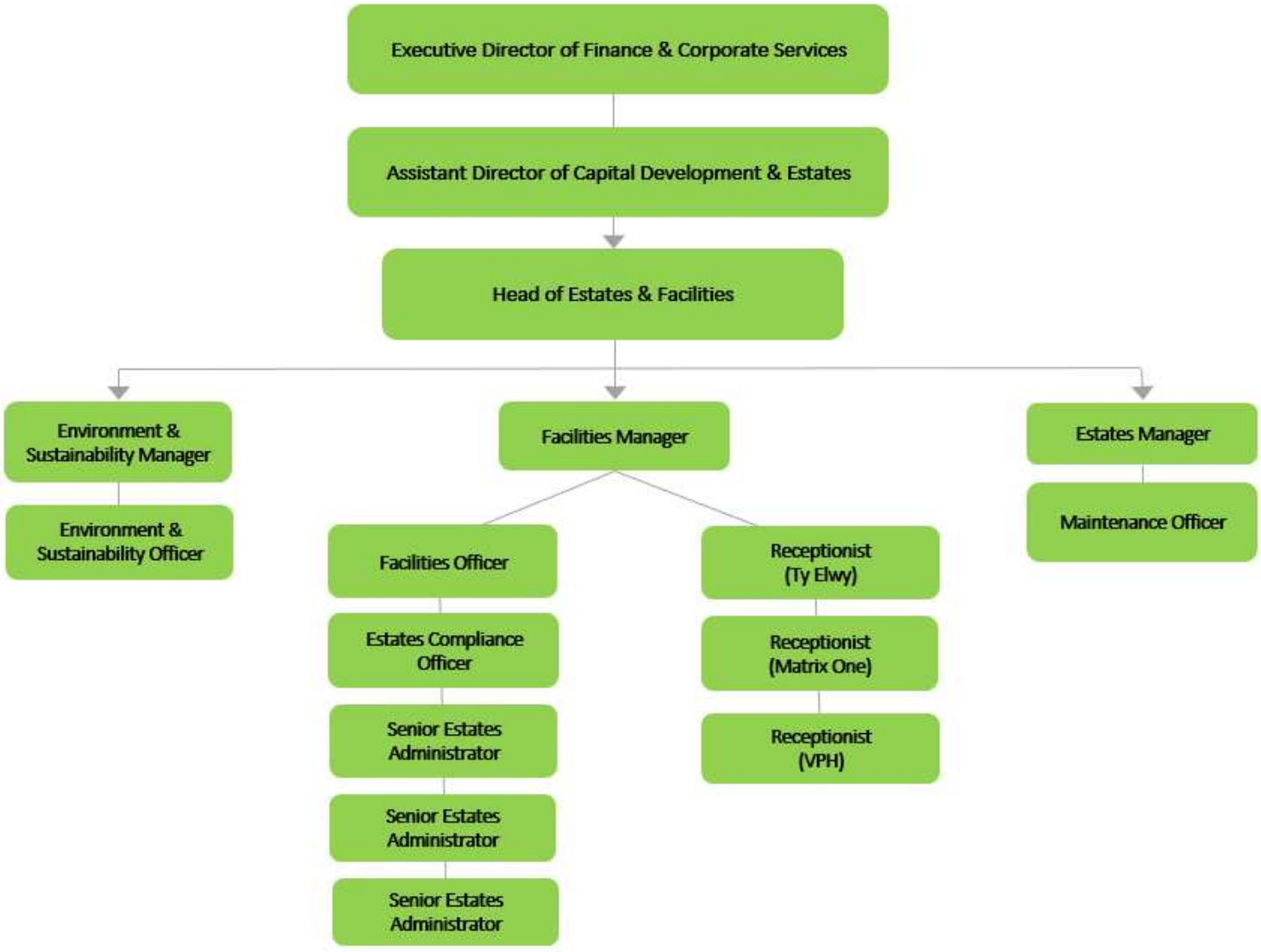
The Assistant Director of Capital Development and Estates acting as Designated Person (DP) is responsible for the overall provision of a compliant, effective, and efficient estates service. The DP provides an essential senior management link between the organisation

and professional support, which also provides independence of the audit reporting process.

The DP works closely with the Head of Estates and Facilities Management, and the Senior Estates Team, to ensure that adequate provision is made.

6.4 Capital Development and Estates Structure

The Assistant Director of Capital Development and Estates will implement, oversee, and operate the Estates and Facilities Management activities and control systems outlined in this policy, and related EPGN's included in this document.



6.5 Senior Estates Team

The Senior Estates Team (SET) is responsible for:

- The development of a programme of inspection, audit, and repair of all Trust premises. This includes environmental compliance and governance, plus the day-to-day management and implementation of this policy in relation to services provided by the Senior Estates team.

- Implementation, maintenance, and audit of the Trusts Environmental Governance System (EGS), which includes the management of the Trust's ISO14001 accreditation.

- Management and timely execution of individual repair works and the annual pre-planned preventative maintenance programme to ensure that any works undertaken are completed to appropriate standards and do not expose the Trust to unnecessary risk. This includes compliance with all building related environmental legislation, as documented on the EGS register of compliance obligations.

- Implementation of the operational requirements of this policy which include:

  a) Ensuring compliance with Estates health and safety policies
  b) Implementing Estates health and safety policies
  c) Compliance with statutory obligations
  d) Conducting risk assessments and safe systems of work
  e) Promoting a culture of safety
  f) Undertaking dilapidation and condition surveys
  g) Compliance with internal and external environmental requirements, energy, and waste management

6.6 Line Managers

Are responsible for:

- Ensuring that the staff for whom they are responsible are aware of and adhere to this document.

  This includes ensuring that:

  - Copies of the Trust policies are readily available and accessible to all staff.
  - Information is disseminated on a regular basis, to ensure staff have read and understood the relevant documents and are aware of any new guidance or revisions.

- The identification of specific staff training needs on the implementation of new or updated documents.
- Systems exist to enable the review, audit and compliance testing of all relevant departmental policies as required.

6.7 All Staff

Are responsible for ensuring that:

- They comply with the provision of this policy and were requested to demonstrate such compliance. For example, completing relevant statutory mandatory training in Fire Safety.
- Information regarding failure to comply with the policy, for example, lack of training, inadequate equipment, is reported to their line manager and that the incident reporting system is used where appropriate.
- Their practice is in line with policies in use across the Trust and specific to their area of work.
- Information regarding any changes in practice, organisational structure or legislation that would require an urgent review of documents is immediately reported to their line manager.

7. AUDIT AND MONITORING

The EEFM Department have a suite of Estates Procedural Guidance Notes (EPGNs). These procedures have been developed to ensure that Government and Healthcare regulations and related guidance are implemented in the activities of the EEFM Department.

The above shall be approved by the Assistant Director Capital Development and Estates, and communicated to the EEFM Department. A review of all documentation shall be conducted by the Assistant Director Capital Development and Estates every three years.

The effectiveness in practice of all procedural documents shall be routinely monitored by relevant sub-groups to ensure the documented objectives are being achieved.

A bi-annual Performance and Compliance Sub-group shall be formed to review water hygiene, fire safety management, statutory compliance, pre-planned maintenance review, low voltage systems and medical gas storage. The group shall be led by the Assistant Director Capital Development and Estates, with all meetings minuted and an action log maintained. The group shall be responsible for developing an action plan and monitoring action progress.

Assurance of Facilities and Estates Services

Quality and fit for purpose estate are assessed against a set of legal and statutory requirements, standards, and best practice guidance. This policy adheres to the guidance outlined in the relevant **Welsh Health Technical Memorandums (HTM)** and will be considered as evidence towards compliance with these legal requirements and standards.

The Trust is committed to ensuring compliance with relevant health and safety legislation; this includes but is not limited to compliance with:

- Health and Safety at Work Act
- Workplace (Health, Safety and Welfare) Regulations
- Management of Health and Safety at Work Regulations
- Construction (Design & Management) Regulations
- Electricity at Work Regulations
- L8 - The control of Legionella bacteria in water Systems
- Regulatory Reform (Fire Safety) Order
- Asbestos Management

The Welsh Health Technical Memorandums (HTM) are the main source of specific Healthcare related guidance for Facilities and Estates professionals. They give comprehensive advice and guidance on the design, installation and operation/maintenance of specialised building and engineering technology used in the delivery of healthcare.

As part of the HTM's, HTM 00 addresses the general principles, key policies, and factors common to all engineering services within a healthcare organisation. Key issues include:

a) Compliance with policy and relevant legislation
b) Design and installation
c) Maintenance
d) Professional support and operational policy
e) Training requirements

The aim of HTM 00 is to ensure that everyone concerned with the management, design, procurement, and use of the healthcare facility understands the requirement (Including Regulatory) of the specialist, critical building/engineering technology.

8. APPENDICES

Appendix 1	Master List of Estates Procedural Guidance Notes (EPGNs)
Appendix 2	Master List of Estates Related Policies

Appendix 1 – Master List of Estates Procedural Guidance Notes (EPGNs)

EPGN001	Control of Contractors
EPGN002	Permit to Work Last updated 18th June 2024
EPGN003	Building Security
EPGN004	Asbestos Last updated 18th June 2024
N/A	Asbestos Management Plan
EPGN005	Disposal of Waste Electrical and Electronic Equipment (WEEE) V1.4 Last updated 26th April 2024
EPGN006	Water Use Last updated 26th April 2024
EPGN007	Legionella 2.3 Last updated 18th June 2024
N/A	Water Safety Plan
EPGN008	Waste Management V1.4 Last updated 26th April 2024
EPGN009	Water Management 1.3
EPGN010	Building Energy Management 1.4
EPGN011	Environmental Procedures V1.4 Last updated 31st May 2024
EPGN012	*Replaced by Waste Policy dated 21st May 2024*
EPGN013	Building Cleaning Draft (assume redundant now re IPC Cleaning policy?)

Appendix 2 – Master list of related Estates policies

Policy 1	WAST Fire Safety Policy
Policy 2	WAST Waste Policy
Policy 3	WAST Environmental Policy Statement

Note: The latest versions of the above policies can be found on in the Trust's intranet 'Siren'.

Agenda Item No. 17

REPORT TITLE

Committee Cycle of Business Monitoring and Priorities Report 2025/26

MEETING

Name of meeting	Finance and Performance Committee
Date of meeting	18 November 2025
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	Steve Owen, Corporate Governance Officer

PURPOSE OF REPORT

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

REPORT SUMMARY:

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

1. This report updates the Committee on progress against the priorities it set for 2025/26 and progress against the agreed cycle of business for the Committee. There is one matter in regard to the cycle of business of note to the Committee, indicated in paragraph six below.

2. During the effectiveness reviews, it was agreed that it is good practice for Committees to set priorities for the forthcoming year. The Committee's priorities, which are set out below, were agreed by the Trust Board in May 2025 and will be tracked quarterly.

3. The Committee's cycle of business was approved by the Committee in May 2025. The agenda is set with reference to that cycle, together with the forward planner, action log and highest rated principal risks.

4. The monitoring report is at Annex 1. The 'pre-agenda setting' key indicates that items in green show where they are cycled for a particular meeting. Items in beige indicate they are a prompt at agenda setting as they may be ad hoc items such as business cases or external reports.

5. The 'post-agenda setting' key indicates that items in blue were either on the agenda as scheduled or is an *ad hoc* item which was discussed in agenda setting and scheduled. The orange indicates where an item was programmed for receipt but has been deferred to a future meeting.

6. The Committee is asked to note that the Waste Management Update Report - which was originally scheduled for the September 2025 meeting - has been deferred to the meeting of the committee in January 2026. This position was agreed and reported to the Committee at its meeting in September. Finally, the Committee's priorities and progress against them is as follows:

Priority	Progress
A focus on financial sustainability	• It has been agreed that an update on the Financial Sustainability Programme will be received at every other meeting of the Committee, and as such has been programmed for July 2025, November 2025 and March 2026 (on the Committee Cycle of Business). This item is on the agenda for the November 2025 meeting.

A focus on Clinical Model Transformation performance	• The August 2025 meeting focused on the implementation of Phase 2 of the Ambulance Performance Framework. The committee provided assurance to the board on readiness ahead of the Extraordinary QuEST and board meetings in October. Updates on the progress are included as part of the Integrated Medium Term Plan (IMTP) Progress Report which is received at every meeting of the Committee. An update on Phase 2 go-live will be given at the November 2025 meeting.
A focus on resilience including information security	• The Information Governance (IG) Report received at every meeting highlight ongoing efforts to enhance information governance and data protection within the Trust, addressing both compliance requirements and operational challenges. • As part of the additional funding secured for the Digital Directorate in 2024/25 and 2025/26, a significant recruitment programme is underway to strengthen capacity.
A focus on the progress of the Manchester Arena Inquiry recommendations	• The Committee will continue to receive progress updates against the Manchester Arena Inquiry (MAI) with regards to the recommendations required via the Operations Directorate report received at each meeting. • An update on the progress of recommendations and the case submitted to the Welsh Government is due to be received in the closed session of this meeting. It should also be noted that an update was provided at the meeting in September 2025.

RECOMMENDATION(S)

See writing and presentation guidance here to inform this section
The Committee is requested to NOTE the update.

ADDITIONAL PAPER(S)

Set out here any annexes. See writing and presentation guidance here regarding materiality and use of the Reading Room
The Committee is requested to receive the following: 1. FPC Cycle of Business Monitoring Report – November 2025

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

STRATEGIC OBJECTIVE(S) THIS REPORT SUPPORTS

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

RISK(S) THIS REPORT MITIGATES

Where relevant note the local, directorate, corporate or BAF risk number
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
18 November 2025	Finance and Performance Committee

PAPER	PRE-C'EE FORUM	FREQUENCY	MAY	JUL	SEP	NOV	JAN	MAR	LEAD	PURPOSE	COMMENT/COMPLIANCE
FINANCE AND PERFORMANCE COMMITTEE - CYCLE OF BUSINESS 2025-26											
TERMS OF REFERENCE NOTED IN RED TEXT											
Refreshes of 2030 Delivering Excellence	STB	Ad Hoc							EDSPP	Endorsement	
Refreshes of long term plans	STB	Ad Hoc							EDSPP	Endorsement	
Long term plans organogram	STB	Annually							EDSPP	Assurance	
IMTP for following year	STB/ELT/Board	Annually							EDSPP	Endorsement	Earmarked for potential preliminary discussions n November/January
IMTP Progress Report	STB/Board	Each meeting							EDSPP	Endorsement	
Annual revenue budget	ELT	Annually							EDOF	Endorsement	SFI 4.2.2 - Boards must approve balanced revenue and capital plans before the start of the year
Annual capital budget (closed)	Capital M'ment Board	Annually							EDOF	Endorsement	
Financial report	ELT	Each meeting							EDOF	Assurance	Financial sustainability report may be included in this report or separately throughout the year; year end report May
Year end M12 report (same time as M1 in new year)	ELT	May meeting							EDOF	Assurance	
IMTP financial plan	STB/ELT	Annually							EDOF	Endorsement	
Financial Sustainability Report	TBC	Every other meeting							DPC	Assurance	Agreed at 18.09.23 FPC to include quarterly updates on the Financial Sustainability Programme (FSP) for future meetings.
Business cases over £500K	TBC	As required							EDOF	Endorsement	FPC to consider if individual business cases should return for PIR, and if so at what time.
Reporting to be developed in 2025/26	TBC	TBC							EDSPP	Assurance	Head of Commercial being appointed in 2025. Reporting to be confirmed following appointment.
Value Based Healthcare Report	TBC	Every other meeting	→	→					EDQN	Assurance	May: VBH deferred to future meeting, in line with update from LW, EDON. Note, this item will now be presented at a BDD
Review of Ambulance Service Indicators	**TBC**	**Bi-annually**							EDSPP	Assurance	**Added in 20062025; reporting placement to be agreed.**
Report on commissioning	TBC	TBC	→						EDSPP	Assurance	Scope of this element to be developed - see Note 1
QPMF update report	QPMF Steering Group	Bi-annually							EDSPP	Assurance	QPMF Benefits map went to July meeting
Monthly Integrated Quality Performance report	ELT	Each meeting							EDSPP	Assurance	
MIQPR review of metrics	ELT/Board Committees	Annually							EDSPP	Endorsement	May: review of metrics not taken, discussions held at BDD.
Annual HART KPI report (Open Session)	TBC	Annually							EDO	Assurance	HART Internal Audit Nov 22 recommended annual reporting of HART KPIs which was accepted. See July FPC on HART KPIs
Metrics for digital systems infrastructure	TBC	Three times a year							DD	Assurance	
Commissioning arrangements	ELT	Consider annually							EDSPP	Endorsement	Consider potential annual report to be developed
Demand and capacity reviews	ELT	Ad Hoc							EDSPP	Endorsement	
Estates Condition and Backlog Maintenance Update [EFPMS Data/Report]	TBC	Annually							EDOF	Assurance	This was added in as a future requirement (following initial receipt in September 2024) by CorGov.
Decarbonisation Update	Decarb Programme Board	Every other meeting							EDOF		Progress also against WG action plan and Trust Plan; metrics in development. Annually to include update on waste management.
Waste Management Update	Decarb Programme Board	Annually			→	→			EDOF	Assurance	Annual update aligned with Internal Audit recommendations. First report in September 2023; Deferred from Sept 2025 to Jan 2026.
Sustainability Report	Decarb Programme Board	Annually							EDOF	Assurance/Endorse	No Sustainability Report requiredf or 2024/25 (to be received in 2025/26)
Fire safety annual report	ELT/Board	Annually							EDOF	Assurance	Timing of annual report TBC (annual compliance report was presented in Jan 24). By exception reporting outside cycle.
Fire safety exception report	TBC	Periodically as required							EDOF	Assurance	By exception outside of annual report
WG Annual Emergency Planning Report (Open session)	ELT/Board	Annually							EDO	Assurance	Report provides for compliance with Civil Contingencies Act 2004; exercises carried out; learning from incidents/exercises/debriefs.
Incident Response Plan Report [closed session]	ELT	Annually							EDO	Assurance	Externally reported - See Note 2
Business Continuity Annual Report (Open Session)	ELT	Annually							EDO	Assurance	See Note 2
Cyber Resilience and Cyber Security Reporting	TBC	TBC							DD	Assurance	Reporting developing in 23/24 - start off at 3 times a year reporting; intention to bring to every meeting if possible.
Information Governance Toolkit	IGSC	Annually							DD	Assurance	
Information Governance Report	IGSC	Each meeting							DD	Assurance	
Policies for review and approval	Policy Group	Ad Hoc							BS	Approval	
Board Assurance Framework	Board	Each meeting							BS	Assurance	
Corporate Risk Register	Board	Each meeting							BS	Assurance	
Audit Recommendation Tracker	ADLT	Each meeting							BS	Assurance	
Audits within purview of Committee	Audit Committee	Ad Hoc							Relevant Director	Assurance	
STANDARD ITEMS											
Quarterly operations update	TBC	Each meeting							EDO	Information/Discussion	Only received in quarter, not at every FPC meeting (if it would otherwise be a duplicate from previous meeting)
GOVERNANCE											
Committee effectiveness review and annual report	Audit/Board	Annually							Board Sec.	Approval	
Review of Terms of Reference	Audit/Board	Annually							Board Sec.	Approval	
Committee cycle of business refresh	N/A	Annually							Board Sec.	Approval	
Committee Cycle of Business review	Audit/Board	Each meeting							Board Sec.	Approval	
Committee Review of Annual Priorities	None	Every other meeting							Chair	Review	
SUB-GROUPS											
Where applicable	N/A	Ad Hoc							N/A	N/A	No sub-committees - but may set up task and finish groups from time to time
PROMPTS											
External Reports	N/A	Ad Hoc							TBC	TBC	UEC report presented 21 July 2025

EDOF - Exec Director of Finance and Corporate Resources
EDO - Exec Director of Operations
EDSPP - Exec Director of Strategy, Planning and Performance
DD - Digital Director
BS - Board Secretary
EDQN - Exec Director of Quality and Nursing
DP - Director of People

Key: Pre-agenda setting
Cycled for each meeting
Ad hoc item - prompt for agenda setting
Reporting developing

Key: Post-agenda setting
Presented as cycled
Ah hoc / item considered - not programmed
Item deferred
Reporting developing

1	**Commissioning**	Review of commissioning standards is the commissioning intentions met as part of IMTP. AQIs published monthly to EASC. Key AQIs included in the 28 KPIs.
2	**Emergency Preparedness**	The Trust is classed as a category one responder under the Civil Contingencies Act (2004) and as a result there is a legislative obligation for us to address 6 key responsibilities, which are - Assess local risks and use this to inform emergency planning - Put in place emergency plans - Put in place Business Continuity Management arrangements - Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency - Share information with other local responders to enhance co-ordination - Co-operate with other local responders to enhance co-ordination and efficiency CCA Part one devolved to Wales. WAST is a category 1 responder under the Civil Contingencies Act (2004) and Regulations (2005). Category 1 responders are required to maintain plans for preventing emergencies; reducing, controlling or mitigating the effects of emergencies in both the response and recovery phases, and has a duty to ensure business continuity plans are in place. Trust is working towards ISO22301 accreditation. Internal Audit on Major Incidents - September 2022 AC - raised F&P review of incident response plan when reviewed next. NHS Emergency Planning Annual Report: return that is signed by JK. Comes to FPC for assurance. One element is assurance the board has received the IRP which FPC does on behalf of the board. WG compile into an All Wales return and in September 2024 the first meeting of the Health Executives for EPRR has been called by WG and likely they will be the primary reviewer of these. Incident Response Plan Report: WG report accompanied by assurance that Incident Response Plan (IRP) in place and approved by ELT. SBAR includes detail of staff training in place, compliance levels, and resourcing for assurance; list of plans that underpin IRP are in date and regularly reviewed. IRP provides guidance and support to commanders on a range of incidents. Taken in closed session due to sensitivities. Business Continuity Annual Report: SBAR to include compliance with CCA 2004 if not included in WG annual report and compliance under policy; list of plans that underpin BCP are in date and regularly reviewed; staff training in place, compliance levels and resourcing for assurance if not included in IRP report above; exercises carried our and planned; learning from incidents/exercises/debriefs.